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May 24, 2006

The Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-1531-IFC
Mailstop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: CMS-1531-IFC:
PROVISIONS OF THE INTERIM FINAL RULE
APPLICATION OF EXISTING RULES

Dear Sirs:

The Centers for Medicare & Medicaid Services (CMS) published on April 12, 2006, an Interim Final Rule (the "rule") related to Medicare Graduate Medical Education (GME) affiliations during times of disaster. The rule contains emergency provisions modifying Medicare's GME affiliated group provisions applicable to teaching hospitals, particularly those in Louisiana and Mississippi, that have been forced to relocate residents as a result of recent hurricanes and flooding. Comments on the final regulation are due no later than 5:00 p.m. on June 12, 2006. East Jefferson General Hospital, whom I represent, would like to comment on the rule.

East Jefferson General Hospital ("EJGH," "East Jefferson", or the "Hospital") is a 550-bed hospital located in Metairie, Louisiana, just outside of the City of New Orleans, and has served as a teaching hospital for residents training in family practice medicine since the late 1990s. East Jefferson, therefore, is fully engaged as a teaching hospital and, as a result of the recent storm damage, has been asked to become even more engaged. Having said that, one section of the Interim Final Rule—the section addressing the three-year rolling average and its application—may prevent this from happening, as described below.

While EJGH was spared much of the direct damage suffered by other New Orleans area hospitals as a result of Hurricane Katrina and the resulting floods, the Hospital was adversely affected by the disaster in many significant ways. Most importantly, the Hurricane and related flooding resulted in a significant reduction in the

number of insured patients seen by the Hospital and in a huge increase in the level of uncompensated care provided at the Hospital. Moreover, because East Jefferson never closed its doors during the disaster, its patient volume remained high, meaning that it continued to bear significant expenses without corresponding revenue. As a consequence, EJGH has been operating in the "red" since the disaster and incurring large financial deficits, deficits that are likely to continue for some time. The three-year rolling average provisions of the Interim Final Rule can only add to this problem.

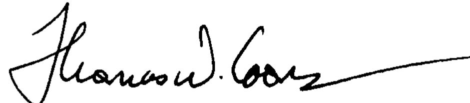
The three-year rolling average provision allows hospitals to count additional residents they receive through Medicare GME affiliation agreements on a graduated basis. This means that, typically, the receiving or host hospital may count only a third of the additional residents it receives in the first year of the affiliation and two-thirds in the second year. It is not until the third year that the hospital may count all of the residents. Although the Interim Final Rule provides some leeway in this provision prior to July 1, 2006, all host hospitals in an emergency Medicare GME affiliated group are to be subject to the full three-year rolling average requirements beginning July 1, 2006. 71 Fed. Reg. 18654, 18662 (April 12, 2006). This undoubtedly will create significant hardship for East Jefferson and similarly situated hospitals, a hardship that may well affect both EJGH's and the other hospitals' ability to serve as teaching hospitals to the extent requested.

This would be a most unfortunate result. As CMS is aware, Hurricane Katrina has forced both LSU New Orleans and Tulane Medical Center to relocate many of their residents to other hospitals. In light of the health care needs of the New Orleans' population, both LSU and Tulane have stated their wish to rotate their residents to New Orleans area hospitals that are in a position both to address the needs of the New Orleans community and, at the same time, provide educational opportunities for their medical residents. EJGH is one of the few area hospitals in a position to furnish this support. As currently written, however, the three-year rolling average provision would require that East Jefferson initially bear most of the expense of training these additional residents without the prospect of receiving Medicare direct GME reimbursement to offset its expense. Given East Jefferson's current financial situation, it is by no means clear that the Hospital can accept this burden.

East Jefferson, therefore, requests that CMS consider an alternative: just as host hospitals have been permitted to do from late August 2005 through June 30, 2006, host hospitals in the emergency area—hospitals such as EJGH—should be allowed to count additional residents in full until the three-year emergency period has expired. In other words, the three-year rolling average should not apply to host hospitals in the emergency area until the three-year emergency period has passed. This proposal would more equitably address the needs of host hospitals, medical residents, and the greater New Orleans community, on the one hand, with those of the Medicare program, on the other.

Thank you in advance for your attention to this alternative.

Sincerely yours,



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TWC/mla

cc: Jack L. Sullivan
East Jefferson General Hospital

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June 9, 2006

The Centers for Medicare & Medicaid Services
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Re: CMS-1531-IFC:
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Dear Sirs:

On April 12, 2006, the Centers for Medicare & Medicaid Services (CMS) published an Interim Final Rule (the "rule") related to Medicare Graduate Medical Education (GME) affiliations during times of disaster. The rule contains emergency provisions modifying Medicare's GME affiliated group provisions applicable to teaching hospitals, particularly those in Louisiana and Mississippi, that have been forced to relocate residents as a result of recent hurricanes and flooding. Comments on the final regulation are due no later than 5:00 p.m. on June 12, 2006. Our Lady of the Lake Regional Medical Center, whom I represent, would like to comment on the rule.

