



**ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES**

2450 N Street, NW, Washington, DC 20037-1127

Phone 202-828-0400 Fax 202-828-1125

www.aamc.org

VIA HAND DELIVERY

July 12, 2004

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-1428-P**

Dear Administrator McClellan:

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; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates.*" 69 Fed. Reg. 28196 (May 18, 2004). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation's medical students and residents.

The primary focus of this letter is to comment on the proposed changes to the regulations for Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments that, if finalized, would dramatically and fundamentally change many aspects of the policies associated with these payments. In particular, we have a number of concerns about the following proposals:

- Resident Limit Redistribution Program,
- DGME Initial Residency Periods, and
- Residency Training at Nonhospital Sites.

We recognize that the provision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for the resident limit redistribution program constrains CMS somewhat in its flexibility regarding implementation. At the same time, we believe a number of changes are both statutorily permissible and critical to ameliorate potential negative consequences for this nation's graduate medical education system.

In stark contrast to the resident limit redistribution programs, the proposals regarding DGME initial residency periods and residency training in nonhospital sites result from recent and current regulatory actions that are not consistent with the Congressional intent of the statutory provisions from which they arise. We urge clarification of these regulations as soon as possible.

Before specifically addressing the proposed rule, we would like to acknowledge and commend the CMS policy staff who work on DGME and IME policies. While the policy and implementation issues associated with DGME and IME payments are some of the most complex within the Medicare program, the CMS staff are knowledgeable and insightful. They also readily listen to, and seek out, information regarding residency training and teaching hospital perspectives on these issues. Both the Medicare program and the academic medical community are well served by staff of this caliber.

After addressing the graduate medical education (GME) proposals, we will comment on proposals related to outlier payments, hospital submission of quality data, payments for new technologies, and long-term acute care hospitals.

I. THE RESIDENT LIMIT REDISTRIBUTION PROGRAM

The Balanced Budget Act of 1997 (BBA) contained a number of provisions that affected DGME and IME payments. Chief among these was the placement of limits on the number of residents teaching hospitals may count for purposes of the calculations associated with DGME and IME payments (so-called resident "limits" or "caps"). While there are exceptions (particularly affecting rural teaching hospitals), the general rule is that a hospital's resident limit is based on the number of allopathic and osteopathic residents reported on the hospital's most recent cost report ending on or before December 31, 1996 (42 U.S.C. 1395ww(h)(4)(F)).

Section 422 of the MMA, entitled "Redistribution of Unused Resident Positions," will affect the resident limits of a large number of teaching hospitals. Its purpose is to reduce the resident limits for those hospitals that are not fully "using" their limits and "redistribute" these slots to hospitals that demonstrate a need to have their caps increased. The resident limit reductions and increases are scheduled to go into effect July 1, 2005.

The resident limit legislation and proposed regulations serve to further complicate a resident limit policy that has been vexing for teaching hospitals and the academic medical community, both operationally and as it affects their educational and other missions.

Before addressing the specific regulatory proposals to implement the resident limit reduction and redistribution program, we first would like to address the resident limit policy generally.

A. THE RESIDENT LIMIT POLICY SHOULD BE REEVALUATED

While some observers have argued that a resident cap is necessary so that teaching hospitals do not increase the number of residents they train to generate additional Medicare DGME and IME reimbursement, this is not the case.

The decisions that academic medical centers make regarding the number and type of residency specialty training programs they maintain, as well as the number of residents they educate are complex and reflect a number of factors, of which Medicare payment may be one but virtually never the dominant one. Data from hospitals' Medicare cost reports support the notion that Medicare payment does not drive increases in resident counts. An analysis of 2002 Medicare hospital cost reports reveals that nearly half (46 percent) of all teaching hospitals had resident counts that were below their corresponding resident caps.

At the same time, nearly half of all teaching hospitals (44 percent) have resident counts above their caps. Despite the lack of Medicare support and the concomitant impact on their overall financial condition, these hospitals have chosen to educate additional residents, because changes in medicine continuously open up new educational opportunities and because education is a central part of their mission.

It is time for the Medicare resident caps to be lifted. While Medicare has periodically imposed other types of regulatory "freezes," these have always been temporary. The current caps have been in place for over six years--far exceeding what typically would be viewed as reasonable and temporary.

The data indicate that lifting the caps will not affect those hospitals that at various times will have resident counts that are under their current caps. Yet for those hospitals that are over their caps, for those hospitals that have been unable to increase their training programs because of cap limitations, and for those hospitals currently under their caps but that may need to increase their counts in the future, reinstating Medicare support associated with these additional residents is critical to retaining and promoting high quality educational programs and fully functioning teaching hospitals that can respond to changing educational and other needs.

B. OVERVIEW OBSERVATIONS ON THE RESIDENT LIMIT REDISTRIBUTION REGULATORY PROPOSALS

The decisions CMS makes in determining final regulations for the resident limit reduction and redistribution program will have a profound and long-lasting impact on the academic medical community. We recognize that in certain situations, the legislative

language is very prescriptive and CMS has little or no discretion. However, there are a number of areas in which CMS has considerable discretion in how to proceed. Given that the outcome of this program is to impose permanent changes in hospitals' resident caps, we urge the Agency to proceed cautiously. We trust the final rule will fulfill Congressional intent, while recognizing the broader Medicare DGME and IME payment context within which the resident limits operate. We also urge CMS to implement regulations that, to the extent possible, minimize the administrative burden associated with those requirements.

We urge CMS to keep in mind that Congress' intent is to redistribute only those resident limit slots that are "unused." There may be situations in which the number of residents training at a hospital equals its resident cap, but for DGME and IME payment purposes, the resident count is determined by CMS to be less than the cap because the hospital does not fulfill paperwork or other requirements associated with receiving DGME and IME payments. We believe the legislation dictates that the hospital's resident cap not be reduced in these situations because the limit unquestionably is being "used" despite the fact that for payment purposes in a given year, the corresponding resident count may be less than the hospital's cap.

C. PROPOSED PROCESS FOR DETERMINING CAP REDUCTIONS

1. Proposed Rule

According to the proposed rule, the decisions about which hospitals will have their resident caps reduced, and by how much, will be made by comparing cost report resident counts with resident caps in a specific year. For hospitals that are not members of a Medicare GME affiliated group, the resident cap/count comparison will be based on numbers reported on a hospital's most recent cost report ending on or before September 30, 2002 ("reference cost reporting period"). For hospitals that are members of GME affiliated groups as of July 1, 2003, CMS will compare their resident counts from the reference cost reporting period to the resident cap contained in the July 1, 2003-June 30, 2004 affiliation agreement.

All hospitals whose resident counts are below their corresponding resident caps and thus are at risk of having their caps reduced¹ have the option of requesting that a different cost report be used for purposes of the cap/count comparison if the hospital meets one or both of the following criteria:

- *Expansions of Existing Programs.* If the resident count on a hospital's most recent *settled* cost report is less than the count on a subsequent cost report due to a program expansion, upon submission of a "timely request," and subject to audit, CMS will use the cost reporting period that includes July 1, 2003.
- *Expansions Due to Newly Approved Programs.* If a hospital had a resident program that was accredited before January 1, 2002 but was not in operation

¹ The cap would be reduced by 75 percent of the difference between the cap and count values.

during the cost report ending on or before September 30, 2002, upon timely request and audit, CMS will increase the applicable resident count by the total number of residents for which the new program was accredited.

CMS' proposed process was also published in an April 30, 2004 and a May 26, 2004 "one time notification" (OTN). According to the May 26 OTN, hospitals desiring an exception had to file a timely request by June 14, 2004.²

Even though the current deadline for timely requests has passed, because the process is included in the proposed rule and is subject to comment and possible revisions, this deadline may need to be modified. CMS recognized this possibility in a notice published on June 15, 2004:

"If, in response to comments, we finalize any policy with respect to application of section 1886(h)(7)(A) [unused resident limit program] that differs from a policy described in the OTNs and the proposed IPPS rule, we will provide another limited opportunity after publication of the final rule for affected hospitals to make or withdraw a timely request under section 1886(h)(7)(A)(ii) [exceptions].

