American Hospital Association™
Advancing Health in America

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February 23, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, D.C. 20201

RE: CMS-1752-FC3, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; Changes to Medicare Graduate Education Payments for Teaching Hospitals; Changes to Organ Acquisition Payment Policies (Vol. 86, No. 245), December 27, 2021.

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) final rule with comment period for fiscal year (FY) 2022.

We thank CMS for not finalizing its proposed changes to hospital payments for organ acquisitions, as well as those to the counting of Section 1115 days for the Medicare disproportionate share hospital (DSH) calculation. As we have previously stated, the organ acquisition proposals would have endangered transplant programs' ability to provide care and access to organ transplantations for vulnerable patients. In addition, the Section 1115 proposal would have redefined an approved 1115 wavier program without considering the impact on hospitals.

The agency did, however, finalize several provisions of the Consolidated Appropriations Act (CAA) of 2021 in this rule, including the methodology for awarding new graduate medical education (GME) slots to teaching hospitals. We support CMS' modified policy to award slots based on the length of the residency program. We strongly believe this change will allow teaching programs to create workable and sustainable training programs, and we appreciate

that the agency has made this modification. In addition, we also appreciate that the agency modified its proposal to determine qualifying hospitals for purposes of awarding slots. Specifically, CMS will no longer require that a hospital's main campus or provider-based facility be physically located in a primary care or mental health professional shortage area (HPSA) in order to be eligible.

The agency is welcoming further feedback on the GME program for potential future rulemaking. We appreciate this opportunity. **The AHA continues to believe that Medicare GME funding is critical to maintaining the physician workforce and sustaining access to care. Therefore, we remain very concerned that CMS' methodology prioritizes GME slot distribution by HPSA score and training time in HPSA areas. These methods do not reflect statutory intent and are operationally complicated. We continue to urge the agency to utilize a clear and simple method to distribute residency slots that reflects statutory intent.**

First and foremost, the reliance on HPSAs to qualify eligible hospitals and prioritize residency slots does not reflect statutory intent. Per statute, only *one* category out of four eligible categories requires that hospitals *serve* areas designated as HPSAs. Yet, the agency has required a high threshold of training time to occur *in* HPSAs and instituted a HPSA score to prioritize residency slots across *all four eligible* categories. This reliance on HPSAs minimizes Congress' other priorities to expand training slots for hospitals in rural areas, training above their cap, and in states with new medical schools.

The statue also requires that 10% of the aggregate number of residency slots must go to each of the four eligible hospital categories. Yet, CMS finalized a policy that applications from hospitals for a fiscal year are grouped by the HPSA score and prioritized by descending HPSA score. The agency asserts its belief that this approach would likely result in the statutory minimum of 10% distributions being met for all four of the statutory categories by the end of the 5-year distribution process. However, the institution of policies that likely meet statutory intent is not sufficient.

In addition, HPSA designations fluctuate year to year, creating instability and administrative burden for hospitals that are required to track residents' training time in a HPSA. For example, in 2022, nearly 15% of all primary care HPSAs are designated as "proposed for withdrawal," which would end their HPSA designation.[1] Additionally, hospitals could theoretically meet the 50% HPSA training requirement across several HPSAs, which adds to the burden for training programs that must track several geographic areas at once. It also would create potential issues when HPSA scores are used to prioritize slots. Indeed, it is unclear how CMS will utilize HPSA score prioritization in these instances.

[1] https://www.aha.org/lettercomment/2022-01-24-aha-urges-hrsa-delay-effective-withdrawal-date-hpsas-designated-proposed

Given these challenges, we urge the agency to prioritize slot distribution based solely on the four categories included in the law and give priority to hospitals that qualify in more than one of the four statutory categories, with the highest priority given to hospitals qualifying in all four categories. This approach would be less burdensome and offer a much clearer metric for qualifying hospitals. It also is consistent with the statutory criteria, which do not place any additional emphasis on HPSA service or scores, and still supports teaching hospitals serving underrepresented and historically marginalized populations.

Because the deadline to apply for FY 2023 residency slots is quickly approaching, we urge CMS to distribute these residency slots for the first year without delay and assess the methodology finalized in this rule for future rulemaking. Given the current workforce challenges, we ask that the agency quickly distribute these much needed slots. Additionally, we ask that CMS publish the results of the FY 2023 distribution and work with the relevant stakeholders to refine the approach for future years.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA senior associate director for policy, at 202-626-2963 or swu@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President