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August 31, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Dear Dr. Berwick:

Re: CMS-1504-P, Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates;...; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services for Graduate Medical Education Costs...*, 75 Fed. Reg. 46170 (Aug. 3, 2010). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems. The Association also represents all 133 accredited U.S. medical schools; 94 professional and academic societies; nearly 110,000 clinical faculty members; and the nation's medical students and residents.

The AAMC is submitting two separate comment letters in response to the CY 2011 Outpatient Prospective Payment System (OPPS) proposed rule. This letter will address proposals relating to CMS's implementation of the direct graduate medical education (DGME) and indirect medical education (IME) provisions of the Affordable Care Act (ACA), P.L. 111-148 and P.L. 111-152. A separate letter will address proposed changes to the hospital OPPS and the CY 2011 payment rates.

Donald Berwick, M.D.

August 31, 2010

Page 2 of 35

Our comments in this letter focus on the following areas:

- Counting resident time in nonhospital settings;
- Counting resident time for didactic and scholarly activities and other activities;
- The unused resident cap position redistribution program; and
- The closed hospital resident cap position redistribution program.

ROLE OF THE MEDICARE PROGRAM IN SUPPORTING THE SPECIAL MISSIONS OF TEACHING HOSPITALS

The Medicare program and teaching hospitals share a long and mutually beneficial history. Since 1965, Medicare has recognized and provided financial support to teaching hospitals for their unique roles that extend beyond the traditional patient care service mission. These include being sites for the clinical education of all types of health professional trainees; providing environments in which clinical research can flourish; being sources of specialized, unique, and referral/standby services; and serving as safety net providers for the poor and uninsured. Because of their education and research missions, teaching hospitals offer the newest and most advanced services and equipment and often care for the nation's sickest and most complex patients.

While we very much appreciate Medicare's recognition of teaching hospitals' special roles, we are very concerned by signs indicating erosion in this support. As a result of using an outdated base year in the calculation of DGME payments, Medicare is underfunding its share of teaching hospital DGME costs by about \$1.3 billion annually. In addition, because of the resident caps imposed by the Balanced Budget Act of 2007 (BBA), teaching hospitals are not receiving DGME or IME payments associated with approximately 8,500 residents, a loss of about \$850 million annually. As a result of these losses, combined with other Medicare payments not keeping pace with costs, staff at the Medicare Payment Advisory Commission (MedPAC) estimate that in 2008, the aggregate overall Medicare margin for major teaching hospitals was negative 1.5 percent.

Through the ACA, Congress took important steps toward promoting flexible policies that will help hospitals as they seek to have residents spend time in ambulatory training sites. Congress also provided a small measure of relief from the resident caps for some hospitals by allowing certain unused resident cap slots and cap slots from closed hospitals to be redistributed to hospitals that are able to use them. While the AAMC recognizes the value of these changes, they are but incremental steps that do little to address such problems as the nationwide physician shortage or the unjustified exclusion of certain didactic and research DGME and IME time from hospital resident counts.

It is critical that Medicare policymakers and academic leaders work together to ensure, as was promised in 1965, that Medicare continues its support of the vital missions of teaching hospitals that represent the cornerstone of America's health care delivery system.

THE ORIGINAL RESIDENT LIMIT POLICY MUST BE REEVALUATED

The academic medicine community understood at the time the BBA was passed that Congress was establishing a cap on the number of physician residents that would be countable for Medicare DGME and IME purposes for two reasons. One reason was so the teaching hospital community, along with many others, could contribute toward achieving a balanced Federal budget. Another reason was to address the concerns of workforce experts in the early to mid-1990s about an impending oversupply of physicians. This conventional wisdom was predicated in large part on reports published in the early 1990s by the Federal Council on Graduate Medical Education (COGME), a body that advises Congress and the U.S. Department of Health and Human Services on GME and the physician workforce.¹ Independent research conducted by health economists and policy experts, including the Institute of Medicine, generally supported these findings. Thus, when adopting the resident cap provision in the BBA, Congress sought to limit significantly the production of physicians in response to the belief at the time that a physician oversupply was looming.

Currently, the vast majority of health policy analysts and physician workforce researchers agree that these earlier studies were in error and that the country now faces a potentially severe physician shortage. The AAMC's Center for Workforce Studies, for example, projects a national shortage of 124,000 – 159,000 physicians by 2025,² a shortfall that will only be exacerbated by an increased demand for services as more individuals are insured under the ACA; many states and physician specialties already are experiencing shortages.

This projected shortage has enormous implications for health care in this country. Considering the amount of time it takes to educate and train a physician—four years of medical school, plus a minimum of three years of residency training—teaching hospitals and medical schools must act rapidly to avert a future shortage. A 2005 COGME report, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, recommends an increase in medical school enrollment along with the cap on Medicare-supported resident positions. In 2006, the AAMC adopted a similar position.

It is time for the Medicare resident caps to be lifted. While Medicare periodically has imposed other types of regulatory “freezes,” these have always been temporary. The current caps have

¹ See, in particular, *Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century* (COGME Third Report, October 1992) and *Recommendations to Improve Access to Health Care Through Physician Workforce Reform* (COGME Fourth Report, January 1994).

² *The Complexities of Physician Supply and Demand: Projections Through 2025*. Center for Workforce Studies, Association of American Medical Colleges, 2008.

Donald Berwick, M.D.

August 31, 2010

Page 4 of 35

been in place for over twelve years—far exceeding what typically would be viewed as reasonable and temporary. We acknowledge that CMS does not have explicit authority to lift the resident caps itself, but we urge the Agency and the Department of Health and Human Services to work with Congress to lift them as soon as possible.

THE MEDICARE PROGRAM IS INTENDED TO SUPPORT ALL RESIDENT TRAINING TIME

To produce a highly-skilled, functioning physician, residency programs require trainees to have myriad educational experiences including inpatient and ambulatory hands-on patient care, scholarly activities, and didactic learning. While such training is critical to the development of a physician, Medicare policies of counting resident time for DGME and IME payment purposes work against these training goals. The AAMC appreciates that the ACA made some headway toward allowing hospitals to claim more of this essential training time, but more needs to be done.

Medicare regulations continue to preclude counting resident time spent in didactic or research-related activities in nonhospital settings for purposes of calculating IME payments; research time is also disallowed for DGME payments when rotations occur at nonhospital sites. Moreover, any time residents spend in nonhospital sites that does not involve direct patient care (but that still contributes to producing well-rounded physicians), such as public health departments, medical examiners' offices, and poison control centers, is excluded for both the DGME and IME payment calculations.

The financial impact of these policies is a *de facto* cut in DGME and IME payments. Equally disturbing (from an educational perspective) is that CMS's policy sends a message to the academic medical community that the Medicare program does not value the full range of education activities necessary to train a physician. In addition to the financial consequences associated with not counting this time, the effects of monitoring what is allowable and non-allowable resident time adds dramatically to the already significant administrative burdens on teaching hospitals.

The AAMC forcefully disagrees with CMS's view that the Medicare statute requires the Agency to scrutinize each and every aspect of residency training and exclude time associated with certain activities. The practical reality is that physician resident training is a fluid activity that comprises direct patient care, educational activities related to patient care, and research activities intended to support patient care. Except in certain specific and very limited cases (for example, an extended special research assignment that is separate and apart from the ordinary course of education and training), these activities blend together to form a seamless educational experience that is not amenable to parsing by the Agency. We believe this parsing was neither intended nor expected by Congress.

We believe the best and most straightforward policy is to allow teaching hospitals to count any and all time residents spend as part of accredited residency programs within the teaching hospital setting and at nonhospital sites. Such a policy would remove any disincentive for programs to minimize important didactic or research activities, or limit time spent in settings that do not provide direct patient care. More importantly, such a policy would also recognize and promote program efforts to provide residents with the experiences necessary (including community-based activities) to become physicians able to address changing health system needs.

The remainder of this comment letter will address CMS's specific regulatory proposals.

COUNTING RESIDENT TIME IN NONHOSPITAL SETTINGS

The Medicare statute authorizes teaching hospitals to receive DGME and IME payments associated with residents training in nonhospital sites if they incur "all or substantially all" of the training costs. In 1999, CMS issued a regulation defining "all or substantially all" of the training costs as the residents' stipends and benefits plus physician supervisory costs. In 2005, CMS changed the regulatory definition of "all or substantially all" of the nonhospital site training costs to be 90 percent of the residents' stipends and benefits plus physician supervisory costs at the nonhospital site.

