

February 24, 2022

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-1752-FC3; Changes to Medicare Graduate Medical Education Payments for Teaching Hospitals

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 final rule with comment.

We applaud the Centers for Medicare & Medicaid Services (CMS) for prioritizing health equity in the final rule. As the largest funder of graduate medical education, Medicare plays a significant role in addressing physician maldistribution and disparate access to care across the nation. The final rule takes several important steps to direct Medicare graduate medical education (GME) funding to the areas of greatest need.

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

Determinations Required for the Distribution of Residency Positions

CMS finalized its criteria, largely unchanged from its proposed rule except for the fourth category, for hospitals to qualify for new GME slots, consistent with the CAA.

- 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)

Under CMS' final policy, an applicant hospital qualifies under Category Four if it participates in training residents in a program in which the residents rotate for at least 50 percent of their training time to a training site(s) physically located in a primary care or mental health only geographic HPSA. The AAFP and CAFM [strongly supported](#) the proposal to require that at least 50 percent of the residents' training



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time must occur at training locations within a geographic HPSA and we are pleased CMS finalized this proposal.

CMS modified the requirements for hospitals to qualify as Category Four based on our organizations' [concerns](#) that the proposed definition did not include non-provider-based facilities where a hospital may count training time for indirect medical expense and direct graduate medical expense (IME/DGME) purposes (such as critical access hospitals, rural health clinics, federally qualified health centers, etc). CMS notes in the final rule that any and all program training that occurs in a geographic HPSA at scheduled program training sites that are physically located in that HPSA and treat the HPSA's population, including non-provider settings and Veterans Affairs facilities, will count towards meeting the 50 percent training requirement to qualify under Category Four. In addition, because CMS is revising the proposed definition of Category Four to allow all of these settings to be qualifying training sites, an applicant hospital (including any provider-based facilities) itself will not be required to be physically located in a geographic HPSA in order to be eligible under Category Four as proposed. Rather, as long as the hospital participates in training residents in a program where at least 50 percent of the training time occurs at scheduled training site(s) that are physically located in a geographic HPSA, that hospital is considered to be eligible under Category Four. Our organizations support this change and appreciate CMS being responsive to our comments.

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

CMS proposed to limit each hospital to receiving 1.0 full time equivalents (FTEs) per year. Our organizations [expressed](#) concerns that 1.0 FTEs per year would be insufficient to establish a new program or meaningfully expand an existing program, and deter smaller hospitals from applying for new residency slots. Based on these and other comments, CMS modified its policy in the final rule to adjust the size of the award to the length of the program for which a hospital is applying. Specifically, the maximum award amount is contingent on the length of the program for which a hospital is applying, with up to 1.0 FTE being awarded per program year, not to exceed a program length of 5 years or 5.0 FTEs. For example, a hospital applying to train residents in a program in which the length of the program is 3 years, such as family medicine, may request up to 3.0 FTEs per fiscal year. **We appreciate CMS' consideration of our comments and agree that this final policy provides a more appropriate level of financial support and certainty for hospitals, which will more effectively address ongoing physician shortages and maldistribution.**

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

CMS finalized without modification the proposal to prioritize applications from qualifying hospitals for residency programs that serve underserved populations in geographic HPSAs or population HPSAs. **Our organizations [commented](#) in strong support of this approach and applauded CMS for finalizing it. We continue to believe that prioritizing applications from qualifying hospitals based on their HPSA score will meaningfully advance health equity and help address disparate access to care in many communities.**

Similar to the modifications CMS made to requirements for qualifying as a Category Four hospital, CMS modified the final policy to note that all training that occurs at program training sites that are physically located in the HPSA and treat the HPSA's population will count towards meeting the 50 percent training criterion. The same policy is applied to population HPSAs. Our organizations support this modification.

