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June 10, 2024

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-1808-P; Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

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 2025 Medicare Inpatient Prospective Payment System proposed rule.

We applaud the Centers for Medicare & Medicaid Services (CMS) for continuing to prioritize health equity in this proposed rule. As the largest funder of graduate medical education (GME), Medicare plays a significant role in addressing physician maldistribution and disparate access to care across the nation. This rule proposes several important steps that will help direct Medicare GME funding to the areas of greatest need. Additionally, our organizations appreciate CMS' recognition of the importance of primary care continuity in its proposal to confirm the patient's primary care provider (PCP) status during a hospitalization or procedure included in the Transforming Episode Accountability Model (TEAM) Mandatory Model. CAFM and the AAFP support the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordinating care with other health care professionals.

Distribution of Additional Residency Positions Under the Provisions of Section 4122 of Subtitle C of the Consolidated Appropriations Act, 2023 (CAA)

In Section 4122, Additional Residency Positions, of the 2023 CAA, Congress allocated 200 new Medicare GME slots to support training beginning in 2026, with 100 of those slots reserved specifically for psychiatry residences. While the 2023 CAA does not provide additional guidance for the 100 remaining slots, it does utilize the same eligibility criteria for a hospital to apply for new slots as was enacted in the 2021 CAA. **Our organizations advocated for and are deeply**

supportive of CMS' proposal to apply the same methodology for distributing the new slots that was finalized for the GME slots enacted by Section 126 of the 2021 CAA, including the proposal to require hospitals that serve areas designated as HPSAs to have at least 50 percent of residents' training time occur at training locations within a primary care or mental health-only geographic HPSA in order to be able to apply for new GME slots. We strongly believe continuing this equity-focused methodology will help mitigate health access disparities and more effectively address physician shortages.

Pro Rata Distribution and Limitation on Individual Hospitals

CAFM and the AAFP continue to support hospital GME awards being aligned with program lengths, so that a hospital applying to train residents in a three-year program can request up to three full-time-equivalent (FTE) residents per fiscal year, as was finalized in the FY 2022 Medicare Inpatient Prospective Payment System final rule. However, we understand that Section 4122, Subsection (B)(iii) of the 2023 CAA, "Pro Rata Application", may prevent CMS from being able to align hospital GME awards with program lengths for these slots. **If so, the AAFP and CAFM continue to strongly recommend CMS award a minimum of 1.0 FTE to qualifying hospitals and not award fractional positions to programs**. We believe anything less than 1.0 FTE funding would harm family medicine residencies – particularly small programs – as it would deter many programs from being able to expand. While fractional FTE awards may be workable in large academic institutions where there are multiple funding options available, it would be a barrier for small residencies that do not have similarly deep resources. **We urge CMS to support the sustainability of small programs by distributing a minimum of 1.0 FTE to qualifying residency programs**.

Distributing at Least 10 Percent of Positions to Each of the Four Categories

Our organizations appreciate CMS' careful tracking of the round 1 and 2 slot distributions related to Section 126 of the 2021 CAA, in which the agency is required to ensure at least 10 percent of slots went to each of the four categories of hospitals that are eligible to apply for residency positions under the Medicare GME program. While it is unfortunate that Category Four hospitals – those serving HPSA-designated areas – did not have their slots filled during distribution rounds 1 or 2 using the finalized methodology in the 2021 CAA, **CAFM and the AAFP are broadly supportive of CMS' proposed amendment to their prioritization methodology for rounds 4 and 5 of Section 126**.

CMS' current methodology for distributing residency slots prioritizes higher HPSA scores, looking at applicants from all four categories in aggregate. To address the current under-distribution of slots to Category Four hospitals, CMS has proposed to prioritize round 4 and 5 distributions from the 2021 CAA to qualifying Category Four hospitals, regardless of HPSA score. This would ensure hospitals serving HPSA-designated areas – communities most in need of increased access to care – would receive the slots their residency programs need in order to continue training the next generation of physicians. Once CMS has reached the statutorily required threshold of at least 100 residency slots from the 2021 CAA having been distributed to Category Four hospitals, the original methodology of prioritizing distribution based on HPSA score would resume and be applied to the other three categories of hospitals. We are supportive of distribution

reverting to being prioritized based on HPSA score after Category Four hospitals have received their slots, as CMS proposes.

While our organizations support this proposal to address the existing under-distribution of residency slots to hospitals that serve HPSA-designated areas, we note that current HPSA methodology only provided seven geographically rural hospitals with residency slots in rounds 1 and 2 of the Sec. 126 distribution—despite a rural carve-out in the regulation.[i,ii] Current HPSA methodology limits the ability of many geographically rural hospitals to receive slots, as their HPSA scores are not high enough or they are not located in a HPSA. **In order to better align with legislative intent going forward, CAFM and the AAFP encourage CMS to consider updating its definition of rural to align with other CMS-defined criteria (all people and territory in an area with less than 50,000 people) and using that parameter to allocate at least 10 percent of slots to rural areas, regardless of HPSA score**. Our organizations applaud the work CMS has undertaken in recent years to promote health and health equity in rural and underserved communities, and we believe this change would support goals of delivering better care where patients most need it.

Evidence indicates that physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees in large academic hospitals leads to physician shortages in medically underserved and rural areas. Compounded by this misalignment of resources, family medicine is also facing a particularly critical workforce shortage. Research shows that increasing the number of primary care physicians practicing in underserved areas – thereby increasing patient access – is associated with lower patient mortality and improved health outcomes. The AAFP and CAFM firmly believe directing Medicare GME resources to underserved areas is an essential strategy for advancing health equity, and we appreciate CMS proposing this solution to resolve the issue identified within the current methodology.

Transforming Episode Accountability Model (TEAM) Mandatory Model

Our organizations applaud CMS' recognition of the importance of primary care continuity in its proposal to confirm a patient's PCP status during the hospitalization or procedure initiating the episode, as well requiring TEAM participants to refer patients to primary care following the anchor hospitalization or procedure. CAFM and the AAFP support the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordinating care with other health care professionals. Involving the patient's physician-led primary care team in ongoing health management is a hallmark and primary objective of family medicine, and we appreciate CMS' recognition of care continuity's importance regarding patient outcomes. **To secure continuity and alignment across care settings for patients, we encourage CMS to clarify that TEAM participants ensure the referral to primary care included in hospital discharge planning is consistent with the patient's PCP status recorded at initiation of the hospitalization or procedure.**

CMS' proposed one-year glide path for hospitals in the TEAM model demonstrates a recognition of the challenges involved in transitioning to new payment models. However, for safety net hospitals and other hospitals experiencing challenges related to their infrastructure, a longer glide path is crucial. An extension to this period enables hospitals to thoroughly prepare by planning,

redesigning workflows, investing in necessary resources, assessing financial stability, and ensuring care continuity during each stage of the transition. **Our organizations strongly advocate for CMS to extend the glide path beyond the suggested one year to ensure a smooth and effective transition for all hospital types, particularly safety net providers serving vulnerable populations.**

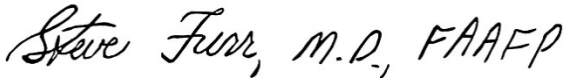
CMS proposes the inclusion of Hierarchical Condition Categories (HCC) in the TEAM model, which our organizations believe should account for both HCC weights and counts in the risk adjustment, in addition to HCCs captured during the episode, as is done in the Bundle Payments for Care Improvement Advance (BPCIA) Model. CAFM and the AAFP recommend CMS use a one-year look back for HCCs, comparable to Medicare Advantage risk adjustment methodologies. Our organizations urge CMS to risk adjust for all clinical data elements in the TEAM model as well as include recognition of social factors that may influence patient risk as they do in the BPCIA methodology, especially whether a patient lived in a nursing home prior to the episode and whether a surgery was due to an emergency.

While our organizations support prioritizing PCPs in the TEAM model, we urge CMS to consider the impacts of the national physician shortage. Hospitals, depending on their location, might experience challenges when referring patients after discharge. We encourage CMS to implement safeguards that would prevent providers from being penalized for situations beyond their control.

Conclusion

Thank you for your consideration of our comments. We look forward to a continued partnership with CMS to streamline processes for physicians and patients, address the primary care physician shortage, and strengthen the Medicare GME program. Should you have any questions, please contact Nina DeJonghe, CAFM Director, Government Relations at ndejonghe@stfm.org and Mandi Neff, AAFP Regulatory and Policy Strategist, Government Relations at mneff2@aafp.org.

Sincerely,



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[i] Rains J, Holmes GM, Pathak S, Hawes EM. The Distribution of Additional Residency Slots to Rural and Underserved Areas. JAMA. 2023 Sep 12;330(10):968-969. doi: 10.1001/jama.2023.14452.
[ii] Rodefeld L, Adhikari M, Hawes EM. Overview of CAA Sec. 126 Round Two Graduate Medical Education Slots. https://www.ruralgme.org/wp-content/uploads/2023/12/CAA-Sec-126-Round-Two-Analysis-Dec-2023.pdf. Accessed May 24, 2024.