Our Lady of the Lake Regional Medical Center ("OLOL" or the "Hospital") is a 721-bed hospital located in Baton Rouge, Louisiana. As a result of the damage caused by Hurricane Katrina, OLOL assumed responsibility for training residents in surgery, pediatrics, emergency care, internal medicine, pulmonary, orthopedics, and otohinolaryngolgy. OLOL, therefore, has been fully engaged as a teaching hospital since late last summer and, as a result of damage caused by Hurricane Katrina, has been asked by the Louisiana State University program and its affiliated hospitals to become more engaged. In light of this, OLOL is concerned about several sections of the Interim Final Rule and of the current GME rules that have a direct impact on payments for services that the Hospital both has already provided in 2005 and 2006, and that it will be providing as a teaching hospital beginning July 1, 2006. Consequently, OLOL offers the following comments on the regulation.

1. Initially, OLOL would like to comment on one aspect of the current Medicare rules that has not been addressed in the Interim Final Rule and, that, it believes, should have been. Under the Interim Final Rule, CMS recognizes that, in emergency situations, home hospitals at times have transferred their residents to "new teaching hospitals" and that new teaching hospitals will need to establish per resident amounts (PRAs) for direct GME payments. Because these new teaching hospitals may be unfamiliar with the obligations that they need to satisfy in order to ensure Medicare payment, CMS reminded the new teaching hospitals of the need to accumulate cost data to establish their PRAs. This advice was quite helpful. New teaching hospitals, however, have additional obligations with which they are likely to be uninformed, and that was certainly the case with OLOL as it relates to the nonhospital training agreements.

As CMS is aware, under 42 C.F.R. § 413.78(e), a hospital may claim time spent by residents in nonhospital settings if the resident spends his or her time in patient care activities, the hospital incurs all or substantially all of the costs, and the hospital either pays all or substantially all of those costs in a timely fashion or there is a written agreement between the hospital and the nonhospital site indicating that the hospital is providing reasonable compensation to the nonhospital site. Such agreements, if entered into, must be executed before the training takes place. The problem faced by OLOL and similarly situated hospitals is that this simply was not done.

The reasons for this are clear. First, as a new teaching hospital whose status was thrust upon it, OLOL was unfamiliar with all of the requirements related to teaching hospital status and unaware of the nonhospital training rules and the need for these agreements. Equally important, however, is that even had OLOL been aware of the requirement for such agreements, circumstances were such that obtaining the agreements was virtually impossible. As soon as the Hurricane struck and the resulting flooding dislocated both patients and medical residents from their home hospitals, chaos ensued. Residents began showing up at OLOL, together with many additional patients. Often, these residents and the patients whom they saw had to be treated in nonhospital settings. In the ensuing confusion, it simply was not possible for OLOL to secure written agreements detailing the reasonable compensation that it would pay each nonhospital site for resident training, and certainly the Hospital could not obtain those agreements in advance of the provision of services. Accordingly, OLOL did not comply with the requirements of 42 C.F.R. § 413.78, which we believe was an understandable lapse.

The situation involving OLOL is, we believe, similar to that experienced by other new teaching hospitals and, we suspect, similar to the circumstances encountered by even experienced teaching hospitals that were caught up in the confusion following the Hurricane. We submit that CMS should make accommodations for this period of confusion and, in this year only, make a special exception to their requirements of 42

C.F.R. § 413.78. What we propose is that § 413.78 be modified so as to allow, at a minimum, new teaching hospitals the opportunity to enter into written agreements retroactive to the time when the teaching services were actually provided if those agreements are entered into within one year of the time the services were, in fact, furnished. In this way, new teaching hospitals are not unfairly penalized for their lack of familiarity with the rules, particularly given the confusing state of affairs during this period.

2. Addressing the specific requirements of the Interim Final Rule, OLOL next wishes to address CMS's position regarding the three-year rolling average and its application. As a hospital located in Baton Rouge, Louisiana, OLOL avoided much of the direct damage that some other Louisiana hospitals suffered as a result of Hurricane Katrina and the resulting flooding. Nevertheless, the Hospital has been adversely affected by the disaster in many significant ways. Most importantly, the Hurricane and its related flooding have had a significant impact on the patient mix of the Hospital. OLOL currently sees a far greater number of uninsured patients than it had previously seen, and its commercially insured population has been reduced. As a consequence, the Hospital's uncompensated care levels are much greater today than they were prior to Hurricane Katrina. Moreover, OLOL remained open during the disaster and continued to provide care to not only the patient population it traditionally cared for but also for thousands of patients who were displaced from New Orleans and the surrounding areas. What this means is that OLOL has continued to incur significant expenses without a corresponding increase in revenue. The three-year rolling average provision of the Interim Final Rule can only exacerbate this problem.