Based on comments provided by our organizations, CMS also finalized a policy to prioritizing smaller hospitals size as a tiebreaker when prioritizing applications with equal HPSA scores. If there are insufficient FTE slots remaining to distribute to applications with equal HPSA scores, CMS will first distribute FTE slots to applications for hospitals with less than 250 beds. Our organizations support this final policy and appreciate CMS' thoughtful consideration of our comments, as well as the importance of supporting training opportunities at smaller hospitals.

CMS noted in the preamble of the final rule that our organizations recommended the incorporation of an "impact factor" that measures the proportion of residents that ultimately go on to practice in HPSAs. CMS agreed that a measure of the extent to which residents later practice in underserved areas may be beneficial. In order to inform potential future rulemaking, CMS welcomed further comment on how to best estimate the impact factor using appropriately comprehensive and transparent data sources across physician specialties, and how to weigh an impact factor in the prioritization. Our organizations appreciate CMS considering our proposed impact factor and are pleased to share additional information and analyses supporting the use of our impact factor and how CMS could weigh it in the prioritization of slots in the future.

Refined Impact Factor Proposal and Analysis of the Value of Using the Impact Factor

Since submitting our [comments](#) on the proposed rule, we have worked to refine the data and methodology used to develop our impact factor to be more easily reproducible. We are only able to obtain the necessary data at the sponsoring institution level (as opposed to the residency program level) and therefore the following impact factor and analyses are applied to sponsoring institutions. However, based on existing analyses, we continue to believe the impact factor could be applied at the program level by CMS, if the necessary data are available.

To develop our impact factor, we use data from the American Medical Association Masterfile (November 2021) to select our cohort of physicians and determine where they practice and the 2020 HRSA HPSA file to determine where primary care HPSAs are located. We used data from the 2020-2021 ACGME file to identify sponsoring institutions. We found all physicians that graduated medical school in 2016 and then narrowed our sample to those physicians that were still in active practice 5 years later. 2016 was chosen because it is the latest year for which data on practice location is currently available. This measures residents in practice 5 years from medical school graduation. This sample includes 21,375 physicians that received residency training from 622 sponsoring institutions. We then determine what proportion of physicians are practicing in primary care HPSAs in 2021 compared to the total number of residents that began training at each sponsoring institution in 2016. For example, if a sponsoring institution had 15 physicians that began training in 2016 and 5 of them are practicing in primary care HPSAs in 2021, that sponsoring institution would have a proportion of 0.33. We then convert the proportions into a score that can be used alongside the HPSA score.

In our comments on the proposed rule, our organizations recommended CMS prioritize applications from hospitals based on a *combination* of their HPSA score (as proposed and finalized by CMS) and our impact factor. Our organizations again recommend that CMS provide at least equal weight to the impact factor score as the HPSA score when combining them. We believe this can best be achieved by adding the HPSA score and impact factor together to get a total score based on 50 possible points. To achieve this, we converted our impact factor, which was originally a proportion, to a 25-point scale to allow CMS to consider it equally to the HPSA score.

In order to make this conversion, we used the standardized ranking method. This method can be roughly translated to multiplying each proportion by 25 (and then rounding to the closest whole number)

to get the impact factor score. Those with the highest impact have a score of 25 and those with no graduates practicing in a HPSA have a score of 0.

We then conducted analyses to better understand the value of including the impact factor in a prioritization for new slots. In our primary analysis, we compared HPSA scores with the impact factor to determine whether there was a significant difference in scores across sponsoring institutions.

In conducting a head-to-head comparison, we found that 39 percent (242 out of the total 622) of the sponsoring institutions differ substantially across the two measures. See table 1.

Table 1. Comparison between Primary Care HPSA Score and Impact Factor score among sponsoring institutions (2016-2021).

