



July 9, 2020

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1735-P  
PO Box 8013  
Baltimore, MD 21244-8013

**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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals**

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am pleased to share our feedback on the Center for Medicare and Medicaid Services' (CMS) Hospital Inpatient Prospective Payment Systems (IPPS) Proposed Rule. Our comments focus on the following sections:

- Payments for Indirect and Direct Graduate Medical Education Costs and
- Proposed Changes to the Promoting Interoperability Program.

The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

**Payments for Indirect and Direct Graduate Medical Education Costs**

ACP supports CMS' proposal to change the definition of a "displaced" resident by considering a resident displaced at the time the hospital or program closure is publicly announced. Placing residents into "displaced" status as soon as a hospital or program closure is announced is a welcome change that allows hospitals and programs to facilitate a logical and step-wise decrease in workforce that coincides with the declining clinical demands of the closing hospital. Redefining when residents enter "displaced" status will also help eliminate ambiguity for some residents who have yet to start their training at the closing hospital or program. Without this rule change, these residents have been one of the most vulnerable cohorts because receiving

hospitals had no guarantee that they would be granted a temporary cap increase for residents starting their advanced program the following year. **The College strongly supports the proposal and asks that it be made retroactive to ensure that none of the hospitals that accepted residents who were displaced when Hahnemann University Hospital in Philadelphia, PA closed in 2019 are disadvantaged by the application of the old policy.**

Although this proposed rule change allows residents to enter displaced status earlier in the process of hospital or program closure, temporary cap transfers are still “voluntary and made at the sole discretion of the originating hospital.” Requiring closing hospitals to agree and sign displacement agreements without any incentive to do so earlier than the date of hospital closure has historically led to delays in residents finding and starting at receiving programs as demonstrated by the experience of displaced residents at Hahnemann University Hospital.<sup>1</sup> **A suggested rule change that would eliminate this ambiguity could include “any available cap will be equally divided and reallocated with each displaced resident in an accredited training program.” Alternatively, requiring closing hospitals to formalize cap calculations and transfers 10 days after the closure announcement would also be helpful to displaced residents and hospitals considering accepting them.**

This proposed rule change does not address the possibility of a financially unstable hospital negotiating to sell their provider number (along with all of their GME slots and funding) prior to the announcement of closure. The owners of Hahnemann University Hospital attempted to auction off their Medicare provider number albeit after the closure announcement and with the approval of the bankruptcy court. The auction was challenged in court by CMS but the winner of the auction withdrew their bid and no judicial decision regarding the legality of such an auction is expected. Agreements that include a transfer of resident slots prior to a hospital closure announcement could significantly affect temporary and permanent GME caps and even reduce available caps for displaced residents if the deals are made prior to a closure announcement. **A clarifying statement from CMS that such transactions are not allowed would help protect displaced residents and the hospitals willing to receive them.**

#### *Proposed Changes to the Promoting Interoperability Program*

For the 2021 Promoting Interoperability (PI) Program, the reporting period for new and returning eligible hospitals and critical access hospitals (CAHs) is a minimum of any continuous 90-day period, and CMS proposes to maintain the 90-day reporting period for the CY 2022 Program as well. The core set of PI Program measures remains the same from the previous year. CMS proposes two updates to the measure set as follows:

- Keep the e-Prescribing “Query of Prescription Drug Monitoring Program (PDMP)” measure as an optional measure worth five bonus points, and

---

<sup>1</sup> Aizenberg, David & Boyer, William & Logio, Lia. (2020). A Cautionary Tale: The 2019 Orphaning of Hahnemann's Graduate Medical Trainees. *Annals of internal medicine*. 172. 10.7326/M20-0043.

- Rename the “Support Electronic Referral Loops by Receiving and Incorporating Health Information” measure to “Support Electronic Referral Loops by Receiving and Reconciling Health Information” measure to better reflect the actions required in the measure’s numerator.

To be considered a “meaningful user” under the PI Program, eligible hospitals and CAHs must report on electronic clinical quality measures (eCQMs) selected by CMS using certified electronic health record technology (CEHRT). CMS previously finalized a list of eCQMs for CY 2021 and subsequent years and is now proposing to progressively increase the number of quarters for which hospitals are required to report eCQM data, from the current requirement of one self-selected calendar quarter of data, to four calendar quarters of data, over a three-year period. This proposal aligns the PI Program with the Hospital Inpatient Quality Reporting (IQR) Program requirements. Additionally, to reach their goal of encouraging data accuracy and transparency, and further align the PI Program with the Hospital IQR Program, CMS proposes to report publicly eCQM data submitted by eligible hospitals and CAHs for the PI Program from CY 2021 and subsequent years. This data would be made available on Hospital Compare as early as the Fall of 2022.

The College generally supports CMS’ proposals for the 2021 PI Program for eligible hospitals and CAHs, including efforts to align eCQM reporting requirements with the Hospital IQR Program. Regarding the reporting period proposals, **ACP remains supportive of the 90-day reporting period for the PI Program and recommends CMS maintain it beyond 2022.** ACP believes that a 90-day reporting period is a sufficient amount of time to capture the necessary information required and allows flexibility for hospitals, CAHs, as well as participating physicians, upgrading or replacing their EHR systems to be able to select the 90 days of data that reflects the highest utilization. Moreover, this shorter PI reporting period allows the opportunity to update or implement new and innovative technology throughout the course of the calendar year without the fear of negatively impacting performance data.

While the College supports the specific PI measure proposals, including keeping the Query PDMP measure optional and renaming of the Health Information Exchange measure, we continue to urge CMS to transform the PI Program from a check-the-box program to one that truly focuses on innovation and leveraging health IT to enhance the patient-physician interaction and improve patient care. As discussed in the College’s comments on the 2020 PFS/QPP proposed rule,<sup>2</sup> while we appreciate CMS’ earlier attempts to simplify and align the hospital and physician PI Programs, there is still much more that needs to be done to improve and evolve the program overall. The existing PI measures, which are the same measures (just a smaller number of them) that physicians have already found to be cumbersome and inappropriate within the Meaningful Use era, do little to promote interoperability or help

---

<sup>2</sup> [https://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_proposed\\_2020\\_pfs-qpp\\_rule\\_september\\_2019.pdf](https://www.acponline.org/acp_policy/letters/acp_comments_proposed_2020_pfs-qpp_rule_september_2019.pdf)

clinicians move forward with health IT utilization to improve care. **ACP continues to recommend CMS shift focus away from the existing PI Program functional-use measures to a selection of health IT-specific activities focused on leveraging technology to enhance patient care and the patient-physician interaction, and can be chosen based on hospital, physician, or specialty (see ACP's previous comments outlining these examples in more detail).**<sup>3</sup>

ACP appreciates the opportunity to comment on the CMS 2021 IPPS Proposed Rule. Thank you for your time and consideration. Please contact Brian Outland, PhD, at [boutland@acponline.org](mailto:boutland@acponline.org) if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Mire", enclosed in a simple oval outline.

Ryan D. Mire, MD, FACP  
Chair, ACP Medical Practice and Quality Committee

---

<sup>3</sup> [https://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_proposed\\_2020\\_pfs-gpp\\_rule\\_september\\_2019.pdf](https://www.acponline.org/acp_policy/letters/acp_comments_proposed_2020_pfs-gpp_rule_september_2019.pdf)