The ACA clarifies this requirement to mean that a hospital incurs "all or substantially all" of the required costs for both DGME and IME purposes, so long as the hospital incurs the costs of the resident stipends and benefits for the time the resident spends in that setting. *See* ACA § 5504(a)(3). The effective date of this provision for DGME purposes is "cost reporting periods beginning on or after July 1, 2010." For IME purposes, the provision is effective "for discharges occurring on or after July 1, 2010."

A. RECORDKEEPING REQUIREMENTS SHOULD BE REEVALUATED

The ACA requires hospitals to maintain and make available to the Secretary records of the time residents spend in nonhospital sites as well as how much time they spend in nonhospital sites compared to a base year. CMS proposes that the base year will be hospital cost reporting periods beginning on or after July 1, 2009, and before June 30, 2010, and that hospitals must provide nonhospital rotation data for primary care programs on a program-specific basis and on an aggregate basis for non-primary care programs. Primary care would be defined using the definition at § 413.75(b), as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, and osteopathic general practice. CMS intends to use rotation schedules as the source for establishing the amount of resident time spent in nonhospital sites and plans to revise the hospital cost report to add lines to collect these data.

While the AAMC believes that the legislative changes will encourage resident training at nonhospital sites and recognizes that the legislation requires the tracking of nonhospital training

Donald Berwick, M.D.

August 31, 2010

Page 6 of 35

time, we want to caution that the data collected will not provide a full and complete portrayal of the amount of time residents spend in nonhospital settings. Moreover, to the extent the goal of such tracking is to study and encourage ambulatory training experiences, it is important to recognize that any results obtained must be viewed in the context that many provider-based settings also provide exemplary ambulatory experiences.

There are many reasons why a hospital's cost report may reflect more or less nonhospital site training from one year to the next that have nothing to do with the residency program's policy decisions or with the proportion of time each resident spends training in a nonhospital site. A hospital's numbers may fluctuate from year to year due to a greater or lesser ability to match residents into a particular program as well as whether any residents within a program take approved leaves of absence in a given year.

Moreover, it will be important to recognize that the data obtained from the proposed reporting requirement will, in many cases, not capture the total amount of time residents spend in ambulatory training. Many provider-based outpatient clinics provide the same ambulatory training experiences for residents as nonhospital-based clinics, yet that time will not be reflected in the tracking report. Ambulatory training in Veterans Affairs (VA) or military clinics also would not be captured in these calculations.

The AAMC recognizes that Congress specifically instructed hospitals to maintain records relating to "time spent in a non-provider setting," rather than ambulatory training sites more broadly. Because of the limitations on these data explained above, we urge CMS in the final rule to discuss explicitly the limitations associated with the output, so that the public and policymakers understand the implications and why individual hospital numbers may vary from one year to the next.

In addition to our broad concerns about the usefulness of the data CMS is required to collect, the AAMC is also concerned about the administrative burden CMS would impose on hospitals by adding cost report lines that require program-by-program reporting. The ACA simply requires that hospitals "maintain and make available to the Secretary" their records regarding resident time spent in nonhospital settings. Congress did not require that hospitals report these data on their cost reports. Moreover, there is no requirement that this information be provided for primary care versus non-primary care training, much less data broken out by each specific primary care specialty. CMS's proposals would only add complexity to already-burdensome resident reporting sections of the hospital cost report at a time when Congress intended to *simplify* the process for sending residents to nonhospital settings. If CMS decides to add cost report lines for this purpose, the AAMC encourages CMS to add only two lines – one for primary care data and one for non-primary care data.

B. CMS SHOULD CLARIFY THE DOCUMENTATION REQUIRED WHEN RESIDENT STIPENDS AND BENEFITS ARE PART OF GLOBAL AGREEMENTS

In situations in which residents are on the payroll of a medical or dental school, or of a third party GME administrative entity, and in which the hospitals reimburse the school or the third party for the entire stipend and fringe benefit costs of the residents for both hospital and nonhospital training, CMS states that “the hospitals could easily document that they have incurred the requisite costs of training in nonhospital sites.” We appreciate this statement and agree that such information could easily be provided. CMS does not, however, specify what type of documentation would be sufficient in situations in which these payments are made as part of a global agreement between the third party and the hospital.

The AAMC agrees with CMS those hospitals that pay resident stipends and benefits as part of global agreements can document that they have incurred these training costs. Many of our member hospitals have invoices (or other similar trainee financial agreements) that reflect the amount of money the hospital is paying to a medical school or third party for resident salaries and benefits, and we ask CMS to confirm that these invoices are an acceptable form of documentation. Not all teaching hospitals use an invoice system for these payments, though, and we believe it would be unduly burdensome for these hospitals to be required to change their internal practices simply to meet documentation requirements. An invoice system simply may not make sense, for example, for hospitals and medical schools that are owned by the same entity. For hospitals that do not use invoices, we suggest to CMS that a memorandum of understanding between the hospital and medical school that is effective at the start of the hospital fiscal year and that projects the expected resident compensation, followed by a year-end reconciliation, should be sufficient for these purposes. Finally, we believe that hospitals would benefit from clear instruction from CMS as to these documentation requirements.

C. CMS SHOULD REDUCE THE REPORTING BURDEN ON HOSPITALS THAT SHARE THE COSTS OF TRAINING RESIDENTS IN NONHOSPITAL SETTINGS

The ACA clarifies that if more than one hospital incurs the costs of training residents in nonhospital settings, each may count a proportionate share of the time. CMS proposes that such an agreement to allocate the time proportionately must be documented in a written agreement between (or among) the participating hospitals and that hospitals must use and document a “reasonable basis” for establishing the proportion. CMS states that hospitals allocating their time proportionally must document this “reasonable basis” in a written agreement, even if the hospitals pay training costs concurrently and do not otherwise have a written agreement with the nonhospital site.

The AAMC is concerned about the burden CMS would impose on hospitals by requiring them to “determine prior to the start of nonhospital rotations (with allowance for modification by June 30 of that academic year) the total cost of the salaries and fringe benefits of the residents that are training for the proportion of the year spent in each nonhospital site.” So long as all of the hospitals that share the residents’ time are funding 100 percent of the resident stipends and benefits in the aggregate, and they are not claiming more than 100 percent of the residents’ time, CMS should permit hospitals to determine for themselves when and how to allocate resident time spent in nonhospital sites. We believe this approach not only complies with the ACA but is what Congress intended, and CMS should modify its final regulations accordingly.

COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES

A. RESIDENT TIME SPENT IN DIDACTIC TRAINING

Prior to the passage of the ACA, the Medicare program paid hospitals for time residents spent in didactic training – i.e., conferences and seminars not related to the care of a particular patient – only when the resident was training in the hospital and only for purposes of DGME payments, not for IME payments.

The ACA now permits hospitals to count resident didactic time spent in nonhospital clinical training sites for DGME purposes, beginning July 1, 2009. Additionally, the ACA now permits hospitals to count resident didactic time spent in the hospital for IME payment purposes, effective January 1, 1983.

1. CMS should clarify the one-day rule for didactic time and should adopt a true one-day threshold for such time.

The AAMC urges CMS to take this opportunity to use the flexibility provided by the ACA to adopt a one-workday threshold – not just the “one-workday” administrative rule CMS announced in the *Federal Register* on August 18, 2006 (71 *Fed. Reg.* 47870, 48091) – for the time residents spend in didactic training, be it for DGME payment purposes in nonhospital settings, or for IME payments in the hospital setting. In § 5504(a)(1)(B) of the ACA (adding paragraph (J) to § 1884(h) of the Social Security Act), Congress gave the Secretary express authority to define what constitutes didactic time and activities:

(J) Treatment of certain nonprovider and didactic activities.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, *as such time*

and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency. (Emphasis added.)

The AAMC believes CMS should use this authority to adopt a one-workday threshold that would allow a hospital to count a day of resident training, so long as the entire day did not consist of didactic training time. Such a policy would advance Congress' goal of reducing the administrative burdens associated with training residents in nonhospital settings and would encourage training in ambulatory settings. It also would eliminate the confusion surrounding CMS's current policy, in which the Agency makes an arbitrary distinction between hospitals whose residents train in block rotations and whose software systems are unable to identify parts of days, and hospitals whose software systems are able to identify resident time in hour-by-hour detail.

In the event CMS is not willing to adopt a one workday threshold, the AAMC encourages CMS to confirm, at a minimum, that the "one-workday" administrative rule will continue to apply for IME payment purposes to didactic time spent in a nonhospital setting. Under this policy, CMS permits hospitals that maintain "block" rotation schedules only to report didactic activities lasting a day or longer. (We recognize that this rule will no longer be necessary for IME payment purposes for hospital didactic time or for DGME payment purposes for nonhospital didactic time, because this time is now countable.)