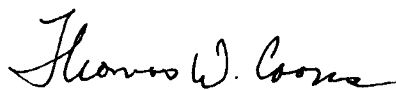
The three-year rolling average provision allows hospitals to count additional residents they receive through Medicare GME affiliation agreements on a graduated basis. This means that, typically, the receiving or host hospital may count only a third of the additional residents it receives in the first year of the affiliation and two-thirds in the second year. It is not until the third year that the hospital may count all of the residents. Although the Interim Final Rule provides some leeway in this provision prior to July 1, 2006, all host hospitals in an emergency Medicare GME affiliated group are to be subject to the full three-year rolling average requirements beginning July 1, 2006. 71 Fed. Reg. 18654, 18662 (April 12, 2006). This undoubtedly will create a significant hardship for OLOL and similarly situated hospitals, all of whom are serving as "safety net" hospitals for the vulnerable population of southern Louisiana.

OLOL, therefore, requests that CMS consider an alternative that mirrors CMS's policy regarding the three-year rolling average and its application to host hospitals during the period from late August 2005 through June 30, 2006. More specifically, host hospitals in the emergency area—hospitals such as OLOL—should be allowed to count

additional residents in full until the three-year emergency period has expired. This proposal would more equitably address the needs of the host hospitals, medical residents who train at the host hospitals, and the patient population of southern Louisiana, on the one hand, with those of the Medicare program, on the other.

3. Finally, beyond the problems of the nonhospital agreements and the three-year rolling average, there is an additional issue that we request CMS address. Currently, the Interim Final Rule requires that emergency affiliation agreements be entered into by no later than 180 days after the Section 1135 emergency period begins or by July 1 of the academic year, whichever is later. Normally, these deadlines would be reasonable. In the case of hospitals that train large numbers of residents and that may need to relocate those residents to multiple hospitals, however, this timeline appears overly restrictive. That is particularly true if, as is currently the case with the LSU system, there are multiple ongoing issues regarding funding, caps, resident program closures, and the abilities of hospitals to serve as host hospitals. Given that the Interim Final Rule requires not only that the home hospital enter into an affiliation agreement with each host hospital in order to transfer capped slots, but that each Medicare affiliation agreement attach to it all other affiliation agreements, the timeline of June 30 is drawing uncomfortably near. As a hospital that wishes to take on additional residents from LSU, and its affiliated hospitals, OLOL is most concerned that these timelines cannot be met. Accordingly, it requests that, at least in the current year, CMS extend the deadline for entering into agreements by 60 to 90 days. This will allow hospitals to reach understandings with one another and will make it more likely that parties enter into emergency affiliation agreements that satisfy all of the regulatory requirements that CMS imposes.

Sincerely yours,



Thomas W. Coons

TWC/mla

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Marilyn Burgess, Staff Attorney
Robert D. Ramsey, CFO
Our Lady of the Lake Regional Medical Center

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June 9, 2006

Ms. Elizabeth Truong
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1531-IFC
P.O. Box 8011
Baltimore, MD 21244-8011

Re: Comments on Medicare Program; Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations; Interim Final Rule with Comment Period

Dear Ms. Truong:

We have the following comments on the interim final rule with comment period for Medicare Graduate Medical Education (GME) affiliation provisions for teaching hospitals in certain emergency situations, published in the April 12, 2006, Federal Register.

We commend CMS for its recognition that an emergency situation, such as resulted from Hurricanes Katrina and Rita, may cause issues that cannot be ordinarily addressed by existing regulations. We believe that these GME affiliation provisions for teaching hospitals in certain emergency situations were made in a manner that promotes the intent of the Medicare program with regard to medical education programs.

Background: Closed Programs with Displaced Residents

In the Q&As that CMS posted on its web site, CMS indicated that the hospitals requesting a temporary increase in the FTE resident cap due to the displacement of a resident from a closed program had to contact the intermediary. However, on page 18656 of the interim final rule, CMS indicates that the provider should submit information about a temporary increase in FTE resident cap directly to CMS. This appears to be a conflict in the instructions. We recommend that the procedures for documentation submission be consistent in order to avoid confusion. We recommend that the provider submit information to both CMS and the fiscal intermediaries for all hospitals involved.

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISIONS

Submission of Information

CMS has been clear that the total number of FTE resident caps transferred from the home hospitals must be equal to the number of FTE resident caps transferred to the host hospitals. However, the interim final rule does not identify any method to ensure that the number of transferred FTE resident caps is proper.

