Advocating for Family Medicine

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August 31, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1504-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1504-P

Dear Dr. Berwick:

On behalf of the Council of Academic Family Medicine, 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, we are pleased to submit comments in response to the proposed rule: *"Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations."* Our comments are focused on the section of the proposed rule that implements changes to regulations regarding graduate medical education costs.

Due to the considerable size of the proposed rule, we are commenting on issues in the order in which they are presented in the proposed rule, not necessarily in order of their importance to us. In the main, we are pleased that CMS has done such a proficient job at implementing the Affordable Care Act (ACA) statute. There are some areas that we believe need more clarity, and a few sections that we would like to see CMS take a more active role in promoting primary care training, but in general, we feel the proposed rule has implemented the statute in a fair and commendable manner. We believe our comments below, should CMS choose to adopt them, would enhance the regulations and provide a positive result.

Counting Resident Time in Nonprovider Settings (Section 5504)
While much of this section is clear and forthright, we believe there needs to be some additional clarity regarding the situation where a hospital does not submit a written agreement, but rather pays the nonhospital site concurrently. The proposed regulation states that even without a written agreement with the non-hospital site, the hospital must still agree in writing to the proportion of the costs and training time they plan to incur and count, in addition to the basis for that proportion. What is not clear is to whom or what the hospital must submit in writing this information. Is it to the non-hospital site? If so, how does this differ from a written agreement? Is it part of the submission of cost report data? We request that CMS clarify the manner in which this information is to be written down and shared.

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Proposed Changes to Regulations Regarding Recordkeeping and Comparison to a Base Year (Section 5504(a) of ACA)
We are very pleased that CMS has included this section, as proposed. An analysis of changes to training in non-hospital settings was requested as part of the Balanced Budget Act of 1997 (BBA)[1], but CMS never implemented it. It is especially important to be counted as CMS has proposed – prior to the application of resident limits. Family medicine has a history of training outside the hospital, and many of our training FTEs were not counted as part of the resident limits because they were already training outside the hospital in 1996.

Distinguishing Between Allowed Nonpatient Care Activities and Nonallowable Research Time (Section 5505)
Research time that is not associated with the treatment or diagnosis of a particular patient is specifically excluded from the list of allowable nonpatient care activities in the ACA. The current proposal just describes such research as "usually comprises activities that are focused on developing new medical treatments, evaluating medical treatments for efficacy or safety, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future." We believe that the definition needs to be refined and clarified.

Family medicine supports more consistency in the training of graduates. Such training should be predicated on competency-based curricula as well as a core set of skills, processes and knowledge. Training should: 1) be consistent with community needs, 2) support innovation to encourage enhanced quality and efficiency, 3) provide graduates with the ability to build and manage clinical practices – including ones delivering care in new models such as the patient-centered medical home, and 4) be able to adjust to meet current and future patient needs and medical knowledge. The line between didactic training in the above areas and research such as defined above is not bright. Acknowledging the restrictions in law, we hope CMS can be clearer in the final regulation about what may be considered allowable as didactic vs. not allowable as research.

It may be helpful for CMS to give examples of cases or situations that can be included as didactic, rather than research. For example, would participation in an IHI improvement that will have direct impact on patient care be considered included? Would case driven scholarly activities such as writing up specific patient cases for presentation or publication be included? Would disease-related review articles inspired by patient cases be included? We would like to ensure that activities whose purpose is to develop critical thinkers about patient care and quality improvement, or critical consumers of evidence – not researchers – be excluded from the definition of research. We believe that the definition of research should be narrowly defined for exclusion of time counted for GME purposes.

Redistribution of Resident Positions – Reductions and Increases to Resident Caps (Section 5503)

Demonstrated Likelihood of Filling – Criterion 1
We support the language included in this section that describes the assessment of level of likelihood of filling. We note that the use of the term "fill" rate is the appropriate term to use. We recommend the use of "fill" rate as the July 1 census of individuals training in a specific program, or nationally, by specialty, for each year.

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[1] Report to Accompany the Balanced Budget Act of 1997 – Congressional Record, July 29, 1997, pg H6238, middle column.

However, there is one portion of the definition that we believe is inappropriate for family medicine, and is perhaps unique to family medicine accreditation. The proposed rule defines fill rate as "the number of residents in a program nationally as compared to the number of accredited slots in that program as of June 30 of that year." Family medicine accreditation process allows for leeway in the number of residents allowed to be trained. In other words, between one accreditation approval process and the next, a program may increase its complement of residents by a limited, yet unstated, number so long as during its next accreditation review/approval cycle it shows that it has an adequate number of faculty, training space and training experiences to accommodate that increase. As such, a specific number would not be stated. We believe CMS needs to include an exception for family medicine in this requirement of the regulation to account for the unique nature of family medicine accreditation.

Demonstrated Likelihood of Filling – Criterion 2
This is another instance, as explained above, where an exception for family medicine is required. Under Section A of this Criterion, the "proof" of expanded need will not work for family medicine programs. The first bullet requires the accrediting body to approve the hospital's expansion of the number of FTE residents in the program – which is not required by the Review Committee of Family Medicine (RC). The second bullet refers to AOA accredited programs, and the third again refers to a hospital submitting paperwork to the RC which includes information about numbers to be increased. We request that CMS include an option with which family medicine would be able to comply to meet this criterion.

Demonstrated Likelihood of Filling – Criterion 3
Similar to the above two criteria, bullet number three of this criterion asks for "copies of most recent accreditation letters on all the hospital's training programs" which will not give the appropriate information for family medicine. In addition, even more importantly for this criterion, CMS seems to have switched from using fill rate data to Match data. The second requirement calls for "copies of the 2010 residency match information concerning the number of residents at the hospital in all its programs." We urge CMS to use fill rate data, and call for "copies of the 2010 residency fill rate, as determined on July 1, 2010, concerning the number of residents at the hospital in all its programs." instead of Match rate data. Match data is incomplete and inaccurate as an aid to determining a resident census.

CMS Evaluation of Application for Increases in FTE Resident Caps – Evaluation Criteria
We applaud the use of evaluation criteria to help rank applicants within categories for increases to their caps. We believe CMS has made a good start at supporting Congress's intent to increase primary care (and general surgery) production, but we recommend a bolder – and more effective – approach. First, evaluation criterion number 3, recommends that a "hospital applicant will use additional slots to establish or expand a primary care program with demonstrated focus on training residents to pursue primary care careers rather than nonprimary subspecialties." The intent behind this is excellent, but it has no teeth.

For programs such as internal medicine ones, with a primary care track, the more important criterion is what the output of primary care physicians has been in recent years, and whether the new slots would, in fact, be used for the primary care track positions. We recommend that CMS require the applicant to include a review of recent graduates of the program regarding what type of practice the graduates are involved in two years following graduation from this program (five years out from medical school.) If CMS would have the institution produce a three year average of its recent graduates (years 2005-2008), it could be used to identify programs that are truly producing large numbers of primary care physicians. If CMS would set a threshold of 50%, to attain these points, it would capture programs that are producing more primary care – than not.

In addition, the language in this section (evaluation criteria number 3) is unclear as to whether family medicine programs would be included in this criterion – not just programs in internal medicine or pediatrics with primary care tracks. We believe it should be clarified that they are included; otherwise, family medicine would be at a distinct disadvantage in relation to other primary care training programs in terms of ability to garner additional points for their applications. We recommend the number of points should be raised to at least 5 for this criterion.

In addition, we recommend that if a program wishes to expand its number of family medicine residents, or establish a new program in family medicine, it should get at least an additional point, as, unlike other primary care programs, the vast majority of family medicine graduates will be serving as primary care physicians upon graduation into practice. According to the Council on Graduate Medical Education (COGME, 20th draft report), "currently 95% of the physicians who complete family medicine residencies will likely practice comprehensive, longitudinal care, 46% of residents completing pediatric residencies will likely practice general pediatrics (Freed 2009), and 10 to 20% of residents who graduate from internal medicine residencies will likely practice general internal medicine with a comprehensive longitudinal outpatient practice (Alliance for Academic Internal Medicine 2009; Garibaldi 2005). "

Criterion number 4, "hospitals will use all the additional slots to establish or expand a primary care or general surgery program," has some of the same limitations. We recommend CMS require documentation of historical output (for those wishing to expand current programs) and documentation that the curricula of the programs are for production of primary care and general surgery physicians, for those wishing to use the slots for the establishment of new programs. Again, we recommend additional points for family medicine training programs, as they are much more likely to produce larger numbers of primary care physicians.

Requirements for Hospitals That Receive Additional Slots under Section 5503
This section requires hospitals to maintain its current number of primary care residents for at least five years after receiving new positions, and not less than 75% of the new positions must be in primary care or general surgery. We applaud these provisions and CMS requirement that hospitals must show for each of the five years that they are in compliance. If CMS has any leeway under the statute, we ask that this requirement be extended beyond five years.

Preservation of Resident Cap Positions from Closed Hospitals (Section 5506)
We would once again step beyond the strict statutory language and ask CMS to utilize its authority to promote regulations that are in keeping with Congressional intent to increase primary care production. Since 1998 there has been a net loss of 30 family medicine residency programs. Fifty-seven programs have closed and 27 have begun. Moreover, there has been a loss of 390 PGY-1 family medicine slots during that time frame.

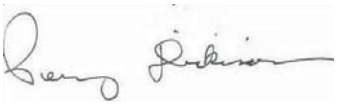
Family medicine has been, and continues to be, the only specialty that solely trains for primary care. Decisions to close programs are made in most cases by the hospital, frequently without the consent of the program; we know that primary care programs are more costly for a hospital to sponsor than other specialty programs. We ask that CMS use its authority to give slots from hospitals that have closed to be used for replacement of positions of family medicine programs that have closed. In other words, frequently a hospital will close its family medicine training program, due to the issues raised above, and use its current slots to promote production of more lucrative specialties. We urge the Secretary to utilize her authority under Ranking Criterion One to distribute slots from the closed hospital to those hospitals in the same core-based

statistical area (CBSA) that have continued to operate a family medicine residency program that was closed by another hospital with the same program director and the same residents with the family medicine residency program. Similarly, we request parallel provisions under Ranking Criterion Two and Three.

Conclusion

We thank you for the opportunity to comment on these proposed regulations. We were very involved in the enactment of the legislative language for these provisions, and are pleased to see CMS's implementation of them. We hope you will be amenable to making changes to your proposal, in keeping with our recommendations. If you have any questions or would like to discuss any of these recommendations, please feel free to contact Hope Wittenberg for more information. (hwittenberg@stfm.org)

Sincerely,



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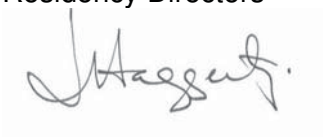

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