2. Didactic time spent in dental clinics should count for DGME payment purposes.

The didactic time provisions of the ACA refer only to counting time in a "nonprovider setting that is primarily engaged in furnishing patient care." In the proposed rule, CMS interprets this term to be a setting in which the "main mission" is to provide patient care, which would include a doctor's office or a community health clinic but not medical and dental schools, hotels, and convention centers. CMS also proposes to continue to use the agency's current definition of "patient care activities" at § 413.75(b), defined as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section."

The AAMC urges CMS to clarify in the final rule that the Agency's reference to dental schools does not include dental clinics that are located on dental schools premises. Dental schools frequently train dental residents in patient-care clinics that are located *on* the dental school premises. Because the "main mission" of these dental clinics is clearly to provide patient care, the time a dental resident spends in the clinic – including any time the residents spends in didactic training in the clinic – should be counted for DGME payment purposes. There is no reason CMS should not view these dental school clinics as "nonprovider setting[s] that [are] primarily engaged in patient care."

B. RESIDENT RESEARCH TIME

In the hospital setting, the Medicare program currently allows hospitals to count resident time spent conducting research not associated with the treatment or diagnosis of a particular patient for DGME payment purposes *only* (i.e. not for IME payment purposes). The ACA clarifies that research time may not be counted for IME payment purposes as of October 1, 2001. The law does not opine on the status of IME research time prior to October 1, 2001, stating that research provision of the law “shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.”

The health reform law also clarifies that resident time spent conducting research in a nonhospital setting does not count for either DGME or IME payment purposes. This does not represent a change, as the Medicare program does not currently reimburse resident time spent conducting research in nonhospital settings.

1. CMS should clarify that hospitals may count time residents spend on projects to improve patient care quality and safety.

In the proposed rule, CMS lists examples of what the agency considers to be nonallowable research time:

“Research not associated with the treatment or diagnosis of a particular patient” usually comprises activities that are focused on developing new medical treatments, *evaluating medical treatments for efficacy or safety*, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future, rather than on establishing a diagnosis or furnishing therapeutic services for a particular patient.

75 *Fed. Reg.* at 46389 (emphasis added).

The AAMC urges CMS to clarify that “evaluating medical treatments for efficacy or safety,” which CMS regards as nonallowable time, does not include quality and safety projects, which should be allowable as didactic time. With the increased emphasis on improving quality in patient care settings, America’s teaching hospitals are working diligently to ensure that resident physicians have experience working on quality and safety projects. These projects are essential to training a new generation of physicians who practice with safety considerations in mind and who are adept at formulating and executing plans for quality improvement.³ The AAMC asks

³ We understand that these projects may be used to satisfy the accreditation requirement that residents participate in “scholarly activities,” but we believe that this need not preclude CMS from designating these projects as didactic for Medicare purposes. These projects also may be used to satisfy the accreditation requirement that residents become competent in practice-based learning and improvement, which includes “the ability to investigate and evaluate the care of patients...and to continuously improve patient care...” See ACGME Common Program Requirements IV.A.5.c and IV.B.

CMS to clarify that the time residents spend on quality projects is in fact countable as didactic time (when didactic time is otherwise allowable).

2. As with didactic time, CMS should also adopt a one-day threshold for research time.

In addition to encouraging CMS to adopt a one-workday threshold for didactic time for the reasons stated above, the AAMC also urges CMS to adopt a one-workday threshold for resident research time. As with didactic time, the Secretary has the authority to establish a one-day threshold for research time and should use this authority to reduce the tracking burdens on hospitals. If CMS chooses not to implement this threshold, we believe that the Agency should at least implement a one-day administrative threshold for research time. Implementing a consistent policy for both didactic and research time is crucial to reducing administrative burden and eliminating confusion between the two policies.

C. RESIDENT VACATION TIME AND OTHER APPROVED LEAVES OF ABSENCE

The ACA clarifies that resident time spent on vacation, sick leave, or other approved leave that does not prolong the total time the resident spends in the program beyond the program's normal duration may be counted for DGME and IME payment purposes. This general principal does not represent a change, as CMS currently permits providers to count this time.

In the proposed regulation, CMS states that regardless of which hospital is paying the resident's stipend and fringe benefits, the hospital to which the resident is assigned during the time the resident takes vacation time is the hospital that should count that FTE time for DGME and IME purposes. If a rotation schedule does not specify where the resident is assigned during the resident's vacation time, CMS proposes that all of the hospitals to which the resident rotates during the year should divide and count the resident's vacation time proportionately, based on the amount of time the resident spent in each of the respective hospitals.

1. If a rotation schedule does not specify where a resident is assigned during the resident's vacation time, how to divide this time should be left to the hospitals' discretion.

The AAMC strongly disagrees with CMS's statement that "if the rotation schedule does not clearly indicate where the resident is assigned during the time the vacation is taken, the hospitals to which the resident rotates over the course of the academic year would divide and count the resident's vacation time proportionately based on the amount of time spent in actual training at the respective hospitals." *75 Fed. Reg.* at 46390. Until this point, hospitals have never been given such a strict mandate regarding how to allocate vacation time and have had no trouble deciding between and among themselves how to divide and count this time. Hospitals currently

use a variety of methods to account for vacation time that is not noted on a rotation schedule – methods the hospitals believe are consistent and fair to all parties that account for paid time off. These methods have been working well, and the AAMC encourages CMS not to second-guess hospitals' decisions regarding how to allocate this time.⁴

If CMS is not willing to continue to give hospitals this discretion, hospitals should, at a minimum, be permitted to choose the period over which they divide the time, so long as the period is used consistently. A number of hospitals make these allocations on a monthly basis, and converting to a one-year period is unnecessarily restrictive and unnecessary. Again, hospitals have for years used their own equitable ways of dividing this time and should continue to be permitted to do so.

D. APPEALS OF OPEN COST REPORTS

The ACA states that hospital cost reports may not be reopened for purposes of any provision of § 5505, unless a proper DGME or IME appeal was pending as of March 23, 2010. CMS interprets this requirement to mean that the “pending, jurisdictionally proper appeal” must be specific to *either* DGME or IME.

The AAMC disagrees with CMS's construction of this provision and believes the statute clearly permits hospitals to reopen cost reports under this section so long as the hospital has an appealable cost report – regardless of whether the issue subject to appeal is related specifically to either DGME or IME payments. Congress did not impose this restriction on hospitals' appeal rights, and given that certain time is countable retroactively (e.g., didactic time for IME payments back to January 1, 1983), CMS should not place additional restrictions on hospitals' ability to appeal.

Additionally, while not specifically addressed in the proposed rule, the AAMC believes that hospitals with cost reports for which the hospital retained a right to timely file a jurisdictionally proper appeal as of March 23, 2010, should be permitted to reopen such cost reports, whether or not the appeal was in fact pending by that date.

THE UNUSED RESIDENT CAP POSITION REDISTRIBUTION PROGRAM

The 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

⁴ With Medicare evaluation and management (E/M) codes used for the hospital outpatient PPS, the emergency departments of hospitals, CMS gives providers the discretion to adopt varying approaches that allow for flexibility while achieving equitable results. CMS currently instructs hospitals to use their own internal guidelines – based on hospital resource use – to determine which CPT level code to report. The AAMC encourages CMS to afford hospitals the same level of discretion with the allocation of vacation and other approved leave time. The Intern and Resident Information System (IRIS) ensures that no time is double-counted.

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 5503 of the Accountable Care Act, entitled “Distribution of Additional Residency Positions,” will affect the resident limits of many teaching hospitals. Its purpose is to reduce the resident limits for those hospitals that have not fully “used” their limits over the past three years and to “redistribute” these slots to certain hospitals. The resident limit reductions and increases are scheduled to go into effect July 1, 2011.

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 minimize, to the extent possible, the administrative burden associated with those requirements.

A. PROPOSED PROCESS FOR DETERMINING CAP REDUCTIONS

1. Hospitals that are over their resident caps in *any one year* of the three-year look-back period should be exempt from resident cap reductions.

CMS proposes that hospitals that are over their caps in *all three* years of the look-back period are exempt from any reductions to their resident caps under this program. *See* proposed 42 C.F.R. § 413.79(m)(4). For all other hospitals -- even those that were at or over their caps in one or two years of the three-year look-back period -- CMS will use the hospital cost reporting period with the highest FTE resident count (for DGME and IME respectively) to determine whether to make a resident cap reduction.