CMS Notice on "Redistribution of Unused Resident Positions" unnumbered, at:
<http://www.cms.hhs.gov/providers/hipps/resident.asp>

2. The Exception Process Should Be Reopened

As discussed below, we believe CMS should modify the proposed process for reducing cap slots. A necessary companion action, therefore, is that the exception process be reopened, as suggested by CMS in its June 15, 2004 notice.

3. The Process For Members of Medicare GME Affiliation Agreements Should Be Changed

The MMA mandated that the cap reduction process be different for members of GME affiliation groups because CMS is required to recognize the situations of hospitals that participate in a Medicare GME affiliated group agreement as of July 1, 2003 date.³ CMS chose to implement this mandate by comparing, for each hospital member of the group, the resident count from its most recent cost reporting period ending on or before September 30, 2002 with its resident cap reported on the July 1, 2003-June 30, 2004 resident limit affiliation agreement. While we appreciate CMS' dilemma in

² We understand that CMS felt it was necessary to publish an OTN prior to the proposed rule because of their perceived need to start the process as soon as possible due to the July 1, 2005 implementation date. The only difference between the two OTNs is that the May 26 OTN extended the deadline for filing timely requests from June 4 to June 14.

³ The MMA states that the "provisions of clause (i) [programs subject to reduction] shall be applied to hospitals which are members of the same affiliated group . . . as of July 1, 2003."

implementing the MMA time frame, we believe the proposed process is a wrong “apples-to-oranges” comparison and should be changed.

Hospitals that enter into GME affiliation agreements often do so because they have a shared rotational arrangement and, in a given year, one hospital’s resident count may be below its corresponding cap and the other hospital’s may be above. Hospitals that enter into GME affiliation agreements are permitted to alter their caps for the duration of the agreement, so long as the sum of the modified individual caps does not exceed the aggregate of the original caps. CMS requires that these agreements be submitted by July 1 of each year.

The modified caps that are set forth in the affiliation agreement generally try to mirror what the hospital believes its resident count will be for that year. However, it often is difficult for a hospital to predict its actual total resident count for the forthcoming year due to changes in resident rotations and other factors. Therefore, the regulations permit hospitals to modify the agreements through June 30 of the following year so they can match, as closely as possible, the ultimate resident count for that year.

Given the GME affiliation agreement process just described, we believe the cap/count comparison process proposed by CMS for members of affiliated groups is not reasonable, accurate, and--perhaps most importantly--could result in inappropriate reductions in hospitals’ permanent resident caps.

We urge CMS to review carefully the comments the Agency receives concerning GME affiliation groups, and implement a process that results in a cap/count comparison that is as accurate as possible. We offer the following modifications to the current proposal:

- Allow members of affiliated groups to elect to have their adjusted cap numbers compared to the resident count for the period July 1, 2003 to June 30, 2004. Using the same time frame for both caps and counts would help allow for an “apples-to-apples” comparison while complying with the MMA mandate to use July 1, 2003.
- Perform the initial comparison at the aggregate level. The proposed rule would conduct the cap/count comparison on a hospital-specific basis. We believe the initial comparison should be at the affiliated group level. This modification is supported by the MMA language which states that the provision will be applied to “hospitals which are members of the same affiliated group; it does not state “each hospital within the affiliated group.” Moreover, this policy is consistent with how CMS currently views members of an affiliated group for payment purposes when the group as a whole is under the aggregate cap.

We believe strongly that no member of an affiliated group should have its resident cap permanently reduced if the aggregate affiliated group resident count is at or above the corresponding aggregate cap. We recognize that if the aggregate count is under the corresponding cap, a hospital-specific comparison may be necessary to determine which hospitals should have their resident limits reduced.

- The comparison cap should be the one reflected in the most current agreement as of June 30, 2004. The language in the proposed rule and each of the OTNs is ambiguous regarding whether CMS would use resident caps from agreements as submitted on July 1, 2003 or as modified through June 30, 2004. The current regulations permit hospitals to modify their affiliation agreements until June 30 of the agreement year, in recognition that a hospital's resident count may fluctuate during the year for various reasons. Thus to maintain the "apples-to-apples" comparison, it is imperative that CMS permit a process that involves using modified agreements.

4. Using Audited Resident Counts and Caps

Some cost reports that ended on or before September 30, 2002 have only been "submitted" to CMS and therefore are still subject to audits and possible provider appeals. This process can take years and may affect a hospital's ultimate resident count and cap for that year.

In the proposed rule, this situation is addressed by using an "estimated" resident count for the cap/count comparison for those hospitals whose reference resident count is not final as of May 1, 2005. This will enable CMS to determine the number of resident cap slots it has to redistribute by the July 1, 2005 implementation deadline. CMS emphasizes in the proposed rule that the "estimated" resident count will only be used to help determine the cap slot pool. It also states that the final determination as to whether a hospital's resident cap will be reduced will be based on audited resident counts when those audited counts are available.

a. Resident Caps Should Be Reduced only if the Cap Slots are "Unused"

We believe that a hospital's resident count used for the resident limit program's cap/count comparison may, and some cases should, be different than the count used for determining DGME and IME payments.⁴ This is because the premise underlying a determination to reduce a hospital's resident cap permanently is that the cap is going "unused" as explicitly specified in the title of section 422.

The audit process is an important component of the Medicare program. It is a necessary part of ensuring that all requirements are met before finalizing Medicare payments. Teaching hospitals' resident counts are closely scrutinized during the audit process because they are a key determinant in a hospital's DGME and IME payment amounts. It is not unusual for a teaching hospital's resident count to be reduced for payment purposes even though the FTE count is accurate. For example, in the recent past, controversial

⁴ The proposed rule also recognizes that the resident count used for payment purposes may be different than the count used for the cap/count comparison (see 69 Fed. Reg. at 28294, discussing the new program exception which increases the hospital's comparison resident count to reflect the full complement of residents in the new program recognizing that the total additional count would not be factored in to payment determinations in the initial years of the new program.)

resident count reductions associated with residents training at nonhospital sites have been imposed because a hospital may have an incomplete written agreement or the hospital entered into agreements with volunteer supervisory physicians (see below).

While we recognize CMS' authority to reduce resident counts for payment purposes, we believe these reductions should not be reflected in the resident count used for purposes of the resident limit redistribution program. The reason is straightforward--the cap slots are being "used" by the hospital, as demonstrated by the submitted FTE resident count, even though the slots may not entitle the hospital to Medicare DGME or IME reimbursement.

We believe that for purposes of the resident limit redistribution program, the audit process should be used only to the extent it furthers Congressional intent to identify "unused" slots. That is, when the audit and appeal process is completed and CMS conducts its final cap/count comparison for the hospital, the resident count used in that comparison should be the audited count adjusted upward to include any resident counts that were excluded due to Medicare payment policy requirements, and not related to the actual presence of residents at the hospital or nonhospital site.

b. CMS Should Implement Policies to Ensure that the Ultimate Sum of Resident Limit Reductions is No Greater than the Aggregate Slots Redistributed

We recognize that CMS must use an estimated aggregate resident cap reduction count to distribute those cap slots to other hospitals by the July 1, 2005 implementation deadline. However, we are concerned that the final number of resident limit reductions might exceed the number of redistributed cap slots. If this were to occur, the result would be a permanent reduction in the total number of resident positions eligible for Medicare support. This was not the intent of the MMA.

The MMA requests CMS to submit a report to Congress by July 1, 2005 that contains recommendations regarding whether to extend the application deadline for hospitals seeking to increase their resident limits. Because of audit and appeal timeframes, CMS may not know the final aggregate resident count reductions by July 1, 2005. We urge CMS to address this situation in its report and recommend that the application process be extended or reopened in the event that the final resident limit reductions exceed distributed slots.

c. CMS Should Clarify the Process of How a Hospital's Cap May Change Upon Audit

Several of our member hospitals have informed us that their 1996 resident cap has yet to be made final, or was only recently made final. We request that CMS factor in these situations when finalizing the cap/count comparison process. For example, some hospitals may have a resident count in the reference cost report year that matched their corresponding cap, but that cap was later increased during the audit and appeal process. If the settled cap amount were to be used in the cap/count comparison, the hospital would

lose resident cap slots even though the hospital was at its cap as it knew it to be as of 2002. Such a result would be patently unfair and should be addressed in the final rule.

5. The New Program Exception Should Be Modified

We believe the current proposed “new program” exception to the cap/count comparison is too narrow to reflect all residents from new programs. Under the proposed exception process, a hospital’s resident count would only be increased if the entire program was not in operation during the relevant cost reporting period. However, there may be new programs that were accredited prior to January 1, 2002 (the MMA requirement) for which only a partial complement of residents is reflected on the relevant cost report. For example, if a new five-year residency program was accredited on January 1, 2001 and began training residents on July 1, 2001, the hospital’s relevant cost reporting year for the cap/count comparison (July 1, 2001 to June 30, 2002) would likely reflect only residents in the first program year. If this hospital’s resident count is below its cap, it is at risk of having its cap reduced even though it has already committed to training additional residents. We believe such a result is contrary to the intent of the resident limit legislation. Consequently, to ensure compliance with legislative intent, we believe the “not in operation” language of the MMA should be interpreted as meaning not fully in operation and that the proposed rule should be modified accordingly.

6. The Final Rule Should Clarify the Policy for New Teaching Hospitals

The final rule should clarify that new teaching hospitals that have yet to have a cap established because they are in the middle of their three-year start up period are excluded from any resident cap reductions.

D. PROPOSED PROCESS FOR ALLOCATING CAP INCREASES

1. Proposed Rule

The MMA sets forth several key requirements for distributing additional cap slots to qualifying hospitals. First, hospitals may receive no more than 25 additional cap slots. Second, hospitals must demonstrate the likelihood that the cap slot positions will be filled within three cost reporting periods beginning on or after July 1, 2005 (“demonstrated likelihood” requirement). Third, CMS must distribute the slots to hospitals according to the following priority order (“priority categories”): hospitals in rural areas, hospitals in small urban areas, hospitals in which the residency program involved is in a specialty for which there are no other residency programs in the state and, finally, all other hospitals. The MMA also authorizes CMS to determine cap distributions within the priority categories. This last provision is necessary in the event that the cap slot “demand” exceeds the corresponding “supply.”

To implement the MMA mandates, the proposed rule sets forth a number of proposals. First, CMS proposes four options by which a hospital can meet the “demonstrated

likelihood” requirement: starting a new residency program, expanding a current residency program, having a resident count that exceeds the current cap, and operating a residency program that is at risk of losing accreditation because of an insufficient resident complement (see a full discussion of these requirements below). Next, CMS sets forth its proposed priority categories. Because of the interplay between a hospital’s geographic location and whether it is operating the only specialty training program in a state, CMS proposes the following six priority categories:

1. The hospital is located in a rural area and has the only specialty program in the state
2. The hospital is located in a rural area
3. The hospital is located in a small urban area (less than one million population) and has the only specialty program in the state
4. The hospital is located in a small urban area
5. The hospital has the only specialty training program in the state
6. The hospital meets none of the statutory priority criteria

69 Fed. Reg. At 28302

(Note, the last two categories refer to hospitals in large urban areas.)

To determine cap slot distributions within a priority category (in the event there are not enough available cap slots to be redistributed), CMS proposes an elaborate schema that involves 10 “evaluation criteria” and awards hospitals and their corresponding residency programs one point for each criterion they meet (see specific discussion of evaluation criteria below).

CMS proposes an application process that will link together all of the requirements. The central component of this process is the completion and submission of a “CMS Evaluation Form.” (69 Fed. Reg. at 28308). Under the proposal, this form would be completed for each residency program for which the applicant hospital is seeking additional slots. The form includes information related to the “demonstrated likelihood” requirement, the priority categories, and the 10 evaluation criteria. In addition, the hospital must indicate the “number of FTE slots requested for each *program*” (emphasis added).

Overarching the entire application process is a requirement that a senior hospital official sign and submit a comprehensive attestation clause stating that the information in the application is “true, correct, and complete.”

2. The Redistribution Process Is Unnecessarily Burdensome and Should Be Simplified

By its very nature, the process for distributing cap slots will be difficult and administratively burdensome. The proposed rule unnecessarily complicates this process and places inordinate burdens on hospital applicants. We believe the process can be simplified significantly without compromising the intent and requirements of section 422. We urge CMS to modify its proposal as suggested below.

3. The Application Process Should Be at the Hospital, Not Program, Level

While we recognize that significant effort was required to develop the proposed application and evaluation process, we have fundamental and serious concerns with the overall direction of the proposed process. We particularly are concerned about the disproportionate focus on residency programs, rather than hospitals.

When the BBA mandated the Medicare resident limits, Congress made clear that the limits were to be implemented and managed at the hospital, not residency program, level. Specifically, the Conference Report accompanying the resident limit legislation stated:

“The Conferees also note that a facility limit on the number of residents was provided, rather than any direction on payments according to specialty of physicians in training to specifically avoid the involvement by the Secretary in decision making about work force matters. The Conferees *emphatically* believe such decisions should remain within each facility, which is best able to respond to clinical needs and opportunities.” (emphasis added).

BBA Conference Report at S-203

We think CMS’ proposed process could lead, at a minimum, to a de facto situation of program-specific caps, which is contrary to the spirit and intent of the BBA.

Teaching hospital leaders work closely with their institutional GME leaders,⁵ program directors, and department chairs to determine the number, type, and resident complement of their training programs. A facility limit allows these hospitals to respond to changing residency training needs so long as the overall limit is not exceeded. To be consistent with a facility limit, the proposed process must be changed so that the hospital is the applicant entity for the additional cap slots. The hospital should also be the focus of the “demonstrated likelihood” and evaluation criteria.

We believe a program-level application process will also be administratively burdensome for both CMS and hospitals, as well as inappropriately intrusive to hospitals. To illustrate, we will use the situation of a hospital that requests additional cap slots because its current resident count exceeds its cap. This represents the type of hospital that we expect to be the largest applicant group.

The hospital can easily determine that it needs additional cap slots to accommodate its excess resident count. However, the proposed evaluation form requires that the number of slots requested be at the program level. Because the cap is at the hospital level, it may be difficult, if not impossible, to allocate accurately this overage among its residency

⁵The institutional GME leader is the hospital staff member who has authority and responsibility for the oversight of the hospital's residency programs. Typical titles are "Director of Graduate Medical Education," "Director of Medical Education," "Vice President for Academic Affairs," and "Medical Director."

programs, nor should the hospital be required to do so. This hospital obviously needs cap slots and such a request can and should be easily accommodated in a hospital-based application. The leadership of this institution will then determine how best to allocate these slots among its residency programs.

A program-based focus also raises questions, and potential conflicts with Congressional intent, for those hospitals that are not over their caps. For example, hospitals may meet the “demonstrated likelihood” requirement by documenting that they are starting a new program or expanding a current program. If they chose one of these options, are they limited to submitting an evaluation form only for that program? If yes, and CMS ultimately grants additional slots to the hospital, it seems unclear whether CMS would take the view that the additional cap slots could only be used for the program listed on the application. We believe such a view would certainly be in violation of current Medicare policy. Even if that is not CMS’ position, the application process would provoke confusion at the institution as to whether the slots could be used by the hospital in a manner it deems appropriate.

The MMA’s use of the term “likelihood” again emphasizes Congress’ intent that the ultimate determination of how these cap slots should be utilized should be made by the hospital. The MMA specifically uses the term “likelihood” rather than “certainty” to recognize the inherent uncertainty, and need for flexibility, regarding resident complements for individual residency training program.

We recognize that when distributing cap slots, the MMA requires CMS to give priority to hospitals requesting additional cap slots because they have, or would like to initiate, a residency program that is the only one of its specialty in the state where the hospital is located. Even in this situation, the MMA focuses the priority requirement on the “hospital” not the program. Moreover, the MMA’s specific inclusion of the “single specialty” priority supports the conclusion that the statute intended for hospitals to receive all other additional cap slots without regard to the individual residency programs for which the additional slots would be used.

The “single specialty” priority can be accommodated within a hospital-level application by having the hospital indicate on the application form how many residents would be associated with that residency program. This legislative provision does not require or even imply that the application process must be-program based.

We also believe that both the IME and DGME cap requests can, and should, be accommodated on a single application. All of the requested information is applicable to both caps except for a possible difference in the number of cap slots requested.

4. “Demonstrated Likelihood” Criteria

a. Proposed Rule

The MMA stipulates that hospitals can receive additional cap slots only if they first “demonstrate a likelihood” that the additional slots will be filled within three cost reporting periods beginning July 1, 2005.

Under the proposed rule, hospitals can demonstrate the likelihood that they will use the additional cap slots in one of four ways: establishment of a new residency program, expanding an existing residency program, having a resident count that is currently over the corresponding resident cap, and operating a residency program that is at risk of losing accreditation due to an insufficient number of residents. Each of these options has multiple documentation requirements and options (see below).

b. The Criteria Should Focus on Hospitals, Not Programs

We agree that it is important for hospitals to provide some level of assurance that they will use the additional cap slots if their application is granted, particularly given the potential that the number of available cap slots will be less than the corresponding demand for those slots. However, as discussed above, we believe the focus of the requirements should be at the hospital, not program, level. Under this view, the “cap exceeds count” requirement would be retained, since it is hospital-based, but the “new program” and “program expansion” options would potentially need to be eliminated or be modified to have an institutional focus.

We believe many hospitals that apply for additional cap slots will do so because their resident counts exceed their caps. Hospitals seeking increases for other reasons should be permitted to submit a narrative explaining their need for and use of the additional resident slots. Such a narrative would eliminate the need for specific requirements associated with “new programs” and “program expansions.” In addition, while such a narrative could discuss specific resident program initiatives or expansions, it would also allow for other rationales that may not have been contemplated by CMS or commenters. The narrative could be signed by a senior official and submitted with the signed attestation.

c. Documentation Requirements Are Unduly Burdensome

Simply put, the proposed documentation requirements for the demonstrated likelihood requirement are excessive and unnecessarily onerous for providers.

At the same time, we believe the proposed rule omits what should be a key documentation requirement associated with a request for additional cap slots: whether the hospital’s decision to increase its residents would otherwise result in the hospital exceeding its cap. While one might argue that hospitals that are not at risk of exceeding their resident caps would not submit an application, we believe that because the cap/count relationship is such a fundamental component of this entire program, such documentation should be required.

Bearing in mind that the legislative threshold is expressly “likelihood,” not “certainty,” we urge CMS to eliminate or significantly reduce many of the proposed documentation requirements. Replacing the proposed criteria with cost report documentation on resident

counts and caps, an accompanying narrative, and a senior official attestation requirement would fulfill the legislative requirement.

d. CMS Should Reconsider the Use of Resident Fill Rates

As explained above, CMS should reconsider the use of program-level criteria. However, if the “new program” and “expanded program” options are retained in some form in the final rule, we are concerned about the associated documentation requirements that involve institutional and national “resident fill rates” (see specific discussion below). While the proposed rule does not explain the rationale for the fill rate requirement, we presume it is intended to demonstrate that the new program or expanded program will be able to attract and train additional residents for which the additional slots are requested.

We have serious reservations about using resident fill rates. At the outset, the definition of this phrase is not set forth in the proposed rule so it is somewhat unclear as to the information required. For example, does the “fill rate” refer to residency matching programs and the number of residents that “match” to a program compared to the number of program slots available through the match? If so, this measure would not accurately identify how many residents are training, or even interested, in a particular program since many programs train residents who are accepted outside of a match process. Moreover, there are more resident match programs than the two mentioned in the proposed rule (the National Resident Matching Program (NRMP) and the American Osteopathic Association Residency Match Program).⁶

Alternatively, does “fill rate” refer to the number of residents training in a program compared to the number of accredited slots? If so, this measure would be misleading for some hospitals that, for various reasons, choose to conduct a training program with fewer residents than their approved level. Again, in these situations, the fact that all of the accredited resident slots are not utilized may have little bearing on the ability of the institution to attract residents to its residency programs. Moreover, for national statistics, these data are not readily available.⁷

Additional comments concerning the proposed resident fill rate proposals are set forth below.

5. Specific Comments on the “Demonstrated Likelihood” Documentation Requirements

As discussed above, we urge CMS to revise the “demonstrated likelihood” requirement option to have a hospital focus. To the extent that CMS retains some or all of the proposed requirements, we offer the following specific comments:

⁶One example is the San Francisco Matching Program, which matches for post graduate year two (PGY-2) positions in Ophthalmology, Neurosurgery, Neurology, Otolaryngology, and Plastic Surgery. Another is the Urology Matching Program, which matches for positions in Urology only.

⁷ We understand that the ACGME may have information on resident counts and accredited slots at the program level, but they only publicize this information at the aggregate specialty level.

Proposed Demonstrated Likelihood Criterion 1: The hospital will use the cap slots for a new program that begins training residents on or after July 1, 2005

Proposed Documentation: Two pieces of required documentation are proposed, each with several options:

a. One of the following: 1) a copy of the new program application submitted to the Accreditation Council for GME (ACGME) or American Osteopathic Association (AOA), OR 2) for allopathic programs, a copy of the hospital's institutional review document or program information form in an application for new program approval, OR 3) Written correspondence from the accrediting body acknowledging receipt of the new program application.

Comment--Clarification is needed regarding the precise documentation options because the preamble and proposed application form differ. Moreover, it seems that option a2 should not also require the submission of a new program application. First, such a requirement seems duplicative since option a1 requires only that the application be submitted. Second, it seems that CMS' intent in option a2 is to provide an alternative to the application; therefore, an application should not also be required. These options should also accommodate those subspecialties that are not accredited by the ACGME or AOA, but rather seek certification from the American Board of Medical Specialties (ABMS).

More importantly, CMS should permit more flexibility in demonstrating that the hospital will use the additional cap slots for a new program or programs. We know that some hospitals have started new programs even though the additional residents result in their cap being exceeded. Other hospitals, however, have not started new programs because it would cause them to exceed their caps. These hospitals may have been waiting for the resident limit regulations to be proposed or finalized to assess whether they can receive additional cap slots before proceeding with new program discussions. The proposed criteria puts these hospitals in a quandary because, even if they presume they are likely to receive additional cap slots, they are not yet ready to submit an application to the accrediting body and, because of the time frame necessary to submit an application, are unlikely to be ready by this December.

The narrative submission we proposed above would address these situations. Alternatively, other types of documentation should be permitted, such as minutes from internal GME committee meetings, board meetings, or similar types of internal correspondence or documentation that demonstrate the institution is seriously discussing initiating new programs.

The requirement that the new program begin on or after July 1, 2005 may be too rigid. For example, if a hospital that has a July 1-June 30 cost report period starts a new program on July 1, 2004, those residents will not be reflected on the hospital's submitted cost report until sometime after June 30, 2005--well after the

application deadline. Either the new program start date should be modified or CMS should modify the “resident count exceeds cap” criterion (see below) to accommodate this situation.

b. One of the following: 1) if the hospital has other residency programs, documentation that each of the other programs has a resident fill rate of at least 95 percent for years 2001 through 2003, OR 2) copies of the cover page of the hospital’s “employment contracts” with the residents who are or will be participating in the new program, OR 3) the new program is in a specialty that has a national fill rate of at least 95 percent.

Comment--Concerning option b1, we seriously question the need for hospitals to submit resident fill rates regarding their other residency programs. While CMS may believe this information could indicate the ability of a hospital to “fill” the new program, it also is equally possible that the two pieces of information are unrelated. It is not uncommon that the fill rates of residency programs within a hospital will vary over time for reasons completely unrelated to the “fill” rate of other programs.

We also believe that requiring this information for three successive years is onerous and excessive.

In terms of option b2, regarding terminology, the arrangements between hospitals and residents are set forth in an “agreement of appointment” not an “employment contract.”⁸ Requiring a hospital to submit this information is burdensome, onerous and unnecessary. On a practical level, hospitals would be unable to provide this information by December, 2004 for residents who will be training in a new program that starts July 1, 2005 since these residents will not be identified until spring, 2005.

