

March 4, 2021

Acting Administrator Elizabeth Richter
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Acting Administrator Richter:

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, and the North American Primary Care Research Group, as well as the American Academy of Family Physicians we write to outline our recommendations for implementing the three Medicare Graduate Medical Education provisions that were included in the Consolidated Appropriations Act, 2021.¹

The Graduate Medical Education (GME) provisions finalized in the Consolidated Appropriations Act, 2021, will help strengthen the GME program and diversify training options for resident physicians. A recent report projects that the U.S. will face a shortage of between 54,100 and 139,000 physicians by 2033.² Currently, most physicians are trained at large academic medical centers in urban areas. Evidence indicates physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees also leads to physician shortages in medically underserved and rural areas.³ These shortages result in access barriers and disparities in health outcomes for Medicare beneficiaries and other patients living in rural communities.⁴ However, our organizations believe that the implementation of these GME provisions could help to correct the maldistribution of physicians and ultimately improve equitable access to high-quality care. It is with these goals in mind, that we make the following recommendations.

§126, Distribution of Additional Residency Positions

This provision adds 1,000 new residency positions (200 per year for five years) and establishes some parameters or limitations regarding the new positions. We ask the Centers for Medicare and Medicaid Services (CMS) to consider some additional parameters when developing regulations to implement the distribution of these new residency positions.

- **Demonstrated likelihood of filling:** We are concerned that rural training programs are disproportionately disadvantaged by the demonstrated likelihood of filling requirement. Rural training programs have difficulty with consistent filling of residency positions over time, due to

¹ Consolidated Appropriations Act, 2021 (PL 113-260) §126, Distribution of Additional Residency Positions; §127, Promoting Rural Hospital GME Funding Opportunity, and §131 Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations

² <https://www.aamc.org/news-insights/us-physician-shortage-growing#:~:text=Even%20as%20the%20nation's%20health,ands%20139%2C000%20physicians%20by%202033.>

³ Fagan BE, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training - Graham Center Policy One-Pagers - American Family Physician. Washington DC: Robert Graham Center; 2013. <https://www.aafp.org/afp/2013/1115/p704.html>. Accessed February 26, 2021.

⁴ Garcia MC, Rossen LM, Bastia B, et al. Potentially excess deaths from the five leading causes of death in metropolitan and nonmetropolitan counties—United States, 2010–2017. (2019) *MMWR* 68(10): 1–11.

the smaller numbers of applicants and the social and other barriers to student choice of rural residency training. Further, rural training programs are smaller than their urban counterparts, meaning one unfilled residency position represents a greater proportion of the overall positions for rural programs. Given this inequitable impact, as well as the provisions in the statute that are clearly meant to preserve and increase rural training programs, we recommend CMS provide an exception for rural so that meeting the demonstrated likelihood of filling requirement won't be as onerous to rural hospitals.

- **Prohibition on distribution to hospitals without an increase agreement:** The statute requires that an agreement is in place “to increase the total number of full-time equivalent residency positions under the approved medical residency training program of such hospital...” Given that only one, and not multiple programs, is stipulated, we interpret that to mean that the application for positions would stipulate the specific program that would be distributed to. After five years those positions can be aggregated in an affiliation agreement with another hospital. We request that specialty type for which a position is applied for remain in that specialty for at least 10 years, even when the positions are aggregated and moved to other institutions under an affiliation agreement.
- **Additional considerations:** The statute specifies a minimum distribution of 10% of the new positions to be distributed to four categories: rural hospitals, hospitals in underserved areas, over cap hospitals, and those in states with new medical schools or branch campuses. To correct the maldistribution of the health care workforce and increase training opportunities in small and rural communities, we recommend CMS (through the Secretary's discretionary authority) add two other areas for consideration of distribution. Smaller hospitals, especially community-based ones, do not have the financial resources or economies of scale of larger hospitals to increase training positions beyond ones for which Medicare reimburses. We recommend adding the following to the set-aside categories (minimum of 10% slots) to help provide additional equity and fairness:
 - Hospitals participating with only one residency. Just under a third (29.4%) of sponsoring institutions host only one training program.¹
 - Smaller hospitals with less than 250 beds. In the implementation of the Affordable Care Act (ACA) redistribution of residency positions (Section 5503) contained an exception for removing positions from rural hospitals with 250 beds or less. We believe CMS should include a parallel set-aside for all hospitals of 250 beds or less in this case.

§127, Promoting Rural Hospital GME Funding Opportunity

This provision removes the requirement for separate accreditation of rural training tracks. Congressional staff have told us the language is permissive for CMS to address additional issues, such as removing the requirement to utilize the rolling average for rural training tracks.

- **Removal of separate accreditation requirement:** We support the removal of this requirement. It will help all specialties develop rural training tracks, which evidence suggests could improve the pipeline of both primary care and specialty physicians for small and rural communities.² There are some questions raised by how the legislative language is written, that we would like to address.
 - The language included in the Balanced Budget Refinement Act of 1999 is “separately accredited approved medical residency training programs (or rural tracks) in a rural area.” Regulations define a separately accredited rural track as one that includes the >50% requirement.³ We are concerned that removal of the separate accreditation requirement also removes the requirement for greater than 50% time to be spent in rural

¹ Pg 114, Academic Year 2018-2019 ACGME Data Resource Book

² Wheat JR, Leeper JD. Pipeline Programs Can Support Reforms in Medical Education: A Cohort Study of Alabama's Rural Health Leaders Pipeline to Engage Community Leaders. *Journal of Rural Health*. 2020. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12531>

