June 25, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1588-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program - Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers

Dear Acting Administrator Tavenner:

On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, the North American Primary Care Research Group, along with the American Academy of Family Physicians (AAFP), we are pleased to submit comments in response to the proposed rule titled Medicare Program - Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers as published in the May 11, 2012 *Federal Register*. Our comments are focused on the sections of the proposed rule regarding graduate medical education (GME).

In summary, our organizations appreciate your proposal. We especially appreciate your efforts to implement new policies consistent with the intent of the *Affordable Care Act* and its focus on promoting the maintenance and expansion of primary care residency positions.

New Teaching Hospitals: Proposed Change in New Program Growth from 3 Years to 5 Years

This proposal would extend the window of time an institution has to establish a full time equivalent (FTE) resident cap for GME payment purposes from 3 to 5 years. The CAFM and the AAFP support this modification and appreciate that CMS responded to the provider community by offering this change.

Clarification regarding 5 year period following implementation of the redistribution of residency slots included in the *Affordable Care Act* (Section 5503)

Statutory language implementing the redistribution of residency slots requires that institutions receiving an increase in their cap on the number of residency positions meet two requirements to retain their new slots. The first is the primary care average, in which "the number of FTE primary care residents is not less than the average number of FTE primary care residents during the 3 most recent cost reporting periods" prior to the addition of the new slots. The second is the 75% threshold, in which not less than 75% of the positions added are in primary care or general surgery. The HHS Secretary establishes the methodology to determine whether a hospital has met both requirements. The consequence of not meeting these requirements is loss of the "new" positions. This proposal reacts to activities by certain institutions that delayed the onset of "filling" the newly redistributed positions, calling it "inappropriate and in direct conflict with a base consideration in the awarding of slots under section 5503 for hospitals to refrain from using their slots until after the initial three years after the slots have been awarded, in an attempt to circumvent the primary care average or the 75% threshold requirements." The proposal modifies the timeframe upon which institutions must fill new positions and meet the primary care/general surgery thresholds.

The CAFM and the AAFP support the proposed changes since they drive earlier implementation of new positions and strengthen requirements that institutions fulfill the obligations of the statute regarding primary care and general surgery positions. We are appreciative that CMS has included these revisions in the proposed rule.

We particularly support the proposed requirement that Medicare contractors would determine whether a hospital filled at least half of its section 5503 slots in any of the first three years' cost reporting periods. If a hospital fails to fulfill this requirement, after audit, contractors will permanently remove all section 5503 slots from any cost report still subject to re-opening. We suggest a further modification of this requirement, based on precedent from a previous final rule published in November, 2010 (CMS-1504-FC and CMS-1498-IFC2)

As part of Criterion number 3 for the application for positions related to a focus in primary care CMS stated in the final rule,

> "We believe that implicit in Evaluation Criterion Three, which is targeted to primary care programs with a "*demonstrated* focus" on residents who pursue careers in primary care is the assumption that applicant hospitals that wish to receive the 3 points under Evaluation Criterion Three must "demonstrate" that residents graduating from their programs actually do practice in primary care, and do not enroll in nonprimary care subspecialty programs or work

> as something other than a primary care practitioner. The commenter's recommendation that applicants include a review of recent graduates of the program, including information regarding what type of practice the graduates are involved in 2 years following graduation from this program, is a reasonable method for documenting that focus. For example, hospitals applying for consideration under Evaluation Criterion Three could provide documentation regarding residents who completed the primary care program in question in June 2008, and in what capacity those graduates have been practicing, at least through June 2010. ….We believe that a threshold of *greater than* 50 % would be acceptable as a basis to demonstrate that a program produces physicians who pursue careers in primary care. We are choosing more than 50 % as the threshold because this is consistent with the Evaluation Criterion added in this final rule for hospitals that request additional slots for an existing program(s) for which the hospital can demonstrate that more than 50 % of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA."

Given that Medicare contractors will be able to identify which positions are filled primary care positions after the third year, we request that CMS utilize the above threshold and require Medicare contractors to identify the number of graduates who remain in primary care practice in the fifth year after medical school (two years after primary care residency completion), and remove slots from institutions that do not graduate over 50% who remain in primary care. This can be accomplished by counting those residents who are not in residency or fellowship training in their fifth year, in relation to those who are continuing training.

Calculating Cap When Residents Rotate during Cap-Building Period
To accompany the extended cap-building window, CMS proposes a new methodology for allocating cap adjustments to new teaching hospitals that rotate residents to other hospitals during the first five training years. This proposal seeks to attribute caps to non-teaching hospitals that accept resident rotations, whether or not those hospitals seek payment for training the residents.

Our concern is that when a teaching hospital rotates residents to a non-teaching hospital, even for a month or two, CMS begins the cap and per-resident amount (PRA) establishment process at that non-teaching hospital. This effectively forces it to become a teaching hospital with an extremely small cap which essentially bars it from ever establishing a viable residency program in the future. In addition, we have heard from the field that that this policy has been adopted with respect to Teaching Health Centers (THC), established in section 5508 of the *Affordable Care Act*. We are especially concerned about this as it would have a profoundly negative effect on the creation of new THCs.

The CAFM and the AAFP oppose this policy, which hinders a community's flexibility to meet its physician workforce needs. If CMS continues to pursue this policy, we ask that CMS implement recommendations proposed by the American Osteopathic Association (AOA), to include the following:

- A teaching hospital should be allowed to rotate residents for a period equal to or less than three months (or a maximum percentage of training time) per resident per year without triggering the calculation of a cap and per resident amount (PRA)
- A new teaching hospital should be allowed to rotate residents in high-need specialties (e.g., primary care, general surgery) without triggering a cap or PRA in a non-teaching hospital.
- Hospitals located in rural areas should be allowed to rotate residents to non-teaching hospitals without triggering caps or PRAs in those institutions

Moreover, we propose the addition of a fourth recommendation should CMS choose to continue its current policy. A time limit should be set on the cap established by the initiation of these positions. If an institution has not had residents rotating through it for a reasonable period of time (perhaps 3 or 5 years), its cap should expire, returning the hospital to a non-teaching hospital classification.

Proposed Policy Change Relating to Treatment of Labor and Delivery Beds in the Calculation of Medicare Disproportionate Share Hospital (DSH) and the Indirect Medical Education (IME) Payment Adjustment

The proposed rule would amend existing regulations to include labor and delivery beds in "available beds" for purposes of calculating the indirect medical education (IME) adjustment. According to CMS, GME payment rules are designed to ensure that Medicare pays its share of physician training costs. Even though, in theory, these beds could be used for Medicare patients, it is difficult to see what relevance labor and delivery beds have for the Medicare patient population. Moreover, the term "beds" generally is interpreted to mean licensed, routine beds. By definition, a patient in an ancillary area such as labor and delivery is not occupying a routine bed.

We oppose the addition of labor and delivery beds to the "available bed" definition for IME purposes. The only result would be to dilute the intern and resident-to-bed ratio, thereby decreasing IME payments.

Conclusion

We thank you for the opportunity to comment on these proposed regulations. We were very involved in the enactment of the legislative language included in the *Affordable Care Act* with respect to these provisions, and are pleased to see CMS implement these sections. We hope you will be amenable to making

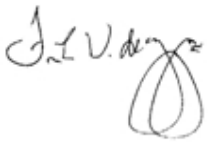
changes to your proposal, in keeping with our recommendations. Should you have any questions regarding this letter, please feel free to contact Hope R. Wittenberg, the CAFM Director of Government Relations, at hwittenberg@stfm.org or 202-986-3309 or Robert Bennett, the AAFP Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Jerry Kruse, MD
President
Society of Teachers of Family Medicine

Glen Stream, MD, MBI
President
American Academy of Family Physicians

Grant Hoekzema, MD
President
Association of Family Medicine Residency Directors



Frank V. deGruy, III, MD, MSFM
President
North American Primary Care Research Group

Tom Campbell, MD
President
Association of Departments of Family Medicine