The AAMC strongly disagrees with CMS’s approach and finds it to be contrary to Congressional intent. Under CMS’s proposal, hospitals that were in fact at or over their resident caps in one or two years of the three-year look-back period may lose cap slots through the redistribution program. (This would happen, for example, when the adjusted resident cap of a hospital in a GME affiliated group changed from year to year, and the year with the hospital’s highest resident count was not the same year the hospital had the smallest difference between its resident count and its adjusted cap.) In passing the *unused* residency redistribution program, Congress’ clear

intent was to redistribute only those residency cap slots that were in fact unused for three consecutive years. Any hospital that was at or exceeded its resident cap in *any* year of the look-back period has plainly “used” its resident slots over that period and should not be subject to cap reductions.

The AAMC understands that CMS may have felt compelled to offer this interpretation of “reference resident level,” given the statute’s use of the phrase “the highest resident level”: “The term ‘reference resident level’ means, with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.” However, given Congress’ instruction that the “reference resident level” is to be “determined by the Secretary,” we believe CMS has the authority to interpret the statute in such a way as to not reduce the resident cap of hospitals that are in fact using all of their resident cap slots at some point throughout the three-year look back period.

CMS should use the discretion granted by Congress to interpret the cap reduction provisions in a manner consistent with the goals and purpose of the legislation. CMS should amend proposed 42 C.F.R. § 413.79(m)(4) to exempt a hospital that is training at or above its otherwise applicable FTE resident cap “for any of the three most recent cost reporting periods ending prior to March 23, 2010.” This revised approach would conform to Congressional intent and would avoid perverse consequences for hospitals that were part of GME affiliated groups and whose adjusted caps changed from year to year.

2. For hospitals in GME affiliated groups, CMS should perform the initial cap-count comparison at the aggregate level.

Hospitals that enter into GME affiliation agreements often do so because they have a shared rotation arrangement and, in a given year, one hospital’s resident count may be below its corresponding cap while 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.

For a hospital that participates in a Medicare GME affiliation agreement or an emergency GME affiliation agreement, CMS proposes to compare the hospital’s resident count in the “reference year” to its cap as adjusted by the affiliation agreement (i.e., the cap as listed on Worksheet E-3 Part IV, line 3.03 for DGME and on Worksheet E, Part A., line 3.06 for IME). In other words, CMS proposes to perform the cap-count comparison on a hospital-specific basis. A hospital whose count is below its adjusted cap for that year will be subject to reductions under the redistribution program. Unlike with the prior Medicare Modernization Act (MMA) Section 422

redistribution program, CMS does *not* propose to look first to the affiliated group as a whole to determine if the group as a whole is under its aggregate cap, at which point CMS would look at data from individual hospitals to determine the extent of each hospital's cap reduction.

While the AAMC appreciates that CMS is using adjusted cap numbers to account for situations in which hospitals share cap slots through a GME affiliated group, we believe CMS's *initial* cap-count comparison should take place at the affiliated group level. This modification is supported by the statutory definition of "otherwise applicable resident limit" in the ACA:

The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

This definition includes a reference to subparagraph (4)(H) of § 1886 of the Social Security Act, which contains the following language:

(ii) Aggregation.—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

Thus, as part of the Agency's authority to "prescribe rules" regarding GME affiliated groups, CMS clearly has the authority to view the affiliated group as a whole for purposes of the unused resident cap redistribution program.

Moreover, viewing the group as a whole as in initial matter would be entirely consistent with Congressional intent only to redistribute resident cap slots that are *actually* unused. If a group as a whole is at or over its aggregate cap, the slots clearly are being used by hospitals within that affiliated group.

3. The final rule should clarify the policy for new teaching hospitals.

The final rule should clarify that new teaching hospitals that had their cap established within the last three cost reporting periods ending on or before March 23, 2010, or 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. These new teaching hospitals are still in the process of building their programs (some of which have initial residency periods even longer than the three-year start up period) and should not be at risk of losing slots for the programs they are attempting to establish.

4. The AAMC agrees that any resident cap reductions should not take into account slots awarded through the prior Section 422 redistribution program.

In determining whether to reduce a hospital's DGME and IME resident caps, CMS proposes that the Agency will *not* consider whether the hospital has used any residency slots it may have obtained through the prior Section 422 redistribution program (under Social Security Act § 1886(h)(7)(B)). The AAMC agrees with CMS's interpretation of the statute with respect to these Section 422 slots and believes, as CMS does, that it would be "inappropriate to include increases made under section 1886(h)(7)(B) in determining the hospital's reference resident level for purposes of cap reductions."

B. PROPOSED PROCESS FOR ALLOCATING CAP INCREASES

The ACA sets forth several key requirements for distributing redistributed cap slots to qualifying hospitals. First, hospitals may receive no more than 75 additional cap slots. Second, hospitals must demonstrate the likelihood that the resident cap positions will be filled within three cost reporting periods beginning on or after July 1, 2011 (the "demonstrated likelihood" requirement). Third, CMS must distribute the slots to hospitals as follows: 70 percent of the redistributed slots to hospitals in states with resident-to-population ratios in the lowest quartile and 30 percent of the redistributed slots to hospitals located in (a) the 10 states with the highest proportion of their populations living in a health professional shortage area (HPSA, which CMS proposes to be solely a Primary Care HPSA), and (b) rural areas (which CMS proposes to be a hospital located in an area that is not a Metropolitan Statistical Area, regardless of any geographic reclassification).

To implement the ACA, CMS sets forth a number of proposals. First, CMS proposes three options by which a hospital can meet the "demonstrated likelihood" criteria: starting a new residency program, expanding a current residency program, and having a resident count that exceeds the current cap. Next, CMS sets forth the Agency's proposed "priority categories" to determine the order in which hospitals will be eligible to receive cap increases:

1. Hospital is in a state whose resident-to-population ratio is within the lowest quartile, AND hospital is in a state whose Primary Care HPSA population-to-state population ratio is in the top 10 states, AND the hospital is located in a rural area.
2. Hospital is in a state whose resident-to-population ratio is within the lowest quartile, AND is either in a State whose Primary Care HPSA population-to-state population ratio is in the top 10 States, or it is located in a rural area, or is an urban hospital and has a rural training track as of July 1, 2010.
3. Hospital is in a state whose resident-to-population ratio is within the lowest quartile.

4. Hospital is in a state whose Primary Care HPSA population-to-state population ratio is in the top 10 States, AND either the hospital is located in a rural area or the hospital is an urban hospital and has a rural training track as of July 1, 2010.
5. Hospital is in a state whose Primary Care HPSA population-to-state population ratio is in the top 10 states, or hospital is located in a rural area.

To determine the cap slot distributions within each priority category, CMS proposes both to move down each list of states (beginning with the state with the lowest resident-to-population ratio and the state with the highest HPSA population) and to award hospitals varying numbers of “points” as follows:

- Medicare inpatient utilization over 60 percent, as reflected in at least two of the past three most recent audited cost reporting periods for which there is a settled cost report = *5 points*
- Use new slots to establish a new or expand an existing geriatrics residency program = *5 points*
- Use new slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in nonprimary subspecialties of those primary care programs (e.g., internal medicine program with a designated primary care track); may qualify by documenting that hospital is advertising its internal medicine program with a primary care track in the March 2011 NRMP = *3 points*
- Hospital is located in a Primary Care HPSA = *2 points*
- Hospital is in a rural area and is or will be by July 1, 2011, a training site for a rural training track, but it cannot count all of the residents in its rural track because it is over its cap as of July 1, 2011 = *1 point*

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.” 75 *Fed. Reg.* at 46416. Under CMS’s proposal, this form would be completed for each residency program for which the applicant hospital is seeking additional slots. An applying hospital must indicate on the form the “number of FTE slots requested for [each] program.” Additionally, CMS proposes that a senior hospital official must sign and submit a comprehensive attestation clause stating that the information in the application is “true, correct, and complete.”

1. Initial observations on the allocation provisions.

The AAMC appreciates that some (65 percent) of the nation’s unused resident slots will be redistributed to hospitals that intend to use them. We would like to emphasize, however, that this redistribution of a relatively small number of resident positions will not begin to address the

severe physician shortage that exists across the entire county. While acknowledging the constraints of the current redistribution legislation, we believe the process of awarding slots should promote fairness and equity among hospitals electing to apply for additional slots under the program. We offer the comments that follow with these equity principles in mind.

2. CMS should extend the application deadline to March 1, 2011, for all hospitals.

CMS proposes that applications for additional resident cap slots will be due to the CMS Central Office and to the CMS Regional Office for the hospital's region by December 1, 2010. Under CMS's proposal, the only exception would be for hospitals whose counts have not been audited by December 1, 2010, for possible cap reductions under the redistribution program; these hospitals would be permitted to submit an application by March 1, 2011.

The AAMC is concerned about the extremely early proposed application deadline. While we understand the constricting nature of the July 1, 2011, statutory deadline for awarding these slots, we do not believe that a December 1, 2010, deadline affords hospitals sufficient opportunity to prepare applications between the likely November 1, 2010, publication date of the final rule and an application deadline that is only one month later.

CMS proposes to offer an extended deadline of March 1, 2011, for certain hospitals whose cap-to-count audits have not taken place by December 1, 2010. The AAMC suggests that CMS adopt this March 1, 2011, deadline for *all* hospitals applying for slots under the redistribution program. The Agency would need to wait for the March 1 applications to be submitted before beginning the process of awarding slots anyway, and a March 1, 2011, deadline would provide hospitals with a much more realistic timeframe to prepare application documentation.

3. For hospitals in states on both the low resident-to-population list and the high HPSA population list and for rural hospitals in states on the low resident-to-population list, CMS should award slots from both the 70 percent and 30 percent "pools" on a prorated basis.

CMS proposes to give hospitals in states on both the low resident-to-population ratio list and the high HPSA population list (and states on the low resident-to-population list that are also rural hospitals) top priority to receive resident slots under the redistribution program. CMS proposes to accomplish this by placing these hospitals in the first and second "priority categories" in the redistribution process. Throughout the proposed rule, CMS also references periodically a single "redistribution pool" while also, on occasion, referring to a "70 percent pool" and a "30 percent pool."

From the way CMS has described the proposed slot allocation process, CMS appears to envision a single redistribution pool, out of which 70 percent of slots will first be awarded to hospitals in

Priority Categories 1, 2, and 3, with the remaining 30 percent of the slots being awarded to hospitals in Priority Categories 4 and 5. It also appears that the Agency intends to award hospitals that would qualify for slots from both the so-called “70 percent pool” and the “30 percent pool” *first*, and intends to award them solely from the “70 percent pool.”

The AAMC believes that Congress intended a more equitable distribution with respect to these particular hospitals, such that hospitals in states further down the low resident-to-population list would not have their chances of being awarded slots unduly diminished by hospitals that qualify under both categories. For equity purposes, we think the most appropriate way to allocate slots to hospitals that qualify for both “pools” is to prorate the number of slots awarded between both pools. (For example, for a rural hospital in a state on the low resident-to-population list that is awarded 10 slots through the redistribution program, 7 slots would come from the “70 percent pool” while 3 slots would come from the “30 percent pool.”) We believe that this result is more easily achieved with two distinct pools of slots, but we defer to CMS as to how to implement the mechanics of prorating.

4. The documentation requirements for “Demonstrated Likelihood Criterion 3” (hospitals already training residents in excess of their caps) are excessive.

CMS proposes that a hospital may meet the “demonstrated likelihood” requirement by training residents in an existing residency program in excess of its DGME FTE cap or its IME FTE cap, or both. To meet this “Demonstrated Likelihood Criterion 3,” CMS proposes to require a hospital to submit: (1) copies of most recent Medicare cost reports, documenting the DGME and IME caps, and (2) copies of the 2010 residency match information (National Residency Matching Program (NRMP), NRMP’s Specialties Matching Service, the San Francisco Matching Program, the AOA Residency Match Program, or the Urology Matching Program) concerning the number of residents at the hospital in its existing programs (all programs – not just the programs for which the hospital is requesting additional slots), and (3) copies of the most recent accreditation letters on all of the hospital’s training programs for which the hospital trains and counts residents for DGME and IME payments.

While the AAMC agrees that a hospital’s training residents over its cap is an appropriate way of demonstrating the likelihood of using slots awarded through the redistribution program, we believe that the proposed documentation requirements are excessive. It is particularly perplexing to us that *three* pieces of documentation would be required for a criterion that is the most straightforward rationale for requesting additional cap slots.

The need to submit 2010 residency match information is unclear, because these data do not necessarily indicate the total number of residents training at an institution. Submitting

accreditation letters is also unnecessary and burdensome, particular for institutions with 75 or more residency and fellowship programs – which is not uncommon.

We urge CMS to adopt only the first documentation option – submitting copies of the most recent Medicare cost reports – as the only requirement for Demonstrated Likelihood Criterion 3. At a minimum, we suggest the first documentation option should be the only requirement for hospitals that were over their caps in all of the past three cost reporting years.

5. CMS should award points under the redistribution program to several other categories of hospitals to accomplish additional policy goals.

In addition to the categories for which CMS already proposes to award points, the AAMC believes the Agency should award points to hospitals for three additional reasons.

First, CMS should award points 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 to the point of exceeding their resident caps – i.e., without any corresponding increase in Medicare IME or DGME payments. The decisions to increase resident counts in these situations are based on many factors and have important negative financial implications for institutions that must worry constantly about their financial health. Nonetheless, these hospitals often make such 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 communities. CMS should reflect these situations in the evaluation criteria and should consider giving even more weight to those hospitals that are significantly over their resident caps compares to other hospitals that are over their caps.

Second, CMS should award points to teaching hospitals that are in the process of building programs and would lose slots in the middle of a build-up period. We are aware of hospitals that have what appear to be unused slots, but in reality these hospitals are in the middle of a several-year program build-up process. Given the amount of time it can take for hospitals to get approval for new programs from the Accreditation (ACGME), we encourage CMS to grant these hospitals additional consideration in the slot allocation process.

Third, CMS should award points to hospitals that lost slots for purely technical reasons – for example those hospitals for whom their “highest” resident count during the three-year look back period did not occur in the year with the smallest difference between their cap and their count. Under CMS’s current interpretation of the statute, these hospitals will lose more slots than would otherwise be equitable and should be granted some preference in the redistribution process.

6. CMS should modify and clarify Evaluation Criterion One (5 points for Medicare inpatient utilization over 60 percent).

CMS proposes to award 5 points (the largest number of points awarded for any of the proposed evaluation criterion) to hospitals with a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. As a threshold matter, the AAMC urges CMS to reduce the number of points awarded for this criterion to one point. CMS pays hospitals their proportionate Medicare share for their resident training costs, regardless of what that Medicare share may be, and hospitals with smaller Medicare utilization numbers have no less need for Medicare support for their residency programs.

The AAMC also suggests that CMS 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.

Additionally, because of the time lag often associated with settling cost reports, CMS should also accept *submitted* cost reports (and not just settled cost reports) for this evaluation criterion.

Finally, CMS should clarify that Medicare Advantage patients may be counted toward a hospital's Medicare inpatient utilization for purposes of this evaluation criterion.

7. Comments regarding the 5-year restrictions on use of the redistributed slots.

The additional slots a hospital receives through this program are subject to certain restrictions. The ACA requires that for five years (beginning on the date the hospital's limit was increased), the hospital may not reduce its pre-redistribution number of primary care residents below the average number of primary care FTEs training in the hospital during the three most recent cost reporting periods ending before March 23, 2010. For these purposes, a primary care resident is defined as a resident enrolled in an approved program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. CMS proposes that a hospital use the data reported on Worksheet E-3, Part IV, line 3.19 and subtract out the OB/GYN count from this line, to determine the number of primary care residents for DGME purposes, and that the hospital develop its IME primary care counts from rotation schedules. Additionally, at least 75 percent of the additional slots a hospital receives through the redistribution program must be used for primary care or general surgery residency programs.

a. CMS should clarify the requirements for hospitals that are over their caps and that are awarded additional slots under this program.

The AAMC encourages CMS to clarify how the 5-year restrictions on the use of redistributed slots apply to a hospital that trains residents in excess of its resident cap. We believe that such a hospital may in fact use the additional cap slots it is awarded through this program for over-the-cap residents, so long as the hospital converts over-the-cap specialist positions to primary care or to general surgery to meet the maintenance-of-effort and the 75 percent requirements. We acknowledge that this would involve a hospital's changing its complement of primary care, general surgery, and specialist trainees. We believe this interpretation is supported by the ACA and by the proposed rule, which permits a hospital to demonstrate the likelihood of using awarded slots by training residents in excess of its cap, and we would appreciate confirmation of this interpretation in the final rule.

b. Determinations regarding whether a hospital met the 75 percent requirement for using slots for primary care and general surgery should be made at the *end* of the 5-year period, (not on an annual basis) and should allow hospitals some flexibility.

CMS proposes that during *each* of the five years from July 1, 2011 through June 30, 2016, for IME and DGME respectively, and for *each* cost report during those five years, 75 percent of the resident FTEs added in each year must be used for residents training in primary care or general surgery programs.

The AAMC disagrees that hospitals should be required to prove they have met the 75 percent requirements in each cost reporting year. Not only does this requirement add administrative burden both to the hospitals and to CMS contractors, but hospitals do not always fill all positions they offer through the match process, even if they are ready and willing to fill them. The ACA clearly gives CMS the authority to make determinations about whether hospitals have met the 75 percent requirements at the end of the five-year period: "The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period" (emphasis added).