The home and host hospitals are not necessarily serviced by the same intermediary. One home hospital may transfer displaced residents to multiple host hospitals serviced by multiple intermediaries through the emergency affiliation agreements. Intermediaries will only receive information relating to the hospitals that they service. Therefore, the intermediaries for the host hospitals will not, in many cases, have complete information on the displaced residents from the home hospitals.

However, all hospitals engaging in the emergency Medicare affiliation agreements are required to send information on all transfers of the FTE resident caps to CMS directly. We recommend that CMS act as an information clearinghouse to verify that the home and host hospitals are receiving all the proper adjustments to the FTE caps. CMS can verify that the FTE caps redistributed from the home hospitals to the host hospitals do not exceed, in total, the FTE caps of the home hospitals.

Alternately, CMS could require that the home hospital transferring the FTE residents provide complete reconciliations of their affiliation agreements to CMS and the intermediaries demonstrating that the number of transferred FTE resident caps is the same for the home and host hospitals.

In addition to submitting information on the affiliation agreements and the transfer of the FTE resident caps, CMS requires hospitals to submit information on the displaced residents themselves. We recommend that CMS use a matching system between the intermediaries so that there are no duplicate interns and residents.

Decrease in Inpatient Bed Occupancy

In determining whether a hospital qualifies as a home hospital, the hospital must demonstrate that its inpatient bed occupancy decreased by at least 20 percent from the period before the emergency to the period after the emergency. The interim final rule gives a timeframe of one week before the emergency (or the evacuation due to an anticipated emergency) to one week after the emergency began.

We believe that some hospitals that have experienced a significant decrease in inpatient utilization may not be able to obtain information on that timeframe. Many of the home hospitals experienced complete or partial loss of their records due to flooding, etc., from the disaster. These hospitals may have difficulty obtaining documentation to support their inpatient occupancy

one week before the date of the emergency and one week after the date of the emergency. We recommend that CMS be flexible in terms of the time periods required to demonstrate a decrease. For example, the last cost report submitted to the intermediary may be the last available information for that provider. If the provider has experienced a loss of records, this could be a reasonable source of information on the inpatient bed occupancy to the period prior to the disaster.

EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISIONS

Each hospital participating in the emergency affiliation must submit a copy of the emergency Medicare GME affiliation to CMS and the intermediary servicing each hospital in the agreement by 180 days after the emergency period begins or by June 30 of the relevant training year, whichever is later. Amendments to the emergency Medicare GME affiliation agreement to amend the original emergency Medicare GME affiliation can be made through June 30 of the academic year for which they are effective.

We recommend, at least for the first cost reporting period after the emergency, that a hospital be allowed to amend a Medicare emergency affiliation agreement after the end of the cost reporting period. In these emergency circumstances, some of the home hospitals had to place their residents in host hospitals quickly. Home hospitals' recordkeeping abilities were severely impeded due to disaster, and they may not been able to keep track of all the residents' placements on a timely basis. We note that the emergency regulations were issued several months after the disaster occurred, and hospitals could not know all the details of the CMS instructions before they were issued.

Examples of the Emergency Medicare GME Affiliated Group Provisions

The examples on pages 18659 and 18660 address the FTE resident caps for the home and host hospitals with fiscal years ending June 30, the residency training period. How should the FTE resident caps be treated for hospitals that do not have fiscal years ending June 30?

Section 422 FTE Caps

CMS is providing that any slots gained under section 422 of the MMA may not be used in any emergency Medicare GME affiliation agreement. This mirrors the Aug. 11, 2005, final rule's prohibition on allowing hospitals in a Medicare GME affiliation agreement from transferring section 422 FTE cap slots to another hospital. The intent of the original prohibition was to guard against Program abuse, or gaming the system.

However, the 1135 emergency represents an aberrant situation, and we recommend that CMS reconsider its position on temporary emergency affiliation of the section 422 FTE caps. Home hospitals with section 422 FTE slots were not in a position to train the residents relating to the section 422 FTE slots due to the effects of the disaster. We recommend that the host hospital that agrees to train these residents should be able to get an FTE cap increase regardless of whether there was a section 422 addition. We note that the cost report treatment for the section

422 FTE cap increases merely applies the FTE residents in excess of the original cap to the section 422 FTE cap. The FTE residents are not identified as subject to the section 422 cap. If a home hospital places all its FTE residents at host hospitals, how can the home hospital differentiate which displaced FTE residents are subject to the base year FTE cap and which ones are subject to the section 422 FTE cap?

Timeframe for Emergency Medicare GME Affiliation

On page 18658, CMS states that "...an emergency Medicare GME affiliation agreement is permitted to remain in effect for no more than three training years, beginning with the first day of the section 1135 emergency period."

