



2450 N STREET, NW, WASHINGTON, DC 20037
PHONE 202-828-0400 FAX 202-828-1125
HTTP://WWW.AAMC.ORG

July 8, 2002

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave, SW, Room 443-G
Washington, DC 20201

Attention: **CMS-1203-P**

Dear Administrator Scully:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems (PPS) and Fiscal Year 2003 Rates,*" 67 Fed. Reg. 31404 (May 9, 2002). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. medical schools; 98 professional and academic societies; and the nation's medical students and residents.

This letter addresses a number of important issues that affect teaching hospitals. First, we will address issues related to Medicare payments associated with direct graduate medical education (DGME) and indirect medical education (IME) payments. Afterwards, we will comment upon outliers, transfers, new technologies, the wage index, and diagnosis-related group (DRG) assignments. Finally, we will address the proposed criteria for provider-based entities and the Emergency Medical Treatment and Active Labor Act (EMTALA).

I. RESIDENT LIMIT AFFILIATION AGREEMENTS

The proposed rule would add two new sections to the DGME regulations (42 C.F.R. §413.86). (These new sections would also be cross-referenced to the IME regulations (42 C.F.R. §412.105)). Proposed section 413.86(b) would set forth a definition of "affiliated agreement" and 413.86(g)(7) would add additional requirements for hospitals that enter into affiliation agreements. It also is proposed that these provisions would be effective for agreements that *terminate* on or after October 1, 2002.

A. Resident Limit Changes Upon Agreement Termination

Under proposed section 413.86(g)(7), hospitals that enter into resident limit affiliation agreements would be precluded from agreeing to permanent changes in their resident limits upon termination of the agreement, so long as the aggregate limit of the agreeing hospitals does not change. Such actions are currently permitted.

We believe the existing policy makes sense, is fair, and should not be changed. According to Congressional views accompanying the Balanced Budget Act of 1997 (BBA), one of the purposes for implementing resident limits was to limit the aggregate number of residents reimbursed under Medicare. CMS was given certain flexibility in implementing the resident limits, but that flexibility is “limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels.” (BBA Conference Agreement at S-203). The existing policy complies with this Congressional intent because the aggregate limit does not change.

The Conference Agreement also states that CMS should not be involved in decision-making about workforce matters: “such decisions should remain within each facility, which is best able to respond to clinical needs and opportunities” (ibid.). The existing policy also advances this intent. Individual hospitals are in the best position to determine whether the training needs of residents within the local community are best served by permanently redistributing the aggregate limit among the hospitals participating in the affiliation agreement. These decisions are not entered into lightly, particularly given that the result is that one hospital will have a permanent resident limit that is lower than it otherwise is entitled to under the BBA so that another hospital can have a higher limit. The uniqueness of these occurrences is highlighted by the proposed rule preamble’s statement that very few hospitals have agreed to alter their caps following an agreement’s termination.

In some situations, hospitals may choose to alter their resident limits at the end of the agreement because one of the hospital participants has had a significant change in patient volume or is considering a) closing, b) relinquishing its teaching mission, or c) closing a particular program, and the other hospital participant is already at its resident limit. In such situations, both hospitals may agree that it is desirable that the programs and/or residency positions be maintained within the community. The resident limit affiliation agreement is currently the only option available to retain these resident slots and receive critical Medicare support.¹

We urge CMS to rescind its proposal and permit hospitals the flexibility to agree to permanently change their resident limits at the end of a resident limit affiliation

¹ Under the existing regulations, a hospital that takes on and completes the training of residents that come from closed hospitals or programs may receive an adjustment to its limits, but such an adjustment is temporary—available only until the displaced residents have completed their training.

agreement, so long as the aggregate limit (the sum of both hospitals' limits) is not exceeded.

While we oppose any change to existing policy, we also believe that to the extent any changes are included in the final rule, they should be effective with affiliation agreements *beginning*, not terminating, after October 1, 2002. A number of hospitals may have entered into affiliation agreements that comply with existing policy. These agreements would become noncompliant after October 1 if the proposed position is made final. A policy should not be implemented that would require retroactive changes to existing lawful agreements.

