

June 26, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1607–P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Graduate Medical Education provisions within CMS–1607–P

Dear 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](#), published in the May 15, 2014 *Federal Register*, titled “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program; Proposed Rule.” Our comments focus on the sections of the proposed rule regarding graduate medical education (GME).

Our comments below originate from a strong belief 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 CMS can and should do more to remove barriers to increased production. We hope CMS will take to heart its authority to provide special consideration for underserved rural areas 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.

Proposed Indirect Medical Education (IME) Medicare Part C Add-On Payments to Sole Community Hospitals (SCHs)

Effective for discharges on or after October 1, 2014, CMS proposes to provide all teaching hospital SCHs an IME add-on payment for discharges of Medicare Part C (Medicare Advantage) patients, regardless of whether the SCH is paid under the federal or hospital-specific rate. To do that, CMS would remove the Part C related add-on payment from the federal rate, then calculate which of the federal or hospital-specific payment rates is higher, and then add the Part C IME adjustment factor (which will be multiplied by the federal rate payment amount to determine the add-on payment amount) to Part C patient discharges, no matter which rate is used. We support the inclusion of an add-on to account for Part C patient discharges.

The Part A IME add-on payment would be removed from its current position in the formula prior to the comparison of rates and added post-comparison. We are concerned that by removing the Part A add-on payment prior to calculating whether the federal or hospital-specific rate is higher, the hospital’s eligibility for Disproportionate share hospital (DSH) payments might be compromised. We recommend keeping the Part A add-on in its current place in the formula, and then adding the Part C add-on after the calculations have been made.



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Proposed Changes in the Effective Date of the FTE Resident Cap, 3-year Rolling Average, and Intern and Resident-to-Bed (IRB) Ratio Cap for New Programs in Teaching Hospitals.

Currently the time lines for reporting and counting new residents for establishment of a new residency cap for a new teaching hospital vary from the time lines for both the 3-year rolling average and the IRB ratio cap. According to CMS, this has caused difficulty for hospitals and Medicare contractors with respect to accurate completion of cost reports. CMS proposes to “simplify and streamline” the timing of when full time equivalent (FTE) residents in new medical residency programs are subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap. This would affect both urban teaching hospitals that have not yet had caps established and for rural teaching hospitals that may or may not have a cap established. Rural hospitals are allowed to adjust their cap with the inclusion of additional new residency programs after the initial cap is set, unlike urban hospitals.

CMS would retain its current process for calculating new FTE resident caps, but would change the timing of when they would be effective. CMS states its purpose is to synchronize the effective dates of the cap with the application of the other two provisions with each applicable hospital's fiscal year begin date. Currently, the new FTE caps are applied at the beginning of the sixth program year of the first new program start (July 1). This proposal would change that applicable date from the beginning of the sixth year to match the hospital's cost reporting period that *precedes* the start of the sixth program year of the first new program started. The same applicable date would apply to the rolling average and the IRB ratio cap calculations. The worksheets that a hospital completes will change to accommodate this requirement. Although the time allowed for new programs to be exempt from the cap will be reduced, from the beginning of the sixth year to the beginning of the previous cost reporting period, the calculation for the cap would still be based on the number of resident FTEs in the fifth year of the first new program's existence. This method provides the full five years to build a resident complement that establishes the correct number of resident FTEs to establish the cap. CMS considers this to be harmless in terms of effect on hospital reimbursement. For rural hospitals the same changes would apply for *each* new program started.

We are concerned that programs which rotate residents through more than one hospital would lose the opportunity of including residents throughout the fifth year. Although CMS states the cap-setting would be the same, the imposition of the cap occurs a year earlier and may have an impact on gaining reimbursement in the fifth year of residents rotating through the hospital. Moving the timing up, as this proposal does, creates one more disincentive for hospitals that are concerned about affiliating with or starting a new program. We understand CMS' reasoning behind synchronizing the effective dates of the cap, the IRB ratio and the 3 year rolling averages. However we recommend that CMS impose the cap established in the program's fifth year for the cost reporting period which follows, rather than precedes, the start of the sixth program year.

