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June 8, 2021

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-172-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 and Fiscal Year 2022 Rates

Dear Administrator Brooks-LaSure:

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 2022 Medicare Inpatient Prospective Payment System proposed rule.

The Graduate Medical Education (GME) provisions included in the Consolidated Appropriations Act, 2021, will help strengthen the GME program and diversify training options for resident physicians. A recent report projects that the U.S. will face a shortage of between 54,100 and 139,000 physicians by 2033.[1] Currently, most physicians are trained at large academic medical centers in urban areas. Evidence indicates physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees also leads to physician shortages in medically underserved and rural areas.[2] These shortages result in access barriers and disparities in health outcomes for Medicare beneficiaries and other patients living in rural communities.[3] However, our organizations believe that the implementation of these GME provisions could help to correct the maldistribution of physicians and ultimately improve equitable access to high-quality care. We applaud CMS for prioritizing health equity in these GME proposals and look forward to partnering to continue to address the maldistribution of physicians and disparate access to care across the country. It is with these goals in mind, that we offer our comments on the proposed rule.

<u>Distribution of Additional Residency Positions Under the Provisions of Section 126 of Division CC of the Consolidated Appropriations Act, 2021 (CAA)</u>

Determinations Required for the Distribution of Residency Positions

The CAA requires CMS to take into account the demonstrated likelihood of filling the residency positions made available within the first five training years after they are effective. CMS proposes that a hospital would show a demonstrated likelihood of filling the additional slots for which it applies by demonstrating that it does not have sufficient room under its current FTE resident cap(s) to accommodate a planned new program or expansion of an existing program. This is often referred to as being “at or over cap.” CMS further proposes that hospitals must submit documentation to demonstrate they are meeting one of two criteria:

1) They are in the process of creating a new residency program
2) They plan to expand an existing residency program

Our organizations support the criteria described by CMS to demonstrate likelihood of filling.

Definition of a Qualifying Hospital

CMS proposes that only those hospitals that meet at least one of the following four criteria will be eligible to apply for new GME slots:

1) Rural hospitals or those with a rural designation
2) Hospitals for which the reference resident level of the hospital is greater than the otherwise applicable resident limit (over cap hospitals)
3) Hospitals in states with a new medical school or branch campus
4) Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs)

In other words, hospitals that do not meet one of the above criteria will not be considered a qualified hospital and cannot apply for new GME slots. Congress indicated in the CAA that CMS must set aside at least 10 percent of the 1,000 new slots to hospitals that meet each of these criteria. However, CMS is proposing that only those hospitals will be eligible to apply for new slots. CMS notes in their proposal that, since some hospitals will meet more than one of the above criteria, more than 10 percent will likely be allocated to each category.

Our organizations support this proposal, but **we recommend that CMS use its discretionary authority to add two additional qualifying criteria: 1) small hospitals with less than 250 beds; and 2) hospitals with only one residency program.** We believe that these two additional criteria are needed to level the playing field for those hospitals that may be small or only have one residency program, but do not meet the other four criteria.

According to the Medicare Payment Advisory Commission (MedPAC), the majority of the 71 hospitals that closed in 2019 and 2020 were small and located in urban metropolitan areas.[4] During the same period, 30 hospitals opened. All of them were small and all but three were located in urban areas.[5] We believe that by adding a qualifying criterion for these hospitals, CMS could help to ensure their financial stability and prevent additional closures. If CMS does not add these eligibility criteria, we are concerned that many small hospitals will be precluded from receiving additional slots in the next five years.

Further, our organizations believe that small hospitals and those with only one residency program may be disadvantaged by the repeated emphasis on over cap hospitals. CMS uses over cap status to demonstrate the likelihood of filling, in addition to making over cap hospitals qualifying hospitals. This emphasis may favor those hospitals with large or multiple training programs over smaller hospitals and those with fewer programs. Adding these two additional qualifying criteria will help ensure these hospitals are not left behind when the new slots are being distributed, negatively impacting the physician pipeline and access to care in certain areas.

Small and single-residency program hospitals function with small, relatively tight GME budgets and therefore are typically not able to function above their cap. Adding these qualifying criteria would allow small hospitals and single residency program hospitals to expand even though they are financially constrained from being over cap and wouldn't otherwise qualify for additional slots, even though these hospitals could be effectively addressing physician shortages. For example, single-residency hospitals tend to be community hospitals instead of large academic institutions and are therefore effectively meeting the needs of a community that otherwise may be underserved. For all of these reasons, our

organizations urge CMS to add two additional qualifying criteria: 1) small hospitals with fewer than 250 beds; and 2) hospitals with a single residency program.