It is unclear as to why three training years were chosen. It is possible that it may take a provider up to five years to rebuild. We recommend that CMS change this requirement to read, "...an emergency Medicare GME affiliation agreement is permitted to remain in effect for no more than three years, unless the provider can demonstrate that the rebuilding of its program will not be complete within three years."

APPLICATION OF EXISTING RULES

Weighted FTE Counts (Three-Year Rolling Average)

CMS will exclude from the three-year rolling average FTE residents associated with displaced residents from Aug. 29, 2005, to June 30, 2006. The final interim rule states that all host hospitals in an emergency Medicare GME affiliated group will be subject to the existing three-year average requirements beginning on July 1, 2006.

We recommend that CMS state that this will be effective for cost reporting periods beginning on or after July 1, 2006. The application of the three-year rolling average must be made with full cost reporting periods, not with portions of cost reporting periods. If a full cost reporting period is not used, it is conceivable that there would have to be two concurrent three-year rolling averages to accommodate the partial cost reporting periods created with the July 1, 2006, effective date.

We also recommend that the cost reporting instructions be rewritten to clearly show how the FTEs that are exempt from the three-year rolling average should be reported.

Although CMS has granted affected hospitals an exception to the three-year rolling average, there is no indication of a similar exception to the current/prior year resident-to-bed ratio limitation. If such an exception is not made, the host hospitals will not receive reimbursement for the displaced resident FTEs in the first year of training. We recommend that CMS provide an exception to the resident-to-bed limitation for the displaced residents for the same time period for which the exception to the three-year rolling average was made.

NON-HOSPITAL SETTINGS

In some situations, the home hospital will continue to pay for the salaries of the displaced residents being trained by the host hospital. In order to claim the time the resident spends at a non-hospital setting rotation, the host hospital must pay for all, or substantially all, of the costs of training the resident in the non-hospital setting. Since the home hospital will be paying the residents' salaries, the host hospital cannot be considered to be paying all the costs of training in a non-hospital setting. Therefore, in this situation, the host hospital cannot claim the time the resident spends in a non-hospital setting. We recommend that CMS require that the home and host hospitals state, in the information submitted to CMS and the intermediaries for the emergency Medicare FTE affiliations, which hospital will pay the salaries for the displaced residents.

Thank you for the opportunity to comment on the proposed rule. Please call me at 312.297.5876 if you have any questions on our comments.

Sincerely,

Michael W. Harty
Director
Strategic Government Initiatives

TOURO
INFIRMARY
MEDICAL STAFF OFFICE

June 5, 2006

The Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-1531-IFC
Mailstop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: CMS-1531-IFC:
PROVISIONS OF THE INTERIM FINAL RULE
APPLICATION OF EXISTING RULES AND
PROVISIONS OF INTERIM FINAL RULE

Dear Sirs:

On April 12, 2006, The Centers for Medicare & Medicaid Services (CMS) published an Interim Final Rule (the "rule") related to Medicare's Graduate Medical Education (GME) regulations and, specifically, to Medicare GME affiliations during times of disaster. The rule implements emergency regulations modifying Medicare's GME affiliated group provisions applicable to teaching hospitals, such as those in Louisiana and Mississippi, that have been forced to relocate residents to alternative training sites because of recent disasters. Comments on the final regulation are due no later than 5:00 p.m. on June 12, 2006. Touro greatly appreciates this opportunity to comment on the rule.

Touro Infirmary ("Touro" or the "Hospital") is a 350-bed hospital located in the City of New Orleans, Louisiana. Touro has long served as a teaching hospital for residents training in internal medicine, cardiology, cardiac thoracic surgery, OB/GYN, and plastic surgery, with residents from both LSU New Orleans ("LSU") and Tulane Medical Center ("Tulane") rotating to Touro. Touro, therefore, is actively engaged as a teaching hospital, and it would like to become even more engaged. Unfortunately, one aspect of the Interim Final Rule—the portion relating to the three-year rolling average—may not allow this.

Hurricane Katrina severely affected the Hospital in many significant ways, just as it affected other hospitals within the City of New Orleans. First, the Hurricane and the

1401 Foucher Street • New Orleans, Lousiana 70115-3593 • (504) 897-8392 • FAX (504) 897-8394

flooding that followed required Touro to undertake an extensive and expensive repair and reconstruction process that will continue for a number of years. At the same time, Hurricane and related flooding resulted in the loss of insured patients and a tremendous upsurge in uncompensated care at the Hospital. All of this has strained the Hospital's financial resources, and the three-year rolling average provisions of the Interim Final Rule can only exacerbate the problem.

Under the three-year rolling average proposal, for purposes of Medicare reimbursement, hospitals may count additional residents they receive through Medicare GME affiliation agreements on an incremental basis only. As a general rule, this means that the receiving or host hospital may count only a third of the additional residents in the first year and two-thirds in the second year. Not until the third year may the hospital count all of the residents. Although the Interim Final Rule allows some flexibility regarding the application of rolling average provision prior to July 1, 2006, all host hospitals in an emergency Medicare GME affiliated group will be subject to the full three-year rolling average requirements beginning July 1, 2006. 71 Fed. Reg. 18654, 18662 (April 12, 2006). The result will mean significant hardship for Touro and similarly situated hospitals that may well affect their willingness, if not ability, to serve as teaching hospitals, at least to the extent requested.

Hurricane Katrina has made it necessary for both LSU New Orleans and Tulane Medical Center to relocate many of their residents to other hospitals. Given the health care needs of the New Orleans' population, both LSU and Tulane have expressed a strong desire to rotate residents to nearby New Orleans hospitals that are in a position to address community needs while providing educational opportunities for LSU and Tulane medical residents. Touro is one of two New Orleans' hospitals in such a position. The three-year rolling average provision, however, would compel Touro to assume the costs of training these additional residents without the prospect of concurrent Medicare reimbursement for direct GME to offset the expense. Moreover, as noted above, Touro would need to undertake this cost burden at a time when it is particularly vulnerable financially.

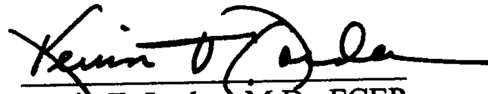
The quandary that Touro faces is representative of the plight of other New Orleans' area hospitals. If the three-year rolling average provision remains in the final rule, only a small number of hospitals in the emergency area, if any, will have the financial ability to serve as host hospitals, an outcome that is contrary to sound public policy. Accordingly, Touro respectfully requests that CMS consider an alternative, namely, just as they have been permitted to do from late August 2005 through June 30, 2006, that host hospitals in the emergency area be able to count additional residents in full until the three-year emergency period has expired. This approach would balance the needs of host hospitals, physicians in training, and the greater New Orleans community with the needs of the Medicare program for fiscal responsibility.

The Centers for Medicare & Medicaid Services
Attn: CMS-1531-IFC
Page 3
June 5, 2006

Beyond the problem of the three-year rolling average, there is one additional issue that we request CMS address. Currently, the Interim Final Rule requires that emergency affiliation agreements be entered into by no later than 180 days after the Section 1135 emergency period begins or by July 1 of the academic year. Normally, this deadline would be reasonable. In the case of hospitals that train large numbers of residents and that may need to relocate those residents to multiple hospitals, however, this timeline may be overly restrictive. That is particularly true if, as in the case currently with the LSU system, there are multiple ongoing issues regarding funding and caps, resident program closures, and the abilities of hospitals to serve as host hospitals. In light of these problems, particularly as they present themselves this year, we suggest that CMS extend the deadline for entering into agreements by 60 days for one year only—2006. This will allow hospitals to reach understandings with one another and will make it more likely that the parties enter into emergency affiliation agreements that comply with all regulatory requirements.

Thank you in advance for your attention to these comments.

Sincerely yours,



Kevin T. Jordan, M.D., FCEP
Vice President, Medical Affairs
Chief Medical Officer

TWC/mla

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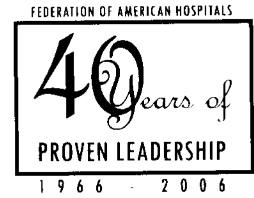

Charles N. Kahn III
President

June 12, 2006

Dr. Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS Interim Final Rule with Comment Period, Medicare Program; Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations, Federal Register (April 12, 2006)

File Code: CMS-1531-IFC

Dear Dr. McClellan:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") interim final rule ("IFR") regarding graduate medical education affiliation provisions for teaching hospitals in certain emergency situations.

FAH generally supports the provisions of the IFR and appreciates CMS's efforts in expeditiously promulgating this helpful regulation. In particular, FAH agrees that the regulatory provisions should be aimed at assisting both host and home hospitals. See, e.g., 71 Fed. Reg. 18,654, 18657 (April 12, 2006) (the IFR will "address the needs and incentives of home and host hospitals. . . ."). Specifically, FAH agrees that this IFR should address home hospitals' efforts and incentives to rebuild their programs after the significant disruption of Hurricane Katrina. See, e.g., 71 Fed. Reg. at 18,658 (modified

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affiliation policy "would allow affected hospitals the maximum degree of flexibility following the disaster so that residents displaced by the disaster can continue their residency training at other hospitals, while the home hospitals can remain committed to reopening their programs." [emphasis added]). FAH, however, believes that the proposal does not provide sufficient incentive for host hospitals to take on and continue the training of displaced residents. Moreover, unfortunately, FAH believes that CMS has not addressed a significant disincentive to home hospitals' rebuilding efforts: the three year rolling average. FAH sets forth its specific comments and proposals immediately below.

