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June 7, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1785P; Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

Dear Administrator Brooks-LaSure:

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 (AAFP) we write to provide comments on the FY 2024 Medicare Inpatient Prospective Payment System proposed rule.

Training in New Rural Emergency Hospital Facility Type

Congress created Rural Emergency Hospitals (REHs) as a new Medicare provider type and CMS finalized regulations defining and setting requirements for REHs to begin operations effective January 1, 2023. In this proposed rule, CMS proposes regulations to designate REHs as graduate medical education (GME) eligible facilities similar to the GME designation for critical access hospitals (CAHs).

Specifically, CMS proposes that effective for portions of cost reporting periods beginning on or after October 1, 2023, an REH may decide to be a nonprovider site such that if other regulatory requirements are met, a hospital can include the FTE residents training at the REH in its direct GME and indirect medical education (IME) FTE counts for Medicare payment purposes, or, the REH may decide to incur direct GME costs and be paid based on reasonable costs for those training costs.

Family physicians are an essential source of emergency care in rural areas and are uniquely suited to work in REHs. Multiple studies have demonstrated that, while many family physicians provide emergency care in urban and suburban communities, rural family physicians are more likely to work in emergency departments. A 2019 study found that more than 15 percent of family physicians in small rural areas and more than 10 percent in frontier areas practice primarily in emergency department settings.[1] About 13 percent of family physicians in small rural areas and 29 percent of family physicians in frontier areas provide emergency department coverage in addition to their primary ambulatory practice.[2] An analysis of 2017 Medicare claims data found that 7.9 percent of rural family physicians, which is equal to 635 physicians, practice solely in an emergency department,

with another 879 rural family physicians (or 45.6 percent of rural family physicians) practicing in emergency departments in addition to other settings.[3] These data confirm that a significant and increasing number of family physicians practice emergency medicine in rural areas.

Emergency medicine is an integral part of family medicine training. The Accreditation Council for Graduate Medical Education (ACGME) requirements for family medicine residents include several proficiencies important for providing emergency care.[4] In addition to emergency services, REHs can offer other outpatient services like pregnancy and delivery care, behavioral health services, and primary care, all of which are within family physicians' scope of training. Our organizations therefore believe that REHs would be a valuable training site for family medicine residents.

Our organizations support designating REHs as GME training facilities and aligning the REH GME policies with those established for CAHs. We expect this will enable REHs to serve as rotator sites for Rural Track Programs (RTPs), which would enhance resident physician training in rural areas and potentially improve timely access to care in areas with an REH. However, we request CMS clarify in the final rule that REHs will be able to serve as rotator sites in RTPs.

Additionally, for REHs that elect to incur direct GME costs and be paid based on reasonable cost, **we urge CMS to provide REHs with 101 percent of the reasonable costs for those training costs, as the agency does with CAHs**.[5] The REH provider type was created with the express goal of enabling CAHs to transition into REHs in order to keep their doors open amid financial challenges. We do not believe REHs should be penalized in their GME payments when transitioning from a CAH to an REH. CMS should modify this in the final rule.

Calculation of Prior Year IME Resident to Bed Ratio When There is a Medicare GME Affiliation Agreement

We submit the following comments related to CMS's determination of prior year IME resident to bed ratio when there is a Medicare GME affiliation agreement between rural and urban hospitals. As we stated last year during the comment period for the FY 2023 Medicare Inpatient Prospective Payment System proposed rule, **our organizations do not support the use of affiliation agreements to resolve concerns over the current method for determining caps for rural track programs.**

CMS's current process for distributing caps between rural and urban hospitals is inequitable, in most cases it would provide the urban hospital more slots than it needs for the residents training in a rural track and provides the rural site less FTEs than it would typically need. Our concern is that this problem -- the inequitable distribution of FTE caps between rural and urban hospitals training residents jointly through a rural track program – is not solved by CMS's proposal and, in fact, the proposal establishes additional barriers to many programs.

While we recognize CMS expanded regulations in the FY 2023 IPPS/ LTCH PPS final rule (87 FR 49075) regarding Medicare GME affiliation agreements', to permit urban and rural hospitals that participate in the same separately accredited family medicine Rural Track Program (RTP) and have rural track FTE limitations to enter into ''Rural Track Medicare GME Affiliation Agreements', **our organizations believe this solution is too narrow, as it applies to accredited training tracks established prior to the Consolidated Appropriations Act, 2021 (CAA).**

We applaud CMS's effort to aggregate GME caps. However, the decision to continue the use of GME affiliation agreements ultimately remains urban-centric and significantly disadvantages rural hospitals, as it does not address the inherent power differential between the two hospitals. Furthermore, by establishing an additional annual process that requires negotiation and attestations, etc., it is much more cumbersome, if not impossible for hospitals to come to an agreement that will address the existing inequities.

Unfortunately, CMS's use of such agreements impedes the ability to adequately support and address existing workforce issues impacting communities across this nation. For these reasons, our organizations vehemently oppose the use of affiliation agreements for this purpose. **We again urge CMS to set the caps associated with these training programs and provide special consideration to the rural hospital by counting the highest year, rather than all five years when setting the cap**.

Thank you for your consideration of our comments. We look forward to a continued partnership with CMS to address the primary care physician shortage and strengthen the Medicare GME program. Should you have any questions, please contact Meredith Yinger, the AAFP's Senior Manager of Federal Policy at myinger@aafp.org and Nina DeJonghe, CAFM Director, Government Relations at ndejonghe@stfm.org.

Sincerely,

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[1] Peterson LE, Puffer JC, Nasim U, Petterson S, Newton WP. Family Physicians' Contributions to Rural Emergency Care and Urban Urgent Care. J Am Board Fam Med. 2019 May-Jun;32(3):295-296. doi: 10.3122/jabfm.2019.03.180338.
[2] Ibid.
[3] Byun H and Westfall JM. Family Medicine and Emergency Redeployment: Unrealized Potential. Fam Med. 2022 Jan;54(1):44-46. doi: 10.22454/FamMed.2022.404532. Available at: https://journals.stfm.org/media/4550/byun-2020-0542.pdf
[4]ACGME Program Requirements for Graduate Medical Education in Family Medicine. 2022. Available at: https://www.acgme.org/globalassets/pfassets/programrequirements/120_familymedicine_2022.pdf
[5] Centers for Medicare and Medicaid Services. Medicare Learning Network: Information for Critical Access Hospitals. April 2023. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf