AAMC
655 K Street, NW, Suite 100
Washington, DC 20001-2399
T 202-828-0400
aamc.org

Submitted electronically via www.regulations.gov

March 26, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6098-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz,

The AAMC[1] welcomes this opportunity to comment on the proposed rule entitled "Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)," 91 FR 9803 (February 27, 2026), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

CMS is seeking feedback on how to prevent bad actors from engaging in fraud, waste, and abuse in healthcare, stating its goal of "protec[ing] taxpayer dollars and the Americans we serve" (p. 9804). CMS intends to use this feedback to make potential regulatory changes in a future proposed rule, as well as other programmatic changes to address fraud, waste, and abuse. The agency is interested in evaluating potential solutions in several areas including Medicare, Medicaid, and automation.

The AAMC and its member academic health systems and teaching hospitals are committed to tackling fraud, waste, and abuse and ensuring that Medicare and Medicaid funds are being used within the confines of the law and to benefit Medicare and Medicaid beneficiaries. As large institutions advancing clinical, research, educational, and community collaboration missions,

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, 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, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

academic health systems have a vested interest in ensuring the integrity of federal programs that sustain these missions. The AAMC recognizes that bad actors engaging in egregious conduct divert dollars from the Medicare and Medicaid programs,[2] ultimately harming the beneficiaries intended to benefit from these funds and the institutions best suited to provide their care. Academic health systems maintain comprehensive oversight and compliance functions to ensure that their organizations follow all applicable laws and regulations, whether at the federal, state or local level. Their efforts include establishment of compliance plans, updating policies and procedures to align with regulatory requirements, training and education, implementation of robust internal audit and compliance programs, conducting internal investigations, adherence to accreditation requirements and the Medicare conditions of participation, documenting and reporting extensive financial information through their Medicare cost reports, and working with governmental oversight bodies like CMS and OIG. Any future policies that CMS considers should be calibrated to target the bad actors driving fraudulent behavior and not legitimate programs that sustain academic health systems and allow them to provide the range of services that they are uniquely situated to provide to their patients. The AAMC supports the administration's efforts to combat fraud, waste, and abuse, and would be happy to partner with CMS and OIG to provide feedback on ways to identify bad actors and fraudulent activity in a reasonable and meaningful way.

Ensure Medicare Comparative Billing Reports are Sent to the Appropriate Hospital Staff to Facilitate their Program Integrity Efforts

One tool that CMS has within its discretion to ensure program integrity in Medicare is the use of comparative billing reports (CBRs). CBRs, which CMS sends to providers, include data on Medicare billing trends, allowing providers to compare their billing practices to peers in the same state and nationally. CBRs educate providers about Medicare's coverage, coding, and billing rules and act as a self-audit tool for providers. AAMC members have indicated that these reports are often sent to individual providers instead of to the compliance officers within the institution, who are the ones responsible for utilizing and acting on findings from the CBRs. **CMS should ensure that these CBRs are being accurately routed to the appropriate contacts within hospitals so they can take appropriate action and benefit from the information contained in the CBRs.**

Maintain the Claims Filing Deadline of One Year for Most Part A and Part B Claims

CMS seeks feedback on reducing the Medicare Parts A and B one calendar year claims filing deadline to either 90 or 180 days for high-risk items and services, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). CMS also seeks comment on whether the shorter claim filing deadline should apply more broadly to all items and services performed by all providers and suppliers (and not just high-risk ones) (p. 9806). We support CMS' goal of reducing back-billing fraud and recognize that shortened deadlines may be

[2] KFF. 5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments. March 18, 2025.

appropriate for certain high-risk actors where the fraud problem is concentrated. **However, we strongly urge CMS to narrowly tailor reduced claims filing deadlines to high-risk actors and services and exclude hospital claims and Part B professional claims from any shortened filing deadlines.** There are legitimate, documented reasons for academic health systems to require the full calendar year filing deadline, including complex inpatient cases, such as organ transplants and complex surgical procedures that require extended documentation and coding review before a complete and accurate claim can be submitted. Claims from academic health systems often involve complex, multi-service care that involves multiple departments, specialists, and high acuity patients. These cases inherently take longer to code accurately and reconcile services across departments. Shortening to 90-180 days would increase the risk of incomplete or inaccurate claims, and resubmissions. Absent any evidence of fraudulent billing in other contexts, we urge CMS to very narrowly tailor a future proposal that would seek to limit the claim filing deadline only to bad actors in high-risk areas.

Ensure States Continue to Have Flexibility to Tailor Their Medicaid Programs to Meet the Unique Needs of Providers and Beneficiaries

In Sections K and L of the RFI, CMS seeks feedback on questions related to Medicaid and the Children's Health Insurance Program (CHIP). CMS' fraud, waste, and abuse efforts in Medicaid should be targeted at high-risk areas identified by CMS, where there is evidence showing egregious conduct that diverts resources from the Medicaid program. We urge CMS not to frame fraud, waste, and abuse so broadly that legitimate payments and financing mechanisms, which are explicitly authorized by the Medicaid statute and regulations, end up being curtailed. Restricting critical financing mechanisms like intergovernmental transfers (IGTs) or vital payments like state directed payments (SDPs) would erode key Medicaid initiatives that support academic health systems and the Medicaid beneficiaries they treat.

Academic health systems and teaching hospitals are particularly vulnerable to changes in Medicaid financing and reimbursement as they serve a disproportionate number of Medicaid beneficiaries. Adequate funding for Medicaid is essential to ensure access for the patients served by AAMC members. Our member hospitals are major providers of many of the medical services that are essential for addressing the needs of the Medicaid population. AAMC member academic health systems and teaching hospitals account for 29 percent of Medicaid days, 55 percent of Level IV maternal care, 68 percent of burn unit beds, 65 percent of pediatric ICU beds, and a disproportionate amounts of transplants (such as 85 percent of lung transplants) of all hospitals nationally.[3]

[3] Notes: Data reflect short-term, general, non-federal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members. Level IV Maternal Care centers have "on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care".
Source: AAMC analysis of FY2024 American Hospital Association Annual Survey Database. AAMC membership data, December 2025

In recognition of the inadequacy of Medicaid base payment rates, the Medicaid statute and regulations authorize different supplemental payments that are targeted to safety net and teaching hospitals, including disproportionate share hospital (DSH) payments to cover uncompensated care costs, upper payment limit (UPL) payments to bring Medicaid fee-for-services rates up to Medicare (and in some cases, commercial) rates, and in Medicaid managed care, SDPs. Among the classes of providers authorized by CMS to receive SDPs and UPL payments are physicians providing services at academic medical centers. States also leverage Medicaid GME payments as a form of supplemental payments that target academic health systems and teaching hospitals. Academic health systems and teaching hospitals rely on these revenue sources to provide patient care and train the future physician workforce. Underpayment for Medicaid services or loss of supplemental payments further strains the financial stability of many hospitals that care for a disproportionate number of Medicaid beneficiaries. Enabling states to maintain adequate funding for their Medicaid programs helps to ensure Medicaid beneficiaries' access to care, including specialty and sub-specialty care, some of which is only provided at specific institutions, such as academic health systems.

Preserve the Ability of States to Use Statutorily Approved Financing Mechanisms Like Intergovernmental Transfers

CMS asks for input on "how to improve the prevention, identification, and resolution of fraud, waste, and abuse related to non-federal share financing sources, including IGTs." (P. 9807). CMS must preserve the use of intergovernmental transfers (IGTs), which are a statutorily authorized and longstanding mechanism used by states to finance the non-federal share of Medicaid to advance the aims of the Medicaid program and protect beneficiaries' access to care.

State expenditures on Medicaid services are "matched" by the federal government at a rate determined by the state's Federal Medical Assistance Percentage (FMAP), which range from 50 percent to 83 percent in 2027.[4] The state must determine how to finance the non-federal share of Medicaid and must do so within guardrails provided by the Medicaid statute and regulations. Under the Medicaid statute, at least 40 percent of the non-federal share must be financed by state general revenues—states are permitted to finance the remaining 60 percent using other methods. These other methods include taxes on health-care providers, certified public expenditures, and intergovernmental transfers (IGTs). IGTs entail a state or local government agency or a unit of a local government, which could include a local or state governmental hospital, transferring money to the state to draw down federal Medicaid funding. The Social Security Act gives states clear authority to use IGTs and limits CMS' ability to restrict them, stating "the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of

[4] https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

whether the unit of government is also a health care provider…"[5] Local government sources of funds (which include both IGTs and CPEs) make up 12 percent of the non-federal share for all Medicaid payments. These local sources of funds pay for an even larger share of non-federal funding for key supplemental payments, such as 40 percent of non-federal share financing for disproportionate share hospital (DSH) payments and 25 percent for non-DSH supplemental payments.[6]

The IGTs CMS seeks to limit are used to increase Medicaid reimbursement to providers, including additional SDPs and Medicaid GME. States are in the best position to determine their budgetary needs and how best to finance the non-federal share using a combination of general revenue, provider taxes, and local government funding. Therefore, flexibility to make decisions about how to finance the non-federal share is important, particularly when states face budget pressures or financial losses. In addition to other changes that are expected to result in the loss of coverage for nearly 10 million Americans by 2034, the One Big Beautiful Bill Act (OBBBA)[7] significantly restricts the use of provider taxes as a financing mechanism for states. Considering these other changes, it is imperative that CMS allow states to continue to leverage IGTs as a financing mechanism. **We urge CMS to preserve this critical mechanism, including by maintaining the ability of governmental hospitals, including state university teaching hospitals, to transfer funds (IGTs) to the state, even when the source of these funds is from patient care revenues.**

Ensure Adequate Medicaid Payment by Preserving SDPs and Ensure Transparency in State Directed Payments through the use of Separate Payment Terms

As part of its campaign to combat fraud, waste, and abuse, CMS solicits feedback on increased transparency in the Medicare and Medicaid programs. One clear area CMS can apply the principle of transparency is to how SDPs are structured and delivered under the Medicaid regulations. Specifically, we recommend that CMS permit the use of separate payment terms for SDPs. SDPs are a critical form of payments to providers that bring Medicaid managed care payment rates up to par with other payers. Medicaid fee-for-service base payment rates are woefully inadequate—payments to physicians are 30 percent below Medicare rates and payments for inpatient hospital services are 22 percent below Medicare rates.[8] While data on managed care payment rates is sparse, managed care base rates are not generally thought to be substantially higher than FFS rates, particularly because managed care plans frequently set payment rates using FFS rates.[9]

[5] Social Security Act §1903(w)(6)(A); 42 CFR 433.51).
[6] MACPAC June 2024. https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing-1.pdf
[7] OBBBA, P. Law No 119-21. July 4, 2025.
[8] https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact
[9] Ibid.

As states transitioned to Medicaid managed care, a mechanism was needed to ensure managed care rates were adequate. CMS has approved and supported SDPs since first authorizing them to bolster managed care rates in its 2016 managed care final rule.[10] SDPs provide states with the flexibility to direct payments to providers, but they include strict regulatory guardrails, including CMS preapproval. CMS requires that an SDP be actuarially sound, be tied to the utilization of services, and that it be used to promote access, quality, and delivery system reform.[11] To create a new SDP, a state must first seek approval from CMS through the submission of an SDP preprint, which in detail specifies the intended class of providers for the SDP, the amount of the SDP, how the state intends to fund the non-federal share, and the quality goals advanced by the SDP. SDPs further the goals of the Medicaid program and expand access to Medicaid beneficiaries by funding initiatives such as addressing workforce shortages, improving maternal and child health, improving access to screening and prevention services, and increasing access to care in geographic shortage areas.[12] SDPs as they are currently structured provide guardrails against fraud, waste, and abuse, as they cannot be implemented without prior CMS approval. Furthermore, CMS publicly posts approved SDP preprints, ensuring transparency by allowing the public to glean more information about these SDPs.

CMS can promote additional transparency by allowing for the use of separate payment terms to distribute SDP amounts to providers. Currently, states have two options for directing payments to specific providers: 1) separate payment terms, in which the state sets aside a fixed amount of SDP funding that is separate from the base capitation rate and allocated to be paid to providers that are eligible for the SDP; and 2) embedding the directed payment within the capitation rate to the managed care organization (MCO), with the expectation but no guarantee that the MCO will pass the correct amount of funds to the provider. CMS estimated that 55 percent of SDPs that began in 2021 used separate payment terms.[13] Beginning in 2027, CMS will phase out separate payment terms, instead requiring that states build SDP amounts into MCO capitation rates. [14] The AAMC strongly prefers the use of separate payment terms, which allow states and providers to track the flow of dollars and ensure providers receive the amount expected. SDPs give providers the ability to identify underpayment of SDP amounts, which is more difficult to do when SDPs are built into capitation rates. When SDPs are built into capitation rates, the flow of funds becomes opaque. The funds become harder to track and due to the incentive for MCOs to limit risk, they could steer utilization away from providers eligible for the SDP to providers ineligible for the SDP.[15] This opacity creates the kind of program integrity vulnerability that CRUSH is designed to address. **Therefore, we urge CMS to reverse its policy in the 2024 managed care**

[10] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability 81 FR 27498. May 6, 2016.
[11] 42 CFR 438.6(c)(2).
[12] See, e.g., Georgia's SDPs.
[13] Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. 89 FR 41002. May 10, 2024.
[14] Ibid.
[15] https://www.manatt.com/insights/newsletters/health-highlights/key-takeaways-for-states,-providers-and-plans-on-s

final rule that phased out the use of separate payment terms and to permit states to structure SDPs using separate payment terms.