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION

The proposed time limit on the emergency Medicare GME affiliation agreement of "the remainder of the academic year during which the section 1135 emergency period began, plus two additional academic years" may not be sufficient for certain specialties with accredited minimum lengths greater than 3 years. Of the 217 allopathic and osteopathic specialties, 140 have 4 to 5 years of accredited minimum length. 61 Fed. Reg. 46,166, 46,208-46,211 (Aug. 30, 1996).

With the 3 year limit, host hospitals will be forced to terminate the training of displaced residents who elect to complete their training at the host hospital rather than return to their home hospital (assuming the home hospital is even able to accept/accommodate such residents). The incentive for host hospitals to continue training displaced residents disappears once the 3 year limit expires.

FAH recommends that CMS allow the emergency affiliation agreements to be effective until the later of: 1) CMS's original proposal (e.g., the 1135 emergency period plus two additional academic years), or 2) the earlier of: a) the date that a displaced resident completes his or her training at the host hospital, or b) the date that a displaced resident's initial residency period ("IRP") expires. Essentially, the host and home hospitals would, at the very least, get the benefit of the timeframe in CMS's original proposal but could extend an emergency affiliation agreement beyond that original proposed time frame to accommodate the completion of training for a resident whose IRP is more than three years (and who chooses to stay at the host hospital or who has nowhere else to finish training).

APPLICATION OF EXISTING RULES

A. HOST HOSPITALS

As indicated in the preamble discussion, host hospitals initially believed (based on CMS's published Q&A) that the exemption from the 3 year rolling average granted to closed programs/hospitals would apply to Katrina affected hospitals. Unlike CMS's proposal in the IFR, the closed program/hospital exemption from the rolling average applies until the displaced residents complete their training at a "host" hospital.

Under the IFR, though, the exemption to the three year rolling average would only be allowed for host hospitals from 8/29/05 to 6/30/06. For periods on or after

7/1/06, there is no exemption. FAH believes that CMS's proposed approach is a disincentive to host hospitals to continue training displaced residents beyond June 30, 2006.

Consider the following example illustrating the impact of the rolling average only:

Host Hospital A with a 6/30 cost reporting year end agreed to train 6 intern and resident full time equivalents ("FTEs") of displaced residents in FYE 6/30/06 and 6/30/07. Hospital A trains these residents only (and no others).

For 6/30/06 – the Host Hospital A will be reimbursed for 6 FTEs because of the exemption from the 3 year rolling average.

For 6/30/07 – the Host Hospital A will be reimbursed for 4 FTEs ((6+6+0)/3). Because there is no exemption, Hospital A will not be reimbursed for 2 of the 6 FTEs it trained.

For 6/30/08 – the Host Hospital A reverts back to training no residents at all.

As shown in the above example, the exemption from the rolling average is one incentive for host hospitals to accept displaced residents and train them. The one time, limited exemption could lead to undue disruption in the training of these residents because host hospitals may not be willing to continue the training after 6/30/06. The displaced residents would therefore have to scramble for openings in other hospitals willing to accept them despite the inadequate compensation for training them.

Furthermore, a hospital that becomes a host hospital for the first time on or after 7/1/06 will not have the exemption granted to host hospitals prior to 6/30/06. Without the exemption, post 6/30/06 host hospitals will be reimbursed at 1/3 of the number of displaced residents they trained in the first year. By granting the exemption throughout the training period of displaced residents, any host hospital, whether before or after 7/1/06, would receive the same exemption. FAH's suggested approach is the same as the one CMS currently uses for closed hospitals and closed programs. That is, the exemption from the three year rolling average lasts until the "host" hospital no longer trains the displaced residents.

The Katrina disaster has a long term effect on the teaching hospitals in the New Orleans area. These hospitals are not yet back to where they were before Katrina. Thus, the home hospitals can not all provide the same level of training to returning residents after 6/30/06. The residents they can not absorb must go to other teaching hospitals.

FAH requests that CMS reconsider its proposal on the exemption from the three year rolling average for host hospitals. FAH believes the exemption should continue until the displaced residents complete their training at the host hospital.

B. HOME HOSPITALS

1. 11 Month Issue

FAH requests that CMS provide home hospitals with an equitable full 12 months of FTEs for the fiscal year that includes the Katrina emergency for purposes of indirect medical education ("IME") and direct graduate medical education ("GME") reimbursement. Many of the home hospitals were unable to train any residents during the one month immediately subsequent to Katrina and, during that same month, the residents were not training at a host hospital. Thus, although the home hospitals were incurring significant training costs associated with the residents, these residents were claimable (for IME and GME purposes) by no hospital (i.e., neither by a host hospital nor a home hospital) for the month immediately after Katrina hit New Orleans.

