American Hospital Association™
Advancing Health in America

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March 18, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Ms. Richter:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) requests that the Centers for Medicare & Medicaid Services (CMS) include in its fiscal year (FY) 2022 inpatient prospective payment system (PPS) proposed rule a policy to extend or modify the residency cap building window for new residency programs impacted by the COVID-19 public health emergency (PHE). Doing so would help ensure that these programs remain viable during this unprecedented time.

Throughout the PHE, CMS has implemented numerous waivers and modified many regulations nationwide, including many focusing on the workforce. Such actions have been essential in allowing hospitals and health systems to react and adapt swiftly to new patient care needs, demands and decisions. We have urged additional actions to help create flexibility in addressing workforce shortages, and we wish to reiterate the importance of allowing extensions to the five-year cap-building period for new Graduate Medical Education (GME) programs. **Specifically, the AHA urges CMS to temporarily amend the regulations for teaching hospitals with new medical residency programs that have been unable to build their programs to full size before the cap is established due to the impacts of the ongoing pandemic and PHE. The agency should extend the five-year cap building window for impacted hospitals by the length of the PHE plus the additional time needed to reach July 1.** Hospitals in hard hit areas will require additional time to align with the July 1 start date of the academic year when residency programs begin. Taking this action would do much to support the long-term sustainability of physician training.

As an example, consider a hospital whose five-year cap building window would have expired on July 1, 2022. If the PHE is in place from Jan. 31, 2020, until Dec. 31, 2021,

23 months, a new teaching hospital's residency cap period would be extended by 23 months plus one additional month to get to the beginning of the academic year on July 1, 2024. We support the agency automatically granting extensions along these lines, but also urge it to create an application process for hospitals needing further extensions due to extenuating circumstances.

While our request to extend or modify the residency cap building window has not been as urgent as other requests, the operational uncertainty this situation creates for teaching hospitals and the time required to stand up a new residency program is now making it a high priority. **Therefore, we urge the agency to include a policy to address this issue in its upcoming FY 2022 inpatient PPS proposed rule.**

Such a policy is necessary because the COVID-19 PHE has created significant and ongoing disruption to hospitals that were already in the process of establishing new medical residency programs. For example, it has hindered the ability of these programs to recruit the program directors and core faculty required before they can begin their accreditation process. Once accredited, the PHE has created difficulty in staffing residency programs with enough faculty to train residents in their specialties; it also has made it difficult to recruit new residents to fill the programs. In addition, the Accreditation Council for Graduate Medical Education (ACGME) – which is responsible for the accreditation of new residency programs – initially suspended in-person site visits due to COVID-19, later switching to remote site visits. Both of these actions delayed a process that can already take 18 to 24 months from recruitment of program directors and core faculty to preliminary accreditation following site survey and committee reviews.

Unfortunately, these delays can be costly to new teaching hospitals, which are under a time constraint to establish permanent direct graduate medical education (DGME) and indirect medical education (IME) residency caps. CMS regulations allow a hospital that first establishes a new training program on or after Oct. 1, 2012, five years to grow the training programs before the resident cap is established.[1]

CMS established this five-year window because it determined that its previous three-year window was not sufficient for the residency training programs to reach full capacity.[2] Hospitals establishing new teaching programs during the PHE face a similar dilemma – they are unable to meet program accreditation requirements, particularly where they are establishing more than one program, under timelines that were planned prior to the pandemic. For example, one of our members in a community that has never had a residency program established an ambitious goal to operate 11 residency programs covering various specialties and training over 200 new residents. However, it has been unable to fully grow its training programs as initially planned due primarily to COVID-19 PHE-related challenges. The pandemic hit 20 months after the hospital started its first residency program. Now, a year into the global pandemic, it has lost at

[1] 42 CFR §413.79(e)
[2] 77 FR 53417

least 18-24 months of time due to the strict requirements of ACGME and one-time-per-year residency program start dates. Similarly, another member teaching hospital in its final year of its cap building window was severely challenged in beginning to train newly recruited residents as COVID-19 cases surged in its region.

These challenges impact not only the hospitals working to build new residency programs, but also, more importantly, the communities that they serve. In the year since COVID-19 hit the United States, communities across the country are seeing an increase in the number of physician retirements due to loss of income, burnout, or ongoing health concerns.[3] In the aforementioned case of the hospital working to build 11 new residency programs, its community is already incredibly medically underserved and cannot afford such loses. Specifically, it has nearly half the number of physicians per 100,000 residents as compared to the rest of its state, and the region is already facing a 4,100-physician shortfall. Although this is but one example, it is not an outlier. The hospitals across the country working to alleviate the disparities in their communities by creating new residency programs need an extension of the DGME/IME cap-building window to make up for time lost due to the pandemic.

Thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at 202-626-2340 or jkim@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

[3] Advisory Board, "Why Covid-19 is leading these doctors to retire early, in their own words," October 6, 2020. At https://www.advisory.com/daily-briefing/2020/10/06/older-doctors