The AAMC urges CMS to use this discretion to make such an evaluation at the end of the five-year period, and to assess whether a hospital, on average, met the 75 percent requirement over the course of those five years. We also encourage CMS to allow hospitals some flexibility in meeting the 75 percent requirement. There are a number of reasons why a hospital's primary care and general surgery numbers could fluctuate slightly from year to year, including

accreditation standards, fill match rates, and leaves of absence. For these reasons, CMS should find a hospital to have met the 75 percent requirement so long as the average number of residents the hospital added over the course of the five years is within the greater of two resident FTEs or 95 percent of the target number of primary care and general surgery residents.⁵

c. Administrative and judicial review should not be precluded for determinations about whether a hospital met the requirements for cap slots awarded through Section 5503.

The AAMC understands Congress's desire to promote efficiency in the implementation of the resident reduction and cap increase provisions of the ACA by precluding administrative and judicial review for CMS's slot reduction and increase determinations. We do not believe, however, that this statutory language applies to the audits Intermediaries will complete – whether on an annual basis or at the end of the five-year period – to determine whether a hospital has met the requirements for how slots awarded through Section 5503 must be used. There is no similar administrative efficiency argument for exempting these audits from administrative or judicial review, and in the interest of equity, hospitals should be granted an opportunity to show that they have in fact met the statutory requirements for the use of these slots.

8. CMS should permit hospitals awarded slots under this program to use the slots toward GME affiliation agreements after five years.

CMS proposes that any slots awarded through the Section 5503 redistribution program may *not* be used as part of the aggregate cap in a Medicare GME affiliation agreement. The AAMC disagrees with this proposal and encourages CMS to permit hospitals to use these slots as part of a GME affiliation agreement after a certain period of time. While we understand CMS's rationale for wanting to impose this restriction, it would impose an administrative burden on hospitals to track these slots separately, and a hospital's circumstances can change over time. We believe it is unlikely that hospitals that were granted these additional slots would share them through an affiliation agreement, but for these reasons, we believe the restriction should be time-limited to five years – a period of time that would coincide with the other restrictions on the use of these slots.

⁵ For example, if a hospital was awarded 20 new slots through the redistribution program and added an additional 20 resident FTEs, 75 percent of 20 would be 15 resident FTEs. CMS should find the hospital to have met the 75 percent requirement so long as on average, at the end of the five year period, at least 13 of those FTE residents were training in primary care or general surgery.

9. If all slots are not redistributed by July 1, 2011, CMS should proceed down the list of states with low resident-to-population ratios and high HPSA populations in distributing slots through a second round of applications.

If slots remain in the redistribution pool after the first round of applications has been processed, CMS proposes to initiate a second round of applications after July 1, 2011, “in accordance with the considerations in redistribution specified at section 1886(h)(8)(C).” To the extent CMS intends to use a redistribution process for this potential second round of applications that is identical in all ways to the first round, the AAMC disagrees with this proposal. Hospitals that were unable to accommodate additional residents in the first round would not be significantly more likely to meet the same requirements in under a year from now. We believe the statute offers CMS the latitude to comply with Congressional intent to give priority to certain hospitals, while still remaining flexible regarding other elements of the program’s implementation. Specifically, we believe CMS should continue down the lists of states with low resident-to-population ratios and high HPSA populations, allowing hospitals in the next several states on each list to apply for slots in a second round of applications.

10. The AAMC agrees that the separate 422 DGME and IME payment rates should only apply to residents in excess of a hospital’s combined 1996 FTE and section 5503 caps.

CMS proposes that if a hospital received slots under the prior Section 422 redistribution program, the only residents for which the hospital would be paid at the 422 payment rates (the locality-adjusted national average for DGME, and a 2.7 percent IME adjustment) would be for residents *in excess* of the hospital’s 1996 cap as increased by the new Section 5503 cap slots. The AAMC appreciates CMS’s proposal on this issue and urges the Agency to adopt this policy in the final regulations.

C. 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 § 1886(d)(5)(B)(vi)(II) (IME) and § 1886(h)(4)(G)(i) (DGME). The proposed rule would subject the resident count 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.

We recognize, as did CMS, that the language of the statute does not expressly exclude the resident counts associated with the redistributed cap slots from the reach of the cap and the three-year rolling average. 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 wanted residents who are redistributed to a hospital pursuant to § 5503 to be used to meet certain specific policy goals during the first five years a hospital is paid for these slots. Hospitals must use 75 percent of the slots they are awarded through this program for primary care and general surgery for five years and also must meet a five-year primary care maintenance of effort requirement. These time-limited restrictions demonstrate that Congress did not intend the normal rules applicable to current resident counts to also apply to redistributed resident counts.

In short, the AAMC believes that Congress, for the most part, viewed § 5503 as a provision that should not apply in conjunction with the IRB cap and the rolling average rules. For these reasons, these residents should be counted without regard to the IRB cap and the rolling average provisions.

D. OTHER TECHNICAL ISSUES AND REQUESTED CLARIFICATIONS

In the final rule, the AAMC asks that CMS address several additional issues:

- Clarify that a hospital with a December 31 fiscal year end may in fact use its hospital fiscal year 2009 as one of the three years of the look-back period for residency cap reductions, so long as the hospital has submitted its FY 2009 cost report by the time the count audit takes place;

- Clarify that CMS's proposed policy regarding hospitals that merged on or after March 23, 2010 (i.e., CMS will treat them as if they merged during the three-year look-back period), also applies to hospitals that merged at any point during the three-year look-back period;
- Clarify that "Demonstrated Likelihood Criterion 3" applies both to hospitals *at* their cap as well as to those training residents "in excess of" their cap (on p. 46397, CMS states that a hospital may meet this demonstrated likelihood criterion "by demonstrating that it is [] already training a number of FTE residents at or in excess of its current FTE caps"; however, the longer description of "Demonstrated Likelihood Criterion 3" on p. 46398 states that a hospital "is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both.");
- Clarify and provide more detail regarding the repercussions to hospitals that are awarded resident slots through the redistribution program but fail to meet the 75 percent primary care / general surgery requirement or the primary care maintenance of effort requirement in a given hospital fiscal year;
- Confirm that CMS's reference in proposed 42 C.F.R. §§ 412.105(f)(iv)(B)(2) and (C)(2) to paragraph "(f)(1)(E)(iv)(B)(1)" is a typographical error, and that the Agency intended to refer in both instances to paragraph "(f)(1)(iv)(B)(1)"; and
- Given that under the psychiatric and rehabilitation prospective payment systems (PPS), teaching hospitals have resident caps and are eligible to receive a teaching adjustment based on their resident counts, clarify whether there is any relationship between the § 5503 redistribution program and the rules for counting residents under the psychiatric or rehabilitation PPS.

PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS

Prior to the passage of the ACA, DGME and IME residency cap slots at teaching hospitals that closed could not permanently be redistributed to other hospitals. A teaching hospital may receive cap slots temporarily for taking on residents displaced by a closure but may retain those temporary cap slots only until the displaced residents complete their training. Under the ACA, the DGME and IME residency slots from any hospital that closed or closes on or after March 23, 2008, will be redistributed permanently to other hospitals. In the proposed rule, CMS establishes a process for distributing these slots that the agency intends to use for all teaching hospital closures since March 23, 2008, including future closings.

CMS is required by the ACA to distribute the slots in the following priority order, with preference given within each category to hospitals in the same GME affiliated group as the closed hospital: (1) hospitals located in the same Core Based Statistical Area (CBSA) as the closed hospital or in a CBSA contiguous to the closed hospital (CMS proposes to define CBSA as the same pre-reclassification CBSAs used for wage index purposes); (2) hospitals located in

the same state as the closed hospital; (3) hospitals located in the same region of the country as the closed hospital (CMS proposes to define “region” as a Census Region); and (4) only if none of the above is possible, to other hospitals using the redistribution program criteria described above in § 5503.

Within each of these priority categories (with the exception of Category (4), because it uses already-established redistribution program criteria), CMS proposes to distribute the slots to applying hospitals in the following order:

- (1) Hospital is assuming (or assumed) an entire program from the closed hospital and will continue to operate that program exactly as it was operated by the closed hospital (same residents, same program director, same or many of the same teaching staff);
- (2) Hospital received slots from the closed hospital under the most recent Medicare GME affiliation agreement of which the closed hospital was a member and will use the slots to continue to train at least the same number of FTE residents as under the terms of that agreement;
- (3) Hospital took in displaced residents from closed hospital and will use the slots to continue to train residents in the same program as the displaced residents, but hospital is not assuming an entire program or programs;
- (4) Hospital does not fit into categories (1), (2), or (3) and will use additional slots to establish a new or expand an existing geriatrics residency program;
- (5) Hospital does not fit into categories (1), (2), or (3), is located in a Primary Care HPSA, and will use all additional slots to establish a new or expand an existing primary care residency program;
- (6) Hospital does not fit into categories (1), (2), or (3) and will use all additional slots to establish a new or expand an existing primary care residency program;
- (7) Hospital does not fit into categories (1), (2), or (3) and will use all additional slots to establish a new or expand an existing general surgery residency program.
- (8) Hospital does not fit into categories (1) through (7).