Sponsoring institutions in 2021-22 with PGY1s in 2016 (n=622)		HRSA HPSA		
		No & Low 0-7	Medium 8-16	High 17-25
RGC Impact Factor	No & Low 0-7	305	99	51
	Medium 8-16	24	66	35
	High 17-25	2	31	9

The black cells in Table 1 represent the sponsoring institutions for which the HPSA and impact factor measures have the same results. The orange and red cells show how many sponsoring institutions for which the results for the measures vary. For example, there are 2 sponsoring institutions with HPSA scores of 7 or below that have an impact factor score of 17 or over. There are also 31 institutions that have a medium HPSA score but a high impact factor score. Given the limited number of available slots, it is likely that these sponsoring institutions would not be awarded new slots under the methodology finalized by CMS. However, these institutions have a track record of training physicians who ultimately go on to practice in physician shortage areas and are therefore meaningfully addressing disparate access to care. **These results indicate that the impact factor adds significant value and should be incorporated into future efforts to distribute new residency slots.**

We noted in our comments on the proposed rule that 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. Table 1 confirms that both of these assertions are true: there are 51 sponsoring institutions with high HPSA scores and low impact factor scores. **Ultimately, CMS' methodology 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.**

In Table 2 we use specific sponsoring institutions to demonstrate how adding the impact factor score to the HPSA score could change how sponsoring institutions are ranked and therefore the distribution of

new slots. The HPSA and impact factor scores in the tables below are actual scores from actual sponsoring institutions but we have removed their names and identification numbers.

Table 2. Sample results of adding together the HPSA and impact factor scores on three sponsoring institutions with low, medium, and high HPSA scores.

Sponsoring Institution	PC HPSA Score	Impact Factor Score	Final Score (HPSA Score + Impact Factor Score)
A	4	25	29
B	13	20	33
C	20	8	28

Sponsoring institution A has a low primary care HPSA score of 4 but a high impact factor score of 25. Sponsoring institution B has a moderate HPSA score of 13 and a high impact factor score of 20. Sponsoring institution C has a high HPSA score of 20 and a low impact factor score of 8. Based on the methodology finalized by CMS, sponsoring institution C would be prioritized to receive new slots first. By adding in the impact factor score, sponsoring institution B would be prioritized first, followed by sponsoring institution A. In other words, adding the impact factor score to the HPSA score may significantly change the way CMS ultimately distributes new slots.

These differences also hold up among only those institutions with the highest HPSA scores. Table 3 shows how all sponsoring institutions with a HPSA score 20 or over would fare if the impact factor score was added in. Under the methodology finalized by CMS, the sponsoring institutions would be prioritized for new slots in the following descending order.

Table 3. Sample results of adding together the HPSA and impact factor scores on sponsoring institutions with the highest HPSA scores.

Sponsoring Institution	PC HPSA Score	Impact Factor Score	Final Score
D	22	25	47
E	21	3	24
F	21	0	21
G	20	15	35
H	20	12	32
I	20	14	34
J	20	2	22
K	20	3	23
L	20	5	25
M	20	3	23
N	20	6	26
O	20	0	20
P	20	25	45
Q	20	25	45
R	20	8	28

Adding in the impact factor score reveals that several of the institutions with the highest HPSA scores do not have a high proportion of trainees practicing in HPSAs. If CMS were to use our proposed methodology, the order of prioritization would change because sponsoring institutions, such as E and F would be ranked closer to the bottom of this list while other sponsoring institutions would move up because they have higher impact factor scores.

Using our proposed methodology, new residency slots would be distributed to these institutions in the order in Table 4.

Table 4. Change in distribution order when the impact factor score is applied to sponsoring institutions with the highest HPSA scores.

Sponsoring Institution	PC HPSA Score	Impact Factor Score	Final Score
D	22	25	47
P	20	25	45
Q	20	25	45
G	20	15	35
I	20	14	34
H	20	12	32
R	20	8	28
N	20	6	26
L	20	5	25
E	21	3	24
K	20	3	23
M	20	3	23
J	20	2	22
F	21	0	21
O	20	0	20

These analyses and examples demonstrate that distribution could be improved by including the impact factor score in the prioritization of future residency slots. Combining the impact factor score with the HPSA score also advances CMS’ goals of improving health equity and access to comprehensive care. While targeting new slots to those institutions and programs located in HPSAs may help improve comprehensive access to care at the institution where a physician completes their training, the impact factor considers the longitudinal impact of each program or institution and enables CMS to more intentionally invest in programs that train physicians who practice long-term in shortage areas.

Our organizations also understand that, in order to use our impact factor for prioritization in future rulemaking, CMS would need a methodology for applying it to new sponsoring institutions or programs, as well as those with too few graduates to have an established track record for the impact factor above.

HRSA has [established criteria](#) for identifying program applications that qualify for underserved funding preference for the Primary Care Training and Enhancement: Residency Training in Primary Care (PCTE-RTPC) Program.

HRSA defines new programs as residency programs that have graduated/completed less than three classes. (New rural track programs within existing residency programs do not qualify, while ACGME Accredited rural training programs that have not yet graduated three consecutive classes do qualify as new programs. Those that have been significantly changed or improved with a new focus do not qualify for the preference.

New programs, as defined above, must meet at least four of the following criteria to qualify for a medically underserved funding preference:

1. The training organization's mission statement identifies a specific purpose of the program as being the preparation of health professionals to serve underserved populations.
2. The curriculum of the program includes content which will help to prepare practitioners to serve underserved populations.
3. Substantial clinical training in medically underserved communities (MUCs) is required under the program.
4. A minimum of 20 percent of the clinical faculty of the program spend at least 50 percent of their time providing or supervising care in MUCs.
5. The entire program or a substantial portion of the program is physically located in a MUC.
6. Resident assistance, which is linked to service in MUCs, is available to residents through the program. Federal and state resident assistance programs do not qualify.
7. The residency program provides a placement mechanism for helping graduates find positions in MUCs.

Our organizations recommend CMS adopt the same policy: new programs should be awarded five points for meeting each criterion, with a maximum of 25 points being awarded for meeting four or more criteria. These criteria are specialty agnostic and were designed to meet the same goal of the impact factor: to prioritize funding for new residency training opportunities to programs with a demonstrated commitment to training physicians who ultimately go on to practice in areas of the greatest need. We also note that HRSA's definition of an MUC is broader than the definition of a HPSA, which we believe would enable more new programs to meet these criteria while still advancing CMS' goal of improving health equity.¹

By awarding points for each criteria met, new programs will be encouraged to take several steps to demonstrate their commitment to addressing physician shortages and maldistribution, but they will not be disadvantaged if they do not have the available resources to meet four or more criteria. Further, by awarding points on a 25-point scale, CMS can add the points to the program's HPSA score, as we proposed for non-new programs.

¹ HRSA's [definition](#) of an MUC: A geographic location or population of people eligible for designation by the federal government as a Health Professional Shortage Area, Medically Underserved Area, Medically Underserved Population, or Governor's Certified Shortage Area for Rural Health Clinic. As an umbrella term, MUC also includes populations such as people experiencing homelessness, migrant or seasonal workers, and residents of public housing.

HRSA requires new programs to provide data and other documentation to prove that they meet the selected criteria. We recommend CMS also require this documentation in order to reward programs with points.

We strongly recommend CMS consider implementing an impact factor score in the distribution of future residency slots. We stand ready to work with CMS to operationalize this proposal.

Implementation of Section 127 of the CAA, “Promoting Rural Hospital GME Funding Opportunity

This section relates to Rural Training Tracks (RTTs), now called Rural Track Programs (RTPs), which historically has been defined as “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, and 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 each such hospital located in a rural area that participates in such a training.

As noted in our proposed rule comments, we are grateful that CMS included the following provisions in the final rule: complying with the new statute to remove the requirement for separate accreditation, the removal of the rolling average, the ability for both the rural and urban hospital to expand their FTE cap for a rural track program, and the ability for an urban hospital to partner with multiple rural sites. We are also appreciative of some of the changes CMS included in the final rule, including the suspension of the intern and resident-to-bed ratio cap, and allowing for flexibility for new rural track programs (starting July 1, 2022) to avail themselves of the exemption from the rolling average for cost reports beginning on October 1, 2022.

There are several areas in this section, however, that we are concerned about and have provided comments with respect to them.

Cap Adjustment for Urban and Rural Hospitals Participating in Rural Training Track Programs

In our previous [comments](#), we noted that CMS should allow an increase to an existing rural RTT “spoke.” In the final rule, CMS “limited the provision of an increase to the urban and rural hospitals’ RTT FTE limitations only to the instance where additional residents are recruited to add a new rural RTT “spoke” to the existing urban “hub”, and not to allow increases to the RTT FTE limitations in the instance where the urban and rural hospital add additional FTE residents to an existing rural RTT “spoke.”

As we highlighted, CMS applied the statute correctly in allowing existing RTPs to expand to new sites, but incorrectly in not applying the same language to existing sites. **The CAA changed the underlying statute (BBA) and gives CMS the authority to make these changes.** Additionally, [the committee](#)

[report](#) accompanying the BBA states (on page 211): “The Conferees are also concerned about the application of the limit on the number of residents to programs established to serve rural underserved areas, which the Conferees believe have special importance in easing physician shortages in such areas. The conference agreement provides the Secretary with statutory direction to provide special consideration to such programs.”

Moreover, CMS states in its final rule that the new CAA 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.**” **The statute does not say that the adjustment to the cap must only be for new sites, or only for those hospitals wishing to create additional RTTs.** The statute simply says, “in the case of a hospital not located in a rural area that established or establishes a medical residency training program (or rural tracks) in a rural area, or establishes...” We believe CMS goes beyond the statute to imply that it only applies to new sites. Given the strength of the statute and report language, as well as CMS’ own interpretation that it has new authority, we believe it is inaccurate for CMS to take the position that it has no leeway in providing relief for expansion of current existing rural training sites of RTPs.

With the understanding that CMS’ position is that it not “render the cap meaningless,” we believe that our recommendation, and that of others, to allow for a one-time cap reset is reasonable and appropriate. We further argue that the statute does not need to delineate an exceptions process in order for CMS to implement a one-time exception, since we believe this is well within CMS’ authority.

CMS has recognized the need for equity in allowing specialties other than family medicine to have the opportunity to expand training in rural sites. They would now have a five year cap-building period for any new training sites that are established for these new rural track programs. While we agree that rural communities would benefit from other specialties creating rural track programs, we note that existing family medicine separately accredited rural track programs should not be disadvantaged for their previous innovation and commitment to serving rural communities. In effect, only family medicine existing rural training sites are disadvantaged by not allowing existing sites to expand as family medicine has been the only (except for a few exceptions) separately accredited rural training tracks. These programs/hospitals, who have been the innovators and pioneers in rural training and the communities they serve, should not be harmed for their innovation.

Based on a strict reading of the statute, and a need for an equitable solution, we believe that CMS should “adjust in an appropriate manner” by allowing a one-time exception to the cap on existing rural hospital sites participating in a rural track program, and further to allow, at a minimum, five years for the expansion to take place. That expansion also shouldn’t be limited to a specific number. It should be up to the hospital and program to see what the community can support for training purposes. We hope that CMS will see that a strict reading of the new statute, not biased by concerns about expansion, allows for the expansion of existing rural site limitations, and recommend CMS revise the final rule accordingly.

