

February 25, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445–G  
200 Independence Avenue, SW  
Washington, DC 20201

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–CMS-1752-FC3; 86 Fed. Reg. 73416, December 27, 2021)**

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS). Specifically, our comments focus on Graduate Medical Education (GME) and other related provisions and Organ Acquisition Payment Policies contained in the final rule.

## **I. GME and Other Related Provisions**

As the United States population grows and ages, the demand for physicians continues to outpace the supply. In the latest study, the projected shortage of physicians is between 37,800 and 124,000 by 2034.<sup>1</sup> The shortage of primary care physicians is projected to be between 17,800 and 48,000 and the physician shortage for non-primary care specialties is projected to be between 21,000 and 77,100 physicians. While new medical schools are opening and existing medical schools are increasing their enrollment to meet the need for more physicians, federal support for residency positions remains subject to a stagnated federal cap that falls dramatically short of the needs of the U.S. population.

Last year, in the first increase since 1996, Congress provided 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act, 2021 (CAA). However, no more than 200 slots may be made available each fiscal year (FY) and no hospital can receive more than 25 additional full-time equivalent (FTE) residency positions in total. Though the AMA applauds CMS for adding the 1,000 new

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<sup>1</sup> The Complexities of Physician Supply and Demand: Projections from 2019 to 2034, <https://www.aamc.org/media/54681/download>.

Medicare funded physician residency slots, we are concerned that most of the suggestions that the AMA offered in our June 28, 2021 comment letter were not addressed.<sup>2</sup>

The AMA does recognize and support that in a few areas CMS made positive changes. For example, CMS had proposed to require that an application must be submitted by January 31 of the prior fiscal year to gain additional residency slots. Then those slots would be awarded by January 31 of the FY in which they are effective. For example, for the initial 200 slots which are effective July 1, 2023 (FY 2023), the completed application would be submitted by January 31, 2022 (FY 2022). The slot award announcement would be made January 31, 2023. The AMA requested that CMS revise the date by which the slots must be announced to October 1 of the federal FY in which the slots are effective since the timing proposed by CMS would not align with the residency recruitment cycle. Though CMS did not change the application deadline to October 1, it did amend the deadline to March 31. While the new timeline will provide some additional time for residency programs to plan and recruit additional residents if they are granted the additional slots, we urge CMS to revise the application deadline to October 1 in order to align with the residency recruitment cycle.

Additionally, the AMA supports the CMS modification to adjust the size of the award to the length of the program for which a hospital is applying. Specifically, the maximum award amount is now contingent on the length of the program for which a hospital is applying, with up to 1.0 FTE being awarded per program year, not to exceed a program length of five years or 5.0 FTEs. However, the AMA still believes that hospitals should be able to apply for up to 15 residency slots to allow programs, depending on specialty, a reasonable expansion over five years. For example, this would allow a five-year general surgery program to recruit three residents for each of the five years. With the assurance of funding for up to 15 slots, hospitals could meaningfully expand one or more training programs. **As such, the AMA urges CMS to make additional adjustments to the program in the future to better allow for program expansion and support.**

The original legislation called for no less than 10 percent of the slots to go to each of the following four categories of hospitals:

- Located in rural areas or treated as being in a rural area;
- Training residents over their Medicare GME cap;
- Located in states with new medical schools or branch campuses on or after January 1, 2000; and
- That serve areas designated as health professional shortage areas (HPSAs).

The CAA does not give preferential treatment to the HPSA category, but rather provides that at least 10 percent of the slots should go to hospitals that serve areas designated as HPSAs. However, the rule currently states that hospitals applying for residency positions for programs that do not serve HPSAs would not be categorically excluded, but those applications would have the lowest priority. However, this distribution methodology does not appear to adhere to statutory intent. Aside from the fact that the Alternative 2 methodology was rejected, which would have provided for a more equitable distribution of slots, prioritizing HPSAs above all other categories has the potential to not adhere to the minimum 10 percent distribution as was required by the legislature.

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 percent of all

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<sup>2</sup> <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-28-Letter-to-Brooks-LaSure-re-IPPS-Comments-v3.pdf>.

primary care HPSAs are designated as “proposed for withdrawal,” which would end their HPSA designation.<sup>3</sup> Additionally, hospitals could theoretically meet the 50 percent 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. As such, it is unclear how CMS will utilize HPSA score prioritization in these instances. **Therefore, the AMA strongly opposes the use of HPSA scores to determine priority for awards of residency slots. Given these challenges, we urge CMS 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 and develop a more refined approach for future years.**

Additionally, CMS is trying to determine how to account for health care provided outside of a HPSA to HPSA residents, and feasible alternatives to HPSA scores as a proxy for health disparities in the prioritization of additional FTE cap slots. CMS agreed with comments previously submitted that training should not be limited to hospital settings physically located in the HPSA to the exclusion of other settings physically located in the HPSA. For a geographic HPSA, any and all program training based on resident rotation schedules (or similar documentation) that occurs in the HPSA at program training sites that are physically located in the HPSA and treat the HPSA’s population, including non-provider settings and Veterans Affairs facilities, will count towards meeting the 50 percent training criterion. For a population HPSA, any and all program training based on resident rotation schedules (or similar documentation) that occurs in the HPSA at program training sites that are physically located in the HPSA and treat the HPSA’s designated population, including non-provider settings and Veterans Affairs facilities, will count towards meeting the 50 percent training criterion.

The AMA strongly opposes the proposed requirement that the hospital or provider-based department be physically located in a HPSA. The AMA also opposes the requirement that at least 50 percent of the resident’s training time occur at facilities located in a HPSA. For example, teaching hospitals may be outside a HPSA but are the primary point of care for a HPSA population. Patients who live in HPSAs may choose to go to a nearby teaching hospital that is adjacent to, but not located in a HPSA, often because it is the closest facility to their home, or it provides specialized services that are needed and are unavailable elsewhere. According to the Association of American Medical Colleges’ (AAMC) analysis of the FY 2019 American Hospital Association Annual Database, AAMC member teaching hospitals represent five percent of all inpatient, short-term, non-Federal, non-specialty hospitals yet they provide 26 percent of all Medicaid inpatient days and incur 32 percent of all charity costs.

Teaching hospitals are best positioned to determine the locations in which to train residents to meet patient needs and accreditation standards. Accreditation standards ensure that residents train in locations with a large enough population to provide them with the necessary mix of patients and conditions for their specialty. Of equal consideration is where adequate teaching physician supervision is available. To mandate that these new residency slots meet the “at least 50 percent” requirement means that hospitals must design residency rotations differently for these residents to ensure that the “at least 50 percent requirement is met.” This is untenable for teaching hospitals and residency programs. Therefore, the way that the HPSA category is determined should be much broader, not require the 50 percent set aside as currently written, and should include health care provided outside of a HPSA to HPSA residents. To help accomplish this, the definition of the HPSA category should be expanded so that a hospital will qualify if (1) it is located within a certain distance, for example 10 miles of a HPSA or (2) is in a geographic, primary care, mental health, or population HPSA.

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<sup>3</sup> <https://www.aha.org/lettercomment/2022-01-24-aha-urges-hrsa-delay-effective-withdrawal-date-hpsas-designated-proposed>.

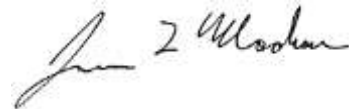
The AMA hopes that this investment in additional Medicare funded residency slots is just the first of many. With this in mind, as CMS hopefully continues to make improvements to the residency positions across the nation, the AMA would encourage CMS to invest additional funding to make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions.

## II. Organ Acquisition Payment Policies

In response to comments<sup>4</sup> from the AMA and other stakeholders, the AMA applauds CMS for not finalizing proposed changes to longstanding Medicare organ acquisition payment policies that had the potential to significantly reduce the deceased donor organs available for transplantation, reduce access to transplantation, and increase the number of patients who die while waiting for a transplant. This feature of the cost accounting system functions as a strong incentive for Transplant Center hospitals to establish effective programs for the identification of potential deceased organ donors and engage in other organ acquisition-related activities. The incentive has worked: Transplant Centers constitute only four percent of Medicare certified hospitals but retrieve 36 percent of deceased donor organs, and organ donation has been increasing over the last few years. In addition, we appreciate the Agency agreeing to perform a comprehensive analysis of the impact of this policy change if it is considered in future rulemaking.

The AMA appreciates the opportunity to provide input on this final rule. We thank you for your consideration and are happy to discuss any of these issues in greater detail with you. If you have any questions regarding this letter, please contact Margaret Garikes, Vice President of Federal Affairs, at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org) or 202-789-7409.

Sincerely,



James L. Madara, MD

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<sup>4</sup> <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-28-TRANSPLANT-STAKEHOLDER-AND-ALLIES-SIGN-ON-LETTER-TO-CMS-IPPS-RULE.pdf>.