CMS further proposes to further define what hospitals will be considered qualifying under the four criteria:

1) CMS proposes to define that a hospital with its main campus located in an area outside of an urban CBSA is a rural hospital. CMS also proposes to apply an existing definition for hospitals that are located in urban areas but are treated as being located in rural areas for purposes of payment under the IPPS if they meet certain criteria.
2) CMS proposes to define hospitals for which the reference resident level of the hospital is greater than the otherwise applicable resident limit (over cap hospitals) based on existing regulatory definitions for the relevant terms that define what a hospital's cap is.
3) CMS proposes to define hospitals in states with new medical schools, additional locations and branch campuses as those located in 35 states and one territory.[a] Hospitals in other states can provide comments or provide CMS with documentation to demonstrate that their state has a medical school or additional location or branch campus established on or after January 1, 2000.
4) CMS proposes to define hospitals located in HPSAs as those whose main campus or provider-based facility is physically located in geographic HPSAs for primary care and mental health providers. CMS also proposes to require that at least 50 percent of the residents' training time over the duration of the program must occur at those locations in the HPSA. Hospitals that only have main campuses or provider-based facilities in mental health only geographic HPSAs may only apply for residency positions for psychiatry residency programs.

Our organizations largely support the above proposed definitions, though we recommend one modification to the definition of hospitals located in HPSAs. **We agree that HPSAs should refer to primary care geographic HPSAs and that hospitals with main campuses or provider-based facilities should be required to be physically located in a HPSA to meet this definition. However, we would add that in addition to provider-based facilities, non-provider-based facilities where a hospital may count training time for IME/DME purposes (such as critical access hospitals, rural health clinics, FQHCs, etc.) be included.** This modification is needed to ensure that community-based settings that often serve as primary training locations for family medicine are included in the definition.

We strongly agree that at least 50 percent of the residents' training time must occur at the hospital locations within the HPSA. It has been established that the location of GME training has an impact on graduates' location of practice – most staying within 100 miles of their residency program.[6] Additionally, those residents who have completed training in rural health clinics, federally qualified health centers, or critical access hospitals are more likely to practice in these settings.[7] Congress clearly intended to ensure that these training slots be allocated to hospitals that provide care to medically underserved populations and this 50 percent training requirement will ensure residency positions obtained under this criterion are not used to primarily serve populations that do not face physician shortages.

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[a] Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, 1080Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin

Number of Residency Positions Made Available to Hospitals and Limitation on Individual Hospitals

As required by the CAA, CMS proposes to make 200 residency positions available each year for five years beginning in FY 2023. CMS further proposes to limit the increase in the number of residency positions made available to each individual hospital to no more than 1.0 FTE each year. The statute also requires that a hospital not receive more than 25 additional residency positions.

Our organizations support the proposals to limit the number of residency positions distributed to 200 per year and to no more than 25 positions per hospital. We are concerned that the proposal to limit each hospital to 1.0 FTE per year will result in a burdensome and unpredictable reapplication process, limiting hospitals' ability to fully train even one additional physician. For example, in order to fully train one additional family medicine resident, a hospital would have to apply for 1.0 FTE each year for three years. This application process will be particularly onerous on smaller hospitals and those with fewer residency programs. There is no assurance provided that a hospital will receive 1.0 FTEs each year that they apply, and therefore the hospital risks being left to fully fund or relocate a resident they take on beginning in 2023.

We recommend that CMS allow hospitals to resubmit a less burdensome application in subsequent years to be awarded an additional 1.0 FTE so that a hospital can ensure they will have FTEs each year to continue training one new resident. The number of FTEs awarded via the less burdensome resubmission process would be based on the specialty and length of the program for which the hospital applied, or limited by the period for which these additional slots will be awarded. For example, if a hospital is awarded 1.0 FTE for their family medicine program in FY 2023, they should be awarded an additional 1.0 FTEs in FY 2024 and 2025 under the resubmission to ensure they can complete the resident's training period. If a hospital was awarded 1.0 FTE under the resubmission for their family medicine program in FY 2026, they would only be awarded an additional 1.0 FTE in FY 2027, if all one thousand slots have been distributed during the five-year period as planned. We recognize that the statute may require an application period each year, but we urge CMS to make a less burdensome process available to hospitals once they demonstrate that they meet all of the necessary criteria and are awarded an FTE after their initial application.

Prioritization of Applications from Hospitals for Residency Programs that Serve Underserved Populations

In order to fully address health inequities for underserved populations, CMS proposes to prioritize the applications from qualifying hospitals that serve the specific designated underserved population of a population HPSA. Population HPSAs are designated by HRSA on the basis of a shortage of services for a specific subset of the population, including but not limited to: low-income populations, Medicaid-eligible population, Native American populations, homeless populations, and migrant farmworker populations.

CMS further proposes to require that hospitals attest:

1) that its main campus or provider-based facility is physically located in a primary care or mental health population HPSA,
2) that those locations serve the designated underserved population of that HPSA, and
3) at least 50 percent of the residents' training time over the duration of the program for which the hospital is applying occurs at those locations in the HPSA.

CMS does not propose to use facility HPSA designations in the proposed rule. CMS proposes to limit each hospital to one application per year. CMS notes that they expect a hospital would choose to apply for a program that serves the HPSA with the highest score among its programs, though they are not required to do so.

CMS will use HPSA scores, as assigned by HRSA, to prioritize applications as follows. CMS would allocate 1.0 FTE to each hospital with the highest HPSA score, prorating (or assigning less than 1.0 FTE) only in the event that the number of hospitals with the highest score exceeds the number of positions available. If the number of hospitals with the highest score is less than the number of residency positions available, each hospital with the next highest score would receive 1.0 FTE, with proration again occurring only in the event that the number of hospitals with this score exceeds the number of positions remaining. Hospitals applying for residency positions for programs that do not serve HPSAs are not excluded, but would have the lowest priority.

Our organizations commend CMS for this proposal**. We strongly agree with the agency's goal of addressing existing health inequities and improving timely access to high-quality care for underserved populations. We believe that, by including geographic HPSAs, this proposal will also help to address the maldistribution of physicians over time.** Our organizations again urge CMS to include non-provider-based settings in this definition. We agree that prioritizing geographic and population HPSAs, using HPSA scores, would ensure residency slots are awarded to those programs serving a high proportion of underserved patients. **However, we recommend that CMS also consider where a given program's or hospital's trainees eventually go on to practice. In addition to prioritizing hospitals' applications using their HPSA score, CMS should also prioritize hospitals or programs based on the proportion of their trainees that ultimately go on to practice in HPSAs. By adding this "impact factor" to the proposed methodology for prioritizing applications, CMS would also help ensure that the physicians trained using these new residency positions ultimately go on to care for underserved populations throughout their career, not just for the duration of their residency training.**

Our organizations believe that by adding this impact factor CMS would be more comprehensively addressing the pervasive health inequities exposed by the COVID-19 pandemic, as noted in the Executive Order on "Ensuring an Equitable Pandemic Response and Recovery." Our proposed additional impact factor is also consistent with the President's Executive Order on "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," which calls on federal agencies to recognize and address policies and programs that serve as barriers to equal opportunity. Medicare GME is one such federal program that can be modified to address persistent inequities, in part by ensuring it facilitates access to high-quality, comprehensive health care for all Americans, regardless of where they live.

While many residency training programs may be located in HPSAs and provide care to underserved populations, the physicians training in these programs often do not go on to continue practicing in HPSAs. Many other HPSAs also do not have residency training programs located in them and therefore wouldn't benefit from this proposal. Ultimately, CMS' proposal alone does not fully address the maldistribution of physicians or mitigate ongoing shortages in rural and other underserved areas. On the other hand, **by also prioritizing those programs that train physicians who practice in HPSAs after completion of residency training, CMS would be most efficiently using GME funding to invest in physicians who are much more likely to fill existing gaps.**

About three in five HPSAs are located in rural communities. While 20 percent of the U.S. population lives in rural communities, only an estimated 10 percent of physicians practice in those communities.[8] According to the most recent HRSA data, 15,361 additional physicians are needed fully address the need in all HPSAs, and close to 4,000 physicians are needed to fill the need in rural HPSAs.[9] That puts roughly 25 percent of the U.S. population in regions without sufficient primary care, dental and mental health care providers. Evidence also indicates that, absent decisive federal action, these shortages will worsen.

By 2030, the number of practicing rural physicians could be reduced by a quarter as aging physicians retire.[10] Medical school graduates with rural backgrounds, who are most likely to practice in rural areas, are decreasing: from 2002 to 2017, medical school matriculants from rural areas declined by 28 percent, even though the overall number of graduates increased by 30 percent.[11]

The National Academies of Science, Engineering, and Medicine have indicated in recent reports that merely increasing the number of GME slots will not address the existing maldistribution and shortage of physicians.[12][13] More targeted approaches are needed, such as the prioritization of applications based on HPSA scores *and* the proportion of trainees who ultimately practice in HPSAs.

Rural training tracks, teaching health centers, the National Health Service Corps, and other programs are beginning to address these shortages, but because the Medicare GME program still funds the training of the vast majority of physicians, CMS must also ensure this program is leveraged appropriately. We believe that adding our impact factor to the proposed methodology for prioritizing applications is an essential first step.

We conducted an internal analysis using this additional impact factor. As such, we expect that CMS would have access to similar data and could, somewhat easily, add our impact factor and use it to prioritize applications for new slots beginning in FY 2023. Below is an explanation of the methods we used in our internal analysis:

> Physician-level data from the July 2020 version of the AMA Physician Masterfile was used to construct the rural and HPSA GME Sponsoring Institution Impact Factor. This AMA file includes each physician's practice location, year of graduation, GME sponsoring institution, and whether that physician practices in direct patient care. The analysis was restricted to physicians who graduated from medical schools in the U.S. and Puerto Rico between 2012 and 2018. The earlier period was used to determine practice location upon completion of GME training. Multiple years were used to smooth over annual variations across programs. Only GME sponsoring institutions with 20 or more graduates were included in the analysis. The GME Sponsoring Institution Impact Factor provides the number and percent of their graduates actually practicing in a HPSA or rural county.
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> To calculate the percent of GME sponsoring institution graduates practicing in HPSAs, we divided the number of physicians practicing direct patient care in HPSAs by the total number of physicians that graduated from each GME sponsoring institution. The counts are restricted to physicians in direct patient care and exclude those who may still be residents or whose status is unknown as of 2020. HPSAs are identified using a list of HPSAs with geographic identifiers available from the Health Resources and Services Administration (HRSA) Data Warehouse. HPSAs can be whole counties, a combination of Census Bureau tracts or minor civil divisions. Only HPSAs described as “designated” or “proposed for withdrawal” were included. Both geographic and population HPSAs are included. The HRSA file was matched with the geocoded AMA Masterfile.

Our organizations recommend that CMS use this or a similar methodology to determine the proportion of residents who ultimately go on to practice in HPSAs. CMS should then use this raw percentage combined with the HPSA score to prioritize applications for the one thousand GME slots included in the CAA.

CMS Proposed Alternative Approach for Prioritization of Applications

CMS considered an alternative approach for prioritizing applications. Under the alternative, CMS would distribute 200 residency positions for FY 2023 among qualifying hospitals, with higher priority given to those applications from hospitals that qualify in more categories. CMS would distribute 1.0 FTEs to each hospital that qualified under all four categories, prorating only in the event that the number of hospitals that qualified under all four categories exceeds 200. If the number of hospitals that qualified under all four categories is less than 200, each hospital that qualified under three out of four categories would receive 1.0 FTE, with proration again occurring only in the event that the number of hospitals that qualified under three out of four categories exceeds the number of positions remaining. The agency would continue in this manner until all 200 positions are distributed. CMS seeks comment on this alternative, which would also allow additional time to work with stakeholders to determine how best to prioritize applications for the four remaining years.

Our organizations are opposed to this alternative. CMS' original proposal, coupled with our additional impact factor, would advance our shared goals of mitigating health disparities and improving equitable access to comprehensive health care across the nation. We are also concerned that this alternative would disproportionately disadvantage hospitals located in states without new medical schools, additional locations or branch campuses. While we agree that Congress wanted to be sure that states with new medical schools received at least 10 percent of the new available residency slots, it was not Congress' intent to use this to actively disadvantage hospitals in the other states from being awarded *any* new slots.

We also note that new allopathic medical schools train fewer family physicians than older medical schools.[14] There is a large body of evidence and consensus among experts that improving access to primary care results in better health outcomes, while reductions in the supply of primary care physicians results in an increase in deaths due to preventable causes.[15][16][17] Access to and utilization of primary care services also mitigates health disparities and advances health equity.[18] Primary care physicians are also more likely to ultimately practice in rural and underserved areas. Since graduates of new medical schools are 40 percent less likely to become primary care physicians, we are concerned that, by favoring states with new medical schools, CMS could inadvertently reduce the primary care pipeline and worsen physician shortages in rural and underserved areas. Accordingly, CMS should not prioritize providing all 200 slots in FY 2023 to states with new medical schools or branch campuses.

Five Year Fungibility

The CAA allows hospitals to move newly awarded slots after five years if there is an affiliation agreement in place. Our organizations recommend that CMS apply regulatory guardrails to ensure that, even once a position is moved after five years, it must be to a program in which 50 percent of the training time is in HPSAs. We believe that CMS has the authority to establish these types of guardrails and access to data and reports to audit compliance. Applying this guardrail will facilitate equitable access to comprehensive care, address long-term physician shortages, and continue to diversify training opportunities for resident physicians.

Hospital Attestation to National CLAS Standards

CMS proposes that all applicant hospitals would be required to attest to meeting the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). The National CLAS standards are a set of action steps that organizations can take to advance health equity, which is a priority for all of our organizations. We support this proposal and urge CMS to finalize it.

Proposal for Implementation of Section 127 of the CAA, "Promoting Rural Hospital GME Funding Opportunity"

This section relates to Rural Training Tracks, which historically have been defined as "in the case of a hospital that is not located in a rural area (an urban hospital) that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area, or has an accredited training program with an integrated rural track, the Secretary shall adjust the urban hospital's cap on the number of FTE residents under subsection (F), in an appropriate manner in order to encourage training of physicians in rural areas."

The CAA removed the requirement for a separately accredited rural training track and established a new section for cost reporting periods beginning on or after October 1, 2022, for hospitals not located in a rural area that established or establishes a medical residency training program (or rural tracks) in a rural area, or establishes an accredited program where greater than 50 percent of the program occurs in a rural area. The statute requests that CMS prescribe rules for these programs consistent with the principles of subparagraphs (F), (G) and subject to paragraphs (7) and (8) and 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.

There are several areas under this section of the proposed rule that we believe CMS did an excellent job implementing the statute, and we support them without reservation. These include:

- **CMS's suspension of the application of the rolling average to the establishment of new rural training track programs.** For new RTTs started in cost reporting periods beginning on or after Oct 1, 2022, the three- year rolling average will not apply until the 5-year cap-setting period is completed. Specifically, residents would not be included in a hospital's 3-year rolling average calculation during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of each rural track. This applies to both the urban and rural hospital. See below for the one change we would like to see regarding new programs coming on-line in July 2022.
- **Proposal to allow for increases in both the urban AND rural caps (limitations on FTEs).** Prior to this proposal, based on CMS's reading of the statute, it would only allow increases in a rural cap for new programs. This proposal allows for changes to a rural cap. CMS proposes that each time an urban hospital and rural hospital establish a RTT program for the first time, even if the RTT program does not meet the newness criteria for Medicare payment purposes, both the urban and rural hospitals may receive a rural track FTE limitation. This would allow for an existing RTT to establish new sites of training (locations in rural areas) and adjust both the urban and rural hospitals' cap each time a new training site (RTT) is established. This applies for expansion of new sites for existing RTTs in cost reporting periods beginning on or after October 1, 2022.

- **Allowance to add new locations of training sites to amend the rural limitation on the urban hospital.** Specifically, CMS proposes that if an urban hospital ("hub") with an existing RTT ("spoke") adds an additional RTT ("spoke") to the existing urban core program of the same specialty, the urban and rural hospitals may receive adjustments to their rural track FTE limitation. (For ease of reference, CMS refers to the urban core hospital as the "hub" and the one or more RTTs as the "spokes" associated with that urban "hub.")
- **Removal of the separate accreditation requirement.** In keeping with the statute, CMS proposes to remove this requirement. We support that provision, and especially endorse CMS's maintaining the requirement that in order to be eligible to be considered a rural track, residents within that track must train greater than fifty percent of their time in rural locations.

There are two areas of the proposal that we believe need substantial modification. The first is the restriction to not allow cap adjustments for existing "spokes," and the second is the definitions and nomenclature used for describing these new, non-separately accredited rural track programs.

Restriction to Not Allow Cap Adjustments for Existing "Spokes"

CMS proposes the concept of a "hub and spoke" model where the hub is the urban teaching hospital, and the spoke is the rural training site(s). However, CMS is proposing to not allow an increase to an existing rural RTT "spoke." CMS states that to do so would render the RTT cap meaningless. This would exclude already existing rural training sites from expanding their caps, while new sites would be permitted to receive a new cap and new funding. We believe there is nothing in Section 127 that precludes CMS from providing an opportunity to adjust a cap to allow for expansion of existing rural sites.

CMS states in the IPPS proposed rule, "Because the law now states 'established or establishes,' both past tense and future tense, we believe the 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" (emphasis by CMS) CMS then says this doesn't apply in the case of existing "spokes." **Based on the statutory language referenced above, we believe has the authority to allow for prospective cap adjustments for RTTs.** Indeed, even the language that directs CMS to proscribe "rules for these programs consistent with the principles of subparagraphs (F), (G) and subject to paragraphs (7) and (8) and 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" indicates Congressional intent to allow for such expansion.

Moreover, section 1886(h)(4)(H)(i) of the Act, as added by section 4623 of Public Law 105–33, (Balanced Budget Act of 1997) directed the Secretary, in promulgating rules for the purpose of the FTE cap, to give special consideration to facilities that meet the needs of underserved rural areas, while the Balanced Budget Refinement Act of 1999 stipulated that growth to be 130% of then-current levels. More specifically, in relation to hospitals not located in a rural area, Section 407(c) of Public Law 106–113 (Balanced Budget Refinement Act of 1999) amended section 1886(h)(4)(H) of the Act to add a provision that, in the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment may be made to the hospital's cap on the number of residents in order to encourage the training of physicians in rural areas. Although

CMS, then HCFA, interpreted this to mean that the hospitals must remain under their rural track limitation, it is appropriate with the new legislation to reset that rural track limitation.

We strongly recommend that CMS exercise its authority to permit cap adjustments for existing "spokes." Not doing so will only hinder rural hospitals that have previously developed RTTs to potentially avail themselves of the new opportunity presented by Section 127. It is both expensive and difficult to open new sites of training. The difficulty in developing a rural infrastructure (faculty, staff, etc.) makes the expansion of existing sites as much, if not more, useful than adding new sites, and should be considered a viable option. Evidence indicates that residents trained in rural tracks are more likely to ultimately practice in rural areas and are therefore successfully mitigating physician shortages.[19] This type of evidence-based approach is one that CMS should use its authority to support. **Our organizations strongly recommend against finalizing this proposal. We urge CMS to allow existing RTT spokes to expand by adjusting their cap.**

Definitions and "track" nomenclature

There is a great deal of confusion in this section of the proposed rule relating to terminology that seems to be used interchangeably. For consistency and clarity, we recommend CMS more clearly distinguish between rural tracks and programs as well as stipulate clear definitions of the proposed terminology. For example, the term "program" is used in the rule to convey, variously, an entire residency program or a track within a larger program. The examples CMS uses are particularly unclear. The examples used in the proposal for a psychiatry and internal medicine (IM) program both show small programs where the >50% in rural applies to the entire program, not just a specific "track" within the program. If that is the case, a large urban IM program wanting to set up a rural track (program within a larger program) will never meet that >50% threshold for the entire program. We don't believe that is CMS's view given other statements in this section of the rule that relate to separately identified residents, and the program in its entirety needing to be accredited, so we request that CMS provide additional clarification in the final rule. Moreover, the ACGME is looking at changing its policies regarding rurally designated training and we hope that they will use CMS's definitions as they go forward, to help provide clarity and so there will be no confusion with having two taxonomies in use.

In addition, for the new category of "track" (specified by CMS as one that is not separately accredited, but where a program in its entirety is accredited by the ACGME and the residents spend more than 50 percent of the entire program training time in a rural area) we support CMS's recommendation to require that those residents be designated to rotate to a rural area for greater than 50 percent of the duration of the program. A track within a larger program, and the residents associated with it, should be able to be identified as distinct from the rest of the program. In order for CMS to audit and be sure that the residents are spending more than 50 percent of their time in rural training, they must be identified by the sponsoring institution early on. These residents should be identified at the outset of training or before.

In other words, the track within a large program must have specific residents designated to it, and they must achieve more than 50 percent training in a rural area, where other residents in the larger program, but not in that track, do not have to meet that requirement. In addition, these tracks should also be recognized as having an identifiable director. We do not mean for this to be interpreted as a "new" program director as defined by ACGME for separately accredited rural tracks, but we urge CMS to require an individual that is distinct from the larger program director to be named as the leader of this track. We envision this person as being the rural site director, the larger program's associate program director, or another identified individual.

We propose the following nomenclature, in the table below, along with specific definitions, which we hope CMS would use and include in the final rule.

Residency "type" **(Two are defined in statute)**	**Our Recommended Nomenclature**	**Proposed CMS Definition**	**ACGME**
Statute: Separately accredited rural program (/or rural track):	Program	Existing language for separately accredited rural track programs.	Existing language, with their new process
Statute: An accredited program where >50% of the program occurs in rural area:	Track	Definition: An accredited program with a track within an approved residency program where >50% of the training of specific, identified residents occurs in a rural location. A separate individual should be named to lead this track.	Needs definition AND label consistent with CMS.
Other rural rotations or pathways, <50% in rural location:	Pathway	Not needed for CMS purposes	Current policy

Starting Date for Application of Rules for New Rural Training Tracks

We are concerned with the language of the proposed rule regarding the use of prospective application of rules, including the exemption of inclusion from the rolling average, for RTTs started in cost-reporting periods beginning on or after October 1, 2022. We realize that CMS is making a good-faith effort to comply with the statutory requirements, but we feel there needs to be a recognition, and special consideration for programs that begin July 1, 2022. There is a misalliance between the start of the federal fiscal year (October 1) and the start of the Academic Year for residency training (July 1). This is a predicament that will affect four programs and approximately ten rural resident positions in both family medicine and psychiatry planned to begin training due to the efforts of another government program related to rural residency training – the Rural Residency Development Program. This is a grant program funded out of the Health Resources and Services Administration (HRSA) whose purpose is to help develop rural residencies, and it is heavily weighted toward rural training tracks. Many programs are just at the point where they are ready to field their first residency class in July of 2022. It would be disheartening to see the communities these programs would serve have to wait a year to begin training needed physicians due to a technical misalliance.

We recommend CMS modify the language in the final rule to allow these programs to start on July 1, 2022, without exclusion from the new provisions of Section 127 of the CAA. The statute states that the new provisions apply for cost reporting periods beginning on or after October 1, 2022,

that established….or establishes medical residency training program (or rural tracks), etc. Similar to other places in the proposed rule, CMS can apply the term “that established” to mean programs or tracks that started prior to October 1, and yet still apply the same rules. Below is the section of the proposed rule that we think can be changed. Although we support the argument that CMS uses in applying both the exclusion from the rolling average, and the beginning of the cap setting window, we think that due to the statutory language of “that established,” not just “establishes”, CMS can make an exception and include counting residents for the last three quarters of the academic year of a program that started in July 1, 2022 – including excluding them from the rolling average – thereby keeping in alignment with the statutory date of cost reports starting on or after October 1, 2022, but not delaying the start of four RTT programs developed in concert with the HRSA Rural Residency Development program.

The proposed rule states the following (emphasis added):

Because section 127 of the CAA amends section 1886(h)(4)(H)(iv) to add in new subclause (II) which contains language modeled on the language for providing for FTE resident cap and rolling average exemptions in the case of new programs started on or after January 1, 1995, we are proposing that similarly, during the 5-year cap growth window for RTTs, the FTE residents participating in the RTT either at the urban hospital or a rural hospital would not be included in a hospital’s 3-year rolling average calculation during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of each rural track. That is, just as residents in new programs are exempt from the 3-year rolling average until the cost reporting period that coincides with or follows the start of the sixth program year, *similarly, effective for RTTs started in cost reporting periods beginning on or after October 1, 2022,* for each rural track started, full-time equivalent residents at an urban hospital or rural hospital in a rural track program are excluded from the rolling average calculation during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of each rural track.

We recommend that CMS amend the italicized statement above. Instead of “similarly, effective for RTTs started in cost reporting periods beginning on or after October 1, 2022,” adjust the language to state something to the effect of, “effective for RTTs starting in Academic Year 2022-23 (July 1, 2022) and beginning with their cost reports starting on or after October 1, 2022….”

We note that there is an interim period for those RTT programs starting July 1, 2022, where there is a 3-month period that would be under the prior rules; we suggest that these be handled under current policy, i.e., they would be claimed under the pertinent cost report, pro-rated for that FTE, and with the rolling average applied only to those 3 months.

Proposal for Implementation of Section 131 of the CAA, Addressing Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals

Section 131 was commonly referred to as the Rotator bill before it was included in the CAA. It allows hospitals, in certain situations, to reset the low or zero per resident amounts (PRA) and/or to reset the low IME and direct GME FTE resident caps. Each of these provisions, resetting the PRA and establishing a new cap limitation for DGME and IME, are addressed separately in the proposed rule.

Resetting of a hospital's PRA

Under this subsection, CMS establishes two categories for hospitals qualifying to reset their PRA. CMS calls them Category A and Category B. Note: The reset in each of these categories is "triggered" based on FTEs, not solely due to low PRAs.

- A Category A hospital is one that, as of the date of enactment (December 27, 2020), has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. (Note: These are relatively easy to identify as CMS established caps in 1997 for all hospitals.)
- A Category B Hospital is one that, as of the date of enactment (December 27, 2020), has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment (December 27, 2020).

The Secretary will establish a new PRA for each hospital if the hospital trains at least 1.0 FTE (in the case of a Category A hospital) or more than 3.0 FTE (in the case of a Category B hospital). For a Category A Hospital, CMS proposes not to reset its PRA until they determine that the Category A Hospital trains at least 1.0 FTE, and that training must occur in a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025 (5 years after enactment). Similarly, for a Category B Hospital, CMS proposes not to reset its PRA until they determine that the Category B Hospital trains more than 3.0 FTEs, and that training must occur in a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025 (5 years after enactment).

This subsection of the proposal is mostly straightforward and is in keeping with the legislative language. We support the language in the proposed rule that states, "to redetermine the PRA, the training occurring at a Category A Hospital or a Category B Hospital need not necessarily be training residents in a new program; the residents may be in either an approved program that is "new" for Medicare IME and direct GME purposes or may be in an existing approved program." In addition, we also endorse CMS's proposal not to "round" up the number of FTEs, but to use the actual number of FTEs without rounding in determining whether a hospital trained the requisite thresholds of 1.0 or more than 3.0 FTEs.

However, one part of this subsection does concern us. CMS proposes that it plans "on issuing instructions to the MACs and to hospitals to provide for an orderly process of request and review for the purpose of receiving replacement PRAs. The MACs of the Category A and Category B Hospitals would review the Medicare cost reports, GME costs, FTE counts, rotation schedules, etc. to determine at what point the requisite threshold of FTE residents are trained." Given that hospitals and training programs must plan for rotations at these hospitals, **we believe that the instructions issued to the MACs and hospitals should be issued as an interim final rule and should allow for public comment. This is especially important for those hospitals who may have already triggered the reset during this cost reporting period (after date of enactment). There are a number of hospitals affected THIS year and many will be far along in their cost-reporting year by the time the final rule is published.**

We are also concerned about the hospitals, many of them rural, who have no immediate plans to become a teaching hospital, who have no cap, and who are unaware of any PRA. These do not fall under Category A or B. Per resident amounts have not been proactively assigned to every hospital in the US, and under current regulations a PRA of $0 is only discovered when a resident is first reported on a cost report and the required audit reveals a past incident of resident training for which the hospital

claimed no cost. In an earlier letter to CMS we requested that CMS publish a list of eligible hospitals; if that is not possible, **we would request that CMS require its MACs to identify – as soon as possible – hospitals that would fit the criteria for a PRA reset and communicate that information to the hospitals who would be eligible if a PRA had been set.**

Resetting of a Hospital's Cap (Limitation on FTEs)

The second subsection of this proposed rule concerns the resetting of a hospital's cap or FTE limitation. It details the eligibility criteria for a cap reset, based on two categories similar to the PRA section:

- A Category A Hospital is one that, as of the date of enactment (December 27, 2020), has an IME and/or direct GME FTE resident cap that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. Typically, a Category A hospital is one that did train less than 1.0 FTE in its most recent cost reporting period ending on or before December 31, 1996, and therefore, received FTE caps of less than 1.0 FTE (along with a very low or $0 PRA).
- A Category B Hospital is one that, as of the date of enactment (December 27, 2020), has an IME and/or direct GME FTE resident cap that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment (December 27, 2020).

This subsection regarding resetting a cap limitation is more complicated than the PRA subsection, and we have significant concerns with CMS's interpretation of the statute in its proposal. The statute states that "the Secretary shall adjust the FTE resident caps if the hospital "begins training" at least 1.0 FTE (in the case of Category A) or "begins training" more than 3.0 FTE (in the case of Category B) in a program year beginning on or after such date of enactment and before the date that is 5 years after such date of enactment (use of quotes for emphasis were added)."

Yet in the proposed rule, CMS proposes that **"begins training"** means future training in a new program for the **"first time"** on or after enactment. To qualify for a replacement FTE resident cap, both a Category A Hospital and a Category B Hospital would have to wait to start training residents in a new program in a cost reporting period beginning on or after enactment; if they started training residents in a new program at some point prior to enactment, CMS proposes that they would not qualify to receive replacement FTE resident caps.

CMS has gone beyond the legislative intent in this subsection. CMS introduces an entirely new criterion for eligibility that is not in the statute. By adding the term "first" or "first time", in front of "begins training" CMS changes the entire meaning of the provision. The concept of this provision is to identify what will trigger eligibility for a reset. The statute clearly indicates that beginning a new program should be the trigger. We don't believe requiring a hospital to have never started a new program since its cap was set is in keeping with the statute. For example, it leaves hospitals with a cap of less than 3, (Category B hospitals) but who started a new program after that cap was set, but before the bill was enacted, with no recourse. These hospitals would never be able to reset their cap. Hospitals had no way of knowing that the law would be changed to allow for a reset of the cap in certain circumstances; they should not be deemed ineligible based on CMS's proposed additional criterion.

CMS should count all FTEs training in the hospital at the time the reset is triggered by the start of a new program or programs with more than 3 FTEs beginning on or after the date of

enactment and before a date that is five years after enactment. CMS should ensure that the concept of "Community support and redistribution of costs" not be applied under this provision. This principle, where Medicare will not reimburse for situations after another entity has paid for resident training, is not appropriate because it was statutory and regulatory actions that prevented hospitals from appropriate reimbursement for residency positions from Medicare.

At a minimum, CMS should change its proposal to allow hospitals in the situation described above to count the FTEs in the new program or programs established following enactment in setting its new CAP during its five-year cap-setting window.

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Thank you for the opportunity to provide comments on the proposed rule. Should you have any questions, please contact Hope Wittenberg, CAFM Director, Government Relations, at 202-986-3309 or hwittenberg@stfm.org or Meredith Yinger, AAFP Senior Regulatory Strategist at 202-235-5126 or myinger@aafp.org.

Sincerely,

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