



June 19, 2019

Administrator Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1716-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the 2020 Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule as published by the Centers for Medicare & Medicaid Services (CMS) in the May 3, 2019, *Federal Register*.

**The AAFP applauds and strongly supports the section of the proposed rule regarding Graduate Medical Education (GME) related to Critical Access Hospitals (CAHs).** We are delighted to see that CMS proposes to define the term “non-provider” to include CAHs for the purposes of Section 5504 and urge CMS to finalize the proposal. Doing so helps address Medicare reimbursement for residents’ training time spent at CAHs, and we believe the proposed change will help better meet the healthcare needs provided in CAHs in rural America.

This appropriate proposal removes an unnecessary barrier and, if finalized, would help increase the production of family physicians and primary care physicians, particularly in underserved rural areas. The AAFP appreciates this step and requests the agency consider additional actions. We urge CMS to further refine the proposal:

- **CMS Should Remedy the Harm Caused by Previous Definition:** CMS proposes the change would be effective for cost reporting periods beginning October 1, 2019. **The AAFP urges CMS reconsider this proposed effective date.** First, those IPPS hospitals partnering with CAHs in rural residency programs which completed their cap-building period during the six intervening years since implementation of the 2014 IPPS final rule. These institutions are permanently and continually harmed by an effective date of October 1, 2019. Second, some hospitals have been harmed by CMS’ previous position since they could not claim FTE’s for reimbursement (under the IPPS system) and for which no claims have been made by the CAH for direct educational costs. For these reasons, we urge CMS to make the effective date fiscal year 2014, especially since the proposed rule discusses how the agency has “reassessed and agree with prior comments we have received...” and that it is “important to support residency training in rural and underserved areas, including residency training at CAHs.”
- **Hospitals in Cap-building Period During Between FY2013 and October 1, 2019:** The AAFP suggests that for IPPS hospitals partnering with CAHs in rural residency program

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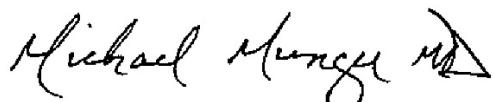
implementation which are still within the 3 year “re-opening window” for cost reports, and for which a cap was set due to the end of the five year cap-building period, that **CMS allow the recalculation of such hospital’s cap to include time spent by residents in CAHs**. Doing so would not require any changes or resubmission of cost reports, but would allow the Medicare Administrative Contractors to recalculate the cap to include time spent by residents in CAHs and help remedy harm caused by previous CMS policy.

- No Claims for Training Time (FTEs) or Direct Educational Expenses Between FY2013 and October 1, 2019: Since there are resident rotations at CAHs in the intervening time between October 1, 2013 and the present for which no IPPS hospital has claimed FTEs and for which no claims have been made by the CAH for direct educational costs, there are clear barriers to receiving payments based on incurred training costs. If a CAH does not have the resources, financial or otherwise, to develop this payment mechanism, this new interpretation has the power to disrupt existing training relationships and discourage training in rural areas. Since the 2014 final rule determined that IPPS hospitals could not claim time, and many CAHs were unable to claim allowable direct expenses related to residency training, additional resident training time and costs was not reimbursed. The AAFP urges CMS to allow an IPPS hospital to claim CAH rotation time for unsettled cost reports (in the 2013-2019 window) should they wish and if the CAH agrees. This would be with the understanding that the CAH where the resident was training may also have its cost report(s) opened for the affected year(s), but solely for the purpose of assuring that the CAH did not claim allowable resident direct costs for these resident rotations.

The AAFP appreciates the proposed changes and urges CMS to provide additional consideration for underserved rural areas. Doing so will greatly enhance institutions’ ability to produce physicians who will practice in rural areas and serve underserved rural populations.

We appreciate the opportunity to comment on this proposed rule. Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 [rbennett@aafp.org](mailto:rbennett@aafp.org) with any questions or concerns.

Sincerely,



Michael L. Munger, MD, FAAFP  
Board Chair

### About Family Medicine

Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. Family medicine’s cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient’s integrated care team. More Americans depend on family physicians than on any other medical specialty.