June 28, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program (CMS-1752-P)

Dear Ms. Brooks-LaSure:

The Society of General Internal Medicine (SGIM) appreciates the opportunity to provide comments on the fiscal year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule (CMS-1752-P). SGIM is a member-based medical association of more than 3,300 of the world's leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to delivering high quality care and ensuring patients have access to a well-trained physician workforce. Additionally, our members practice in both inpatient and outpatient settings, serve as the primary internal medicine faculty of every medical school and major teaching hospital in the United States, and are actively involved in all aspects of health services research. SGIM is committed to identifying and addressing system-based disparities of health care delivery. All of our efforts are directed toward equitable and affordable access to the highest quality of care possible.

As such, we have prepared comments on the following sections of the FY 2022 IPPS proposed rule:

- Distribution of Additional Residency Positions Under the Provisions of Section 126 of Division CC of the CCA;
- Proposal for Implementation of Section 127 of the CAA, "Promoting Rural Hospital GME Funding Opportunity"; and
- Request for Information – Closing the Health Equity Gap in CMS Hospital Quality Programs.

Proposed Payment for Indirect and Direct Graduate Medical Education Costs

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Distribution of Additional Residency Positions Under the Provisions of Section 126 of Division CC of the Consolidated Appropriations Act, 2021 (CAA)

SGIM appreciates CMS' proposal to implement Section 126 of the Consolidated Appropriations Act of 2021 ("the Act") which makes available 1,000 new Medicare-funded GME positions to be distributed beginning in FY 2023. We believe this is an important step to ensuring there is an adequate supply of well-trained physicians, including primary care physicians, to meet Americans' health care needs. The Health Resources and Services Administration (HRSA) published a report in 2016 which outlines national and regional projections of supply and demand for primary care practitioners from 2013 to 2025. The findings from this report suggest the U.S. supply of primary care physicians will grow more slowly than demand for primary care physician services.[1] Last year the Association of American Medical Colleges released more current projections, estimating that primary care may face a shortage between 21,400 and 55,200 physicians by 2033.[2] This is why increasing Medicare GME slots is so important for the future primary care workforce.

Determinations Required for the Distribution of Residency Positions

In accordance with the statute, CMS is proposing to prioritize residency positions to qualifying hospitals that meet at least one of the following four categories – (1) Rural hospitals or hospitals that have a rural designation; (2) Hospitals currently training residents above their full time equivalent (FTE) cap; (3) Hospitals located in states with new medical schools or branch campuses; and (4) Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs). CMS is proposing that a hospital qualifying under category four must submit an attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report that it has its main campus or a provider-based facility physically located in a primary care or mental health geographic HPSA. Additionally, the program for which the hospital is applying, at least 50 percent of the residents' training time over the duration of the program must occur at those locations in the HPSA**. SGIM supports CMS' proposal and thanks CMS for prioritizing hospitals with residency programs serving underserved communities.** SGIM appreciates that CMS is trying to avoid the possibility that a hospital with provider-based facilities in multiple locations, some of which may not be located in a HPSA, use an additional residency position to serve populations not facing workforce shortages. We believe this proposal will help address the primary care and other internal medicine subspecialties shortages, improving beneficiary access to these critical services.

Additionally, CMS proposes that the hospital must be able to demonstrate the likelihood of filling the slots within the first five years after receiving the award. Specifically, a hospital must demonstrate and attest to (1) a planned new program, or (2) an expansion of an existing program. **SGIM supports this proposal and believes this is necessary to ensure**

[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/primary-care-national-projections-2013-2025.pdf
[2] https://www.aamc.org/media/45976/download

slots are going where they are most needed to improve access to shortage specialties, including general internal medicine.

Number of Residency Positions Made Available to Hospitals and Limitation on Individual Hospitals

The statute limits the aggregate number of total residency positions made available in a single fiscal year across all hospitals to no more than 200. In accordance with the statute, CMS is proposing to make 200 residency positions available for FY 2023 and each subsequent year for five years. Additionally, CMS is proposing to limit the increase in the number of residency positions made available to each individual hospital to no more than 1.0 FTE each year per hospital. SGIM urges CMS to remove this limitation. 1.0 FTE per hospital per year is not sufficient for a hospital that is trying to expand an existing program or start a new residency program. Moreover, a hospital would need to have 1.0 FTE for three years in order to train one resident in an internal medicine training program, for example. Under this proposal, it is unclear whether the hospital would be guaranteed 1.0 FTE for each subsequent year. If a hospital is not guaranteed additional FTEs, they face the risk of not being able to fund the resident for subsequent years. **For these reasons, SGIM respectfully requests that CMS remove this limitation.**