B. Definition of "Affiliated Agreement"

The definition of "affiliated agreement" in proposed section 413.86(b) would mandate that the agreement specify resident limit adjustments based on a 12 month period that begins July 1 and ends June 30. We believe the requirement should be changed so that hospitals may execute resident limit affiliation agreements at any time during the year. While most residency programs follow a July 1 to June 30 academic cycle, some do not. In addition, for reimbursement purposes, the more important time period relates to a hospital's cost reporting period. Regardless of the date it is executed, the resident count set forth in the agreement must be reconciled with the hospital's cost reporting period. Establishing a uniform July 1 date requirement does not address this situation because many hospitals have different cost reporting periods. Consequently, we believe that permitting hospitals to execute agreements throughout the year would reduce hospitals' administrative burdens without imposing much, if any, additional hardship on Medicare program administration.

On a more technical matter, we would like to suggest that CMS change its terminology for these agreements from "affiliation agreements" to "resident limit aggregation agreements" or "aggregation agreements." Affiliation agreements historically are a term of art in the academic community and generally relate to agreements made between hospitals and medical schools or among sponsors of medical residency education programs. Making a change such as the one we are proposing would help to reduce confusion between these very distinct types of arrangements.

II. IRB LIMIT AND RESIDENCY PROGRAM CLOSURES

In addition to mandating a resident limit for purposes of IME payments, the BBA also imposed a cap on the intern and resident-to-bed (IRB) ratio—a key component in determining a teaching hospital's IME payment level. In general, a hospital's IRB ratio may not exceed the ratio calculated during the prior cost reporting period.

In the August 1, 2001 inpatient PPS final rule, CMS provided for a temporary adjustment to the resident limits of hospitals that take on and complete the training of residents from

residency programs that have closed. However, no provision was made to address the receiving hospital's IRB limit in this situation

The proposed rule would permit an adjustment to a hospital's prior year IRB ratio to account for the displaced residents, but only for the first year in which the receiving hospital is training the displaced residents. In the cost reporting period following the departure of the last displaced residents, CMS proposes to calculate the IRB ratio for the prior year *as if* the displaced residents had not trained at the receiving hospital in the prior year.

We appreciate the proposed rule provision to increase a hospital's prior year IRB for the first year in which a receiving hospital is training the displaced residents. However, we believe the proposal concerning the IRB calculation for the year after the displaced residents have completed their training seems overly burdensome. The regulations relating to resident limits have already expanded the hospital cost report by at least 40 lines of information. Given the minimal resident count likely to be affected by this provision, and the significant associated reporting requirements, we urge CMS to finalize only the portion of the proposed regulation that affects the first year IRB calculation.

III. ROTATING RESIDENTS TO OTHER HOSPITALS

In the proposed rule, CMS addressed its current position on the counting of residents that train at multiple hospitals. According to the preamble, CMS believes that the Medicare statute prohibits one hospital from claiming the time spent by residents at another hospital regardless of whether the first hospital is incurring all of the costs associated with the training of residents at the other hospital.

We will not argue that the statute envisions a scenario in which the hospital where the resident is actually training is the only entity entitled to claim the resident time for purposes of DGME and IME payments. However, we believe that in those situations in which one hospital is incurring all of the training costs and the other hospital, because of lack of resources, infrastructure, or other similar reasons, chooses not to seek DGME and IME reimbursement, it is inequitable that no Medicare reimbursement is available. In those cases, the training costs are still being incurred, but Medicare is not paying its share of those costs.

We believe the statute permits, and CMS should consider, allowing hospitals to enter into agreements that would permit one hospital to claim the resident time of another hospital so long as the hospital claiming the resident time is incurring "all or substantially" all of the training costs at the other hospital. We believe such a policy would be particularly helpful in situations where residents receive important educational experiences in rural or small urban hospitals and Medicare reimbursement is a critical source of financial support to help offset some of the additional costs associated with educating these residents.

IV. COUNTING BEDS FOR IME AND DSH ADJUSTMENT PURPOSES

For purposes of both the IME and Medicare disproportionate share (DSH) methodologies, CMS proposes to specify that if a hospital's reported bed count results in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent. In the preamble, CMS states that it is proposing this change to "exclude beds that represent an excessive level of unused capacity." (67 Fed. Reg. at 31462). CMS believes that small urban hospitals, in particular, might be maintaining excess beds in order to qualify for higher DHS payments (69 Fed. Reg. at 31463).

We believe this proposal should not be implemented. There already is significant guidance as to which beds may be counted for purposes of these methodologies. Occupancy rates should not be used as a means to override these valid methodologies.

As the preamble notes, this change in policy appears to be directed largely at the DSH methodology. It is worth noting, however, that, CMS currently is looking into modifying the DSH methodology so that it better reflects a hospital's uncompensated care burden. Given this activity, it seems unwise to implement a controversial technical change to the current policy when major changes may be occurring in the near-term.

