

June 30, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244-1850

CMS-1406-P

Dear Ms. Frizzera:

On behalf of the Academic Family Medicine Advocacy Alliance and American Academy of Family Physicians, we take this opportunity to comment on the May 22, 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," Specifically, we are commenting on the section under Payments for Direct Graduate Medical Education entitled, "Clarification of Definition of New Medical Residency Training Program," although its impact would be the same as a new regulation.

Essentially, the proposal states that if a program closes (no matter the reason behind the closure), and a university, medical school, hospital or other entity applies to the RRC to get approval for a "new" program at a different hospital (that has never had residents before), CMS will no longer guarantee the counting of those residents for GME reimbursement purposes. The rationale for the proposal is that the BBA put a cap on residency positions. By setting up shop in a new hospital, as a new entity, a "new" program allows the "old" hospital to retain its residency positions based on its historic cap, and then new positions are added in the "new" hospital.

The language for a "new" program, that most programs and hospitals were acting on (in good faith), was included in regulations to implement the Balanced Budget Act of 1997 (BBA): a new medical program is defined as "a medical residency [program] that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995. (*Federal Register*, Vol. 63, No.91, May 12, 1998)

With this proposed regulation CMS requires the hospital to evaluate whether a particular program is a newly established one for Medicare GME purposes – by considering whether it is a program that existed previously at another hospital. The criteria CMS has included in the proposal do not truly clarify the situation for any hospital interested in establishing a residency program. There is no clarity regarding how the criteria would be applied in a real-life situation. How will these criteria be weighted? Does a hospital have to answer "no" to each of the following questions; half of them? Will there be variability among fiscal intermediaries as to how many of these criteria must be addressed?

- Are there new program directors and/or
- Are there new teaching staff, and/or
- Are there only new residents training in the program(s) at the different site
- Is there common ownership between the hospitals or a shared medical school or teaching relationship
- What is the degree to which the hospital with the original program continues to operate its own program in the same specialty

The criteria, and their application, are so ambiguous that a program would never be able to know, until several years in the future, whether it passes muster as a “new” program. This ambiguity will have a chilling effect on the ability of any new programs to be established. A program would be very averse to hiring a program director with experience at another hospital. Similarly, they would be reluctant to hiring experienced faculty.

While we believe this entire proposal should be withdrawn, if CMS moves forward with a final rule, we recommend that a program must meet all the criteria listed in the proposal to be considered NOT a new program. In other words, the term “and/or” should be changed to “and” and it should be added after each criterion, not just the first two.

### **Policy Impact: Wrong position, wrong time**

We are surprised that at the same time the President is outspoken his support for primary care, and the need for more primary care physicians, that one of his Administration’s agencies is initiating a proposal that will have a chilling effect on primary care production.

We are very concerned that CMS is promoting new regulations without an assessment of the impact of such a proposal. We are extremely concerned that primary care programs in general and family medicine in specific, will be disproportionately affected. The loss of primary care resident positions, at a time when our nation needs a larger production of primary care physicians is not the direction federal policy should take.

Since 1998 there has been a net loss of 39 family medicine residency programs. 57 programs have closed and 27 have begun. That means that family medicine has, at a minimum, 27 programs potentially at risk under this proposal. 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 is fully primary care at all levels. Now is not the time to reduce the ability of family medicine programs to establish themselves and provide critical training for primary care physician production.

Below are four graphs<sup>1</sup> which paint an unambiguous picture of the trends in graduate medical education positions since the BBA. The first graph shows the change in the number of programs for various specialties, clearly identifying the major loss of family medicine programs, followed by internal medicine. The second graph shows the changes in slots or training positions for various specialties. Again, one sees a precipitous decline in family medicine, as well as an even larger reduction in internal medicine positions – when adjusted to include only those positions that do not lead to subspecialty training positions. The third and fourth graphs help identify potential reasons for these changes. The growth in specialty programs and positions is occurring without additional federal funding. It seems to roughly correlate with median incomes of various specialties. Moreover, this expansion appears to be unrelated to local health care needs but instead is related to the relative cost benefits that various specialties provide for their supporting hospitals. This is clearly not the direction our policy makers should move in. Any regulation which hinders primary care training, such as the current proposal, makes a difficult situation even worse.

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<sup>1</sup> Aggregate number of GME programs for each specialty raw data obtained from JAMA, Graduate Medical Education Edition, 1998,2002,2004,2008. Data modified and graph created by Robert Graham Center. <sup>2</sup>Raw Data obtained from JAMA, Graduate Medical Education Edition Data Tables. Data modified and graph created by the Robert Graham Center. <sup>3</sup>Specialty Income Data via Medical Group Mangement Association with slot data via JAMA. Data modified and graph created by The Robert Graham Center. <sup>4</sup> Data via ACGME [www.acgme.org/adspublic](http://www.acgme.org/adspublic), aggregated and modified by the Robert Graham Center.

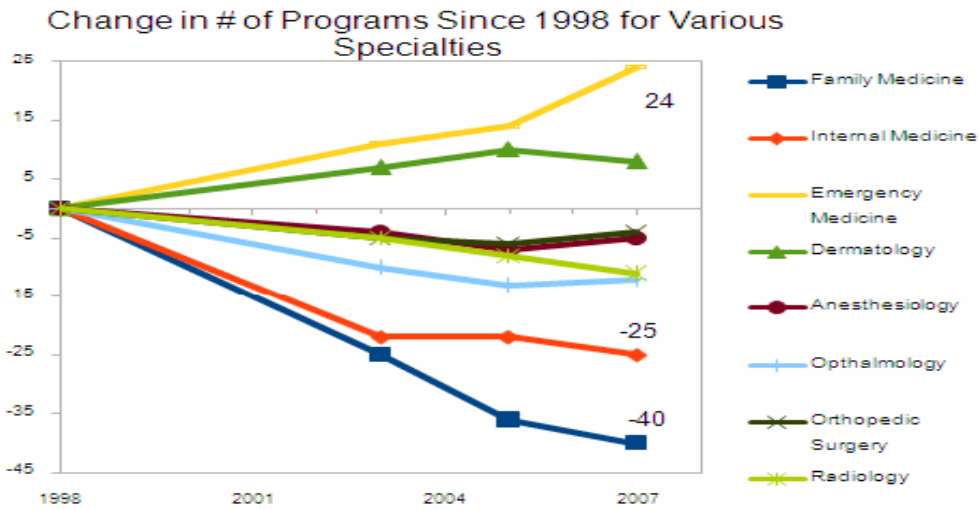


Figure 1. Total change in the number of GME programs for various medical specialties since 1998.

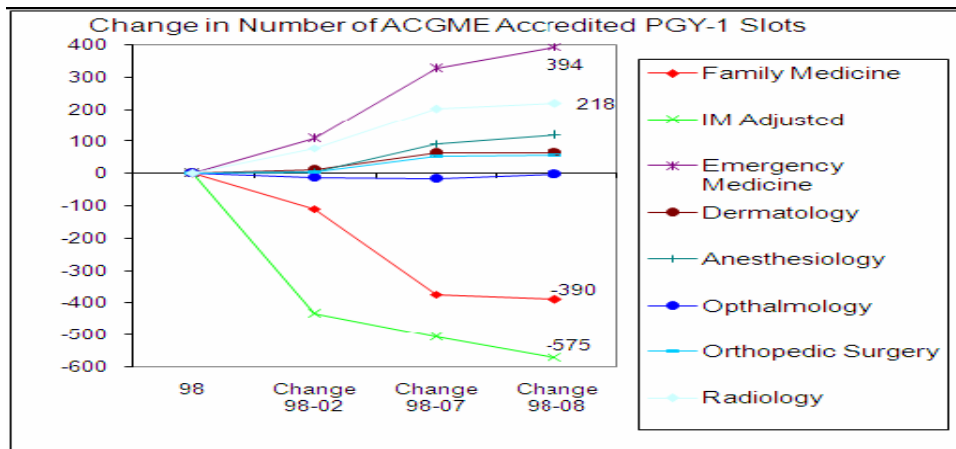


Figure 2. Total change in the number of post graduate year 1 slots available in GME programs for eight medical specialties since 1998