Prioritization of Applications from Hospitals for Residency Programs that Serve Underserved Populations

SGIM recognizes that CMS is proposing to prioritize applications from qualifying hospitals by their HPSA score. HRSA designates HPSAs for primary care, mental health, and dental health, defining primary care as the specialties of general internal medicine, pediatrics, obstetrics and gynecology, and family medicine. Hospitals applying for residency positions for programs that do not serve HPSAs are not categorically excluded, but those applications would have the lowest priority as proposed. Consequently, this approach will ensure that an appropriate number of new GME slots go to primary care disciplines. **SGIM supports this proposal and believe CMS should implement this HPSA-based approach as we believe it the most effective method to address the current maldistribution of the physician workforce and mitigate workforce shortages in primary care, including general internal medicine.** This approach will also help address health inequities in the health care system and benefit underserved populations.

Alternative Considered for Prioritization

We understand that CMS is considering an alternative approach that would give highest priority to qualifying hospitals that meet all four categories, beginning in FY 2023. Hospitals that qualify under all four categories would receive top priority, and those hospitals qualifying on three or fewer categories would be prioritized according. **SGIM strongly opposes this proposal and believe this will disadvantage hospitals that do not meet all four categories.** For example, hospitals located in states that do not have a new medical school but do serve underserved communities would be disadvantaged under this alternative methodology. Moreover, it is unlikely that there are very many hospitals that

would qualify under all four categories. SGIM recommends that CMS look at data to determine which, if any, hospitals would qualify under the four categories to complete a thorough evaluation of this proposal and its potential impact. SGIM believes prioritizing applications from qualifying hospitals by their HPSA score is a stronger approach and will ensure an appropriate number of the new residency positions will go to the hospitals where they will have the greatest impact on access to care—where there are well-documented shortages in primary care and other internal medicine subspecialties.

Proposal for Implementation of Section 127 of the CAA, "Promoting Rural Hospital GME Funding Opportunity"

CMS proposes to implement Section 127 of the Act to expand GME and indirect medical education (IME) FTE resident cap slots for both urban and rural hospitals participating in Rural Training Track (RTT) program. SGIM thanks CMS for implementing this section of the Act as it will provide flexibility for rural hospitals that partner with urban hospitals to address workforce shortages. Specifically, this will allow certain rural training hospitals to receive a GME cap increase when participating in the RTT program and will provide new opportunities for residents to train in rural areas. **SGIM supports the following proposals and believe these efforts will increase access to health care services for Americans in rural areas.**

- Each time an urban and rural hospital establishes a RTT program for the first time, even if the RTT program does not meet CMS' criteria as a "new" residency program, both the urban and rural hospitals will be eligible for a rural track FTE slot increase. SGIM supports this provision and urge CMS to implement as proposed.
- CMS will allow for FTE slot increases for both urban and rural hospitals when (1) an urban hospital that has an RTT expands a qualifying RTT to a new rural hospital training site; and (2) an urban hospital that has an RTT at a rural hospital starts an RTT in a different specialty at that same rural hospital. SGIM supports this and believe this provision will incentivize urban hospitals to establish new RTT programs.
- CMS is removing the requirement that residency programs need "separate accreditation" to be eligible for RTT funding. However, in order for urban or rural hospitals to receive FTE cap adjustments for residents training in RTTs, the residents must still be in "an ACGME accredited program where greater than 50 percent of their training occurs in a rural area." We believe this flexibility will promote primary care and other specialties to develop RTTs.
- Exempt residents in RTTs from the three-year rolling average during the five-year "cap building" period for RTTs. SGIM believes this provision will provide more flexibility for hospitals.

<u>Request for Information – Closing the Health Equity Gap in CMS Hospital Quality Programs</u>

SGIM appreciates CMS including this request for information (RFI) focused on closing the health equity gap in its hospital quality reporting programs and is pleased to provide comments on the following requested areas:

- Future potential stratification of quality measures results by race and ethnicity;
- Improving demographic data collection and mechanisms for incorporating other demographic characteristics into analysis that address and advance health equity;
- Potential creation of a hospital equity score to synthesize results across multiple social risk factors; and
- The inclusion of an attestation-based structural measure assessing the degree of hospital leadership engagement in health equity performance data.

In addition to addressing these areas, SGIM believes the agency must address the structural inequities in current hospital value-based payment programs that financially penalize safety-net hospitals which is directly related to social risk and quality measurement. These programs, such as the Hospital Readmissions Reduction Program (HRRP), Hospital Value Based Purchasing Program (HVBP) and Hospital Acquired Conditions Reductions Program (HACRP) have consistently been shown to penalize safety-net hospitals for caring for patients with higher social risk, who have higher health care spending and worse outcomes that cannot be solely attributed to the quality of care provided by the hospital.[3][4][5][6][7][8] These flawed financial incentives must be fixed in order to close the health equity gap.

SGIM appreciates CMS' ongoing consideration of social risk in these reporting programs as per recommendations made by the Assistant Secretary for Planning and Evaluation, the *National Academies of Sciences, Engineering, and Medicine*, the National Quality Forum, and others. As CMS notes, as of 2019 HRRP must now stratify payment adjustments within peer groups according to percentage of dual-eligible beneficiaries. This change in methodology has been demonstrated to significantly reduce payment penalties to safety net hospitals,

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[3] Ryan AM. Will value-based purchasing increase disparities in care? N Engl J Med. 2013 Dec 26;369(26):2472-4. doi: 10.1056/NEJMp1312654. PMID: 24369072.

[4] Gilman M, Adams EK, Hockenberry JM, Milstein AS, Wilson IB, Becker ER. Safety-net hospitals more likely than other hospitals to fare poorly under Medicare's value-based purchasing. Health Aff (Millwood). 2015;34(3):398-405.

[5] Joynt KE, Jha AK. Characteristics of hospitals receiving penalties under the Hospital Readmissions Reduction Program. JAMA. 2013 Jan 23;309(4):342-3. doi: 10.1001/jama.2012.94856. PMID: 23340629.

[6] Gilman M, Hockenberry JM, Adams EK, Milstein AS, Wilson IB, Becker ER. The financial effect of value-based purchasing and the Hospital Readmissions Reduction Program on safety-net hospitals in 2014: a cohort study. Ann Intern Med. 2015;163(6):427-436. doi:10.7326/M14-2813

[7] Rajaram R, Chung JW, Kinnier CV, et al. Hospital characteristics associated with penalties in the Centers for Medicare & Medicaid Services Hospital-Acquired Condition Reduction Program. *JAMA*. 2015;314(4):375-383. doi:10.1001/ jama.2015.8609

[8] Zogg CK, Thumma JR, Ryan AM, Dimick JB. Medicare's Hospital Acquired Condition Reduction Program disproportionately affects minority-serving hospitals: variation by race, socioeconomic status, and disproportionate share hospital payment receipt. *Ann Surg*. 2020;271(6): 985-993. doi:10.1097/SLA.0000000000003564

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thereby levelling the playing field.[9] Studies looking at other programs such as hospital acquired conditions have shown that the effect would be similar if applied.[10] **Thus, SGIM recommends applying this same peer grouping to other hospital value-based programs to immediately reduce the unfair penalties to safety net hospitals that directly hinder CMS' stated goal of closing the health equity gap.**

Dual-eligible status is an inadequate individual-level measure of social risk. At best, it is an incomplete initial proxy measure for social vulnerability of the entire patient population served by a hospital and likely underestimates at-risk populations in Medicaid non-expansion states, in the unhoused and in the working poor. Neighborhood indices which evaluate the social vulnerability of the communities which the hospitals serve based on census-tract data are widely accepted as better measures of social risk, do not require additional data to be captured by the health system, and have been used in various studies of Medicare payment models.[11][12][13][14] Many such composite measures of social determinants of health (SDOH) exist, including the Social Vulnerability index, the Area Deprivation Index, the Community Needs Index , and the Distressed Communities Index. **SGIM recommends that CMS explore the use of such indices as the basis for fairly evaluating social risk and adjusting value-based payments.**

While such efforts to reduce unfair payment penalties to safety net hospitals are critical, they alone are inadequate to provide these hospitals with the resources they need to invest in programs to address and improve SDOH and truly begin to close care gaps. With value-based care models, additional mechanisms exist to provide increased financial support to hospitals caring for socially vulnerable patients and to thus incentivize health systems to provide meaningful care for them, such as bonus point or bonus payment systems that explicitly acknowledge the challenge and value of caring for socially at-risk people. **If CMS truly wishes to close the health equity gap, it must offer better financial support for the health systems caring for vulnerable patients.**

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[9] Joynt Maddox KE, Reidhead M, Qi AC, Nerenz DR. Association of Stratification by Dual Enrollment Status with Financial Penalties in the Hospital Readmissions Reduction Program. JAMA Intern Med. 2019 Jun 1;179(6):769-776. doi: 10.1001/jamainternmed.2019.0117. PMID: 30985863; PMCID: PMC6547154.

[10] Shashikumar, AB. Association of Stratification by Proportion of Patients Dually Enrolled in Medicare and Medicaid with Financial Penalties in the Hospital-Acquired Condition Reduction Program. JAMA IM, 2021

[11] Zhang Y, Li J, Yu J, Braun RT, Casalino LP. Social Determinants of Health and Geographic Variation in Medicare per Beneficiary Spending. JAMA Netw Open. 2021 Jun 1;4(6):e2113212. doi: 10.1001/jamanetworkopen.2021.13212. PMID: 34110394; PMCID: PMC8193453.

[12] Ash, A. S., et al. (2017). "Social Determinants of Health in Managed Care Payment Formulas." JAMA Intern Med 177(10): 1424-1430

[13] Joynt Maddox KE, Reidhead M, Hu J, Kind AJH, Zaslavsky AM, Nagasako EM, Nerenz DR. Adjusting for social risk factors impacts performance and penalties in the hospital readmissions reduction program. Health Serv Res. 2019 Apr;54(2):327-336. doi: 10.1111/1475-6773.13133. PMID: 30848491; PMCID: PMC6407348.

[14] Hu J, Kind AJH, Nerenz D. Area deprivation index predicts re-admission risk at an Urban Teaching Hospital. Am J Med Qual. 2018;33(5):493-501.

Future potential stratification of quality measures results by race and ethnicity

SGIM appreciates CMS' desire to identify care caps in vulnerable populations such as traditionally marginalized racial and ethnic groups. However, we strongly caution against focusing on race and ethnicity alone, as they are not the SDOH which are the direct primary mediators of inequities and poor health outcomes. As an example, a New England Journal of Medicine (NEJM) cites a large cohort study in Louisiana in which "76.9% of the patients who were hospitalized with Covid-19 and 70.6% of those who died were black, whereas blacks comprise only 31% of the Ochsner Health population. Black race was not associated with higher in-hospital mortality than white race, after adjustment for differences in sociodemographic and clinical characteristics on admission."[15] This makes sense given the assignment of race is historically based on social constructs and that decades of oppressive policies regarding these social constructs and interpretations of race have dictated the resources allocated to these groups. For these reasons and others, SGIM believes that census-tract level indices of community social vulnerability are the best way to currently assess social risk.[16]

To truly close the health equity gap, SGIM recommends that CMS not only stratify existing clinical quality measures by proxies of social risk but support the creation of health equity measures that specifically evaluate the care being provided to address SDOH for at-risk populations. Collecting this data should first and foremost be for the purpose of screening the health-related needs of patients (e.g., housing insecurity, food insecurity) so that they can be addressed. Drawing from the Accountable Health Communities Model, SGIM believes that equity measures must be developed to evaluate aspects care delivery, such as:

- Demonstration of language-concordant care delivery at levels that match the language proficiency of the communities served;
- Appropriate referrals for social services, and the degree to which those referrals are acted upon and completed, with the loop being closed;
- Outcomes related to whether the patient received the social service resources;
- Completion of Community Health Needs Assessments (CHNAs) and its embedment in the health system's annual strategic planning;
- Oversight that the CHNA adheres to specific IRS regulations and industry standards;
- Degree to which needs assessment findings are acted upon;
- Level of investment in social services;

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[15] Price-Haywood EG, Burton J, Fort D, Seoane L. Hospitalization and Mortality among Black Patients and White Patients with Covid-19. N Engl J Med. 2020 Jun 25;382(26):2534-2543. doi: 10.1056/NEJMsa2011686. Epub 2020 May 27. PMID: 32459916; PMCID: PMC7269015.

[16] Our assumption here is that CMS is considering indirect estimates of race in an attempt to impute missing data that is not collected or missed at the health system level. We are unclear as to whether CMS is attempting to indirectly measure race as a marker for social risk, or whether CMS is attempting to have a better (although imputed) measure of race to then measure risk in the future. If the former, we contend that there are already many indices for measuring social risk in communities, and that we have census-level data (albeit imperfect) which provide self-reported data (the gold-standard) on patient demographics.

- Level of community partnerships, including collaboration with county health departments and the state departments of health;
- The degree to which hospitals utilize evidence-based strategies identified by local departments of health and community partners, which have proven to be successful in their local communities; and
- Implementation of processes for bi-directional feedback between health systems and states, health departments, and CMS as to gaps existing in addressing SDOH and health disparities within communities served by the health system

This is a long-term agenda which will require significant partnership between CMS and other entities, but is one the agency can drive forward.

Improving Demographic Data Collection and Mechanisms for Incorporating Other Demographic Characteristics into Analysis that Address and Advance Health Equity

Building on the Agency for Healthcare Research and Quality's framework for addressing health equity, SGIM supports CMS efforts to describe disparities in outcomes using more nuanced social risk data as well as using and developing methodologies that link Medicare administrative data to census-tract data. **Self-reported race and ethnicity through the census better achieves the gold-standard for capturing race and ethnicity, as opposed to indirect measurements of race.**

We agree with a standard approach to assessing SDOH that is conducted across all health systems that care for Medicare and Medicaid beneficiaries. We also agree that the collection of structured, robust, individual-level SDOH data has the potential to help describe health-related unmet needs in the Medicare population. **SGIM recommends CMS invest in the development of a nationwide SDOH tool to capture this relevant data on a regular basis, in line with the current standards of determining beneficiary address. However, we also caution that the collection of socioeconomic data at a more individual patient level can be a sensitive topic, open to potential abuse, and may retraumatize patients already affected by bias, barriers, and structural racism**. Furthermore, training of hospital and health system staff to collect this information in a sensitive and robust way is time- and resource-intensive; care is required. Mandating hospitals collect this data without support and training in well-established frameworks, alongside fully engaged and empowered community partners, can have unintended consequences, including inaccurate data collection (e.g., assigned rather than self-reported race/ethnicity/gender), patient mistrust (particularly among individuals historically traumatized by the healthcare system), psychological harm, and moral injury to providers who feel they have "nothing to offer" their patients.

These issues notwithstanding, when social and demographic data are captured for individual care through trusted and trained healthcare teams empowered with community resources and partnerships to address social determinants, this data may serve as a powerful tool to combat existing health inequities at their source. **It is our expert opinion that significant resources are required to develop frameworks for structured systems**

to collect, maintain, and utilize these socioeconomic data in trusted, caring, and sensitive ways. In our experiences, it is likely that the persons tasked with collecting such sensitive information are those who share longitudinal and trusted relationships with patients, perhaps in the form of patient navigators, community health workers, and nurse care coordinators who "follow" patients across the healthcare continuum (e.g., across inpatient and outpatient settings and health systems). **Once such frameworks are created, their potential can be unleashed to build health equity-focused value metrics in the inpatient, outpatient and post-acute settings, and across transitions of care.**

Potential Creation of a Hospital Equity Score to Synthesize Results Across Multiple Social Risk Factors

SGIM appreciates the agency's dedication to better assess quality in the context of social risk factors and equity gaps. However, performance on traditional measures stratified by race and ethnicity is an incomplete approach to measuring disparities as previously discussed. Equity-specific measures must be developed.

To the extent that any hospital equity score is used to assess performance, care must be given in making across-hospital comparisons. Well-resourced hospitals which care for a small number of socially vulnerable patients in a geographic area with access to more community resources cannot be compared to underfunded hospitals which predominantly care for vulnerable patients in impoverished neighborhoods. **Thus, any across-hospital comparison must be done within peer groups composed of hospitals of similar patient populations, size, and resources.**

Interventions hospitals could institute to improve a low hospital equity score and how improved demographic data could assist with these efforts.

Hospitals with high equity scores should be incentivized to share their models of care delivery and lessons learned with those who score lower in the same peer group.

The inclusion of an attestation-based structural measure assessing the degree of hospital leadership engagement in health equity performance data

SGIM supports assessing the degree of hospital leadership engagement in health equity as a starting point; however, we again believe that much more must be done to develop meaningful health equity measures. In addition to the areas identified by CMS for self-attestation, additional critical areas to assess include:

- Level of hospital engagement and investment in performing robust hospital CHNAs and the degree to which findings are acted upon;
- The degree to which hospitals invest in social services;
- The degree to which hospitals have forged community partnerships and employ those partnerships to address SDOH and health inequities; and

- The degree to which patients impacted by health inequities serve as key informants for implementing pilot programs and designing iterative versions of interventions that address disparities in care.

Thank you for the opportunity to provide these comments. If you have any questions or require additional information on any of our comments, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

Monica Lypson, MD, MHPE
President

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