V. OUTLIER PAYMENT THRESHOLD

The proposed rule would increase the fixed-loss cost threshold for outlier payments to \$33,450, a *59 percent increase* over the FFY 2002 threshold of \$21,025. Such an increase is unprecedented, excessive, and should be reevaluated.

CMS' methodology for calculating the cost threshold is dependent on estimating a rate of cost increase from FFYs 2001 to 2003. While generally, CMS would make this estimate based on Medicare hospital cost report data from FFYs 1999 and 2000, this year CMS had to resort to an alternative methodology because the FFY 2000 cost reports are not yet available.² The proposed methodology calculates an annual rate of change using a three-year moving average of the differences in annual rates of change. Based on this methodology, CMS proposed a two-year cost inflation factor of *15.0 percent* for FYs 2001 to 2003. This rate of change is significantly higher than recent cost growth patterns and other projections of cost growth for the years in question. For example, data from the American Hospital Association's annual survey show increases in total costs per adjusted admission in FFY 1999 and FFY 2000 (the most recent data available) of 1.9 percent and 2.5 percent respectively.

The AAMC, along with several other major hospital associations, commissioned noted health economist Henry W. Zaretsky, Ph.D., to examine CMS' methodology, as well as

² While not definitive, the proposed rule preamble indicates that the alternative methodology would likely not be used in the future when the relevant year cost report data are available (see 67 Fed. Reg. at 31510).

alternatives he felt were reasonable, and give his opinion as to which methodology he believes should be used to calculate the cost growth factor. A copy of his report is included at the end of this comment letter.

In addition to analyzing the proposed methodology, Dr. Zaretsky examined three alternatives: 1) using a three-year moving average of annual rates of change (rather than differences in annual rates of change), 2) using CMS' usual method in predicting cost inflation but substituting a four-year lag in data, rather than the typical three year lag due to the lack of 2000 cost reports, and 3) using changes in the hospital market basket index. These three methodologies result in a projected increase in hospital cost inflation from 2001 to 2003 of 4.1 percent, 4.8 percent and 7.1 percent, respectively.

Dr. Zaretsky concludes that while the market basket methodology yields the highest cost growth factor of the three alternatives to CMS' approach, he believes it is the most stable method and should be used by CMS as the cost inflation factor. He notes that the CMS methodology yields the most volatile projections when examined on a historical basis.

It is important to remember that the purpose of outlier payments is to help offset extraordinary losses that hospitals incur from treating very sick or complex patients. These payments are critical to the many teaching hospitals relied upon by these patients for care.³ In addition to the mix of patients treated, the outlier payments for a particular hospital are based on the cost threshold, as well as the payment rates for FFY 2003 and the hospital's per case cost growth. The AAMC commissioned Vaida Health Data Consultants to conduct an analysis of outlier payments. Using FFY 2003 payment rates and various cost growth assumptions, Vaida estimated the impact of the proposed rule outlier changes on approximately 300 major teaching hospitals (those with an IRB ratio of 0.25 or higher).

Vaida's results indicate that, if finalized, CMS' proposed threshold would have serious negative financial impacts on major teaching hospitals. Even if CMS' estimate that hospitals' costs will increase 15 percent between FYs 2001 and 2003 is correct—and this is highly unlikely—these institutions will receive \$400 million *less* in outlier payments than they received in FY 2001. The average major teaching hospital would lose an estimated \$1.4 million, and 10 percent of these institutions would have average annual losses of \$8 million or more each. Even more distressing, if costs grow at the rate of the market basket estimate (7.1 percent)—a more likely scenario, the loss in outlier payments between FFY 2001 and 2003 could reach \$600 million for major teaching hospitals alone.

Viewed from another perspective, if CMS' cost growth factor is finalized and it ultimately turns out to be an overestimate, the result will be unwarranted underpayments to hospitals. For example, if costs grow at a 7.1 percent rate, outlier payments will be only 4.1 percent of total operating payments—a nearly \$700 million shortfall. This

³ It is worth noting that even with outlier payments, hospitals sustain significant losses treating these patients. Outlier payments reimburse only 80 percent of hospitals' costs *beyond* the threshold level.

shortfall will only be exacerbated to the extent costs grow at less than the 7.1 percent level.

While a market basket cost growth estimate will still result in a cost threshold that is likely to be 30 to 40 percent higher than the FFY 2002 level—with resulting negative financial consequences for major teaching hospitals—we believe that given all of the factors, the 7.1 percent growth factor is the best option available and should be reflected in the final rule.

We should also emphasize that we do not believe that CMS should consider lowering the 80 percent outlier payment level in order to reduce the cost threshold. Such an action would result in hospitals with higher cost outlier cases being paid less than hospitals with lower cost cases. This result is antithetical to the purpose of outlier payments—which is to provide some financial relief to hospitals with high cost cases.

VI. TRANSFER PAYMENT POLICY

Medicare patients who are sent from one acute care hospital to another are viewed as “transfers.” Under Medicare’s transfer payment policy, a full DRG payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment.

In FFY 1999, in accordance with the BBA, CMS expanded its transfer policy such that hospitals that discharge patients in one of 10 specified DRGs to either a PPS-exempt hospital or unit, skilled nursing facility, or home health agency, receive per diem payments, not to exceed the full DRG payment.

In the proposed rule, CMS expressed some thoughts about the possibility of expanding post-acute care transfer policy to include additional DRGs. Two options were generally discussed. The first would be to expand the policy to all DRGs. According to CMS, this option would result in \$1.9 billion less in Medicare program payments to hospitals. The second option would expand the policy to a subset of DRGs, CMS suggested 13, that have high rates of discharges to post-acute facilities. CMS estimates this option would result in about \$916 million less in Medicare payments to hospitals.

We believe that CMS should not implement an expansion of the post-acute care transfer policy. Such a policy penalizes hospitals that ensure that Medicare patients receive care in the most appropriate setting. Moreover, it undercuts the fundamental principle of the PPS, which is that some cases will cost more than the DRG payment, while others will cost less, but on average, the overall payments should be adequate. It also is important to recognize that to the extent there still are cost reductions associated with discharging patients to post-acute care facilities (a debatable presumption given the current low average lengths of stay), such reductions will be reflected in lower DRG case weights during the DRG recalibration process.

We believe expanding the post-acute care transfer policy to all DRGs would effectively destroy the Medicare prospective payment system. And, in fact, because of the consequences and incentives associated with a transfer policy, expansion to any additional DRGs must be thoroughly examined before being implemented.

On a related topic, we believe CMS should analyze the current post-acute transfer policy in relationship to DRG 483 (Tracheostomy/Mechanical Ventilation) to determine whether that DRG should be removed from the list of DRGs that are subject to this policy. Unlike the other DRGs that are subject to the post-acute transfer policy, DRG 483 has an extremely long average length of stay (35 days). Consequently, the large standard deviation around this length of stay results in great volatility in lengths of stay that are not related to use of post-acute care. Yet, the current policy has a significant impact on the hospitals that treat these very sick patients.

VII. PAYMENTS FOR NEW TECHNOLOGIES

Pursuant to a provision in the Medicare Benefits Improvement Act (BIPA), in a September 7, 2001 final rule (66 Fed. Reg. 46902), CMS established a methodology that would provide additional payments to hospitals for new technologies that they use that are not yet reflected in the DRG payment system. In order to qualify for the additional payments, the new service must meet thresholds related to “new,” “significant improvement” over the current service, and “inadequate payment” under the DRG system. The policy is required to be budget neutral, achieved by funding the additional payments through reducing the standardized payment.

According to the proposed rule, it is likely that no new technology payments will be made in FFY 2003 because no new technology applications met the applicable criteria. Teaching hospitals are often the sites where new technologies are first introduced and used. These technologies often are very costly when first introduced—costs that must be absorbed by teaching hospitals because they are not recognized in the DRG payment rates until several years after their introduction. Consequently, providing adequate payments in these situations is critical to ensuring payment equity for the institutions that shoulder this important responsibility. At the same time we recognize that under current law, payments for new technologies are budget neutral and thus funded by reducing payments for all cases. Thus, it is important that this policy be limited to only those technologies that are truly cutting edge and costly.

We are concerned that CMS’ methodology yielded no technologies that would be eligible for additional payments. It may be because the final rule containing the methodology was published as recently as last September. Alternatively, CMS’ cost criteria could be too stringent. We urge CMS to conduct a historical review of technologies that likely would have met the “new” and “substantial improvement” criteria and determine the relationship between the costs of those items and the Agency’s cost threshold. Such an analysis may provide useful insights as to whether a more flexible cost criteria is needed.

We also have concerns that the new technology payment methodology does not ensure payment equity for teaching hospitals that use new technologies and, perhaps more importantly, may not comply with the BIPA requirement that the additional payment “adequately reflects the estimated average cost of the service or technology.” If the criteria for identifying cutting-edge technologies are implemented appropriately, we believe only a limited number of technologies will qualify for additional payments. For these limited technologies, we believe BIPA requires that hospitals receive an additional payment that much more closely approximates average costs than what has been proposed; eighty percent, for example, rather than the current 50 percent level.

VIII. CHANGES TO THE HOSPITAL WAGE INDEX

The Medicare hospital wage index adjusts DRG payments to reflect differences in labor costs across geographic areas. The proposed rule contains a number of changes relating to the wage index.

A. Removal of Wage Costs Related to GME and Certified Registered Nurse Anesthetists (CRNAs)

In FFY 2000, CMS began a five-year phase-out of salaries related to teaching physicians, residents and CRNAs in the calculation of the wage index. Under that schedule, the FFY 2003 wage index would blend 20 percent of a wage index with GME and CRNA costs included with 80 percent of a wage index with GME and CRNA costs removed. CMS proposes to abandon this schedule in favor of removing 100 percent of the GME and CRNA costs in FFY 2003.

We vigorously oppose CMS’ decision and believe the FFY 2003 wage index should be based on an 80 percent removal of the GME and CRNA costs, which continues the 5 year phase-out process that CMS has adhered to since FFY 2000. According to CMS’ analysis, more than 20 percent of labor market areas (80) would be negatively affected by the proposal to go directly to a 100 percent carve-out. Almost all of these areas are urban--where teaching hospitals are more likely to be located. Moreover, regardless of the impact, CMS’ proposal would undo the results of an arduous negotiating process among hospital associations that resulted in the five-year phase-out plan that CMS adopted. We urge CMS to maintain the phase-out scheduled it has adhered to and endorsed since FFY 2000.

B. Increase in the Labor-Related Share

The proportion of the PPS standardized rate to which the wage index is applied is known as the “labor-related share.” CMS’ methodology for updating the hospital market basket dictates that the labor-related share for purposes of the wage index be increased from 71.1 percent to 72.5 percent and, accordingly, has included this increase in the proposed rule.

We support the proposed increase. CMS' methodology is both sound and fair. It reflects inputs that are not only purchased in the local labor market, but also those that are "related to, influenced by, or vary with the local labor market, even if those services may be purchased at the national level" (67 Fed. Reg. at 31477). As CMS notes in the preamble, the methodology the Agency is using is both consistent with its past practices and is consistent with its statutory mandate (*ibid.*).

We should also note that proposed rule impact table indicates that, as a group, major teaching hospitals will experience the greatest negative financial impact under the proposed rule provisions. The estimated losses would have been even greater if the labor-share increase was not proposed.

While we feel strongly that CMS should finalized the labor share that was proposed, we also believe that were CMS to consider a methodology for calculating a labor-share that is different from what was proposed, the Agency must separately propose that methodology so as to permit public notice and comment.

C. Occupational Mix Adjustment

BIPA mandates that, beginning in FFY 2005, the hospital wage index be adjusted to reflect the occupational mix of employees. In the proposed rule, CMS states that the Agency is still working on developing a data collection tool for purposes of implementing an occupational mix adjustment to the wage index. CMS will issue instructions as to the type of data to be collected in advance of actually requiring submission of the data by hospitals.

A wage index that includes an occupational mix adjustment essentially only recognizes differences across geographic areas in terms of the price hospitals must pay for a particular labor category. The fact that a hospital—such as a teaching hospital—may have higher overall labor costs because its patient population requires a larger quantity of highly skilled, higher priced employees is not reflected in this type of wage index. Accordingly, we continue to believe that the current wage index is appropriate and should not be changed. However, we recognize that this is a legislative issue.

Analyses of the Medicare Payment Advisory Commission (MedPAC) have shown, the inclusion of an occupational mix adjustment in the hospital wage index will lower the wage indices for many areas where major teaching hospitals are located, thereby lowering the Medicare DRG reimbursements for these institutions. Given the redistributive effects of this policy, we believe it is imperative that CMS proceed prudently as the Agency develops the occupational mix adjustment methodology. We would be happy to work with CMS staff on this area.

On a related issue, we believe that if an occupational mix adjustment is ultimately added to the Medicare wage index, it should not be included unless it is accompanied with DRG refinements.

Typically, major teaching hospitals treat Medicare beneficiaries with complex conditions, as evidenced by these hospitals' higher case-mix indices (CMIs). These patients generally require caregivers with high skill levels, which results in higher labor costs for teaching hospitals.

It is generally acknowledged that the current DRG payment system does not adequately recognize patient severity and reimburse for the higher resource costs associated with complex patients. However, under the current wage index methodology, teaching hospitals could recoup some of these losses because their higher employee skill mix was reflected through higher wage indices in the areas where they are located. This will no longer be the case if an occupational mix adjustment is added to the wage index. Consequently, if this occurs, it will be imperative that CMS refine the DRG system to ensure that complex cases are adequately reimbursed. An example of one such system is the "all patient refined diagnosis-related groups (APR-DRGs)," although alternative DRG refinement systems might also be appropriate. We urge the Agency to use the authority it has under the Medicare statute to implement refined DRGs through the regulatory process.

IX. DRG ASSIGNMENTS

The proposed rule would make a number of changes to the DRG classification system. We support the proposal to create a new DRG for cases involving implantation of ventricular assist devices (LVAD). However, we understand that the proposed DRG weight may underestimate the average costs of providing this procedure. We urge CMS to reevaluate the costs of these cases, including the costs of the device itself, to ensure that hospitals providing this important service are not financially penalized.

CMS also addressed the issue of drug-eluting stents. In clinical trials, these stents have shown promise to significantly advance the treatment of coronary artery disease by combating artery restenosis. Currently, this technology has not yet been approved for use by the Food and Drug Administration. The manufacturer expects this approval to occur sometime in FFY 2003. Given the likely event that it will be approved, the manufacturer would like CMS to assign cases using these stents to DRG 516 (percutaneous cardiovascular procedure with Acute Myocardial Infarction (AMI)) even when no AMI is present. The rationale is that the payment rate for this DRG more approximates the costs associated with using the new stent compared to the DRG that it might otherwise be assigned (DRG 517—percutaneous cardiovascular procedure with coronary artery stent procedure without AMI).

We appreciate CMS' recognition and close monitoring of the drug-eluting stent issue. When these items receive FDA approval, teaching hospitals will incur significant additional costs when they are utilized. It is important that hospitals receive adequate reimbursement for these important procedures.

X. PROVIDER-BASED CRITERIA

The AAMC supports CMS's efforts to reduce the burden on providers that have provider-based entities. In particular, the proposal to replace an application for provider-based status with an attestation is a move in the right direction. However, the AAMC believes that departments located on the hospital's main campus clearly are provider-based and should not be subject to either an application or an attestation process. Further, any department that is located within the four walls of the hospital and provides ancillary services should be considered provider-based and should not have to apply for (or attest to) such a designation.

The AAMC supports the suggestion by the American Hospital Association that if CMS has questions or concerns about whether a department or entity is provider based, the agency should initiate an investigation. This should include notice by CMS as well as an opportunity for the departments to fix any discrepancies prior to losing provider-based status.

The AAMC also believes that grandfathering should be made permanent, so that facilities treated as provider-based on October 1, 2000 need not go through the application or attestation process.

The AAMC notes that further guidance and clarification are needed on the following:

- ❑ If CMS adopts the attestation approach, the agency must make clear what supporting documentation must be maintained in the event that CMS chooses to conduct an audit.
- ❑ There must be guidance about multi-campus settings, such as:
 1. Does any entity located on one of the campuses have to apply for a provider-based designation in relation to any of the hospitals that are on the campus.
 2. When there is a multi-hospital system, what is considered to be the main campus.
 3. Do clinics that are on the campus of one of the hospitals have to apply for provider-based status in relation to a hospital that is part of the same system but is located on another campus.
- ❑ Under current policies, hospitals may claim the resident time spent at sites physically separate from the hospital (known as "nonhospital sites") only when there is an agreement between the hospital and nonhospital site. No such agreement is needed if the site is provider-based. Consequently, it is important that the final rule clarify that if CMS subsequently determines that an entity does not meet the provider-based criteria, the IME payments that were received by the hospital under the good faith belief that the site qualified as provider-based are not affected.

Thomas A. Scully

July 8, 2002

Page 13

XI. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

The AAMC supports the changes that CMS has proposed regarding the Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the “anti-dumping law. In addition, we support the AHA’s comments on EMTALA issues. However, we believe the Agency should clarify that it will apply EMTALA regulations only if a site is functioning as a designated emergency department.

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President of the Association, Ivy Baer, Director and Regulatory Counsel (provider-based issues), or Karen Fisher, Associate Vice President (all other issues). These individuals may be reached at (202) 828-0490.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC
Ivy Baer, AAMC