Advocating for Family Medicine

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June 16, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1655–P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Graduate Medical Education provisions within CMS–1655–P

Dear Acting Administrator Slavitt:

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 published in the April 27, 2016 *Federal Register*, titled "Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System (LTCH PPS) and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports."

Our comments focus on the sections of the proposed rule regarding Graduate Medical Education (GME) and originate from our experience, as well as data, indicating that the primary health needs of rural America are not being met. Of particular note, the production of primary care physicians, especially family physicians, is a key area where we believe the Centers for Medicare & Medicaid Services (CMS) can and should do more to remove barriers to increased production. We hope CMS will provide special consideration for underserved rural areas under statutory authority given to CMS for that specific purpose, and will revise this proposal and construct regulations that enhance institutions' ability to produce physicians who will practice in rural areas and serve underserved rural populations.

1. CMS Correctly Proposes to Apply a Five-Year Growth Window to Rural Training Track (RTT) Programs

Changes made in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50111) modified the time-period for growth of residency programs to the establishment of an institution's Full Time Equivalent (FTE) cap from three to five years, to allow sufficient time for its programs to grow to completion. The FTE cap for new residency programs in rural hospitals applies to the cost reporting period that coincides with or follows the start of the sixth program year of each new program started for rural hospitals. The same FTE limitation applies to cap-setting in new urban teaching hospitals.

In this 2017 IPPS/LTCH PPS proposed rule CMS states that when the agency implemented those changes, the regulators inadvertently neglected to change the growth window and effective date of

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