Cap Adjustments When the Urban Hospital Adds Additional Rural Training Tracks

Our organizations request CMS support a different way of determining the slot allocation between the rural and urban hospitals from the current one. This is not a new issue, but it is one that has come to light as the new rules highlighted the process for allocating new cap adjustments, and as rural hospitals are allowed to set a rural track FTE limitation. We hope that CMS can use the authority granted in the CAA (...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.”) to provide relief to rural hospitals training residents of RTPs.

Currently, CMS counts the time residents spend training at the rural site, across five years, and the time spent in the urban setting, and then counts the highest number (in any program year) during the fifth year of the cap-setting window across all participating hospitals. That number is multiplied by the program accredited length and then for each hospital a ratio of that hospital’s FTE’s training over the entire five years over the total training time of training for both sites (rural hospital and rural non-hospital site counted together.) Because a rural track program typically has its residents train in the urban hospital in year one, rather than in the rural setting, the urban hospital gets more than its fair share of the cap, and the rural site gets less than the actual number of FTE’s training in that site. When apportioned this way, rural sites are disadvantaged compared to urban hospital sites. See the example below.

	Year 1	Year 2	Year 3	Year 4	Year 5
PGY1 all urban	2.0	2.0	2.0	2.0	2.0
PGY2 all rural	0.0	2.0	2.0	2.0	2.0
PGY3 all rural	0.0	0.0	2.0	2.0	2.0
Total	2.0	4.0	6.0	6.0	6.0

Calculations

- 5 Year Total FTEs claimed = 24
 - o 10 by urban hospital and 14 by rural hospital
- Cap calculated as $2 \times 3 = 6$
- Apportioned:
 - o Urban $10/24 * 6 = 2.5$ slots (but they will be claiming 2 FTEs in all future years)
 - o Rural $14/24 * 6 = 3.5$ slots (but they will be claiming 4 FTEs in all future years)

Since the first couple years of an RTPs existence always have more urban versus rural hospital time compared to the mature program this distorts how the cap is apportioned. The urban hospital gets more cap than needed versus the rural hospital that gets less than needed in all future “mature” years.

We recommend that CMS, for the purposes of providing “an adjustment in an appropriate manner” give special consideration to the rural hospital by counting the highest year, rather than using all five years when determining the ratio for apportionment.

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

We are very pleased that CMS has responded positively to our request to allow hospitals who started new programs between when their low (eligible) cap was set and the passage of the CAA, and who are starting new programs within the five-year window to be able to adjust their cap once they meet the 3 FTE trigger to account for the new programs begun after enactment.

We also appreciate that CMS has given an opportunity for a choice of base period for establishing a new PRA. The final rule provides an option for hospitals which have already started training at least 1.0

FTE or more than 3.0 FTEs in a cost reporting period beginning immediately following enactment. The hospital could choose to use either that cost report as the PRA base period, or the hospital could wait to see if the first cost reporting period beginning after issuance of this final rule would result in a more favorable PRA. Moreover, we support CMS' new position that it will not require that residents be on duty during the first month of the PRA base period for teaching hospitals receiving a PRA reset, and for new teaching hospitals in general.

Lastly, we appreciate the forbearance of CMS in recognizing that there has been a great deal of confusion in the past for hospitals who have not claimed residents who had rotations training with them, and which would have caused the zero PRAs and low caps if CMS was aware of them. Much of the confusion was due to lack of understanding of the regulations as some do not consider themselves teaching hospitals. We appreciate that CMS created a mechanism for these hospitals to accurately set caps in the future. We also appreciate that CMS is developing guidance through the Medicare Learning Network to help address this problem. This and any additional efforts by CMS to publicize this requirement will be extremely valuable.

Thank you for your consideration of our comments. We look forward to continuing to work with CMS to address the primary care physician shortage and strengthen the Medicare GME program. Should you have any questions, please contact Meredith Yinger, the AAFP's Senior Regulatory Strategist, at myinger@aaafp.org and Hope Wittenberg, CAFM Director, Government Relations hwittenberg@stfm.org.

Sincerely,



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