California Hospital Association

February 24, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

SUBJECT: CMS–1752–FC3, 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 (Vol 86, No 245), December 27, 2021

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide feedback on the questions raised in the Centers for Medicare & Medicaid Services' (CMS) inpatient prospective payment system (IPPS) final rule supplemental for federal fiscal year (FFY) 2022 regarding the distribution of additional residency slots as authorized by Section 126 of the Consolidated Appropriations Act (CAA) of 2021.

Section 126 of the CAA authorizes the Secretary to distribute 1,000 new full-time equivalent (FTE) slots over five years (limited to 200 per year) to applicant hospitals beginning in FFY 2023. In determining the qualifying hospitals for which an increase is provided, the law requires the Secretary to take into account the demonstrated likelihood of the hospital filling the positions made available within the first five training years from the date the increase would be effective.

The Secretary is required to distribute at least 10% of the aggregate number of total residency positions available to each of four categories of hospitals:

1) Hospitals located in rural areas or treated as rural for IPPS purposes
2) Hospitals that are training more residents than their FTE cap
3) Hospitals in states with new medical schools or additional locations and branches of existing medical schools
4) Hospitals that serve patients from areas designated as Health Professional Shortage Areas (HPSAs)

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Identifying Teaching Hospitals that Serve Patients Residing in Designated HPSAs

Specific to Category 4, CMS finalized its proposal with the modification that the hospital does not need to be physically located in the HPSA to qualify under Category 4. CHA greatly appreciates CMS' recognition that residents in HPSAs frequently travel outside the HPSAs to access both primary care and specialty care. It is widely recognized that the geographic boundaries that define an HPSA may not accurately reflect an area's health care needs or the market that serves those needs[1].

In the final rule, CMS seeks feedback on how it might develop a measure of how hospitals outside an HPSA are serving patients who reside in an HPSA. In comments on the 2022 IPPS proposed rule, CHA[2] and many other commenters strongly urged CMS to consider a hospital as serving patients in an HPSA if it is physically proximate to that HPSA based on mileage criteria or located in the HPSA. Despite the rejection of the recommendation related to using mileage to identify teaching hospitals that are proximate to an HPSA due to concerns that a "single fixed mileage threshold may not equitably address tertiary care situations because hospitals providing equivalent tertiary care to residents of HPSAs may be located varying distances from those HPSAs," we appreciate CMS' stated willingness to consider it in the future and strongly encourage the agency to do so.

Given CMS' belief that a fixed threshold may not equitably address the health care needs of residents living in HPSAs, we ask that CMS explore a flexible definition of "proximate." For example, if there are no teaching hospitals within a fixed distance of a given HPSA (e.g., 25 miles from the HPSA), then the closest hospital with a resident training program would be deemed as serving the HPSA for purposes of allocating the new residency slots created by Section 126 of the CAA.

If CMS does not believe the methodology described above will equitably address the needs of patients living in HPSAs as they relate to tertiary or quaternary care, we encourage the agency to explore the possibility of using a claims-based analysis to identify teaching facilities that deliver relatively high volumes of care to individuals residing in an HPSA. This methodology could be conceptually analogous to the one used by the Health Services Resources Agency to distribute funds from the $8.5 billion American Rescue Plan Rural Distribution. For each teaching hospital that is not located in an HPSA, CMS could calculate the percentage of Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries who reside in an HPSA the hospital serves. In the equation, the numerator would be defined as Medicare, Medicaid, and CHIP beneficiaries[3] (both fee-for-service and managed care) who reside in an HPSA and received care from the teaching hospital in question. The denominator would be defined as all Medicare, Medicaid, and CHIP beneficiaries (both fee-for-service and managed care) who received care from the teaching hospital in question. Those teaching hospitals, not located in HPSAs, with the highest percentage of Medicare, Medicaid and CHIP beneficiaries who reside in HPSAs relative to their Medicare, Medicaid, and CHIP patient population would then qualify for the distribution under Category 4.

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[1] https://www.gao.gov/assets/gao-07-84.pdf
[2] https://calhospital.org/wp-content/uploads/2021/06/CHA-Comments-FFY-2022-IPPS-Proposed-Rule-062821_FINAL.pdf
[3] This definition could also be expanded to include Medicaid and Children's Health Insurance Program (CHIP) beneficiaries to ensure a focus on reducing access issues for at risk populations. If the definition is expanded to include Medicaid and CHIP, the analysis must include both fee-for-service and managed care claims.

Prior to finalizing any methodology to identify teaching hospitals that provide care to patients who live in designated HPSAs, we strongly encourage the agency to model the results of the various options it explores and make those results available to the public for comment.

Using HPSA Scores to Prioritize Applications for Available Residency Slots

The rule also finalizes the use of HPSA scores as the mechanism to prioritize hospitals for the distribution of available residency slots by awarding them to applicants representing HPSAs with higher scores. In the rule, CMS seeks feedback on feasible alternatives to HPSA scores as a proxy for health disparities to inform potential future rulemaking.

CHA strongly opposes this provision. It is widely acknowledged that HPSA scores are highly flawed[4], given that some states are more diligent about updating HPSAs than others. Further, prioritizing applications based on HPSA scores duplicates criteria that the agency are already mandated by Congress to consider as part of the application process. CHA reiterates that Congress mandated only a minimum of 10% of the new residency positions be allocated to programs serving HPSAs, not 100% — which is what CMS' scoring criteria implies. Had Congress wanted to achieve this outcome through Section 126 of the CAA, it would have explicitly done so. Therefore, using population-based HPSA scores to prioritize the distribution of new residency positions ignores Congress' other priorities — expanding residency slots for hospitals that are training over their cap, residency programs in rural areas, and states with new medical schools, or additional branches of existing medical schools.

Further, many teaching hospitals are adjacent to population HPSAs but are not located in one. Therefore, many teaching hospitals that care for underserved populations will have lower priority to receive FTEs under CMS' criteria. And as such, CMS will have missed an opportunity to expand access to care for underserved populations.

Given these concerns, CHA strongly encourages CMS to use the alternative distribution methodology discussed in the FFY 2022 IPPS proposed rule that prioritizes applicants for the additional slots created by Section 126 of the CAA based on the number of categories for which the hospital qualifies. Under this framework, priority for the additional slots would be given to hospitals that qualify in more than one category with highest priority given to hospitals that qualify in all four categories. CHA believes a distribution based on this framework better aligns with congressional intent as it is based on the four categories Congress specifically included in the legislation to identify hospitals to which the additional slots should be allocated.

If CMS does not adopt the alternative distribution methodology, CHA respectfully asks that the agency publish the results of the FFY 2023 distribution and seek public comment on them to reassess the methodology finalized in this rule. If the methodology finalized in this rule leads to a maldistribution of the residency slots created, we again ask CMS to collaborate with teaching hospitals and create a simplified methodology that allocates these slots in accordance with Congress' intent as defined in Section 126 of the CAA.

[4] https://www.gao.gov/assets/gao-07-84.pdf

HPSA Training Time Requirement

CMS also finalizes the requirement, with clarification, that a hospital that receives one or more slots under Category 4 must attest that at least 50% of the resident's training time over the duration of the program will occur in an HPSA location. CHA remains concerned that this limits the residency program types these slots can be used to train. And, for those types of residency programs that could comply with this requirement, it may limit the resident's development opportunities if the program is forced to adhere to the rigid requirement that the resident spend at least 50% of their time in a rural area. CHA believes the limitations placed on residency programs is exacerbated by the clarification that the 50% requirement applies to the program in its entirety, not to individual residents. **Given these challenges, CHA again respectfully asks CMS to withdraw this burdensome requirement related to Category 4 that will hinder a physician's ability to gain experience practicing in multiple settings during their residency.**

CHA appreciates the opportunity to provide comments on the questions raised by CMS in the FFY 2022 IPPS final rule supplemental. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy