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June 28, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Attention: CMS-1752-P

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***

Dear Administrator Brooks-LaSure:

On behalf of the New Jersey Hospital Association (NJHA) and its over 400 hospital and health system members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2022.

Core-Based Statistical Areas (CBSAs) For the Proposed FY 2022 Medicare Wage Index

The New Jersey Hospital Association (NJHA) strongly supports the proposal included in the Medicare Hospital IPPS proposed rule (CMS-1752-P) to continue applying a transition to the FY 2022 wage index for hospitals negatively impacted by the agency's adoption of the Core-Based Statistical Area (CBSA) updates in OMB Bulletin 18-04. We urge CMS to adopt a similar transition policy for the other Medicare PPS facilities that have experienced – or will experience – deleterious cuts due to the agency's adoption of OMB Bulletin 18-04. As discussed below, we also respectfully request that CMS hold these facilities harmless for an additional year (through FY 2023).

In three separate final rules – the FY 2021 Hospital Inpatient Prospective Payment System final rule (CMS-1735-F), the FY 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System final rule (CMS-1729-F), and the FY 2021 Skilled Nursing Facility (SNF) Prospective Payment System final rule (CMS-1737-F) – CMS finalized a proposal that will use the Office of Management and Budget's most recent core based statistical areas (CBSA) delineations (OMB Bulletin No. 18-04) as the basis for determining the AWI adjustments for acute care hospitals.

Under the final rules, four New Jersey counties – Middlesex, Monmouth, Ocean, and Somerset – shifted from their previous core-based statistical areas (CBSAs) to a newly-created CBSA for FY 2021. Relying on what we believe is inaccurate and out-of-date employment and commuting data, CMS adopted what the agency described as "significant rearrangement in the constituent counties among the New York City Area Metropolitan Divisions" – rearrangements that the agency itself noted will result in a nearly 17 percent decrease in the wage index for the impacted providers. NJHA estimates that the hospitals, inpatient rehabilitation facilities, and skilled nursing facilities impacted by this policy will experience a reduction in Medicare payments by well over $200 million per year beginning in FY 2022.

While CMS did provide transitional relief to affected facilities in the form of a 5 percent cap on any decrease in a health care facility's wage index from the previous year, under current regulations, that cap is scheduled to sunset at the end of FY 2021. NJHA appreciates that the agency recognized the need for a transitional policy, but – as we have communicated on numerous occasions – a one-year cap is wholly insufficient to offset the enormous cuts scheduled for FY 2022.

For this reason, NJHA appreciates CMS' willingness to apply a transition to the FY 2022 wage index for hospitals negatively impact by the new CBSA delineation. In the FY 2022 Hospital IPPS proposed rule (CMS-1752-P), the agency notes that, given the unprecedented nature of the ongoing COVID-19 Public Health Emergency (PHE), CMS is seeking comment on whether and in what form such a transition should be applied. We are disappointed, however, that the agency did not propose a similar transition policy for the other health care facilities experiencing the same cuts under the SNF and IRF payment systems (CMS-1746-P and CMS-1748-P, respectively).

On behalf of the 400 New Jersey hospitals and other health facilities currently facing steep cuts amid the ongoing COVID-19 crisis, ***NJHA strongly urges CMS to adopt a transition policy that holds the FY 2022 and FY 2023 wage index for all affected facilities harmless from any reduction relative to their FY 2021 wage index. Specifically, we fully support the agency's proposal to ensure that an affected hospital's wage index for FY 2022 would not be less than 95 percent of its final wage index for FY 2020. We also request that this policy be applied to all the health facilities (e.g., inpatient rehabilitation facilities and skilled nursing facilities) that have been negatively impacted by the newly created CBSA. We also request that this policy be applied for two years instead of just one.***

Expanding the proposed policy to all categories of affected health care facilities – and applying the transition policy for two additional years – will ensure that hospitals and others vulnerable health care facilities in affected New Jersey counties will not suffer devastating cuts to their Medicare reimbursement until OMB is able to release updated CBSA delineations based on up-to-date data from the 2020 Census.

Graduate Medical Education; New Residency Slots

CMS proposes to implement several provisions of the Consolidated Appropriations Act of 2021 that affect Medicare direct GME and indirect medical education (IME) payments to teaching hospitals. Our member hospitals are concerned about CMS' proposed method to award a maximum of one full-time equivalent (FTE) residency slot per hospital per year and the agency's proposal to prioritize slot distribution by health professional shortage area (HPSA) scores.

CMS proposes to phase in no more than 200 residency slots each year until 1,000 new Medicare-funded residency slots have been distributed. By statute, there are limitations on the distribution of residency slots – hospitals may

not receive more than 25 additional FTE positions in total. Yet, CMS would impose a drastically more severe limitation on hospitals—limiting each individual hospital to no more than one FTE each year.

Such a limitation is unworkable and unproductive and such a prioritization method reflects neither statutory intent nor the reality of teaching hospital service areas. ***Instead, NJHA urges CMS to provide sufficient FTE slots as appropriate for the length of a residency program and to implement an alternative method for prioritization, which reflects statutory intent in a streamlined and simplified manner.***

Implementation of Sec. 131 of CAA 2021; Adjustment of Low PRAs for Certain Hospitals

Section 131(a) of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) amends section 1886(h)(2)(F) of the Act to direct the Secretary, for hospitals with such extremely low or $0 per resident amount (PRA) that meet certain criteria, to establish new PRAs using the methodology described in 42 CFR 413.77(e) if the hospital trains resident(s) in a cost reporting period beginning on or after its enactment (December 27, 2020) and before the date that is 5 years after enactment (December 26, 2025). For ease of reference, CMS refers to these hospitals as Category A and Category B.

A **Category A Hospital** is one that, as of the date of enactment (December 27, 2020), has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. Typically, a Category A hospital is one that trained less than 1.0 FTE in its most recent cost reporting period ending on or before December 31, 1996 and received a very low or $0 PRA.

A **Category B Hospital** is one that, as of the date of enactment (December 27, 2020), has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment (December 27, 2020).

CMS is proposing that to redetermine the PRA, the training occurring at a Category A Hospital or a Category B Hospital need *not necessarily* be training residents in a *new* program; the residents may be in either an approved program that is "new" for Medicare IME and direct GME purposes, or may be in an existing approved program. This is because the new subclause does not state that the training be in a "new" program, and furthermore, CMS's current policy is that for a hospital which starts training residents for the first time, the PRA can be established based on the training of residents in either a "new" approved program, or an existing approved program.

However, NJHA respectfully asserts that in the FY 2022 IPPS Proposed Rule, CMS does not directly address a category of hospitals who are eligible to establish new FTE caps. CAA Sec. 131, Subparagraph ii, states that, in the case of "a hospital that trains residents and has not entered into a GME affiliation agreement…on or after the date of the enactment of this clause (December 27, 2020), the Secretary shall not establish an FTE resident amount until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in an approved medical residency training program in a cost reporting period."

This additional category of hospitals includes those organizations who may have historically been training residents in training programs established before January 1, 1995, ceased training residents in any residency training programs since then, and who begin training residents in a new approved medical residency training program(s) that starts after December 27, 2020, so long as at least 1.0 full-time-equivalent resident in the new program(s) is training in a cost report period.

As currently written, the proposed rule does not address this option, effectively limiting eligibility to the Category A and Category B criteria set forth in Subparagraphs iii and iv of CAA 2021 for hospitals that previously trained residents in the distant past. This is a critical omission. Nothing in the drafting of subparagraphs ii, iii, and iv of the Act indicates that a hospital's eligibility is conditioned *solely* on whether a hospital falls into Category A or Category B. Otherwise, any hospital that has ever reported FTE residents on a cost report but was unable to meet the technical requirements of Category A or Category B would be barred from establishing a new FTE resident cap, which we believe is contrary to the legislative intent of the Act.

Therefore, NJHA respectfully requests that CMS clarify that a hospital that has previously reported FTE residents on a cost report may pursue a new FTE resident cap determination under a new residency program pursuant to Subparagraph ii of the *Consolidated Appropriations Act, 2021*.

Organ Acquisition Payment Policy Proposals

For FY 2022, CMS proposes to limit Medicare payment for organ acquisition costs in several ways, including limiting Medicare payment for non-Transplant Center donor hospitals and payment for certain costs associated with living donors. CMS estimates that these changes would result in substantial Medicare payment reductions for organ acquisition costs.

The most significant proposed change would eliminate a longstanding feature of the payment system under which organs that are procured at a Transplant Center hospital and transplanted at another Transplant Center are "counted" as Medicare organs for the purpose of determining Medicare's portion of organ acquisition costs. This feature of cost apportionment was initially adopted when the organ acquisition cost reporting rules were put in place three decades ago to incentivize Transplant Centers to retrieve organs. This incentive works: According to the American Society of Transplant Surgeons, in 2020, despite representing <15% of acute care hospitals, hospitals with transplant programs contributed 35% of livers and lungs; 36% of kidneys; 38% of hearts; 41% of pancreas; and 48% of intestines.[1]

The Proposed Rule would require a Transplant Center to ascertain the insurance status of all recipients of organs recovered in their hospital by the OPO for placement at another center regardless of the location of that center. Transplant programs would be allowed to count as Medicare organs only those organs transplanted into recipients at other centers whose procedure was covered by Medicare Fee for Service as the primary payer or organs transplanted to recipients for whom Medicare makes a payment as the recipient's Secondary Payer.

New Jersey's Transplant Centers rely on these Medicare payments to offset the substantial costs associated with organ acquisition. The elimination of this feature of the payment system -scheduled to begin as early as October of this year – could significantly reduce the deceased donor organs available for transplantation and reduce access to transplantation for New Jersey patients. Further, our member hospitals are concerned that the requirement to obtain third-party payer contract information from Recipient Transplant Centers, as well as the requirement to track recipients' Medicare eligibility determinations, will pose an unreasonable practical and financial burden on Donor Transplant Centers.

[1] American Society of Transplant Surgeons. (2021). *CMS Proposal Would Reduce Medicare Payment for Organ Acquisition Costs by $230 million in FY 2022, $4.150 billion over 10 years.*

While NJHA understands that CMS' stated intention is reimburse only for organs procured for Medicare patients, the agency is either unaware of, or unwilling to address, the potential unintended consequences of the proposed rule. **Accordingly, NJHA respectfully requests that CMS conduct a study of the potential impact of the Proposed Rule on organ transplantation and that the agency consider alternative approaches to controlling costs. We also ask that the agency refrain from implementing transplant-related provisions of the Proposed Rule in FY 2022, pending the completion of the study.**

We thank you for the opportunity to provide these, and further, comments on this proposed rule and look forward to working with you in the future to find solutions that will benefit all hospitals.

Sincerely,

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