COBTH
CONFERENCE OF BOSTON TEACHING HOSPITALS

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Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS 1752-P

Dear Administrator Brooks-LaSure:

The Conference of Boston Teaching Hospitals, on behalf of our 12 member hospitals, appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2022. Below, we highlight several proposals of critical importance to our members and provide some recommendations that we urge CMS to adopt as part of the final rule.

Graduate Medical Education

COBTH is strongly supportive of the effort to create 1,000 new Medicare-funded GME slots as part of the Consolidated Appropriations Act, which will help address the nationwide physician shortage. While we recognize the need for CMS to quickly create a distribution process for these new positions, we have significant concerns about CMS's proposed methodology. CMS's first proposed methodology relies on Health Professional Shortage Area (HPSA) scores. While we agree that placing residents in underserved areas is a worthy goal, we are concerned that the use of HPSA scores is not the most appropriate single metric. We are particularly concerned about the requirement that hospitals be located within HPSAs to qualify. While not all of COBTH's member hospitals are physically located within HPSAs, they all serve Massachusetts residents who reside in them. Additionally, in dense areas with many health care facilities like Greater Boston, measurements like population to provider ratio and travel time to care outside of the HPSA may not capture the reality of ongoing workforce shortages, especially, in the wake of the COVID-19 pandemic.

While we support including HPSA scores as a factor in distribution of the GME slots, we are concerned on overreliance on a single factor resulting in a fair distribution, and believe the restriction that a facility be located within a HPSA is overly limiting. We are also concerned about the requirement that 50 percent of a residents training take place in a HPSA. Residency training locations are chosen based on a number of factors to ensure that trainees encounter the necessary variety of patients and cases to adequately complete their training.

While HPSA scores may adequately indicate places in the country where there is a need for more providers, they may not be the best representation of where hospitals are prepared to provide the best and most complete training environment. While we applaud CMS for focusing on underserved areas, we strongly encourage the agency not to rely too heavily on a single metric and ensure residents are given the best opportunity for a well-rounded training experience. Should HPSA scores be included in any distribution

methodology, it will be important for CMS to be more transparent about HPSA scores and how they will be assigned to each hospital.

CMS's proposed alternative distribution for the new slots would look at rural hospitals, hospitals currently over the residency cap, hospitals in a state with a new medical school, and hospitals serving a HPSA population. While we prefer a methodology that looks at a variety of factors, we are again concerned about potential for an over-emphasis on placing new slots at rural hospitals. While we agree that these hospitals are in need of support for taking on additional trainees, we know that urban and suburban hospitals, many of which are already over their residency caps, are also in need of these slots. We urge CMS to work with hospitals to develop a fair distribution methodology that allows all types of hospitals in need of additional Medicare GME support the opportunity to be awarded new slots.

We are also concerned about other aspects of CMS's proposed implementation, including the limitation that each hospital can be awarded no more than one FTE slot per year. This is significantly below the statutory cap of 25 slots per hospital prescribed in the Consolidated Appropriations Act. This limitation would make it difficult for any hospital to create a new residency program or substantially expand an existing one. We are also concerned that the combination of a single FTE per year limit with an annual application process may present a significant administrative burden for our residency programs.

Finally, we have some concerns about the operational implementation of these new slots, especially as it relates to the timeline of the awards. For FY2023, CMS proposes January 31, 2023 as the date that awards will be announced. The National Residency Match Program also uses January 31 as the deadline for changes to a program's quota. This will not leave adequate time for programs to adjust their program sizes accordingly for the purposes of matching with residents and will affect their ability to recruit new residents to their programs. Announcing awards earlier in the cycle is necessary to ensure programs can take full advantage of the new slots.

Overall, we look forward to working with CMS as you continue to work toward implementation of these new residency slots, which are desperately needed to address the physician workforce shortage.

Organ Transplants

In the FY22 proposed rule, CMS proposes changing Medicare's usable organ counting policy to count only organs that are transplanted into Medicare fee-for-service beneficiaries as eligible for Medicare payment for organ acquisition costs. We are deeply concerned that this proposal will adversely impact transplant hospitals and remove a longstanding incentive for transplant hospitals to retrieve donor organs. This policy will only serve to disincentivize procedures, in contrast with CMS's stated goal of increasing the amount of successfully donated organs. Additionally, it would place significant administrative burden on transplant hospitals, who under this proposal would be required to track down where all their recovered organs were transplanted and the insurance status of all organ recipients. We are also concerned about the disproportionate impact the proposed policy would have on children's hospitals, where many procured organs are transplanted into Medicaid beneficiaries. Under the proposed rule, CMS would no longer cover acquisition costs for these organs, resulting in significant losses to children's hospitals and a reduced number of pediatric transplants.

Medicare's existing organ acquisition cost policy serves to streamline and incentivize organ procurement and transplantation. Any proposal with the potential to decrease the availability of donor organs will not only harm patients but is also significantly likely to increase long-term costs to the Medicare program. We urge CMS not to move forward on the implementation of this proposal in order to ensure a full accounting of the potential ramifications for transplant hospitals, administrative staff, and most importantly, for patients in need of transplants.

Redistributive Wage Index
While COBTH shares CMS's concerns with the disparities that exist under the Medicare Wage Index, we believe continuation of CMS's efforts to address these disparities in the FY22 IPPS proposed rule continues to unfairly punish high wage index hospitals. CMS proposes continuing to increase the wage indexes of low wage index hospitals, while decreasing those of high wage index hospitals to maintain budget neutrality. COBTH members hospitals are located in the Greater Boston area and are high wage index hospitals, but this is due to many contributing factors, including the high cost of living and average wages in Boston, Massachusetts.

COBTH understands CMS's goal of helping hospitals in the lowest quartile for the wage index to increase wages to attract and maintain a stable workforce. However, this policy ignores that COBTH members and other high wage index hospitals also face staffing difficulties due to the ongoing national physician and nursing shortage, operating in a high-cost environment compared to the national average, and increasing upward pressure on wages. These conditions have only been exacerbated by the COVID-19 pandemic. To that end, we encourage CMS to continue its transitional five-percent cap on wage index reductions for all hospitals to provide some measure of stability. The cap should be applied to reductions resulting from the new CBSA wage delineations or other factors.

COBTH also urges CMS to consider the efficacy or using wage data collected during the COVID-19 public health emergency to evaluate wage indexes. Severe workforce shortages in Massachusetts and other areas of the country resulted in temporarily inflated wages for health care workers. We recommend that CMS exclude wage index data collected during the public health emergency from the calculation of area wage indexes.

Although COBTH generally supports CMS's goal of addressing challenges faced by lower wage index hospitals, we urge CMS to tackle these issues in manner that improves the standing of low wage index hospitals without impairing the standing of others. This is especially important while all hospitals are facing continued and significant financial uncertainty as we continue to respond to COVID-19 and its effects.

CAR T-cell Therapy and Cancer Hospital Reimbursement
In the rule, CMS proposes to rename the new MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies. While COBTH understands the need to group similar therapies into DRGs, we urge CMS to continuously reevaluate the appropriateness of a single MS-DRG to reimburse for the entire category of therapies. As additional CAR T-cell and other immunotherapies are approved, various volumes and prices for these therapies will contribute to a single relative weight, which may result in significant under-reimbursement for particularly novel and expensive therapies. We hope to continue a dialogue with CMS to provide the hospital perspective on how to appropriately reimburse for these therapies as the category continues to grow and evolve.

We also continue to be concerned about the reimbursement methodology for cancer hospitals, which are reimbursed under the Tax Equity & Fiscal Responsibility Act (TEFRA). Cancer hospital payment under TEFRA was designed to address existing reimbursement challenges under a Medicare PPS based on averages which do not appropriately account for providers who only treat cancer patients and are typically caring for the sickest patients. TEFRA payments were meant to help make up reimbursement shortfalls for high-cost cancer treatments, but current TEFRA reimbursement rates are based on cancer care treatment costs that are many years old. As such, current TEFRA reimbursements are often inadequate for new types and modalities of treatment, including immunotherapies & emerging treatments like CAR T-Cell therapies. Therefore, COBTH recommends that:

- CMS implement a prompt and automatic adjustment for cancer hospitals providing CAR T-cell therapy in recognition that it is a reasonable cost directly related to patient care under TEFRA,

- The agency should update reimbursement under TEFRA, beyond the provision of CAR T-cell therapy, as there are many other shifts in care that have caused reimbursement to become severely outdated since the mid-2000s, and
- CMS should allow hospitals to apply for rebasing to a year that more accurately reflects the current state of cancer care.

Price Disclosure Requirements

Finally, we would like the thank CMS for repealing the FY21 requirement that hospitals report median payer-specific negotiate rates for inpatient services to inform a market-based MS-DRG relative weight methodology. Negotiated rates are based on a variety of factors that are unique to the health care provider and insurance company, and disclosure of these rates would not have helped patients better understand their cost of care. We urge CMS to work with hospitals, health care providers, and insurance companies to ensure that patients have the information they need to help them make the best decisions about their care.

Thank you for your consideration of our comments. COBTH's member hospitals are also members of the Association of American Medical Colleges (AAMC) and strongly support the in-depth comments submitted by AAMC on behalf of the nation's academic medical centers and teaching hospitals. Please do not hesitate to be in touch with any questions or if we can provide additional information on these or other matters.

Sincerely,

Patricia McMullin
Executive Director
Conference of Boston Teaching Hospitals

Anna Esten
Government & Community Affairs Specialist
Conference of Boston Teaching Hospitals