If the fill rate requirement is retained, the threshold percentage should be reduced. If fill rates refer to resident matching data (see discussion above), 2004 data from the NRMP indicate that a number of specialties had fill rates that were below the 95 percent threshold. (These data can be accessed via the NRMP web site at http://www.nrmp.org/res_match/data_tables.html (table 6)). Prominent examples include: family practice (78.8 percent) and obstetrics-gynecology (93.3 percent).

Proposed Demonstrated Likelihood Criterion 2: Additional cap slots will be used for additional residents due to a residency program(s) expansion on or after July 1, 2005 and before July 1, 2008

Proposed Documentation: Two pieces of documentation are required, with several options under each one:

a. One of the following: 1) ACGME or AOA approval of the program expansion, OR 2) the NRMP or AOA Residency Match Program “has accepted or will be accepting the

⁸ For more information, see the ACGME web site at www.acgme.org.

hospital's participation in the match" for the existing program with its expanded number of residency slots, OR 3) for allopathic programs, a hospital's institutional review document or program information form for the residency program expansion.

Comment--Concerning option a1, to be consistent with the new program criteria, applications for residency program expansions should be a permitted option, as well as any internal documentation concerning a desire to expand a program.

The purpose of option a2 is unclear. First, if CMS will recognize only program expansions that take effect on July 1, 2005, hospitals will not submit this resident match information until early 2005 ("resident match information) —after the December, 2004 application deadline. Second, it is unclear how a hospital would demonstrate that the matching program "will be accepting" the hospital's match participation with the expanded resident slots.

We believe option a2 should be replaced, or modified to include an option that grants hospitals more flexibility to meet this requirement.

We also believe that this option should recognize and accommodate hospitals that are planning to expand a residency program(s), but have already received ACGME accreditation for the additional slots. For various reasons, residency programs may choose not to train the total number of residents for which the program is accredited. For cap distribution purposes, hospitals needing additional cap slots for these program "expansions" are no different than hospitals seeking accreditation for program expansions because they currently are at their accredited levels. While option a2 may be aimed at this situation, as discussed above, we believe it is unworkable. Thus, potential documentation for these hospitals could be a document from an accrediting body indicating the number of approved resident slots for the program(s), and their associated resident counts for the current or previous year(s).

Finally, as under the first demonstrated likelihood criterion, we believe the options should accommodate subspecialties certified by ABMS.

b. One of the following: 1) if the hospital has other residency programs, documentation that each of the other programs has a resident fill rate of at least 95 percent for years 2001 through 2003, OR 2) copies of the cover page of the hospital's "employment contract" with the residents who are or will be participating in the expanded program, OR 3) the expansion is occurring in a residency program that has a national fill rate of at least 95 percent.

Comment--We reiterate the concerns we expressed under the "new program" proposed criteria. Additionally, if a residency fill rate requirement is retained, it should be sufficient for the hospital to demonstrate that the program it is planning to expand has historically had significant residency fill rates

Proposed Demonstrated Likelihood Criterion 3: The hospital's resident count exceeds its corresponding cap.

Proposed Documentation: The following three forms of documentation are required: 1) copies of the most recent as-submitted hospital cost reports with the corresponding DGME and IME resident counts and caps; AND 2) copies of the 2004 residency match information, AND 3) copies of the most recent accreditation letters on the residency programs for which the hospital counts residents for DGME/IME payment purposes

Comment--We reiterate that the proposed documentation requirements are excessive. It is particularly perplexing that three pieces of documentation would be required for a criterion that is the most straightforward rationale for requesting additional cap slots.

The need for submitting 2004 residency match information is unclear since such data do not necessarily indicate the total number of residents training at an institution. Submitting accreditation letters is unnecessary and burdensome, particularly for institutions that may have 75 or more residency and fellowship programs--which is not uncommon.

We urge that documentation option one be the only requirement.

Proposed Demonstrated Likelihood Criterion 4: Residency program at risk of losing accreditation because of insufficient residents

Proposed Documentation: Accrediting body documentation that the hospital is at risk of losing accreditation of a residency-training program because of an insufficient number of residents.

Comment--In addition to the proposed documentation, hospitals should document that the additional cap slots are necessary because otherwise increasing the resident count would cause the hospital to exceed its resident cap.

In addition, if CMS decides to retain fill rates as part of the documentation requirements for proposed demonstrated likelihood criteria one and two, it is unclear why similar requirements would not be applicable for this criterion.

6. Evaluation Criteria

a. Proposed Rule

In the event that the number of requested cap slots exceeds the number of available cap slots for distribution within a given priority category, CMS proposes a scoring scheme to determine which hospitals should receive cap slots first. Under the scheme, hospitals and their associated residency programs would receive one point for each of 10 criteria that they meet.

The proposed criteria are:

1. The applying hospital has a Medicare inpatient utilization over 60 percent in two of its last three most recent audited settled cost reports
2. The additional slots will be used to start a geriatrics program or to add residents to an existing geriatrics program.
3. The additional slots will be associated with a program in which at least 25 percent of the residents' training time occurs in one or more of the following: a rural area, a rural health clinic, or a Federally Qualified Health Center.
4. The hospital has continued the training of residents from closed hospitals or programs after the temporary upward adjustment has expired.
5. The hospital's base-year cap does not reflect residents from a program that was new during the base year but due to legislative requirements was not able to be reflected in the base cap.
6. The hospital's base-year cap is lower than it should be because a new program was not at its full resident complement when the cap was established.
7. The hospital is located in a geographic or population health profession shortage area, or a Medicare physician scarcity county
8. The hospital is located in a rural area and is a site for a rural track residency program but currently is unable to count those residents because it is over its cap
9. The hospital is affiliated with a historically black medical college
10. The hospital is training residents in residency program(s) sponsored by a medical school(s) that is designated as a Center of Excellence for Underserved Minorities Under the Public Health Service Act.

b. The Evaluation Criteria Should Focus on Hospital-Level Characteristics

Consistent with our comment that the application process should occur at the hospital-level, we believe the evaluation criteria should focus on hospital, rather than program, characteristics. This would result in the elimination or modification of proposed criteria two and three. To the extent CMS retains some program-level criteria, we again believe such criteria can be accommodated in a hospital-level application by referring to both "program" and "programs" where relevant.

c. The Evaluation Criteria Should Give Preference to Hospitals With Resident Counts That Exceed Their Caps

Because educating future physicians is a central mission of teaching hospitals, a number of teaching hospitals have added and/or expanded residency programs without any corresponding increase in Medicare IME or DGME payments because these actions result in them exceeding their caps. The decisions to increase resident counts in these situations are based on many factors, and have important negative financial implications for institutions that must consistently worry about their financial health. Nonetheless,

these hospitals often make these decisions because they have a mission obligation to do so--new specialties are emerging, specialist shortages are occurring, and/or additional physicians are needed in their community.

A primary purpose (if not **the** primary purpose) of section 422 is to provide cap “relief” to hospitals that have resident counts that exceed their caps. Consequently, we believe that, at a minimum, CMS should reflect these situations in the evaluation criteria. Moreover, it is reasonable to give special weight to this criterion; for example, by assigning it more than one point. In addition, CMS also could consider giving even more weight to those hospitals that are significantly over their resident caps compared to other hospitals that are over their caps.

d. Specific Comments on the Proposed Evaluation Criteria

The preamble discussion and the proposed application form do not seem to address documentation requirements associated with the evaluation criteria. Consequently, it appears that the attestation is all that is required for those hospitals that indicate on the application form that they meet one or more of the criteria. While this proposal seems somewhat at odds with the proposed documentation requirements associated with the demonstrated likelihood criteria, it is in concert with our comments to significantly reduce those documentation requirements.⁹

In the event that CMS decides to retain some or all of the proposed evaluation criteria, we offer the following specific comments:

- Because of the time lag often associated with settling cost reports, CMS should also accept submitted cost reports for the Medicare 60 percent utilization criteria. CMS also should consider modifying this criterion to include those hospitals with a 60 percent Medicare share calculation determined by calculating Medicare inpatients as a share of Medicare and privately insured patients, or Medicare patients plus Medicaid patients plus uninsured patients as a share of total patients. Many teaching hospitals treat a significant number of Medicaid and uninsured patients and they should not be put at a disadvantage under this criterion.

E. THE 3-YEAR ROLLING AVERAGE AND PRIOR YEAR IRB CAP SHOULD NOT APPLY TO RESIDENTS ASSOCIATED WITH THE ADDITIONAL CAP SLOTS

The proposed rule would subject resident counts associated with additional IME and DGME cap slots to the three year-rolling average (“rolling average”) that exists for current resident counts (see Social Security Act section 1886(d)(5)(B)(vi)(II) (IME), and § 1886(h)(4)(G)(i) (DGME)). The proposed rule would subject the resident count

⁹ It also seems that a response by CMS that the criteria would be subject to later audits would not be permissible since the MMA does not mandate that the additional cap slots be used in a manner dictated by CMS. This also is supported by the fact that the MMA does not require that hospitals document that they have used the slots, only that they demonstrate the “likelihood” that they will use the slots.

associated with additional IME cap slots to the IME cap on resident-to-bed ratios (“IRB cap”) that exists for current resident counts up to and including the cap level (see Social Security Act §1886(d)(5)(B)(vi)(I)). The seeming basis for CMS’s proposal is the absence of statutory language that explicitly excludes the redistributed FTEs from the IME cap and the three-year rolling average. (*See* 69 Fed. Reg. at 28283 and 28305-306).

We recognize, as did CMS, that the language of the statute does not expressly exclude from the reach of the cap and the three-year rolling average the resident counts associated with the redistributed cap slots. We submit, however, that the absence of a direct mandate to exclude redistributed FTEs from the IRB cap and rolling average does not compel the result that CMS proposes. Indeed, in the past, CMS created exceptions to the application of the rolling average and the cap when there were compelling reasons to do so, even in the absence of a statutory mandate. This is best evidenced by the fact that CMS created exceptions to the cap and rolling average for residents who are displaced by the closure of a hospital or a hospital’s residency training program and who are then temporarily added to the resident count of another hospital. CMS wisely recognized that in those situations, the application of the rolling average and the cap would create an unfair result, so the Agency excepted those displaced resident counts from the reach of those provisions. *See* 42 C.F.R. § 413.86(g)(5)(vi) and 42 C.F.R. § 412.105(a)(1)(i). Similarly, CMS recognized that if a hospital became a new teaching hospital with a new program, it made little sense to apply the cap and rolling average rules to limit the number of FTEs that could be counted in the initial program year. *See* 42 C.F.R. § 413.105(a)(1)(i) and 42 C.F.R. § 413.86(g)(5)(v).

Just as in the examples cited above, it makes little sense to apply the cap and rolling average rules here. Congress plainly wanted residents who are redistributed to a hospital pursuant to section 422 to be treated differently than other residents that already are subject to that hospital’s limits. Section 422 directed that the IME payment for the redistributed FTEs be considerably lower than that otherwise applicable to the hospital’s current resident count and that the per resident amount used in the DGME payment calculations be different than the amounts for current residents. While we strongly disagree with Congress’ decision to provide a lower IME payment for these resident counts, the decision further demonstrates that Congress did not intend the normal payment rules applicable to current resident counts to also apply to redistributed resident counts.

Consistent with this, Congress should not be viewed as intending that the cap and rolling average rules, otherwise applicable to a hospital’s current residents, apply to the hospital’s new, redistributed resident counts. To apply those rules, in conjunction with the payment limitations applicable to redistributed resident counts, would impose a double penalty on the hospital that is considering obtaining additional cap slots--the first being a payment rate penalty and the second being an inability to count the residents fully in the first and second years. There is nothing in the MMA that suggests that Congress intended to impose such a double penalty. Moreover, it runs contrary to the limited financial relief Congress wanted to provide hospitals that have resident counts above their caps.

In short, we believe that Congress, for the most part, viewed section 422 as a “stand-alone” provision that should not apply in conjunction with the IRB cap and the rolling average rules. The resident counts associated with the cap slots that a hospital receives by virtue of redistribution under section 422 are reimbursed in accordance with special payment rules. Similarly, we submit, these resident counts should be counted without regard to the IRB cap and the rolling average provisions.

F. OTHER REQUESTED CLARIFICATIONS

In the final rule, we ask that CMS address several additional issues:

- Clarify which hospitals are eligible to submit the additional cap request applications by March 1, 2005 rather than December 1, 2004
- Explain why the resident cap redistribution process is not included in the proposed regulations; only summary information is provided under proposed 42 CFR § 413.79(c)(4).

II. INITIAL RESIDENCY PERIOD DETERMINATIONS FOR RESIDENT PROGRAM SPECIALTIES REQUIRING A GENERAL CLINICAL TRAINING YEAR

We are very pleased that the proposed rule recognizes the need to clarify initial residency period (IRP) determinations for residency programs in specialties that require a year of general clinical training (69 Fed. Reg at 28310.) IRPs are used, in part, to determine Medicare DGME payments. A clarification is necessary to ensure that CMS policy reflects Congressional intent and that teaching hospitals with residents in these selected specialties are paid equitably.

Certain specialties (for example, radiology, anesthesiology, dermatology, neurology, psychiatry, ophthalmology, and physical medicine and rehabilitation) require that residents spend a year in general clinical training, with the remaining years being devoted to specialty-specific training. Under requirements established by the ACGME, the organization that accredits allopathic residency programs, the general clinical year requirement can be met through one of two pathways: by 1) spending the first year in internal medicine, family medicine, pediatrics, or surgery, or 2) participating in a one-year, freestanding “transitional year” program. A large number of residents meet the general clinical year requirement by entering a preliminary year internal medicine program before entering their specialty of choice. Residents are accepted for only one year into a preliminary year program with the understanding that in their second year they will enter a training program in a discipline in which they wish ultimately to specialize.

To determine DGME payments, residents are counted as 1.0 full time equivalents (FTEs) during the number of years required to achieve first board eligibility (known as the IRP), though no resident can be counted as a 1.0 FTE for more than five years. For any training beyond the IRP, residents are counted as 0.5 FTEs. Under the Medicare statute,

the IRP is “determined, with respect to a resident, as of the time the resident enters *the* residency training program.” (emphasis added). The statute also states that: “ ‘the period of board eligibility’ means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.” (Social Security Act Section 1886(h)(5)(F) and (G)).

Under the interpretation of the statute described in the proposed rule,¹⁰ hospitals providing specialty training for residents who select a specialty that requires a general clinical year may not be able to count those residents as a 1.0 FTE for the full length of the specialty training. This is because using the IRP based on the specialty in the first year of training, regardless of the specialty in which the resident actually trains, may yield an incorrect labeling of the resident that does not reflect the resident’s clear intent with regard to specialty training. Thus, a resident who enrolls in a preliminary year internal medicine program is assigned the internal medicine IRP of three years. For a resident who intends to train in radiology, for example, this means that for the first three years of training (preliminary medicine year plus two years of radiology), the hospital counts the resident as a 1.0 FTE and that for the required years four and five of radiology training, the resident is counted as only a 0.5 FTE. By contrast, a resident who meets the general clinical year requirement through a “transitional year” program is assigned an IRP based on the specialty in which the resident is training in the second year--for residents entering radiology, this would be five years.

The statute does not support CMS’ interpretation as set forth in the proposed rule. The statute requires that the initial residency period be determined at the time the resident enters the residency training program, but nowhere does the statute require assigning an initial residency period to a resident during the first year of the resident’s training. If the statute did mandate such a requirement, then a resident training in a separately accredited transitional year program would not be eligible to have the initial residency period determined in the second year of training. CMS’ longstanding policy allowing the initial residency period to be determined in the second year for residents training in transitional year programs is clear evidence that such a timeframe is permissible under the statute.

As noted in the proposed rule, the most recent statement of Congressional intent with regard to this issue was contained in the conference report accompanying section 712 of the MMA:

The conferees also clarify that under section 1886(h)(5)(F), the initial residency period for any residency for which the ACGME requires a preliminary or general clinical year of training is to be determined in the resident’s second year of training.

The proposed rule preamble states that CMS is considering establishing an IRP policy for these specialties based on the conference report language (69 Fed. Reg at 28311-312). However, the proposed rule also suggests a policy that would be limited to only those

¹⁰ Prior to this proposed rule discussion, there had been no pronouncement of this policy in either the regulation, preamble discussions, or program memorandum.

residents who “simultaneously match” (through a national residency matching program) to both a first year general clinical program and a second year specialty program (ibid.). For only these residents, their IRP would be based on the period of board eligibility for the specialty program, not the general clinical program.

In the proposed rule, CMS shares its concern about the conference report language:

“[T]here would be no way to distinguish in the second year of training among those residents who simultaneously matched in a specialty program prior to their first year of training; those residents who did not match simultaneously, but participated in a clinical base year and then continued on to train in a different specialty; and those residents who simply switched specialties in their second year.”

69 Fed. Reg. at 28312

Analyses which we have provided previously to CMS indicate that the number of residents in these scenarios represent a minority of residents pursuing these specialties. More importantly, these concerns do not outweigh Congress’s clear intent: if a resident is training in a specialty, such as radiology or anesthesiology, for which the ACGME requires a preliminary or general clinical year of training, then the initial residency period is to be determined by the resident’s specialty in the second year of training.

There is no need to look at whether a resident matched into two specialties simultaneously, nor should there be. Not every resident who is in a specialty that requires the initial broad-based clinical year of training matches simultaneously into both programs, and there is no ACGME requirement that the resident do so. It is possible to be admitted into a residency program other than through a residency match, and it is possible that some programs do not participate in a residency match.

We also believe it unwise for CMS to incorporate “resident matches” into Medicare payment policy or to define this term. National resident match programs are not easily defined and have many connotations. At the present time, only the National Resident Matching Program and the American Osteopathic Association matches offer positions for the first training year. Moreover, not all matches use the same mathematical algorithm, nor do they have the same policies and/or participation requirements.

We urge that the IRP issue be addressed in the inpatient final rule (or in an interim final regulation), and that the reinterpretation should reflect the statute, as restated by Congress in the MMA conference report language by clarifying that, for residents whose first year of training is completed in a program that provides a general clinical year as required by ACGME for certain specialties, an IRP should be assigned based on the specialty the resident enters in the second year of training.¹¹

¹¹ If CMS decides to pursue an option that involves focusing on residents’ first year of training to identify their intentions regarding their second year specialty training choice, we believe the requirement should be

III. RESIDENT TRAINING AT NONHOSPITAL SITES

Under the Medicare statute, for DGME and IME payment purposes, teaching hospitals are allowed to claim residents training in nonhospital sites so long as the teaching hospital incurs “all or substantially all” of the costs of the residency training in those sites and the resident count does not exceed the hospital’s resident cap. Until 1999, “all or substantially all” the training costs was defined to be the resident’s stipend and benefits. Effective in 1999, CMS changed the definition to include supervisory physician costs, if any. In addition, there must be a written agreement between the hospital and nonhospital site setting forth the hospital’s obligations.

A. CMS MUST MODIFY ITS PROPOSAL REGARDING WRITTEN AGREEMENTS AT NONHOSPITAL SITES

The proposed rule would eliminate the requirement for a written agreement between the hospital and nonhospital site, and replace it with a requirement that the hospital pay all or substantially all of the costs of the training in a nonhospital site by the “end of the month following a month in which the training in the nonhospital site occurred.” (69 Fed. Reg. at 28316). As a result, under this new change, the resident count associated with training at nonhospital sites would be determined on a month-to-month basis, and depend on the whether the hospital had paid for the training costs of the previous month.

We appreciate CMS’ recognition of the administrative burden associated with the written agreement requirement. However, our members are essentially unanimous in their opinion that the payment time frame associated with CMS’ proposal is too short and will result in more, rather than less, disallowances of resident counts. The billing arrangements of complex organizations such as teaching hospitals and their business partners often exceed 30 and even 60 days. Moreover, for many hospitals, their fiscal office cannot send a payment to any entity without first receiving an invoice from that entity. Often these invoices do not arrive at the hospital within the 30-day proposed deadline.

We believe that a reasonable alternative would be for hospitals to demonstrate proof of payment when the cost report is audited. Alternatively, hospitals could be required to make these payments within one year after the end of the cost reporting period.

This time frame would be consistent with Medicare’s general policy regarding liquidation of short-term liabilities (See Medicare Provider Reimbursement Manual at § 2305). Either of these alternatives achieves the same result as CMS’ proposal--to ensure that hospitals make any required payments to nonhospital sites--but in a much less burdensome manner.

more broad so that CMS will accept any type of documentation (in addition to simultaneous matches) that demonstrates the resident’s intention.

We urge CMS to adopt one of these options in the final rule, in conjunction with the elimination of the written agreement. If CMS rejects these comments, we believe teaching hospitals should be given the option of the current policy (maintaining a written agreement) or, eliminating the written agreement and complying with the payment time frame that CMS ultimately adopts. Otherwise, we believe that CMS should rescind this proposal pending further study of this issue.

We also note that contrary to what CMS states in the preamble, we do not agree that the regulations require the written agreement be signed prior to when the hospital may begin counting the residents training at the nonhospital site. Rather, consistent with generally accepted accounting principles, we believe it is permissible that a written agreement be signed near the end of a hospital's fiscal year with an effective date at the beginning of the same fiscal year.

**B. CMS SHOULD PUBLISH A CLARIFICATION ALLOWING
VOLUNTEER SUPERVISORY PHYSICIANS AT NONHOSPITAL SITES**

Since the regulatory change in 1999 to expand the definition of "all or substantially" resident training costs in nonhospital sites to include physician supervisory costs, the AAMC has voiced concerns about CMS' rhetoric regarding the use of volunteer supervisory physicians. Prior to this year's proposed rule, CMS had recognized the use of volunteer supervisory physicians in two regulation preambles and a program memorandum.¹²

¹² See 63 Fed. Reg. at 40996 (July 31, 1998) "[F]or purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a non-hospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs."; 64 Fed. Reg. at 41518 (July 30, 1999) ("We will continue a volunteer supervisory physician policy consistent with the policy stated in the July 31, 1998 final rule, as requested by the commenter. Hospitals may receive payment for the costs of training residents in the nonhospital site even though the hospital might not be incurring any costs for supervisory physician activities."); and Medicare Program Memorandum A-98-44 (December, 1998) ("The hospital may count the resident for indirect and direct medical education in this situation if the written agreement indicates that the physician is voluntarily supervising residents and the nonhospital site does not incur graduate medical education costs.") Moreover, in the Physician Self-Referral Regulation, CMS has created an academic medical center exception (42 CFR § 411.354(e)). The preamble to the regulation states that "a teaching hospital can include any faculty, including courtesy and volunteer faculty. . . ." (69 Fed Reg at 16109), and the regulation itself states, "any faculty member may be counted [to meet the requirement that a majority of physicians on the medical staff must be faculty members], including courtesy and volunteer faculty" Clearly, in the context of this regulation CMS has recognized the existence of volunteer faculty within an academic setting.

This year's proposed rule preamble seemingly states that a hospital must incur supervisory costs even though the physician is volunteering:

Because the existing regulations... state that the hospital must incur all or substantially all of the direct GME costs, including those costs associated with the teaching physician, regardless of whether the written agreement states that the teaching physician is 'volunteering,' we have required that the hospital must pay these costs in order to count FTE residents training in the nonhospital site, as long as these teaching physician costs exist."

69 Fed. Reg. at 28314

The AAMC strongly supports Medicare payments for training in nonhospital sites. These sites include physician offices, nursing homes, and community health centers, cornerstones of ambulatory training for graduate medical education programs. Congressional intent underlying these payments was to expand and enhance residency training beyond the hospital setting. We are very concerned about the statement in the proposed rule, which we believe essentially ignores the long-standing tradition of volunteer supervisory physicians. Such a position could have a chilling effect on residency training programs in non-hospital settings.