³ §413.79 (k)(1) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows....

areas. Should CMS interpret the legislative language to retain the requirement for greater than 50% time in rural areas, our organizations would support that. If this requirement is removed, CMS should clarify in regulation the following:

- A rural track must be separately defined and identifiable. Residents in the rural track should be identified to CMS in a similar fashion to the way that Teaching Health Centers (THC) report their residents (especially when a program is a mix of traditional Medicare CMS resident positions and THC positions). The separately defined track for a portion of the program's residents should include the entire training duration, with a defined selection of residents, and a defined sequence and content of training that is unique from other residents in the program.
- One year minimum for rural track: A minimum threshold must be identified for a rural training track. If it is too difficult, due to ACGME requirements, for other specialties to meet the greater than 50% rural training requirement for the entire program, we recommend that CMS require a rural track of at least one year, and that at a minimum more than 50% of the time included in the rural track would be spent training in rural locations. For example, if general surgery program established a two-year rural track (within the five-year training program), at least one year of the time in the track must be spent in a rural location. A minimum requirement of at least one year in the rural track would allow for at least six months in rural training locations. Data from a Canadian study regarding rural training of family physicians supports this minimum requirement.⁴
- **Setting a new RTT cap (rural cap limitation) for an urban hospital:** There are several questions regarding the cap-setting related to the new language as well as recommendations we would make. Among them are:
 - We recommend CMS implement the language in the bill (in italics below) to allow the urban hospital to expand a program to a new site (allowing an expansion of the cap): “the Secretary shall, consistent with the principles of subparagraphs (F), (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs with respect to such a program and, in accordance with such rules, *adjust in an appropriate manner the limitation under subparagraph (F) for such hospital and each such hospital located in a rural area that participates in such a training.*
 - We recommend that CMS develop regulations to uncap RTTs, allowing established RTTs to grow, and/or urban hospitals with established RTTs to participate in new RTTs involving other rural communities/sites. If CMS determines that the definition of “new” program would need to be changed to accommodate the expansion of a program to more than one rural location/site we recommend the following language: Revise §413.79 (e) or include this as an exception under §413.79 (k)(1): For cost reports beginning on or after October 1, 2020, non-rural hospitals operating training programs in rural areas establishing rural training at an additional site, the new site can be considered to be establishing a new approved training program if the rural site has separately recruited new residents and some new teaching staff, but does not need a separate program director.
- **Setting a new RTT cap on a rural hospital:** Rural Inpatient Prospective Patient System (IPPS) hospitals must claim time that RTT residents spend in the rural hospital or its provider-based clinics. If the RTT is not a “new program” under the current regulatory definition (separate program director, separate faculty, separately recruited residents) then those rural hospital GME claims will not be paid. The urban IPPS hospital can't claim time residents spend in Rural IPPS hospitals or their provider-based clinics. To provide clarity for residency programs, we recommend the following.
 - Apply slightly revised definition above to the rural hospital, not just the urban hospital -- To redefine new program revise §413.79 (e) or include this as an exception under §413.79 (k)(1): For cost reports beginning on or after October 1, 2020, non-rural hospitals operating training programs in rural areas establishing rural training at an additional site, the new rural site (including rural hospitals) can be considered to be

⁴ <https://www.cfp.ca/content/cfp/52/2/210.full.pdf>

establishing a new approved training program if the rural site has new residents and some new teaching staff, but does not need a separate program director.

§131 Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations

This section, also known as the “Rotator” provision, allows hospitals caught with extremely low caps and/or PRAs due to brief rotations of residents training in what otherwise would not be a teaching hospital to reset, on a one-time basis, their cap and/or PRA, if they begin the process within 5 years.

- The eligibility parameters for the cap as written in the statute are a cap set in 1996 of less than 1.0 FTE and between 1996 and date of enactment no more than 3.0 FTEs. CMS should identify which hospitals meet those parameters based on what was in effect at the time the cap was set (not on what may have happened to program growth since then).
- CMS should ensure that the concept of “Community support and redistribution of costs” not be applied under this provision. This principle, where Medicare will not reimburse for situations after another entity has paid for resident training, is not appropriate because it was statutory and regulatory actions that prevented hospitals from appropriate reimbursement for residency positions from Medicare.
- We recommend CMS develop a public list of all eligible hospitals under this provision. This is needed as many hospitals are unaware of their status as teaching hospitals since they never ran a program or charged Medicare for resident training. Given that the window to re-set the cap and/or PRA is only five years and the hospitals need to go through an accreditation process that often takes 2-3 years, it would be helpful for CMS to identify the eligible hospitals. This is particularly important for those hospitals which may have had a cap or PRA set since 1997.

As your staff develops the proposed rulemaking for the implementation of these provisions, we hope the input we provide here will be useful. Please contact Hope Wittenberg, CAFM Director, Government Relations, at 202-986-3309 or hwittenberg@stfm.org with any questions or concerns, or Meredith Yinger, AAFP Senior Regulatory Strategist at 202-235-5126 or myinger@aafp.org.

Sincerely,



Tricia C. Elliott, MD
President
Society of Teachers of
Family Medicine



Steven R. Brown, MD
President
Association of Family
Medicine Residency Directors



Chelley Alexander, MD
President
Association of Departments
of Family Medicine



Gillian Bartlett, PhD
President
North American Primary Care
Research Group



Ada D. Stewart, MD, FAAFP
President
American Academy of Family Physicians