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February 25, 2022

Ms. Chiquita Brooks-LaSure Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1752-FC3
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; Changes to Medicare Graduate Medical Education Payments for Teaching Hospitals; Changes to Organ Acquisition Payment Policies (CMS–1752–FC3)

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the final rule with comment period entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; Changes to Medicare Graduate Medical Education Payments for Teaching Hospitals; Changes to Organ Acquisition Payment Policies 86 *Fed. Reg*. 73416 (December 27, 2021), issued by the Centers for Medicare & Medicaid Services (CMS or the Agency).

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Additional information about the AAMC is available at aamc.org.

The AAMC is providing comments in response to several requests for information that may be used for future rulemaking related to § 126 and § 131 of the Consolidated Appropriations Act, 2021 (CAA) that were included in the December 2021 IPPS final rule. In working with members to understand the rules related to the implementation of § 126 we have identified several issues that we believe should be addressed promptly by CMS and have also included those in this letter.

CMS Request for Comment on Alternatives to Measure Care Provided Outside the HPSA to HPSA Residents for Purposes of Prioritization of Residency Slots

Section 126 of the CAA (or the Act) provides for 1000 new Medicare-funded graduate medical education (GME) full-time equivalent (FTE) resident cap slots. No more than 200 slots may be distributed in a year and a maximum of 25 slots may be awarded to any individual hospital over the life of the program. Among the requirements for receiving slots is that a hospital must show a demonstrated likelihood of filling the slots within five years from when the slots are effective. Additionally, only four categories of hospital are eligible to receive slots distributions: (1) Hospitals located in rural areas or that are treated as being located in a rural area (pursuant to § 1886(d)(2)(D) and 1886(d)(8)(E) of the Act); (2) hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit; (3) hospitals in states with new medical schools or additional locations and branches of existing medical schools; and (4) hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs). By statute, each category of qualifying hospital must receive at least 10% of the distribution of awarded slots. The first awards will be effective July 1, 2023.

In the final rule, CMS made some revisions to the proposed rule but in large part retained a similar methodology for slot distribution as was in the proposed rule. In particular, CMS will rely on the HPSA score of training sites as the sole criterion for prioritizing which hospitals will be awarded slots. We also remain concerned regarding the criterion that qualifying for slot prioritization requires that at least 50% of the training of the program must occur at a site located in a HPSA.

As we said in our comments to the proposed rule, we believe that a more equitable method for slot distribution—and one that has been used to distribute residency slots under § 5503 and § 5506 of the Affordable Care Act—is to award slots first to those hospitals that meet all 4 of the qualifying criteria, then three, two and finally a single qualifying criterion. We believe that reliance solely on the HPSA scores of areas in which residents receive training for slot distribution does not reflect the language in the legislation. For example, many teaching hospitals are located close to HPSAs and provide care to the residents of HPSAs, even if not more than 50% of the training occurs in a HPSA. The AAMC appreciates that CMS included in the final rule a request for "comment to inform future rulemaking on incorporating a measure of care provided outside of a HPSA to HPSA residents into the § 126 of the CAA methodology." (p. 73437).

As we suggested in our previous comment letter to § 126, one option is to consider a hospital's proximity to the HPSA. It is not unusual for individuals residing in HPSAs to travel outside the HPSA for care. We understand CMS's reluctance to adopt a single fixed distance as meeting this requirement. As we learned from our members, distance is related to the geography and population of the area with some treating hospitals being adjacent to HPSAs whereas others are miles away. One possibility to address this variation is to look at the teaching hospital or hospitals that are closest to the HPSA.

Another possibility is that a hospital would be eligible for slot prioritization when it serves a certain percentage of the population that resides in the HPSA. CMS could use a hospital HPSA

"utilization ratio" to demonstrate that it provides sufficient care to the HPSA's residents. The ratio would be calculated as the number of HPSA residents who receive care in the hospital divided by the total population of the HPSA. The utilization ratio represents an important aspect of patient care that is vital for HPSA populations. Further work is needed to determine how to prioritize slot distribution if some hospitals qualify based on HPSA scores whereas others qualify based on the utilization ratio.

Request for Additional Modifications Regarding § 126

Publication of Information on Slot Applicants and Awardees

To understand and evaluate the impact of the slot distribution methodology proposal that CMS will be using, the AAMC requests that CMS publish the following information at the time that the slot awards are announced:

- For each applicant:
    - Provider number
    - Qualifying category (1,2,3, or 4)
    - HPSA score
    - Number of slots requested (DGME and IME)
    - Specialty for which slots are requested
    - If slots awarded, number of slots (DGME and IME)

The AAMC believes that publishing the requested § 126 application information would be beneficial to all stakeholders and will provide information that may inform the need for further changes in the methodology for awarding §126 slots.

Aggregation of HPSA scores

In our previous comment letter, the AAMC opposed the proposal to require that at least 50% of training occur in a HPSA to receive priority in the distribution of slots. CMS finalized this criterion. Some AAMC members that train in multiple sites across multiple HPSAs have expressed frustration. These hospitals cannot reach the 50% training requirement at any one of their training sites but do train residents at least 50% of the time in a HPSA when two or more HPSA sites are combined. Determining where residents should train is outside the scope of the CAA and puts the program in a situation where they must meet a new CMS regulation rather than choose the best site for training. We understand that CMS has imposed this requirement in the hope that residents who train in HPSAs may be more likely to practice in those areas. However, this is unlikely to affect the area where a physician practices as there are complex decisions made to determine where a particular physician decides to practice.

The AAMC requests that in future rulemaking, CMS consider whether this requirement should remain and if so, consider allowing hospitals to aggregate training time from sites located in different HPSAs for purposes of prioritization. Since one of the goals of requiring training in

HPSAs is to provide access to patients who live in HPSAs, that goal is accomplished regardless of whether training is in one or multiple HPSAs. Allowing programs to aggregate HPSA training time to meet the "at least 50%" would strengthen the current policy.

If a program uses an aggregation of sites in different HPSAs, different approaches could be used to arrive at a single HPSA score for the § 126 prioritization. One possibility is to average the scores from all HPSAs where training occurs to derive a single score. Another possibility is to weight the scores from each HPSA depending on the amount of time that residents train in the HPSA.

HPSA designations Made after November of the Year Prior to the Award

Under CMS's current policy, a list of qualifying HPSA IDs will be published on the CMS DGME website in November of the year prior to award. This information is made available to hospitals to ensure that they have access to the correct HPSA ID for the electronic application for the § 126 slots. This leaves approximately a four-month lag between the CMS publication of the information and the March 31 application deadline. Areas that receive a HPSA designation after the publication of the list will not find a HPSA score when they enter the address of the HPSA training site into the application, and thus cannot complete the application process.

The AAMC asks that CMS allow a hospital that has a training site that was designated as being in a HPSA after the publication of the HPSA ID list to contact CMS and provide the new HRSA HPSA designation along with a request that CMS update the HPSA ID list promptly and prior to the March 31 application deadline. CMS also should update the HPSA designations on its website on a monthly basis.

CMS Request for Comment on How to Handle Closed Cost Reports and Disputes about Low PRA Amounts and FTE Counts for Purposes of § 131

Section 131 of the CAA allows certain hospitals to reset low or zero per resident amounts (PRAs) or low full time equivalent (FTE) caps. CMS proposed two categories of hospitals eligible for a reset. Category A hospitals would have set a low or zero PRA or FTE cap as the result of less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. Category B hospitals would have set a low or zero PRA or FTE cap with 3.0 or less FTEs in any cost reporting period beginning on or after October 1, 1997, but prior to December 27, 2020. A hospital that reflects the requisite number of FTEs on any cost report beginning on or after December 27, 2020, and December 26, 2025, would be eligible for a reset.

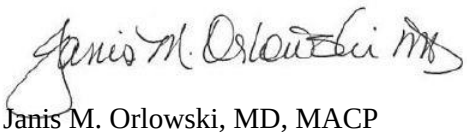
Normally, hospitals have 3 years after the close of their cost reporting period to reopen and make corrections to the cost report. To assist hospitals with resets, CMS provides a downloadable HCRIS file on the CMS DGME website.[1] The HCRIS file contains relevant information necessary to ascertain when a hospital set its PRA or FTE cap, and the number of FTEs that triggered the PRA. CMS has requested "comment on how to handle reviews of PRAs or FTE caps from cost reports beyond the 3-year reopening period" (p. 73462) when the hospital disagrees with the information in HCRIS. For a small set of hospitals that had a PRA or FTE cap

[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

set long ago, it is likely that there is a lack of verifiable information to corroborate a disputed PRA or, more likely, FTE cap. If contemporaneous documentation exists, such as rotation schedules or other internal information, the hospital may be able to provide the information to the Medicare Administrative Contractor for review. If no documentation exists, the AAMC requests that CMS consider an attestation from the hospital administrator or from another official in the hospital's GME program regarding what the correct FTE count should be.

Thank you for your consideration of these comments. The implementation of the CAA provisions will be an on-going process and we appreciate the opportunity to continue to work with you and your colleagues. If you need additional information, please contact Ivy Baer (ibaer@aamc.org) or Bradley Cunningham (bcunningham@aamc.org).

Sincerely,



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