Section 713 of the MMA specifies that for one year beginning on January 1, 2004, CMS is not to continue its practice of disallowing volunteer faculty, but this applies only for selected programs. Hospitals will be allowed to continue to count osteopathic and allopathic residents in family medicine residency programs in existence as of January 1, 2002, who are training in non-hospital sites without regard to the financial arrangement between the hospital and the supervisory physician.

Section 713 also requires the Office of the Inspector General (IG) to conduct a study on volunteer physicians and issue a report with any potential recommendations to Congress by December, 2004.

The final rule should clarify that where supervising physicians freely agree to forego compensation as faculty at a nonhospital site and the teaching hospital pays the residents' stipends and benefits and other training costs, if any, as agreed to by the parties, the hospital has incurred "all or substantially all" of the costs of the program and is entitled to count the residents for DGME and IME purposes.

At minimum, CMS should extend, through regulatory action, the moratorium established by Section 713 of the MMA and expand its coverage to all residency programs regardless of specialty. The extension of the moratorium will allow both Congress and CMS the opportunity to review, evaluate, and act upon the IG report released later this year. We strongly support the expansion of the moratorium to all specialties based upon the fact that the IG report will evaluate all residency programs, not just family medicine residency programs. Therefore, we feel it is more than appropriate to provide protection for all residency programs pending future action.

Finally, for those sites where the hospital is paying supervisory costs, we are extremely concerned that the preamble language seems to mandate a payment formula for determining these costs:

The amount of supervisory GME costs is dependent upon the teaching physician's salary and the percentage of time that he or she devotes to activities related to the residency program at the non-hospital site.

69 Fed. Reg. at 28314.

This language contradicts CMS' statements made at the time the change in the regulations to add supervisory costs was finalized:

These agreements and amounts paid by the hospital to the nonhospital site may be the product of negotiation between the hospital and the nonhospital site. The hospital does not have to report the nonhospital site's GME costs. We anticipate that in the course of any negotiation between the hospital and nonhospital site, the nonhospital site may need to identify its training costs. However, *this is a matter between the hospital and the nonhospital.* (emphasis added).

63 Fed. Reg. at 40993 (July 31, 1998)

We agree strongly with CMS' position in 1998 that, where supervisory costs exist, the level of payment should be determined by the parties. We request CMS to reaffirm this policy in the final rule. While some parties may choose to determine this amount according to the physician's salary and supervisory time, this should only be an option, not a mandate. If using physicians' salaries is the only option allowed by CMS, this could have a significant chilling effect on ambulatory training because many physicians believe their salary arrangements and determinations are, and should be a private matter. Rather than reveal this information as a prerequisite to being a supervisor some physicians might simply choose not to take on this important role.

IV. OTHER PROPOSALS OF PARTICULAR IMPORT TO TEACHING HOSPITALS

A. THE OUTLIER COST THRESHOLD MUST BE REDUCED

Under the Medicare inpatient outlier policy, if the costs of a particular Medicare case exceed the relevant diagnosis-related group (DRG) operating and capital payment (including any disproportionate share, IME, or new technology add-on payments) plus a fixed-loss cost threshold, determined by CMS, the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation. Outlier payments, which help offset extraordinary losses that hospitals incur

from treating very sick or complex patients, are critical to the many teaching hospitals relied upon by these patients for care.¹³

The cost threshold is set at a level that is intended to result in outlier payments that are between five and six percent. Outlier payments are budget-neutral and therefore the Agency reduces the inpatient standardized amount by 5.1 percent and each year estimates a cost threshold that will result in outlier payments that equal 5.1 percent.

The proposed rule would set the fixed-loss cost threshold at \$35,085, well above the current level of \$30,150. Prior to April 1, CMS had set the threshold at \$31,000 for FY 2004, effective October 1, 2003.

CMS estimates in the proposed rule that outlier payments will be approximately 4.4 percent of total DRG payments, 0.7 percentage points lower than the 5.1 percent amount CMS had projected in setting the FY 2004 threshold and 0.7 percentage points less than the amount that was removed from hospitals' base payment amounts.

We believe the FY 2005 fixed-cost threshold must be reduced. We agree with comments of the American Hospital Association (AHA) that CMS' methodology for determining the threshold is flawed and does not take into account the June 9, 2003 final rule significantly changed the outlier payment policy (68 Fed. Reg. at 34494). We urge CMS to reduce the threshold so that teaching hospitals will receive the appropriate level of outlier payments to help offset those cases with extremely high costs.

B. REPORTING QUALITY DATA TO RECEIVE FULL HOSPITAL PAYMENT UPDATE

The MMA requires that in order for hospitals to receive a full market basket update to their base per case payment rates, they need to submit quality data on ten quality measures established by the Secretary. The program is referred to as the Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU). The proposed rule sets forth a process for the RHQDAPU to be implemented. The data submission process is the same as what has already been established through the National Voluntary Hospital Reporting Initiative (NVHRI), and our hospital members appreciate this consistency. However, several new procedures have been introduced regarding sampling and validation for which we are suggesting alternatives.

1. CMS Should Modify the Proposed Data Sampling and Validation Process

Since the beginning of the NVHRI, hospitals have been submitting data to the Quality Improvement Organization (QIO) data warehouse. Most of these hospitals have been utilizing their ORYX vendors to submit their data¹⁴ and not CMS Abstraction and

¹³ 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.

¹⁴ Hospitals use these vendors to submit required quality data to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Reporting Tool (CART). The proposed validation rules state that the Clinical Data Abstraction Centers (CDACs) will be re-abstracting data from the QIO data warehouse for sampling and validation utilizing the CART tool. Since the CDACs will be using a different abstraction tool than most hospitals used to submit the data, this could yield different results for various data elements. Therefore, there should be an opportunity for hospitals to reconcile any discrepancies that may arise from the differences in data abstraction methods.

The specifications for calculating hospital validation results outlines what are considered to be acceptable variances between the CDAC data abstraction and data submitted by the hospitals to the QIO data warehouse. It could be the case that a hospital has submitted a value outside of the variance's acceptable range, but the value could still be valid for that data element. Therefore, individual data variances should only be flagged if it results in not meeting the criteria for the entire measure rather than for that specific data element.

Further documentation provided by CMS outlines how the annual validation rates would be calculated. Any hospital that does not meet the validation requirement will not be eligible for their full market basket update. The current rate is set at 80 percent or higher for all four quarters in order to be eligible. Due to the fact that the validation procedure is new and hospitals are not yet familiar with the process, we suggest a phased in approach to ensure hospitals will not be penalized for initial operational difficulties inherent in a new process. We recommend that for FY 2006, the annual validation rate be set at 60 percent and passing two of the four quarters of 2004, or set the rate at 70 percent beginning with the second quarter of 2004, and passing two out of four quarters. After having a year to familiarize everyone with the process, the annual validation rate would then go to the full 80 percent for FY 2007.

C. CMS SHOULD INCREASE THE PAYMENT THRESHOLD FOR NEW TECHNOLOGIES

We urge CMS to raise the add-on payment level for new technologies from 50 percent to 80 percent of the difference between the standard DRG payment and the cost of the procedure using the new technology. This change is supported in the MMA's report language. In addition, it would mirror the current 80 percent marginal cost factor for inpatient outlier payments.

D. CMS SHOULD RECONSIDER ITS PROPOSALS ON LONG TERM CARE HOSPITALS

The emergence of long term care hospitals (LTCHs) has been an important addition to the health care continuum, particularly for medically complex, long stay patients. To ensure a more seamless course of treatment, some teaching hospitals have created an LTCH within its main facility, known as a "hospital in hospital" (HIH) LTCH.

The proposed rule would change certain qualification criteria for LTCH HIHs. We have serious concerns about the provisions that would limit the existing governance and

Administrator McClellan

July 12, 2004

Page 31 of 31

separateness criteria for HIHs. We support the comments of the AHA on this issue and urge CMS to withdraw these provisions from the final rule.

V. CONCLUSION

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, Health Care Affairs, or Karen Fisher, Senior Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC