February 25, 2022

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 Ave. SW
Washington, DC 20201

Ref: 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

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the above-captioned final rule with comment period. America’s Essential Hospitals appreciates the Centers for Medicare & Medicaid Services’ (CMS’) work to implement graduate medical education (GME) provisions of the Consolidated Appropriations Act (CAA) of 2021 in a way that will close the existing health equity gap. But we believe the chosen methodology falls short of achieving that goal. As the agency revisits GME policies in future rulemaking, we ask it to ensure it bolsters residency programs at teaching hospitals that train the next generation of health care leaders to provide culturally competent care to marginalized and historically underserved communities.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care. Our more than 300 member hospitals fill a vital role in their communities, promoting health, improving health care access, and championing equity. They provide a disproportionate share of the nation’s uncompensated care (UC), and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.¹ These narrow operating margins result in minimal reserves and low cash on hand, circumstances which have been exacerbated by the financial pressures of COVID-19.

Compounding these challenges are essential hospitals’ complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of

essential hospitals’ patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. In communities served by essential hospitals, approximately 10 million people struggle with food insecurity and nearly 22.3 million live below the poverty line.² Essential hospitals are uniquely situated to target these social determinants of health and advance health equity, including by addressing health disparities. But these circumstances strain our members’ resources, necessitating ongoing support to ensure they can continue to provide vital services and promote health equity in their communities.

As CMS begins accepting applications for the new GME slots created by the CAA, we urge the agency to implement a methodology that prioritizes hospitals with a proven track record of providing holistic training to future health care leaders that prepares them for careers providing culturally competent care in underrepresented areas. America’s Essential Hospitals is pleased CMS did not finalize Medicare disproportionate share hospital (DSH) and organ acquisition cost policies that would have harmed essential hospitals and their ability to care for marginalized communities. In future rulemaking on GME, DSH, and organ acquisition cost policies, CMS should consider the following recommendations.

1. **CMS should adopt policies that will encourage the training of health professionals experienced in serving marginalized communities and addressing health inequities.**

CMS should implement policies that will promote residency programs that are focused on training residents in providing culturally competent care to underrepresented populations and marginalized communities. Essential hospitals are committed to training the next generation of health professionals and equipping them with the necessary skills to provide culturally and linguistically competent care. In 2019, the average member hospital trained 240 physicians, more than three times as many as other U.S. teaching hospitals. Further, our members trained an average of 59 physicians above their GME funding cap versus 17 at other teaching hospitals.³

By virtue of their mission to serve all patients regardless of social or economic circumstance, as well as their work to combat structural racism—which is inextricably linked to health care—essential hospitals are well-situated to promote health equity. Because of their own diverse workforce and experience treating diverse patients, essential hospitals are uniquely prepared to provide the culturally competent care their patients need. They incorporate cultural competency and implicit bias training in their residency programs, preparing the next general of health care leaders who go on to practice in underserved communities.

CMS finalized policies implementing the GME provisions in the CAA, including adding 1,000 new teaching slots beginning in fiscal year (FY) 2023 and further detailing the four categories of hospitals eligible for the new slots:

- rural hospitals;
- hospitals training over their Medicare cap;
- hospitals in states with new residency programs or additional locations and branches of existing medical schools; and
- hospitals that serve geographic health professional shortage areas (HPSAs).

² Ibid.
³ Ibid.
In addition to defining the categories of eligible hospitals, CMS finalized a methodology for prioritizing applications from hospitals that will use the new residency positions to treat underserved populations. The agency cited the administration’s focus on addressing health and social inequities as the rationale for prioritizing these hospitals. To achieve this goal, CMS will rank hospitals based on the HPSA scores of the geographic or population HPSAs served by the residency program for which the hospital is seeking additional slots. At least 50 percent of the residents’ training time must occur at sites in the chosen HPSA. Applicant hospitals with the highest HPSA scores will be given precedence, and in cases where there are more applicants than slots available in an HPSA score grouping, CMS will prioritize hospitals with fewer than 250 beds. America’s Essential Hospitals strongly supports the agency’s focus on promoting health equity, but we believe CMS’ chosen methodology will fall short of achieving this goal.

CMS already accounts for hospitals located in a HPSA as one of the four eligibility criteria, so it is duplicative to prioritize applications based on HPSA scores alone. Moreover, while HPSAs measure lack of access to providers in a given area and other social determinants of health, such as poverty and infant mortality, they do not capture the full range of social determinants of health affecting the well-being of marginalized communities. A hospital being in a HPSA is not necessarily indicative of the types of patients the hospital is treating, because hospitals typically treat patients from large geographic areas that extend past their immediate vicinity. Therefore, a hospital can be outside of a HPSA but still treat patients living in multiple other nearby HPSAs, which CMS would not account for under its chosen methodology. In fact, the very presence of a large health system with a vast network of providers of various specialties serving patients in the hospital and its affiliated outpatient locations often results in the immediate geographic area not qualifying as a HPSA. Notwithstanding the absence of a HPSA designation, these hospitals still treat predominantly low-income and other underrepresented patients.

In addition to these shortcomings, prioritizing hospitals solely based on the presence of a high HPSA score leaves out key indicators of a hospital’s commitment and experience treating underrepresented populations, including whether a residency program’s curriculum incorporates elements such as implicit bias training and an exploration of the effects of structural racism on the provision of health care and health outcomes.

We urge CMS to instead prioritize applications from hospitals committed to serving marginalized populations, with a proven track record in training the health care workforce to treat these communities and provide culturally competent care. **Beginning in FY 2024, CMS should target the slots to these hospitals—specifically, teaching hospitals that offer access to essential community services for low-income, uninsured, and vulnerable populations, such as the continuum of primary through quaternary care, including the provision of trauma care, public health services, mental health services, and substance abuse services. Teaching hospitals that fit this description and already have a proven commitment to GME, as evidenced by their training above their GME cap, should be prioritized.** These hospitals reach outside the hospital walls to fill four key roles:

- provide specialized, lifesaving services, such as level I trauma and neonatal intensive care, emergency psychiatric services, and burn treatment;
- train the next generation of health care professionals to ensure the community’s supply of doctors, nurses, and other caregivers meets demand;
- deliver comprehensive, coordinated care across large ambulatory networks to bring services to where patients live and work; and
• meet public health needs by improving population health and preparing for and responding to natural disasters and other crises.

By prioritizing these hospitals for the additional slots, CMS will ensure a steady pipeline of health care workers in the nation’s marginalized communities.

In addition to changing its prioritization methodology, we urge CMS not to use bed size to rank hospitals within a priority grouping. As noted above, CMS says that in cases in which applications exceed available slots within a HPSA score grouping, it will prioritize hospitals with fewer than 250 beds. Instead of focusing on bed size—an arbitrary metric that does not reflect a hospitals’ commitment to underrepresented populations—the agency could give additional weight to hospitals that meet multiple eligibility criteria. For example, within a given HPSA score grouping, hospitals that meet three or four out of four categories of eligibility would receive precedence over hospitals that meet one out of four of the eligibility categories. Focusing on these criteria—instead of the number of beds—better reflects a hospital’s commitment to teaching underrepresented populations relative to other applicants and is consistent with the intent of the CAA, which explicitly listed these eligibility categories.

2. CMS should allow hospitals with a low full-time equivalent (FTE) cap to reset their cap without having to establish a new residency program.

CMS should allow hospitals with low historical FTE caps to reset their FTE caps, even without creating a new residency program. Under Section 131 of the CAA, Congress allowed for certain hospitals that inadvertently triggered the creation of a low GME cap or low per-resident amount (PRA) after hosting a minimal number of resident rotators to re-establish their FTE or PRA. These hospitals have been bound by these low caps and PRAs for Medicare GME reimbursement and under GME rules, have been unable to reset their caps and PRAs, even if they created a new residency program and trained more residents.

Under Section 131, hospitals can reset their PRA and their FTE cap based on the number of residents between December 27, 2020, and December 26, 2025. However, CMS interprets the legislation to mean that for the purposes of resetting its FTE cap, the hospital must conduct this training in a new residency program that was established after December 26, 2020. We urge CMS to interpret this provision more broadly to account for situations in which a hospital is training a significant number of residents in an existing program and intends to reset its FTE cap to reflect the increased residency training occurring at the hospital. CMS’ finalized policy allows hospitals to reset their PRA based on training that occurs in existing residency programs, and it would be consistent for CMS to allow for FTE cap resets based on training in existing residency programs, as well.

3. CMS should include Medicaid Section 1115 waiver days associated with premium assistance programs and UC pools in its calculation of the Medicaid fraction.

We are pleased CMS withdrew its proposal to limit the types of Medicaid Section 1115 waiver days that can be used in the Medicare DSH calculation. However, CMS notes it will consider this policy for future rulemaking, and we urge the agency to refrain from implementing such a policy in future years. The Medicare DSH program provides crucial funding for essential hospital services, including offsetting a significant amount of UC. In 2019, our members provided $6.9 billion in UC, representing 16 percent of all UC
As mandated by Section 3133 of the Affordable Care Act, the majority of DSH payments is distributed based on a hospital’s UC level relative to all other Medicare DSH hospitals (factor 3). While DSH hospitals continue to receive 25 percent of their otherwise payable DSH payments, the remaining 75 percent is decreased to reflect the change in the national uninsured rate and distributed based on UC burden (referred to as UC-based DSH payments). This change incorporates UC costs into the DSH formula to better target dollars to hospitals with the greatest need.

To determine if a hospital is eligible to receive DSH payments, CMS uses a hospital’s disproportionate patient percentage (DPP), consisting of a Medicare fraction and a Medicaid fraction. CMS then uses the DPP to calculate a DSH adjustment percentage, which determines the amount of empirically justified DSH payments a hospital will receive. The Medicaid fraction is calculated using the hospital’s number of patient days for patients who were eligible for Medicaid (but not entitled to Medicare Part A benefits) divided by the hospital’s total patient days. **Consistent with the text of the Medicare statute and recent federal court decisions, CMS should include patient days for patients receiving premium assistance through Section 1115 waivers, as well as patient days for patients whose care was reimbursed through a waiver-based UC pool.**

The portion of the Medicare statute that governs the calculation of the DPP says that in calculating the Medicaid fraction, CMS “may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.”

This reference to demonstration projects is to those approved through Section 1115 waivers. In the proposed rule, CMS had proposed to include patient days associated with Section 1115 demonstrations in the Medicaid fraction only when the patient directly receives inpatient hospital insurance coverage through the demonstration project. In other words, CMS specifically proposed to exclude patient days paid for through a waiver-based UC pool, as well as patient days for patients who receive premium assistance to purchase private insurance, arguing that these arrangements do not provide individuals with inpatient hospital insurance coverage. CMS’ policy since 2004 has been to exclude these types of waivers, but several federal court decisions from 2018 to 2020 invalidated CMS’ interpretation of the Medicare statute. In response to those federal court decisions, CMS proposed to rewrite the regulations, to preclude hospitals from counting UC pool and premium assistance waiver days in their Medicaid fractions.

CMS should continue to include these types of Section 1115 waiver days in the Medicaid fraction. Many states expand coverage to individuals through premium assistance programs, while others use UC pools to cover the cost of a variety of services (including inpatient hospital services) for uninsured and underinsured individuals. CMS’ proposed policy would potentially exclude from the Medicaid fraction days associated with all types of premium assistance waivers, including in states that expand coverage to the newly eligible Medicaid-expansion population through premium assistance programs. Excluding these types of waiver days from the Medicaid fraction would effectively penalize hospitals in states that have chosen different types of arrangements to extend coverage or reimburse for health care services through Section 1115 waivers.

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4 Ibid.
6 See HealthAlliance Hosps., Inc. v. Azar, 346 F. Supp. 3d 43 (D.D.C. 2018); Forrest General Hospital v. Azar, 926 F.3d 221 (5th Cir. 2019); Bethesda Health, Inc. v. Azar, 980 F.3d 121 (D.C. Cir. 2020).
CMS’ attempt to distinguish between different types of waiver days is contrary to the Medicare statute. As noted by the U.S. Court of Appeals for the Fifth Circuit, “If patients underlying a given day were Medicaid-eligible or ‘receive[d] benefits under a demonstration project,’ then that day goes into the numerator. Period.” That is, even patients who do not directly receive coverage but “are capable of receiving a demonstration project’s helpful or useful effects,” such as patients covered by UC pools, are to be included in the Medicaid fraction.7

4. CMS should implement policies that will ensure the sustainability of transplant centers and the viability of the organ donation system.

In the proposed rule, CMS had proposed changes to its decades-old policy on how transplant centers are reimbursed for the cost of organ acquisition. Medicare’s long-standing policy is to reimburse transplant centers and organ procurement organizations for the cost of excising donor organs, under the assumption that most excised organs will eventually be transplanted into a Medicare beneficiary. CMS had proposed to change the calculation of the Medicare share of excised organs to permit transplant centers only to claim the costs of organs that are excised and that actually are transplanted into a Medicare beneficiary. By limiting transplant centers’ Medicare share of allowable organ acquisition costs to only those organs that end up being transplanted into a Medicare beneficiary, CMS would have reversed longstanding policy, undermining the organ donation program and viability of transplant centers. **We are pleased CMS has withdrawn this concerning proposal, and we urge the agency to continue to work with stakeholders to preserve the viability of the organ donation system and transplant centers.**

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

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7 *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019)