Minimize Deceptive Marketing Practices to Ensure Beneficiaries are Matched with Plans Based on Health Care Needs

CMS is further seeing to address fraud, waste, and abuse related to beneficiary solicitation practices. (P.9806). The AAMC has previously shared comments with CMS regarding the use of concerning marketing practices by Medicare Advantage plans including the use of agents and brokers seeking to enroll beneficiaries in specific plans.[16] In a 2023 report, the Senate Finance Committee explored themes of beneficiary complaints in response to open enrollment advertisements and marketing. Complaints included promising an increase in a beneficiary's Social Security checks, targeting marketing to beneficiaries with cognitive impairments, and instances of provider network confusion where beneficiaries were encouraged to switch plans without understanding the change could mean their current providers would then be out-of-network.[17] To combat fraud, waste, and abuse and ensure beneficiaries receive the care they need, it is imperative beneficiaries receive accurate information on the plans available. The AAMC is concerned if these practices are left unchecked and unregulated that beneficiaries may be misled and steered towards plans without their trusted providers due to narrow provider networks and increased barriers to care due to utilization management tools. This mismatch can negatively impact beneficiary access to care and worsen health outcomes. **We urge CMS to provide further oversight of marketing and advertising practices, as well as plan agents and brokers, to ensure beneficiaries are matched to a plan best equipped to meet their health needs.**

Additionally, agents and brokers, for Marketplace and Medicare Advantage plans, must provide clear information on all aspects of available plans prior to enrollment, including reliable information on costs and eligibility for other programs. Specific to MA plans, supplemental benefits are often used as a marketing tool to entice beneficiaries. The use of supplemental benefits as a marketing tool may inadvertently steer beneficiaries away from plans best suited for their needs that offer broad, inclusive provider networks or less prohibitive utilization management tools. To combat this, the AAMC supports enhanced transparency in supplemental benefits. Improving the understanding of eligibility or limitations may combat misleading marketing practices that rely on advertising supplemental benefits offered by MA plans.

Monitor the Use of AI in Prior Authorization and Support Legitimate Use in Patient Care

As the use of algorithms and artificial intelligence (AI) continues to grow, the limited data about their inputs, performance, and usage becomes increasingly opaque, creating potential for unscrupulous use. Recent media reports have highlighted the negative effects of unmonitored use

[16] AAMC, Comments on the CY 2026 Medicare Advantage and Part D Policy and Technical Changes Proposed Rule (January 2025)
[17] Majority Staff of the U.S. Senate Committee on Finance, Deceptive Marketing Practices Flourish in Medicare Advantage (November 2023)

of algorithms and AI in MA plans, specifically noting the harmful effects of these practices on patients.[18,19] As reported, AI-powered decision-making tools have been observed prompting providers to make more restrictive decisions regarding continuation of care than Medicare coverage guidelines.[20] The AAMC urges CMS to monitor the use of algorithms and AI, specifically in its use for prior authorization to protect from illegitimate uses. Further, it would be beneficial to understand the categorization of these algorithms to gain insight into how these algorithms are being applied. For example, reporting if an organization is utilizing an algorithm or AI to assist in informing decisions related to the level of care or length of stay would give policymakers and providers greater insight into how plans are using these programs to help navigate patient care. Lastly, understanding what types of data inputs are being analyzed by these algorithms allows for greater oversight on the use of algorithms and AI to prevent fraud, waste, and abuse.

Further, academic health systems and other providers have begun using AI to streamline the administrative side of patient care. AI tools on the provider side support prior authorization processing, claims denial management, contracting, and operational tasks, including inpatient flow, surgical capacity, and scheduling. Through the automation of documentation and administrative tasks, AI can help to reduce clinician fatigue and the burden of documentation allowing for more time focused on patient care. For example, ambient listening and scribe technologies help to capture patient-provider conversations and document relevant clinical information in the medical record. AI may then provide medical coding and billing assistance by analyzing clinical notes, and electronic health record (EHR) data to suggest accurate billing codes. While AI improves workflows, each of these use cases require human review and interaction – none are truly autonomous. Adoption of AI tools in health care requires significant governance and ongoing monitoring and evaluation over the lifecycle of each tool and use case. Academic health systems are developing comprehensive governance structures for the adoption of AI tools across their system. Ultimately there must be a clear balance and understanding of risks across actors to accelerate the adoption of AI tools in clinical care delivery.

Ensure that Accountable Care Organizations (ACOs) and Clinicians Scored Under the Merit-based Incentive Payment System (MIPS) are Held Harmless from Increased Spending Resulting from Egregious Examples of Waste, Fraud, and Abuse

Providers should not be held accountable for wasteful, abusive, or fraudulent spending that is outside of their control. As an example, Medicare spending on skin substitutes experienced unprecedented growth, increasing from $256 million in 2019 to more than $10 billion in 2024. Although some of the spending was for appropriate wound care, there is evidence suggesting that

[18] STAT News, "How UnitedHealth's acquisition of a popular Medicare Advantage algorithm sparked internal dissent over denied care" (July 11, 2023) by Casey Ross and Bob Herman, available at: https://www.statnews.com/2023/07/11/medicareadvantage-algorithm-navihealth-unitedhealth-insurance-coverage/
[19] STAT News, "Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need," (March 13, 2023) by Casey Ross and Bob Herman, available at: https://www.statnews.com/2023/03/13/medicareadvantage-plans-denial-artificial-intelligence/
[20] *Id.*

a considerable amount was due to wasteful and even fraudulent activity. For clinicians participating in ACOs, the use and costs associated with skin substitutes is often driven by factors outside of their control. Such spending poses significant problems for ACOs as it causes their overall spending to exceed benchmarks and therefore hinders their ability to meet targets for shared savings. Ultimately, this leaves the providers in these models financially accountable for improper billing. Additionally, physicians participating in MIPS may be penalized on the episode-based cost measures due to fraudulent or wasteful billing on items, such as skin substitutes. Therefore, to keep participants in MSSP, ACO LEAD and other alternative payment models, we urge CMS to ensure that these providers are not unfairly penalized by wasteful and fraudulent spending. We urge CMS to explore approaches to holding providers harmless in these instances.

Protect Legitimate Uses of Section 1115 Demonstration Waiver Days

CMS is requesting comment on how the agency can support states in addressing fraud, waste, and abuse in section 1915 waiver programs or section 1115 demonstration programs. (P. 9807). As noted throughout, the AAMC is supportive of the agency's goal to combat fraud, waste, and abuse. However, we warn CMS against pursuing or continuing policies that hinder legitimate programs that improve access to care. For example, in 2023 under the prior administration a policy to modify the definition of "'regard as' eligible for medical assistance under a state plan approved" for the purpose of Medicare DSH calculations was finalized with the result that many hospitals would see a decrease in their DSH payments. Under this policy, only patients who receive health insurance or buy health insurance with premium assistance provided to them under a Section 1115 demonstration, where states receive matching funds would be included in the Medicaid fraction of the DSH calculation. Meaning the Medicaid fraction numerator would only include the days of patients who are covered under a Section 1115 demonstration that provides health insurance that covers inpatient hospital services or receive premium assistance that covers 100 percent of the patient's premium cost for insurance that includes coverage for inpatient services — provided in either case that the patient is not also entitled to Medicare Part A.[21] This effectively eliminates the ability to include days associated with patients whose care is funded by uncompensated care (UCC) pools, which are legitimate coverage options and typically utilized by non-Medicaid expansion states, from qualifying towards DSH calculations.

The AAMC opposed the policy when it was proposed,[22] and remains concerned that restrictions on UCC pools disincentivizes and discourages a useful policy option for non-Medicaid expansion state rather than tackling legitimate concerns of fraud, waste, and abuse within section 1115 demonstration programs. Excluding these patients covered under section 1115 demonstration programs from the numerator of the Medicaid DSH fraction does not accurately capture the population of Medicaid eligible individuals who receive inpatient care, creating inaccuracies. Individuals counted in uncompensated or undercompensated care pools are still receiving medical assistance under an 1115 waiver making them Medicaid beneficiaries.

[21] 88 FR 58640
[22] AAMC, Comments on Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction (April 2023)

Therefore, these individuals' inpatient hospital days must continue to be counted in the Medicaid fraction. **We urge CMS to rescind this policy change and recognize uncompensated care pools as legitimate sources of coverage by allowing these days to be included in the Medicare DSH calculation.**

CONCLUSION

Thank you for the opportunity to comment on this RFI. The AAMC supports the administration's efforts to combat fraud, waste, and abuse in a reasonable and meaningful way. Ensuring meaningful use and oversight of limited health care resources is essential to maintaining patient access to care. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Shahid Zaman (szaman@aamc.org) or Katie Gaynor (kgaynor@aamc.org).

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer