CMS rules affecting rural Family Medicine Training:

Comments, change possibilities, scenarios and questions

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CMS's job

- CMS has no work-force training mission.
- Various laws make CMS a conduit for some GME funding
- … but the impact of that funding (or not) on the future workforce of physicians is not the concern of CMS.
- The primary mission of CMS staff is to clarify and enforce (via the MACs) the rules.
- The "rule making" part of CMS looks to established law (primarily) when writing rules but is open to comments and suggestions if these are consistent with existing laws.

How can specific rules be changed?

- Different interpretations by Intermediaries (MACs) or CMS staff?
- The formal rule making process within CMS?
- Which require new legislation?

Scenarios…

- Can a potential program sponsor get a determination ahead of time about whether a specific new residency program scenario will or won't be eligible for Medicare GME funding involving specific hospitals?
- Is that interpretation ("determination") subject then to change by CMS or the MAC once the program is established?

Scenario A: A new RTT

where none has gone before

- A "virgin" rural hospital wants to do a FM RTT.
- They would like the first year rotations to take place at a nearby urban hospital (or two) some of whom already participate in an urban FM residency. There has never been an RTT in any specialty that has used these urban hospitals.
- For scheduling purposes the new RTT will need to coordinate somewhat with the existing programs (many specialties) that use the urban hospitals.
- In all other ways the new RTT will be a completely separate and new program: new program director, new faculty, new R1s recruited (matched) specifically for the new RTT. In this scenario:
  - **Will CMS consider this a "new program"?**
  - **Will the rural hospital establish a PRA and it's own cap?**
  - **Will the urban hospitals get any cap addition?**
  - **Does it matter who is the ACGME sponsor of the new program?**
  - **Does it matter who employs the residents or the program director or faculty?**
  - **Does it matter if the new RTT coordinates recruitment of residents or faculty development with any of the urban programs?**

Scenario B: A new RTT
with another in the region

- A "virgin" rural hospital wants to do a FM RTT.
- They would like the first year rotations to take place at a nearby urban hospital (or two) some of whom already participate in an urban FM residency **and a different FM RTT in a different community.**
- For scheduling purposes the new RTT will need to coordinate somewhat with the existing programs (many specialties) that use the urban hospitals.
- In all other ways the new RTT will be a completely separate and new program: new program director, new faculty, new R1s recruited (matched) specifically for the new RTT. In this scenario:
  - **Will CMS consider this a "new program"?**
  - **Will the rural hospital establish a PRA and it's own cap?**
  - **Will the urban hospitals get any cap addition (some but not all participate in another RTT?**
  - **Does it matter who is the ACGME sponsor of the new program?**
  - **Does it matter who employs the residents or the program director or faculty?**
  - **Does it matter if the new RTT coordinates recruitment of residents or faculty development with any of the urban programs?**
  - **Does it matter if the rural hospital also starts having residents rotating there from other established (urban) programs?**

Pre-submitted questions
(not already answered)

- **Rotations in "virgin" Hospitals** inadvertently triggering PRAs and CAPS or being considered program expansions in future
  - Rotation "preplanned regularity" test. Who interprets? When?
  - Fiscal year payment/claims issues. How far back can a hospital go in amending cost reports to claim residents and when must payments (e.g. resident salary and benefits) actually be made?
  - How can a citizen find out if a hospital has a PRA, a cap and what the current numbers are?
  - It appears that if a rural hospital has trained any residents from an established FM program (e.g. a one month rural rotation) then any Family Medicine RTT started at that rural hospital is considered a "program expansion" of the established FM program. True? Origin of rule?

Pre-submitted questions

- **"Community support" issues**:
  - State supported residency expansions. Does this new funding have to be considered tied to specific residents or can it be considered partial support for the entire (larger) resident class? Clarify how this should be handled on cost reports while state support exists and what about when state support ends but positions continue?
  - If THC program becomes unfunded then can residents be claimed? How to avoid a "zero PRA" scenario for THC programs?
- **SCH (Sole Community Hospital) issues.**
  - If a SCH has **no** Medicare Advantage does this mean that it would get DGME but no additional IME if paid at the Hospital Specific Rate (HSR)?
  - If a SCH has **all** Medicare Advantage does this mean that it would get both DGME ***plus*** additional IME if paid at the HSR?.

Pre-submitted questions

- **Sharing caps** – Clarify limitations on cap sharing for post-1996 teaching hospitals.
  - Old teaching hospitals (pre-1996) can lend cap slots TO another hospital (old or new) but can only borrow cap FROM another old teaching hospital.
  - New (post 1996) teaching hospitals can never lend cap TO another hospital (old or new) but can borrow cap FROM an old teaching hospital
- **Questions beyond the scope of the Medicare GME program:**
  - Questions that concern supervision guidelines:
    - Are THC funded residents NOT eligible for the Primary Care Exception for supervision in the FMC?
    - Supervision of residents by non-physicians (e.g. CNMs)
  - Medicare pilot programs to enhance medication management training by residents?

Other questions?

THANKS Miechal !!!