June 11, 2019

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS–1716–P
P.O. Box 8013
Baltimore, MD 21244–1850

Attention: Graduate Medical Education provisions within CMS–1716–P

Dear Administrator Verma,

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, we are pleased to submit comments in response to the proposed rule published in the May 3, 2019 *Federal Register*, titled "Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System (LTCH PPS) and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs; Proposed Requirements for Eligible Hospitals and Critical Access Hospitals.

Our comments focus on the section of the proposed rule regarding Graduate Medical Education (GME) related to Critical Access Hospitals. They originate from our experience, as well as data, indicating that the primary health needs of rural America are not being met.

We write in strong support of the proposal to address Medicare reimbursement for residents' training time spent at critical access hospitals (CAHs). We applaud the changes that the Centers for Medicare and Medicaid Services (CMS) is proposing which define non-provider to include critical access hospitals for the purposes of Section 5504. In the past we have commented that we believe CMS is not doing enough under its statutory authority to remove barriers to increased production of primary care physicians, particularly in underserved rural areas. We are pleased to be able to congratulate CMS on the change that is proposed regarding CAHs and we write to ask that CMS do even more in refining this proposal. We also note that we are delighted to see that CMS has taken our recommendations made in 2013 to heart and is now defining the term "non-provider" to include CAHs for the purposes of Section 5504.

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CMS Should Remedy the Harm Caused by Previous Definition
We note that this change would be effective for cost reporting periods beginning October 1, 2019. We request that CMS reconsider the effective date of this proposed rule. There are two areas of concern. First, those IPPS hospitals partnering with CAHs in rural residency program implementation that that were in their cap-building period during the six intervening years since implementation of the FY2014 IPPS/LTCH PPS final rule are permanently *and continually* harmed going forward by a mistake that was of CMS's making. The second area where we think hospitals have been harmed by CMS's previous position taken in 2013, is for those situations where no hospital has claimed FTE's for reimbursement (under the IPPS system) and for which no claims have been made by the CAH for direct educational costs. As stated in the proposed rule, CMS has "reassessed and agree with prior comments we have received…" and that it is "important to support residency training in rural and underserved areas, including residency training at CAHs." Our hope is that CMS will help remedy the harm caused in the intervening years in the following situations and manner.

Hospitals in Cap-building Period During Between FY2013 and October 1, 2019
We propose that for IPPS hospitals partnering with CAHs in rural residency program implementation which are still within the 3 year "re-opening window" for cost reports during this timeframe, and for which a cap was set due to the end of the five year cap-building period, that CMS allow the recalculation of such hospital's cap to include time spent by residents in critical access hospitals. This would be a form of limited retroactivity. It would not require any changes or resubmission of cost reports, but would allow the Medicare Administrative Contractor (MAC) to recalculate the cap to include time spent by residents in critical access hospitals and remedy the ongoing harm of CMS's previous position.

No Claims for Training Time (FTEs) or Direct Educational Expenses Between FY2013 and October 1, 2019
There have been resident rotations at CAHs in the intervening time between October 1, 2013 and now for which no IPPS hospital has claimed FTEs and for which no claims have been made by the CAH for direct educational costs. As we stated in our comments to the 2013 proposed rule, "most, if not all, of these facilities [CAHs] are too small to support residency training programs on their own without partner institutions…. " and "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." Since the FY2014 final rule determined that IPPS hospitals couldn't claim time, and many CAHs were unable to claim allowable direct expenses related to residency training, CMS experienced a windfall of resident training time and/or costs that were not reimbursed.

We propose that if an IPPS hospital wishes to claim CAH rotation time for unsettled cost reports (in the 2013-2019 window) they should be able to do so, *if the CAH agrees*, with the understanding that the CAH where the resident was training may also have its cost report(s) opened for the affected year(s), but solely for the purpose of assuring that the CAH did not claim allowable resident direct costs for these resident rotations.

In summary, we believe that CMS should adopt the change it proposes -- to allow an IPPS hospital to claim FTE's who train at CAH hospitals – and should apply it retroactively for cap-building and reimbursement for training during the intervening years between FY2013

and FY2020. We recognize the problematic nature of re-opening cost reports who have already passed their three year “reopening window” so we are only asking for this to apply to institutions who are in that situation, not to all cost reports that may have been harmed. We hope CMS will provide this additional consideration for underserved rural areas which will 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.

Sincerely,

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