With respect to categories (1), (2), and (3), CMS proposes to assign these slots immediately and permanently, with the result that no temporary FTE cap adjustment would be made, because it would not be needed.

CMS will only redistribute slots to hospitals that can demonstrate a likelihood of filling them within three years. CMS proposes methods of “demonstrated likelihood” that are very similar to

those used for the § 5503 redistribution program (e.g., hospital does not have sufficient room under current caps to take in additional residents and has approval from the relevant accrediting body to take over the closed hospital's program(s)). Additionally, CMS will ensure that there is no duplication of slots between this closed hospital redistribution program and the program currently in place that permits hospitals to receive a temporary cap adjustment to accommodate residents from closed hospitals.

A. CMS SHOULD CLARIFY THE AGENCY'S PROPOSED DEFINITION OF A "CLOSED HOSPITAL"

CMS proposes to define a closed teaching hospital for purposes of this section as a hospital (a) that terminates its Medicare provider agreement, and (b) whose cap slots no longer exist as part of any other hospital's permanent FTE resident cap. The AAMC asks CMS to clarify situations in which a hospital's Medicare provider agreement would be terminated but whose slots would still exist as part of another hospital's permanent FTE resident cap.

Additionally, to the extent CMS intended to amend the definition of "closure of a hospital" (as the term is currently defined at 42 C.F.R. §§ 489.52 and 413.79(h) to include the idea that the cap slots no longer exist as part of another hospital's FTE resident cap, CMS did not amend the current regulatory language to incorporate this change.

B. THE CLOSED HOSPITAL SLOT REDISTRIBUTION PROGRAM SHOULD INCLUDE THE REDISTRIBUTION OF SECTION 422 CAP SLOTS

While not discussed in the proposed rule, the AAMC encourages CMS to address the issue of whether cap slots a closed teaching hospital may have received under the MMA's Section 422 redistribution program will be redistributed to other hospitals through this program. The statute is silent on this particular question, but the AAMC believes Congress intended for CMS to redistribute *all* residency cap slots from closed hospitals, including Section 422 cap slots.

We acknowledge that the IME payment rate for these slots is lower than for 1996 or Section 5503 cap slots, and for this reason, we encourage CMS to consider distributing these slots last (to hospitals lower in the priority order). Nevertheless, we believe CMS will best honor Congressional intent by preserving all resident cap slots from closed hospitals – including their Section 422 slots.

C. CMS'S PROPOSED INITIAL APPLICATION TIMEFRAME IS TOO SHORT

CMS proposes that to be eligible for resident cap slots from teaching hospitals that closed on or after March 23, 2008, hospitals will be required to submit applications by January 1, 2011. For future teaching hospital closures, CMS proposes that hospitals will have four months after the Agency notifies the public that slots are available to submit an application for those slots. CMS

Donald Berwick, M.D.

August 31, 2010

Page 29 of 35

does not indicate which deadline will apply to hospital that may have closed during the comment period between publication of the proposed and final rules.

The AAMC is extremely concerned about the short timeframe hospitals will have to complete an application for these resident cap slots. The ability of a hospital to take on displaced residents and ensure their continued training will depend on how many residents were in a given program at a closed hospital as well as the number of residents the existing teaching hospital decides to accept. Receiving ACGME approval for permanent resident positions is also extremely time consuming – particularly when the approval process may involve entire programs.

While we appreciate CMS's recognition of hospitals' desire to have these redistributed cap slots as quickly as possible, we believe that April 1, 2011, might be a more realistic deadline than January 1, 2011, for the initial set of applications. Our understanding is that the process the ACGME may use to approve positions on a temporary basis is different from the permanent approval process, and we believe hospitals would benefit from having additional time to prepare their applications.

Finally, we encourage CMS to consider teaching hospitals that closed at any point after publication of this proposed rule to fall into CMS's second category of hospitals, for which CMS would provide notice and a future application deadline.

D. CMS SHOULD PUBLISH IN THE FINAL RULE A LIST OF CLOSED TEACHING HOSPITALS AND THE NUMBER (AND TYPE) OF CAP SLOTS AVAILABLE FROM EACH

Hospitals interested in applying for resident cap slots under this provision must be put on notice of all slots that will be available through the closed hospital resident slot preservation program. CMS would accomplish this most effectively by publishing in the final rule a list of all hospitals that closed on or after March 23, 2008. In publishing this list, CMS should also indicate how many cap slots are available from the hospital's 1996 cap versus how many cap slots are available from the Section 422 redistribution program.

E. COMMENTS REGARDING CMS'S "RANKING CRITERION ONE" (APPLYING HOSPITAL ASSUMES ENTIRE PROGRAM FROM CLOSED HOSPITAL)

Under CMS's proposal, a hospital would fall into "Ranking Criterion One" if it assumes (or assumed) an entire program from the closed hospital and will continue to operate that program exactly as it was operated by the closed hospital (with the same residents, same program director, and the same or many of the same teaching staff). As a preliminary matter, the AAMC appreciates CMS's efforts to encourage the survival of entire programs, as we believe it is often

in the best interests of resident education and health care for the community for programs to remain intact.

1. CMS should clarify that a hospital qualifies under “Ranking Criterion One” even if the hospital is located in a different location from the closed hospital and assumes an entire program at the time of hospital closure.

In the Agency’s description of when “Ranking Criterion One” will apply, CMS sets forth two examples: a situation in which a closed teaching hospital is acquired by another hospital that continues to train all residents from the program on the same site; and a situation in which a hospital closes some or all of its residency programs a year or more prior to the hospital’s closure, and those programs are assumed by another hospital at a different site. The AAMC agrees that hospitals assuming residency programs under both of these scenarios should be entitled to the preferential treatment of “Ranking Criterion One.”

The AAMC believes that CMS inadvertently omitted to include a third example, however, of when this first ranking criterion would apply. In addition to the two examples listed above, we believe that a hospital should be eligible for this ranking criterion if it is located on a site different from that of the closed hospital and assumes an entire program at the time the hospital closes (not “a year or more prior to a hospital’s closure”). In this third example, the policy goals of “Ranking Criterion One” continue to be advanced, and we see no reason to distinguish this scenario from those CMS listed in the proposed rule. We request that CMS clarify this point in the final rule.

2. To qualify for “Ranking Criterion One,” a hospital should not be required to operate the program with the same program director and teaching staff as at the closed hospital.

CMS proposes that to qualify under this criterion, an applying hospital must “continu[e] to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, and same (or many of the same) teaching staff). While the AAMC believes that such continuity may be desirable and a likely outcome of moving the entire program to a new hospital, we feel that decisions about who the program director and teaching staff should be are better left to the leaders of academic medicine. These decisions should not be dictated by CMS or used as a litmus test for whether a hospital has “assumed” an entire program.

We are particularly concerned about these requirements in situations in which an already-existing teaching hospital takes over the entire program. Unlike non-teaching hospitals just beginning to train residents, such teaching hospitals may not need to hire additional faculty or program directors. While the applying hospital may assume the entire program and operate it as an independent program, separate from already-existing residency programs, the applying hospital may be just as likely to absorb the entire program into one of its own, already-

established residency training programs (perhaps, for example, to avoid having two identical programs at the same hospital). In the later situation, the hospital may already have an appropriate program director and teaching staff and should not be forced to hire these individuals from the closed hospital to meet “Ranking Criterion One.”⁶ Rather, such staffing decisions should be in the hands of the academic medical leaders who assume responsibility for the program.

3. CMS should interpret the term “entire program” to mean “substantially all of the balance of residents in a program at the closed hospital at the time of closure.”

In describing “Ranking Criterion One,” CMS refers to a hospital’s assuming an “entire program” but does not define this term. The AAMC encourages CMS to clarify that a hospital that takes on “substantially all of the residents training in a particular program at the closed hospital prior to the hospital’s closure or at the time of the hospital’s closure” should be deemed to have assumed an “entire program.”