New Program FTE Resident Cap Adjustment for Rural Hospitals Redesignated as Urban Due to changes resulting from Office of Management and Budget labor market determinations (OMB Bulletin No. 13-01), some rural teaching hospitals are now designated as urban. This proposal would allow those hospitals that began training residents in new programs prior to the shift in designation to continue with the expansion of the resident FTE cap for those programs. However, if a new program had not yet begun training residents prior to the change in hospital designation from rural to urban, the cap cannot be expanded to accommodate the new program.

We appreciate the distinction CMS makes between programs that are already training residents and those that have not yet begun to do so, as well as the proposed ability of new programs to complete their growth to a full cap setting. However, we hope CMS will go further with this proposal. There are years of planning that go into the start of a newly accredited family medicine residency training program, and substantial costs associated with it. Initial costs incurred prior to submission of application include operational ones, such as faculty, support staff, consultative, practice initiation, as

well as capital costs such as Family Medicine Center purchase, construction or renovation¹. In order to begin training residents the residency program must receive an initial letter of accreditation. Depending on the timing of that letter, the program may need to wait up to a year before it can participate in the Match and recruit residents to begin the following July 1. Given the tremendous upfront costs associated with the establishment of a new program, and the potential lag time before a program might begin training its residents, we request that CMS amend its proposal to allow new programs in rural hospitals that have been re-designated urban to continue to complete their growth and cap-setting if they received their initial letter of accreditation prior to the re-designation as an urban hospital.

Participation of Re-designated Hospital in Rural Training Track

Rural training tracks in this proposal will be treated differently from full rural hospital programs. According to this proposal, if an urban hospital began running a rural training track at a rural hospital prior to the re-designation of that rural hospital to urban, the three year period to establish an FTE limit can continue, but the cap limitation on the original urban hospital can only be used for counting residents training at that newly designated urban site for two years. After two years, the original urban hospital can claim FTEs for those slots only if it meets one of the following criteria: the re-designated urban hospital reclassifies itself as rural, or the original urban hospital moves the training site to a geographically-designated rural area. In other words, the original urban hospital has two years to either get the newly designated urban hospital to reclassify itself, or set up a new training site in a rural area.

This proposal has several ramifications that are problematic. The first is concern is that the newly-designated urban hospital may not wish to reclassify as rural for several reasons. One reason is the disparity in payment rates associated with rural vs. urban; another is the fact that they would not receive Direct Graduate Medical Education payments for the residents – a severe financial limitation. Should the original track training site not wish to reclassify, the original urban hospital is caught in a Catch-22 position. If it wishes to establish training in another rural area, there is currently no recourse that allows that original urban hospital to grow its cap. This conundrum is due to CMS's own regulations² (and clarifying interpretation expressed in 2009), which limit what constitutes a new program. Since the program would typically have the same program director and staff, and the original hospital remains the same, CMS would not classify it as a new program – thereby excluding it from the ability to grow slots in a rural hospital. We believe it is totally within CMS' purview to fix this problem. In our response to a proposed rule in 2009, we felt that CMS' reasoning regarding its definition of "new program" was faulty. See below for the arguments we made then. Should CMS not agree with this argument as a whole, the agency can still change its definition of "new" under the authority the statute gives the Secretary to "give special consideration to facilities that meet the needs of underserved rural areas."

An additional concern is that two years is too short a time period for the development of a new training site. Typically it takes three years for financial and operational planning, including hiring faculty and staff, creating on-call facilities, establishing educational activities such as grand rounds, accreditation, and recruitment of a different cohort of residents for a new site. In concert with the development of the aforementioned infrastructure, the program would need to seek approval from the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for moving its training site.

We are concerned that CMS, in its rulemaking, has not given the issue of production of rural physicians enough consideration. A recent study by Candice Chen, MD, et al, in *Academic*

¹ Pauwels, Judith; Hoff, David; Mils, Walter. New and Developing Residency Program Development. Presentation at: PDW and RPS Residency Education Symposium; March 2014; Kansas City, Missouri.

² Direct GME payments: Determination of the weighted number of FTE residents. Title 42 *Code of Federal Regulations*, 42 CFR 413.79. 2011.

*Medicine*³ reports that only 4.8% of all graduates of 759 sponsoring institutions practiced in rural areas and 198 of those 759 institutions produced no rural physicians. This percentage compares extremely unfavorably to the 19.3% of the population classified as rural by the 2010 census⁴. We expect that these institutions which have now been reclassified as urban will still have a focus of producing physicians to practice in rural areas, and hope that CMS will recognize that what they produce is a more important consideration than where they are located, by making changes to the definition of “new” programs to give special consideration for rural areas.

The section below is from our comments to May 22, 2009 Federal Register Proposed Rule, “Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates,” “Clarification of Definition of New Medical Residency Training Program.”

Technical issues in CMS’s explanation of its mandate to make this change –

The proposal cites that “the statute clearly requires [emphasis added] that our rules regarding adjustments to the hospitals FTE caps for newly established programs must adhere to the principles of the statutory provision limiting the count of FTE residents for direct GME and IME payments to the count for the most recent cost reporting period ending on or before December 31, 1996”

Actually, the statute says: `(i) NEW FACILITIES- The Secretary shall, **consistent with the principles** [emphasis added] of subparagraphs (F)⁵ and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

The Secretary did not include any regulatory authority that gives special consideration to underserved rural areas –even though they had a mandate to do so. It seems disingenuous to strongly assert one provision of law while not following other statutory requirements.

Fundamentally, we believe that the statutory authority regarding new facilities and programs established after 1995 should take precedence over the institutional cap, as the limitation language in statute states that the number “**may not exceed** [emphasis added] the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.” However, if CMS's main problem with programs leaving one hospital and going to another is the aggregate cap, there are other solutions than the one proposed. One would be for CMS to promulgate rules so that if a hospital closes a program it loses those positions⁶. The positions then, while in effect lost to the system, may be added back into the system by a program opening in a new hospital, thereby keeping the aggregate number relatively stable.

³ Candice Chen, MD, et al. Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions. *Academic Medicine*, Vol.88, No. 9. September 2013.

⁴ United States Census Bureau. FAQ: How many people reside in urban or rural areas for the 2010 Census? What percentage of the U.S. population is urban or rural? Available at: <https://ask.census.gov/faq.php?id=5000&faqId=5971>

⁵ `(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE- Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

⁶ These comments were written in 2009; in 2010, the ACA amended the statute to capture the slots from closed hospitals for redistribution.

The proposal also cites BBA Conference Report language that “indicates concern that the aggregate number of FTE residents should not increase over current levels.” We find it interesting that there is other conference report language (which occurs in at least three separate places in the GME section of the Conference Report to the BBA), that the Secretary, in establishing rules to implement the statute is required to “give special consideration to facilities that meet the needs of underserved rural areas.” While not fully applicable to this point specifically, clearly CMS hasn’t responded or followed all the Conference Report language, so it’s hard to accept the agency’s strong use of certain report language, while ignoring other report language. Conference report language is normally acted upon when there is a lack of clarity or a discrepancy in the bill language – to help give agencies guidance on how to proceed.

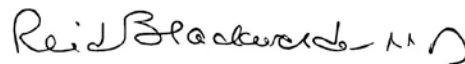
Conclusion

We ask that CMS revise its regulations with respect the establishment of “new programs” to allow the increase in slots for rural training tracks that need to move their sites of training. We appreciate the opportunity to comment on this proposal. We hope CMS will take to heart its authority to provide special consideration for underserved rural areas and will construct regulations that enhance institutions’ ability to produce physicians who will practice in rural areas and serve underserved rural populations. Should you have any questions regarding this letter, please feel free to contact Hope R. Wittenberg, CAFM Director of Government Relations, at hwittenberg@stfm.org or 202-986-3309, or Robert Bennett, AAFP Federal Regulatory Manager, at rbennett@aafp.org or 202-232-9033.

Sincerely,



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