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June 3, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Submitted at [www.regulations.gov](http://www.regulations.gov)

***Re: Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021 (FY 2022), CMS-1750-P***

Dear Administrator Brooks-LaSure:

The AAMC (Association of American Medical Colleges or the Association) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS or the Agency) proposed rule, “Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021 (FY 2022),” 86 *Fed. Reg.* 19480 (April 13, 2021).

The AAMC is a not-for-profit association dedicated to transforming health through medical education, patient care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC’s comments are limited to the proposals in the proposed rule regarding displaced residents. The AAMC strongly supports the proposal to make the determination of when a resident is displaced consistent with the Inpatient Prospective Payment System rule at 42 CFR 413.79(h)(1)(iii); in other words, the determination is linked to the day the closure was publicly announced. We also support the expanded definition of a displaced resident to include “residents who are not physically at the closing IPF/closing program but had intended to train at (or return to training at, in the case of residents on rotation)” (p. 19490). We ask that CMS clarify that this expanded definition will apply to current residents, residents who are on away rotations and not present at their home institution at the time of closure, and residents who have matched into, but

not yet started, an IPF residency program. As CMS notes, this change is necessary to provide residents flexibility to transition institutions or programs due to closure.

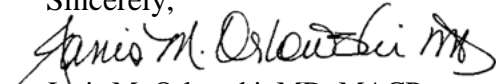
Finally, we support the proposal that if there are more IPF displaced residents than available cap slots, the slots may be apportioned according to the closing IPF's discretion. Institutions have a limited number of slots, and where a closing IPF is training residents above their cap, not enough slots exist at the closing IPF for all displaced residents seeking new training programs. To allow apportionment of residency slots insures that all displaced resident from the closing IPF will come with some Medicare funding.

However, we are concerned that the proposed rule leaves *whether* to transfer a cap slot at the sole discretion of the originating IPF. When a program or IPF that trains residents closes, one of the primary concerns in addition to safe patient care should be ensuring that residents are able to complete their training. As was clear at the time of the Hahnemann closure, it is the expectation of the Accreditation Council of Graduate Medical Education (ACGME) and the medical community at large that when a teaching hospital or program closes, all efforts will be made to find new programs in which the displaced residents can complete their training. To be consistent with ACGME and to support displaced residents, CMS should require that the closed IPF or program temporarily transfer slots to allow residents to continue their training. If a hospital could choose to not temporarily transfer its slots, displaced residents likely would be limited to finding slots at hospitals that are under their caps since hospitals at or over their caps would be unwilling or unable to afford to take them without financial support from Medicare. Residents will have the most flexibility to identify viable programs and ensure continuity in training if CMS requires closing hospitals to temporarily transfer a cap slot until the resident has finished their training.

Once finalized, this proposed rule for IPFs will be consistent with the way in which displaced residents are treated under IPPS. We request that CMS also engage in rulemaking for displaced residents who train Inpatient Rehabilitation Facilities. IRFs face the same issues when a program or hospital closes, and therefore, residents and receiving IRFs should be afforded the same definition for "displaced resident."

Thank you for your consideration of these comments. If you need additional information, please contact Ivy Baer ([ibaer@aamc.org](mailto:ibaer@aamc.org)) or Bradley Cunningham ([bcunningham@aamc.org](mailto:bcunningham@aamc.org)).

Sincerely,

  
Janis M. Orlowski, MD, MACP  
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