CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 26, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Acting Administrator Richter:

On behalf of our more than 400 member hospitals and health systems – and the 40 million Californians who are cared for by our members – the California Hospital Association (CHA) requests that the Centers for Medicare & Medicaid Services (CMS) include in its fiscal year (FY) 2022 inpatient prospective payment system (IPPS) proposed rule a policy to extend or modify the residency cap-building window for new residency programs impacted by the COVID-19 public health emergency (PHE).

The COVID-19 PHE has disrupted the health care workforce in unprecedented ways. We appreciate that CMS has taken steps to address workforce shortages in its many waivers and flexibilities issued during the PHE. Unfortunately, in the year since COVID-19 hit the United States, communities across the country have seen an increase in the number of physician retirements due to loss of income, burnout, or ongoing health concerns. The coming workforce shortages brought on by increased rates of retirements can only be addressed by training the next generation of physicians. However, the pandemic has created significant and ongoing disruption to hospitals that are in the process of establishing new medical residency programs. **We urge CMS to support the long-term sustainability of physician training programs by temporarily amending the regulations for teaching hospitals with new medical residency programs that have been unable to build their programs to full size before the cap is established due to the impacts of the ongoing pandemic and PHE. Specifically, the agency should extend the five-year cap-building window for impacted hospitals by the length of the PHE plus the additional time needed to reach July 1, to align with the start date of the academic year when residency programs begin**.

The COVID-19 PHE has limited the ability of new residency programs to train residents as planned prior to the pandemic in several ways. Early in the pandemic, the Accreditation Council for Graduate Medical Education (ACGME) – which is responsible for the accreditation of new residency programs – suspended in-person site visits due to COVID-19, later switching to remote site visits, both of which delayed the process that can already take 18 to 24 months from recruitment of program directors and core faculty to preliminary accreditation following site survey and committee reviews. Additionally, the pandemic and related travel and infection-control restrictions have greatly impeded the ability of nascent GME programs to interview and recruit the program directors and core faculty required before new programs can even begin the accreditation process. For programs that were able to move forward once accredited, the PHE has created difficulty in fully staffing residency programs with enough faculty to train residents in their specialties, as well as difficulty recruiting new residents to fill the programs.

Unfortunately, these challenges can be costly to new teaching hospitals, which are under a time constraint to establish permanent direct graduate medical education (DGME) and indirect medical education (IME) residency caps. Prior to the pandemic, a CHA member in a GME-naïve community established an ambitious goal to operate 11 residency programs covering various specialties and training over 200 new residents. These programs are being established in underserved San Joaquin County, one of California's areas most hard hit by the pandemic, with an average of 871 new daily COVID-19 cases at its peak. The programs will serve a community with an aging physician population that is already facing a 4,100-physician shortfall. The pandemic struck 20 months after the hospital started its first residency program. Now, a year into the global pandemic, the hospital has lost at least 18 to 24 months of time due to the strict requirements of ACGME and one-time-per-year residency program start dates. Should CMS not extend the five-year cap-building window, this program will have its residency caps permanently reduced and will be unable to benefit its community to its full potential.

CMS has previously used its broad authority under 1886(h)(4)(F) of the Social Security Act to establish and modify the rules at 42 CFR §413.79. While CMS initially allowed newly participating medical residency training programs only three years to reach full capacity, in the FFY 2013 IPPS final rule, CMS changed its policy to allow medical residency training programs five years to reach full capacity. According to the final rule, CMS changed its rule because:

> Providers explained that 3 years is an insufficient amount of time primarily because a period of 3 years is not compatible with program accreditation requirements, particularly in instances where the qualifying teaching hospital wishes to start more than one new program. For example, we understand that a qualifying teaching hospital may not begin all of its new programs at the same time because of accreditation prerequisites; rather, a qualifying teaching hospital must wait until the first program is in place for a specified amount of time before it can begin training residents in a second or third program. This potential delay means that a qualifying teaching hospital may not be able to sufficiently ''grow'' all of its new programs by the end of the ''3-year window.'' (77 FR 53417)

Hospitals establishing new teaching programs during the COVID-19 pandemic face a similar dilemma – they are unable to meet program accreditation requirements, particularly where a hospital is establishing more than one program, under timelines that were planned prior to the pandemic. As such, these programs are operating with a significant amount of operational uncertainty. **CMS can take action to reduce this uncertainty by extending the cap-building window for new programs impacted by the PHE in its FFY 2022 IPPS proposed rule.**

Notably, CMS is considering a similar change in a different policy context as part of its calendar year (CY) 2022 outpatient prospective payment system (OPPS) proposed rule. Under the transitional pass-through payment rules, CMS provides hospitals with additional payment for devices meeting specific criteria with pass-through payment for a period of between two and three years. The purpose of these payments is to provide hospitals with additional payment for innovative devices until the costs of the device are incorporated into the rates CMS uses to determine payment. In the CY 2021 OPPS proposed rule, CMS sought comments on the concern that reduced utilization of procedures that use pass-through devices during the PHE could result in insufficient time for CMS' rate-setting process to include the costs of these products. In the final rule, CMS stated it will consider the issue during 2022 rulemaking (85 FR 86012-86013). CMS has stated it will consider tolling the period of the pandemic to allow additional time for pass-through payment and reducing barriers to utilization of these innovative devices so their costs can

be incorporated into Medicare's payment systems. Not doing so could permanently disadvantage hospitals that use these products, as they may otherwise be furnished at a monetary loss.

This is a situation that parallels the concerns of hospitals establishing their DGME and IME residency caps during the PHE. Should CMS not extend the cap-building window to account for the impacts of the COVID-19 PHE, these programs will face a permanent limit to their GME payments, diminishing their ability to train the next generation of physicians to the full size of the planned residency programs — and impacting the availability of physicians in their communities for years to come.

We thank you for your consideration of our comments. If you have any questions, please do not hesitate to contact me at mhoward@calhospital.org or (202) 488-3742.

Sincerely,
/s/

Megan Howard
Vice President, Federal Policy