

June 17, 2022

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–1771–P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes**

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 2023 Medicare Inpatient Prospective Payment System proposed rule.

Cap Adjustments for Urban and Rural Hospitals in a Rural Track Program

We submit the following comments related to CMS’s proposal to use a GME affiliation agreement specifically for Rural Tracks. This section, the “Proposal To Allow Medicare GME Affiliation Agreements Within Certain Rural Track FTE Limitations,” which CMS is calling a “Rural Track Medicare GME Agreement” describes how CMS proposes to allow, in specific circumstances, sharing of cap slots between hospitals and facilitate the cross-training of residents. CMS has characterized this as a response to a request from stakeholders representing urban-rural training partnerships who specifically raised this request regarding separately accredited 1-2 family medicine programs. CMS further states that “We have been asked that the same flexibility with cap sharing afforded to teaching hospitals to share general FTE cap slots via Medicare GME affiliation agreements also be afforded to urban and rural teaching hospitals that together train residents in a rural track program.”

CMS’s current process for distributing caps between rural and urban hospitals is inequitable because in most cases it would provide the urban hospital more slots than it actually 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. It is too narrow, limited only to family medicine training, and only to separately accredited training tracks established prior to the Consolidated Appropriations Act, 2021 (CAA).

While we applaud the fact that CMS has taken on this concern and recognizes the inequity of the current method of determining rural track cap limitations, we do not support the solution

proposed in this rule. In fact, CMS has not included, or responded to, [comments](#) from our organizations which specifically asked for a redress of concerns over the slot distribution between urban and rural hospitals, in a manner different than is currently proposed. We specifically expressed to CMS, in a phone call during the comment period, our concern over the use of affiliation agreements. We specifically [proposed](#) a different solution as we think the affiliation agreement process significantly disadvantages rural hospitals.

CMS proposes to limit this proposal to “only rural track FTE limitations established under the BBRA of 1999 that are unaffected by section 127 of the CAA. In this proposed rule, we are distinguishing between rural track programs with rural track FTE limitations associated with the BBRA of 1999 in effect prior to October 1, 2022, and Rural Track Programs (RTPs, defined at 42 CFR 413.75(b)) started or expanded to new participating sites under the authority of section 127 of the CAA.” **Our organizations oppose this interpretation of the statute and do not support the use of affiliation agreements to resolve the concerns over the inappropriateness of the current method for determining a cap to be applied to rural track programs.** No rural hospitals to our knowledge have ever established “rural track FTE limitations” – these were designed and implemented only for urban hospitals after BBRA1999. Only after cost reporting periods beginning on or after October 1, 2022, will “rural track FTE limitations” be established for both urban and rural hospitals.

A mechanism already exists for Medicare affiliated groups to aggregate caps other than “rural FTE limitations.” We are aware of multiple occasions where such aggregation has occurred between urban and rural hospitals, always to the disadvantage of the rural hospital that has, for example, been acquired by the larger urban health system. It seems unlikely that urban hospitals would give up “rural FTE limitation” slots to benefit a participating rural hospital’s cap. Urban hospitals are already able to assume costs for an RTT other than residents’ salary and benefits and alleviate any inequity that may have occurred in cap distribution in the past. It doesn’t require a separate RTP affiliation agreement now or in the future.

While it is true that the application of changes resulting from the CAA is October 1, 2022, we strongly disagree that programs described above are unaffected by section 127 of the CAA. It is wrong for CMS to indicate that it doesn’t apply to programs established prior to that date. The statute explicitly states that “in the case of a hospital...that **established or establishes** a medical residency” the Secretary shall consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs with respect to such a program and, in accordance with such rules, **adjust in an appropriate manner the limitation** under subparagraph (F) for such hospital and each such hospital located in a rural area that participates in such a training.” CMS itself stated in its final rule with comment implementing the CAA that the new CAA statute “grants the Secretary **unique authority not previously held; that is, the authority to prospectively allow (under certain circumstances) cap adjustments to existing RTTs expanded in a cost reporting period beginning on or after October 1, 2022.**”

As such, beginning with cost reporting periods on or after October 1, 2022, we believe CMS has the authority to make changes to the rural cap limitations for hospitals participating in rural training for the future and do it by giving them special consideration. **CMS is not restricted to only sharing positions through an affiliation agreement but can, and should, set the caps associated with these training programs for the future, rather than institute affiliation agreements, in both the rural hospital and the urban hospital that is cross-training residents – both in separately accredited rural programs and in rural track programs.**

We have several concerns with using affiliation agreements. Allowing affiliation agreements as a possible solution is inadequate because:

- 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.
- The proposed solution remains urban-centric as it doesn't address the inherent power differential between the two hospitals (For example, what is the benefit for the urban hospital to agree to give up slots?).

For these reasons, our organizations 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.

If CMS insists on the affiliation agreement as a remedy there are still issues that remain, including that there is no mention of what happens for programs still in their cap-setting period after 10/1/22 but already started, and this would need to apply to future programs after 10/1/22, as the issue is the same for them.

In addition, the proposal also states that it would not allow “programs that are not separately accredited in the 1-2 format and are not in family medicine” to enter into “Rural Track Medicare GME Affiliation Agreements.” This proposal does not provide a remedy for programs that had not been separately accredited, but which started prior to the Oct. 1, 2022, date that CMS listed in the final rule. These programs would benefit from the fix we recommended as well.

We appreciate CMS's concern over merging the counts of residents not participating in a rural track program with those who are, but we think CMS has controlled for that in its recommendations regarding specific, new lines in the cost report. That would negate the need for separate attestations, as the representatives who sign the cost reports are responsible for the accuracy of the data included in them. We continue to believe that CMS should fix the problem directly, rather than move toward a more convoluted, bureaucratic process when a more simple and equitable solution is available. It would also be helpful for new programs to know as soon as possible how their cap will be set, rather than wait too long for CMS to decide on this.

#### Definition of New Sites

On a separate issue, not specifically mentioned in this proposed rule, but as a follow up to the final rule implementing the CAA provisions (Dec 27, 2021, CMS-1752-FC3) we understand that CMS has communicated to the ACGME a sub-regulatory decision that it is defining a “new site” as one that has not been previously listed as a “participating site” of the urban program. This would effectively preclude any rural track programs in development from using an existing participating site of the urban hospital partner in the RTP. This is unnecessarily restrictive for the development of future RTPs, particularly in specialties other than family medicine where the availability of rural sites with adequate volumes and types of patient care is already limited, and where many of these sites are already being used for rural rotations. It is extremely common for a program to establish rotations at rural sites to “test” the viability of the site for future, ongoing training. This would preclude that constructive effort.

**Our organizations strongly oppose regulatory or sub regulatory requirements that create barriers to rural training.** The whole intent of Section 127 of the CAA was to remove barriers

to rural training, not erect them. We commented on each of the proposals implementing this law regarding the need to allow existing rural sites to expand, because to not do so would preferentially harm family medicine training, but CMS has not supported that view. Now, CMS is going further and is also harming future training in other specialties in rural sites. We urge CMS to reverse its sub regulatory decision regarding the use of the ACGME “participating site” listing as the criterion for exclusion of new, or increased training.

In conclusion, we believe we have recommended a solution to the inequitable distribution of slots under the “rural track FTE limitation” associated with RTPs that would solve many of the problems CMS has identified, would allow for a more streamlined and accurate process, and would support a more equitable distribution of slots between rural and urban sites. As we stated in our comments to the CAA final rule with comment, we recommend that CMS, for the purposes of providing “an adjustment in an appropriate manner” give special consideration to the welfare of the rural hospital participating in an RTP by counting the highest year, rather than using all five years when determining the ratio for apportionment.

Thank you for your consideration of our comments. We look forward to continuing to work 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 Manager, Regulatory Affairs,, at [myinger@aafp.org](mailto:myinger@aafp.org) and Hope Wittenberg, CAFM Director, Government Relations [hwittenberg@stfm.org](mailto:hwittenberg@stfm.org).

Sincerely,



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