

July 2, 2020

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS–1735–P
P.O. Box 8013
Baltimore, MD 21244–1850

Attention: Graduate Medical Education provisions within CMS–1735–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 29, 2020, *Federal Register*, titled “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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals”

Our comments focus on the section of the proposed rule regarding Graduate Medical Education (GME.) CMS states that it is “proposing policy changes related to closing teaching hospitals and closing residency programs to address the needs of residents attempting to find alternative hospitals in which to complete their training and to foster seamless Medicare indirect medical education and direct graduate medical education funding. This proposal would expand the existing definition of who is considered a displaced resident (beyond residents who are physically present at the hospital training on the day prior to or the day of hospital or program closure). These proposed policies would provide greater flexibility for the residents to transfer while the hospital operations or residency programs were winding down and would allow funding to be transferred for certain residents who are not physically at the closing hospital/closing program.”

Displaced Residents:

We wholeheartedly support CMS’s intent to expand the definition of displaced resident and the intent to provide greater flexibility for residents transferring to other programs. We have some concerns and recommendations regarding the specifics of the proposal that we bring to your attention here.

We appreciate and support the decision by CMS to help address the needs of residents, not just hospitals, in situations where programs and/or hospitals are closing, and residents must find a new program where they can continue their training. Specifically, we support a change where

the temporary funding would follow a resident prior to the day of the program or hospital closure. We are aware of many instances where residents have had to continue to work at the "old" program/hospital until it closed and report for work at the new program/hospital the next day – a move that is very difficult to make if the new program/hospital is in a different town, or even state.

This proposal would identify the key date by which the temporary funding could flow to another hospital as the day the closure is publicly announced, either through a press release or formal notice to the Accreditation Council on Graduate Medical Education (ACGME). One concern we have relates to the situation where the public announcement occurs far in advance of the closing date. We are apprehensive about the impact on programs and hospitals should residents leave their programs too early. Residents provide a needed workforce and have a panel of patients that they care for. We wish to see enough time to allow ease of transition for the resident, but also for the hospital to ensure a sufficient replacement workforce to take care of the patients the residents see and to whom they provide care. We would recommend an outer boundary of time such as 30 to 60 days prior to program/hospital closure. In the case where the announcement is made months ahead of time, this recommendation would allow residents a smoother transition, but still allow safeguards for the hospital to plan for and provide adequate workforce to protect current patient access and care.

We support the new definition of displaced resident included in the proposed rule, with the caveat mentioned above. In particular, we support the additional inclusion in the definition of displaced resident those who 1) are on planned rotations at other hospitals at the time of closure, 2) are matched, but have not yet started training, or 3) is on approved leave. Related to point number two, we would like CMS to clarify that when it uses the term "matched" that it means not only residents who were matched through the National Resident Matching Program (NRMP) on Match day, but also those residents who are offered positions through the Supplemental Offer and Acceptance Program (SOAP) in the days following the initial Match process.

Use of Social Security number:

CMS has stated that in the 1999 IPSS final rule (64 FR 41523), a letter to the Medicare Administrative Contractor containing information regarding temporary residents must include the names and social security numbers, among other data. CMS states that in order "to reduce the amount of personally identifiable information (PII) included in these agreements, we are proposing to no longer require the full social security number for each resident." Instead CMS will require the last four digits of the resident's social security number. While we applaud the basis for this change, we wonder why CMS doesn't replace the social security number requirement with a requirement to provide the resident's National Provider Identification (NPI) number instead? The NPI is a unique identification number for covered health care providers. The NPI is a 10-position numeric identifier, with a check digit in the 10th position and no intelligence about the health care provider in the number. (See 45 CFR 162.406) Once assigned, a provider's NPI is permanent and remains with the provider regardless of job or location changes. Because medical students, interns, residents and fellow are health care providers, they are eligible for NPIs. While not required initially, as soon as residents transmit any health data, such as write prescriptions, refer patients, or order tests for patients in claims transactions, or for faculty to bill for their services, they are considered covered health care providers and must have an NPI number.

In summary, we applaud the changes that CMS proposes to ease the transition of residents from a program/hospital that is closing to a new program and hospital. We ask for CMS to

consider the recommendations we provide for making the transition process even more streamlined and equitable for both residents and institutions.

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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