June 24, 2013

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1599-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Graduate Medical Education Provisions within CMS-1599-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 titled "Medicare Program - Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers and Hospital Conditions of Participation" as published in the May 10, 2013 *Federal Register.* Our comments are focused on the sections of the proposed rule regarding graduate medical education (GME.)

J. 2 Proposed Inclusion of Labor and Delivery Days in the Calculation of Medicare Utilization for Direct GME Purposes and for Other Medicare Inpatient Days Policy

The proposed rule would amend existing regulations to include patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient census is taken. This change would include labor and delivery days as inpatient days in the Medicare utilization calculation.

We oppose the addition of labor and delivery days as inpatient days for direct GME purposes. We are concerned that the impact of this provision will fall proportionately more on community teaching hospitals, rather than academic medical center hospitals, and consequently have a deleterious impact on primary care training. Including these days increases the denominator in the Resident/Bed ratio, thereby lowering that factor in the GME calculations. Primary care in the community, including the community hospital setting, has a proportionally larger number of labor and delivery patients than other settings of more subspecialty oriented hospitals. We are concerned that the result of this change will be proportionately greater reductions in payment to community hospitals, where primary care training predominates.

J. 4 Payments for Residents Training in Approved Residency Programs at CAHs

CMS has allowed Critical Access Hospitals (CAHs) to be paid for reasonable costs associated with GME under its current cost-reimbursement method if they choose to incur those costs, or CAHs could function as a non-hospital setting allowing a hospital to recoup funding if it, rather than the CAH, incurs the cost of training the residents at the CAH. This proposal would amend those options and limit the reimbursement solely to the CAH through its reasonable cost reimbursement mechanism (101% of reasonable costs.) CAHs are not considered hospitals under Medicare statute, but are considered providers.

We are concerned over the potential impact to primary care training in rural and underserved areas. Primary care relies more heavily on these entities and other rural entities as training sites for residents. Data show that training in these locations increases the likelihood that the resident will choose to practice in these locations following training. A publication from the Robert Graham Center for Academic Medicine (in press) will show that the return on investment for training in these settings is high.

Nine of the current 26 Rural Training Tracks (RTTs) use CAHs for teaching. An unknown number of other integrated RTTs or rurally-located programs such as the one in Yakima, Washington, also rely on CAHs for at least a portion of their training. The osteopathic training community does not yet have RTTs, but it is our understanding that several are currently in the pipeline. Add to that the unknown number of allopathic and osteopathic programs in other specialties where residents rotate for a month or more in a CAH, the new rule interpretation and implementation could be devastating to rural training at a time when these programs are most vulnerable.

CMS's proposal hinges on a reading of the statute that is narrow at best. As the proposal mentions, prior to the *Affordable Care Act* (ACA), the language predominantly used was "without regard to setting." CMS acknowledges that the agency has used nonhospital and nonprovider interchangeably over the years. Although previous regulations implementing Section 5504 of the ACA have continued to use these phrases interchangeably, in this proposal CMS changes its interpretation. Section 5504 contains a shift in language to "nonprovider," which is causing CMS to change its policy and no longer allow a hospital to bear the costs for reimbursement of training at a CAH site. We object to this interpretation.

We are troubled that the parsing of this language does not do justice to the intent of the statute to increase training in rural, underserved and community settings. This determination hinges on three criteria:

1. Section 1861(u), of the statute states that "a provider of services" is "a hospital, critical access hospital," etc.
2. Another section of the statute, 1861(e), states that a CAH is excluded from the definition of hospital "unless the context requires otherwise."
3. The term non-provider is not defined in the ACA, but CMS suggests it is reasonable to define it by using settings that do not meet the definition of provider.

We would like to see a different interpretation supported by CMS. We propose two options. The above language in #2 states that a CAH is not a hospital "**unless the context requires otherwise**." [Emphasis Added]. We believe that this language gives CMS permission to make the case that barriers to training in rural and underserved settings should be lowered as much as possible, allowing CMS to consider, **only for the purposes of GME reimbursement**, that the CAH be considered a hospital. We reiterate that this change should only be for the purposes of GME reimbursement so that a larger shift in payment policies does not occur.

Another option for the agency would be to actually define the term "non-provider" from language in #3 for the purposes of this section. In the proposal CMS states that it uses an assumption based on another section of law that determines a provider: only those that do not fit that category would be non-providers. However, by defining the term non-provider differently from its current assumption CMS would have authority to include CAHs as non-providers **for the purposes of Section 5504**.

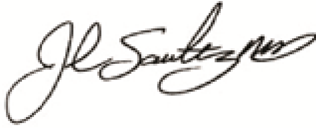
The justification for this recommended definition is that most, if not all, of these facilities are too small to support residency training programs on their own without partner institutions. Others may not be able to support the costs of residents rotating through their settings. CAH's are currently allowed to incur and receive payment for the cost of training. However, since the great majority currently do not claim this time, there are clearly 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.

We believe either of these interpretations should hold sway until reform of GME allows for funding to follow the resident in all primary care training.

As CMS considers this proposal further, we would like the agency to consider the downstream implications of narrowing the focus of GME reimbursement. As our health system shifts to other forms of care, training and reimbursement, including innovative payment, training and delivery models, CMS should be contemplating how Medicare GME must reform to meet this changing training landscape. We do not want current definitions to be barriers to change and needed reform of medical education, particularly in primary care. New regulations should enable a dynamic, changing health care and health care training system. We encourage CMS to avoid changes that will inhibit progress toward reform and improved health care training.

On behalf of the family medicine organizations, we appreciate the opportunity to respond to the proposed rule. We appreciate the agency's efforts to develop regulations in keeping with the Affordable Care Act and hope you will entertain our suggestions regarding the GME provisions. We believe CMS has more leeway than stated in its current interpretations and hope the agency will agree with our perspective. 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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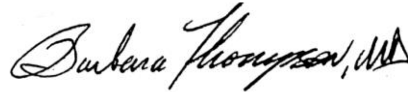

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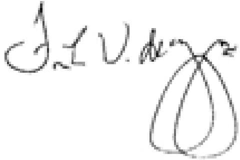

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