It may be possible that for reasons entirely beyond the control of an applying hospital, one or more displaced residents choose not to train at the applying hospital with the rest of their cohort but rather opt to continue their training elsewhere. The failure to adopt a policy that allows applying hospitals some amount of flexibility in situations in which a small number of displaced residents decide to complete training in another hospital would immediately remove these applying hospitals from consideration under “Ranking Criterion One,” even though they effectively assumed an entire program.

Additionally, CMS should define an “entire program” to include only resident FTEs training in the closed hospital at the time of the hospital’s closure. For example, if a particular program at a closed hospital consists of 50 residents, but 20 were training at another hospital at the time of the closure, a hospital that agrees to assume the remaining 30 residents who were all training at the closed hospital should qualify under “Ranking Criterion One,” even though the hospital did not assume the program’s full complement of 50 residents. Requiring the applying hospital to assume both the residents training at the closed hospital *and* residents who may have been part of the same program but were training in other hospitals would defeat CMS’s policy goals of program stability and continuity by promoting the displacement of residents who otherwise need not be displaced.

⁶ Because the applying hospital, in this example, is already a teaching hospital, this situation is easily distinguished from the case of a non-teaching hospital that wishes to establish a new teaching program and from a hospital that sought adjustments to its cap under the BBA’s new residency provisions.

4. Hospitals that assume an “entire program” from a hospital that closed before publication of the final rule should not be required to have continued to operate the entire program “seamlessly.”

In describing “Ranking Criterion One,” CMS proposes in both of the Agency’s examples that to qualify under this criterion, an applying hospital must continue to operate the GME program(s) “seamlessly.” While the AAMC recognizes CMS’s intent to promote continuity and supports this requirement for hospitals that close on a going forward basis, we do not believe the “seamless” operation requirement should apply to hospitals that apply for resident cap slots from hospitals that closed between March 23, 2008, and the date of publication of the final rule. These hospitals may be ready and willing to provide a service to the community by continuing the entire residency program from the closed hospital; they were not, however, previously on notice that they would have to do so “seamlessly.”

It is unrealistic for CMS to have expected such a hospital to have applied for ACGME approval to train an entire program on a permanent basis - even if the hospital received ACGME approval to train the displaced residents on a temporary basis – and many residents displaced by 2008 hospital closures will already have completed their residency training. For these reasons, CMS should adopt the “seamless” requirement for “Ranking Criterion One” on a prospective basis only.

**F. COMMENT REGARDING CMS’S “RANKING CRITERION TWO”
(APPLYING HOSPITAL WAS IN GME AFFILIATED GROUP WITH
CLOSED HOSPITAL)**

1. To meet “Ranking Criterion Two,” CMS should require an applying hospital simply to have been a participant in a Medicare GME affiliated group with the closed hospital.

To qualify for “Ranking Criterion Two,” CMS proposes that a hospital must: (1) be listed as a participant of a GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed; (2) have *received* slots from the closed hospital under that agreement; and (3) use the additional slots to continue to train at least the number of FTE residents it trained under the terms of the Medicare GME affiliation agreement.

The AAMC is concerned that the requirements for this preference category extend well beyond what Congress intended, unnecessarily excluding hospitals from this ranking criterion that Congress intended to include. The ACA states simply that CMS shall give preference within each geographic category “to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital.” Congress never limited this priority to applying hospitals that *received* slots from the closed hospital or that the applying hospital must

continue to train the same number of slots it received under the affiliation agreement. Simply having a relationship with the closed hospital in the context of a GME affiliated group should be sufficient to qualify for this category.

**G. COMMENTS REGARDING CMS'S "RANKING CRITERION THREE"
(APPLYING HOSPITAL TAKES IN RESIDENTS DISPLACED BY
CLOSURE OF HOSPITAL BUT NOT ENTIRE PROGRAM)**

- 1. All hospitals that took in displaced residents should be eligible for this ranking criterion, whether or not they received a cap adjustment for those residents.**

To qualify for "Ranking Criterion Three," CMS proposes that a hospital must take in residents (though not an entire program) displaced by the hospital closure and use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training. In the proposed rule, CMS does not specify the means by which a hospital would need to demonstrate that it took in displaced residents.

The AAMC encourages CMS to clarify that an applying hospital need not have received a CMS cap adjustment for displaced residents to qualify for cap slots under this ranking criterion. A hospital that took in displaced residents but happened not to need additional Medicare cap slots in the year(s) it took them in was performing no less of a service to the community and to resident education as a hospital that required temporary cap slots to be paid for the residents' training time. Such a hospital may have been under its cap during the year it took on the displaced residents but may now be training residents at or in excess of its cap. CMS should offer these hospitals flexibility in the permissible ways of demonstrating they took in displaced residents, including through ACGME documents indicating approval for temporary training.

- 2. Hospitals that take in displaced residents from hospitals that closed before publication of the final rule should not be required to have continued to train the same number of residents "seamlessly" in the same program.**

CMS does not use the word "seamlessly" for "Ranking Criterion Three," as the Agency does with "Ranking Criterion One." Nevertheless, to the extent CMS requires the applying hospital to have permanently expanded its existing programs *immediately* following the completion of the displaced residents' training, the AAMC disagrees with this approach for the reasons discussed under "Ranking Criterion One" above. Here too, CMS should adopt any similar "seamless" requirement on a prospective basis only.

H. CMS SHOULD PLACE A 5-YEAR LIMIT ON ANY RESTRICTIONS ON THE USE OF SLOTS THROUGH THE CLOSED HOSPITAL REDISTRIBUTION PROGRAM

Under CMS's ranking criterion, hospitals are awarded slots through the closed hospital redistribution program for particular uses (e.g., to establish a new or expand an existing geriatrics residency program). Neither CMS nor Congress addressed the period of time during which these slots would be restricted to these specific uses, though. AAMC believes that CMS should place a 5-year limit on hospitals' obligation to use the slots for the purpose for which the hospital is awarded the slots. While it is unlikely that hospitals would change their programs after only five years, they should be permitted the flexibility to adapt their programs as their educational needs or the patient care needs of the community change. We believe that a five-year period is a reasonable amount of time and is in line with the restrictions Congress imposed under the unused residency slot redistribution program.

As with the § 5503 redistribution program, CMS proposes that any slots awarded through the closed hospital redistribution program may *not* be used as part of the aggregate cap in a Medicare GME affiliation agreement. Here too, the AAMC disagrees with this proposal and encourages CMS to permit hospitals to use these slots as part of a GME affiliation agreement after five years.

I. THE 3-YEAR ROLLING AVERAGE AND PRIOR YEAR IRB CAP SHOULD NOT APPLY TO RESIDENTS ASSOCIATED WITH THE CAP SLOTS FROM CLOSED HOSPITALS.

As with the § 5503 redistribution program discussed above and for the same reasons, the AAMC opposes CMS's proposal to subject resident counts associated with additional IME and DGME cap slots under the closed hospital program to the three year rolling average ("rolling average") that exists for current resident counts and to the IME cap on resident-to-bed ratios ("IRB cap") that exists for current resident counts up to and including the cap level. We are particularly concerned about this issue in situations in which CMS proposes to make temporary, displaced resident slots available immediately on a permanent basis. Because of cost issues associated with training residents, a hospital that agrees to take in displaced residents may not be able immediately to take the slot on a permanent basis. In this situation, the rolling average payment methodology should not apply until the time the slot is awarded to the hospital on a permanent basis or, at the earliest, at the beginning of the hospital's next fiscal year.

The AAMC also encourages CMS not to apply the rolling average or IRB cap immediately to hospitals that qualify for slots under "Ranking Criterion One." These hospitals are serving the community by taking on entire residency programs, but they likely did not have an opportunity

Donald Berwick, M.D.

August 31, 2010

Page 35 of 35

to plan for this sudden disruption to their educational and financial plans. They should not be penalized for having rendered this important service to the residents and the community.

J. OTHER REQUESTED CLARIFICATION

In the final rule, the AAMC asks that CMS address the following additional issue:

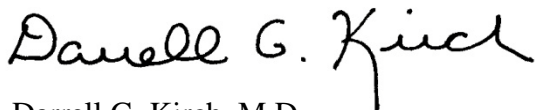
- Clarify whether a non-teaching hospital that takes displaced residents and receives permanent cap slots through the closed hospital redistribution program may still start a new program pursuant to 42 C.F.R. § 413.79(e) and proceed through the normal three-year process of building a permanent resident cap.

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 contact Karen Fisher, Senior Policy Counsel, Health Care Affairs, at kfisher@aamc.org or Lori Mihalich-Levin, Senior Policy Analyst, at lmlevin@aamc.org. These individuals may also be reached at 202-828-4490.

Sincerely,



Darrell G. Kirch, M.D.

cc: Joanne Conroy, M.D., AAMC
Karen Fisher, J.D., AAMC
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