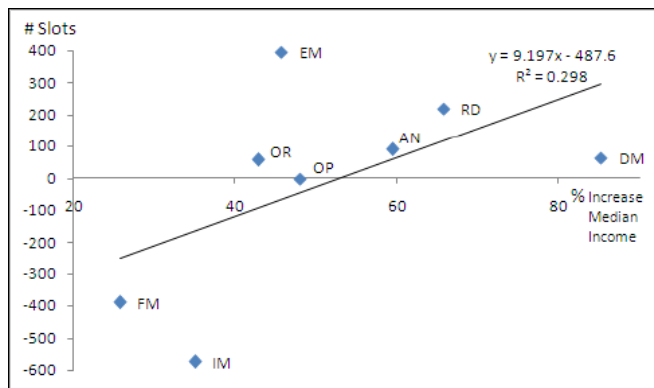


Figure 3. Correlation between percent increase in specialty income and change in the number of ACGME GME slots between 1998-2008 (FM=Family Medicine, IM=Internal Medicine, OR=Orthopedic Surgery, OP=Ophthalmology, AN=Anesthesiology, RD=Radiology, DM=Dermatology)

	New	Withdrawn	Difference
Anesthesiology	4	8	-4
Family Medicine	27	56	-29
Ophthalmology	5	6	-1
Orthopedics	6	2	4
Radiology	4	13	-9
Dermatology	8	5	3
Emergency Medicine	26	1	25
Internal Medicine	14	19	-5

Figure 4. Total number of newly accredited ACGME programs and ACGME program accreditation withdraws for eight specialties between 2000-2007.

In addition to the harm to primary care production, the policy seems to measure the wrong items and penalize the wrong entity. We wonder why CMS is in pursuit of some mistaken assessment of blame for actions that have been taken in good faith, and in support of valuable goals. It is the hospital in most cases that makes the decision to close a program, 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. The program director, faculty and residents must go someplace else (i.e. to another program) to continue their careers. It is unreasonable to suggest that because they take a position in a new program close to

where they live and have worked that that makes the new program the same as the old one. Moreover, as the proposal notes, many programs are sponsored by schools of medicine or other non-hospital entities. This is becoming more prevalent as consortia develop to provide training in newer, more community-based environments.

While CMS has no authority over the statute, the agency should be attempting to find ways to allow new training modalities under the law, rather than continuing to keep trying to fit training for primary care into the dated system of hospital training. Family medicine is trying to change the way residents are trained, to promote better training of primary care physicians. To do this, we must remove the tie that binds primary care training programs to the hospital. While statutory authority is necessary for this change, it seems unreasonable at this point in time, as health care reform is moving through Congress, for CMS to propose this regulation – one more regulatory hurdle that will hinder primary care training.

### **Faulty application of a “clarification”**

CMS is already acting on this clarification, even though it has not yet been finalized, causing many hospitals to pay back reimbursement for resident FTEs. This action is causing additional Family Medicine programs to close.

It is unreasonable for a “clarification” to be applied retroactively. There are many programs and hospitals that have acted in good faith, using language that *prima facie* would allow a program given an initial accreditation by ACGME to be considered “new” for GME residency counts. While we believe this policy is faulty, if CMS continues to pursue changing its definition of “new,” it should be prospectively applied from the time the final rule takes effect.

### **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)<sup>2</sup> 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 positions. 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.

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<sup>2</sup> (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.

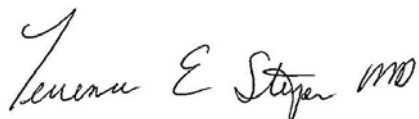
The proposal also cites BBA Conference Report language that “indicates concern that the aggregate number of FTE residents should not increase over current levels.” We find it interesting that there is other conference report language (which occurs in at least three separate places in the GME section 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

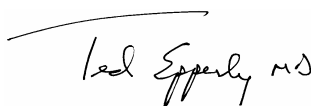
This proposal suffers from an incorrect premise – that CMS is required to “clarify” their regulations that have been in place since 1998. There is neither need nor mandate to do so. We are also concerned that CMS has been acting on this “clarification” already and requiring the reimbursement of millions of GME dollars from the sponsor of these new programs. Moreover, this is the worst possible time for CMS to be contemplating such a change. Primary care training needs all the support it can get; modernization of primary care graduate medical education training and funding is necessary to produce the primary care physicians needed by the U.S. While the Agency cannot change the law, it can certainly support this aim as strongly as possible within the constraints of the current statute. This proposal does the opposite.

We are grateful for the opportunity to respond to this proposal. However, we believe CMS should be promoting regulations that support, not hinder, primary care. We urge CMS to withdraw this proposal and end their current practice of executing it without regulatory authority.

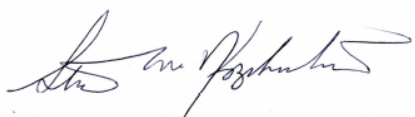
Sincerely,



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