Accordingly, FAH requests that CMS allow home hospitals to use an annualized FTE count for IME and GME purposes that avoids an undue forfeiture as a result of the unforeseen emergency. Specifically, the home hospitals could impute the August 2005 FTE counts to September 2005 so that the September count would equal the August count. Alternatively, the home hospitals could take their FTE count for 11 months and annualize it to 12 months. Either approach would yield an annualized FTE count that does not penalize the home hospitals for the one month when residents were not able to train anywhere.

2. Three Year Rolling Average and IME Ratio Cap

CMS's IFR sets forth a policy that protects host hospitals that train displaced residents from the potential adverse impact of the three year rolling average GME and IME (at least to the limited extent discussed above) as well as the IME intern/resident-to-bed ("IRB") ratio cap (collectively, the "IME/GME Limits"). However, the IFR does not afford home hospitals any relief from the GME/IME Limits. In particular, when the displaced residents return to the home hospitals or when the home hospitals reopen and begin to train residents for the first time post-Katrina, they will be limited by the three year rolling average and the IRB ratio cap.

CMS indicated (71 Fed. Reg. at 18,861) its view that the adverse impacts of the GME/IME Limits when home hospitals start to train residents again are offset by the benefit of being able to continue with the pre-Katrina higher FTE counts by operation of the three year rolling average. For instance, if a home hospital closed and had no FTEs in FYs 2006 or 2007 (and starts up again in 2008), it would still be able to include 2004 and 2005 FTE counts in the three year rolling average for purposes of FY 2006 and 2007 GME and IME reimbursement. Importantly, there is no similar effect with respect to the IRB ratio cap. That is, the IRB ratio cap for a home hospital that has no FTEs in FYs 2006 or 2007 will not be able to get any IME reimbursement in FYs 2006, 2007, or 2008, because the current year IRB ratio is always limited to the lesser of the current year or the prior year.

FAH respectfully differs with CMS's analysis. When a hospital abruptly closes (temporarily or permanently) as a result of Katrina, it does not benefit from the three year rolling average in those first couple of years after Katrina hit. This is because a closed hospital has no Medicare patient load and thus can get no GME reimbursement. Further, as just discussed, a closed hospital cannot get IME because its IRB ratio is zero (and its PPS DRG payments would also be zero). Thus, when the hospital reopens, it will be quite adversely impacted by the three year rolling average and the IRB ratio cap as it begins to train residents again.

Furthermore, even those New Orleans hospitals that did not completely close experienced a severe disruption to their operations, which caused their revenue to dramatically decrease. Additionally, the New Orleans teaching hospitals that remain open have experienced a sharp decrease in the number of FTEs (as they transferred away many residents) as well as a considerable decrease in Medicare patient loads. In fact, Medicare patient loads went down after Katrina in large part because the region's patient mix was dramatically impacted by which individuals remained in New Orleans or were able to (and wanted to) return to New Orleans.

Significantly, for GME, a hospital with reduced Medicare patient load will not particularly "benefit" from the pre-Katrina FTE counts that are part of the three year rolling average for the first two years post-Katrina. This is because GME payments are largely driven by Medicare patient load. Likewise, for IME, a hospital with significantly reduced Medicare volume/DRG payments will not "benefit" from the three year rolling average. This is because IME payments are largely driven by DRG payments.

When crafting the adjustments to the GME/IME Limits for host hospitals, CMS likely decided that home hospitals did not need relief from the GME/IME Limits because either: 1) they were permanently closed, or 2) they continued to operate normally except for a minimally disruptive closed residency training program. This is simply not the case for the New Orleans hospitals impacted by Katrina. The New Orleans hospitals were abruptly and severely disrupted for a significant period of time (even if they did not fully shutter). The IFR does not adequately address this situation for Katrina-impacted home hospitals that will soon start (or already have started) to revive their residency training programs.

Since home hospitals are quite adversely impacted initially (despite CMS's initial view that the three year rolling average would ameliorate the immediate impact), FAH requests that CMS provide relief from the GME/IME Limits for home hospitals as they build up their residency programs again (either by taking back previously transferred residents or by starting to train new residents in their already existing programs). The relief could be quite similar to the type of relief offered for new residency programs and for the host hospitals. That is, with respect to FTEs added back (not necessarily associated with the same individuals transferred), the home hospital would not be subject to the three year rolling average for a preset period of years. For instance, the three year rolling average exception could begin on a date certain (e.g., January 1, 2007 or July 1, 2006) or as of the date certain events take place (e.g., after the transferring hospital takes back its first resident or after the transferring hospital is at x% of its pre-Katrina FTE

count). Once the exception starts to run, FAH believes it makes sense for it to end after two or three years.

Likewise, as with new programs and for host hospitals, the home hospitals should get limited relief from the IRB ratio cap. FAH suggests that in some particular fiscal year (when most New Orleans hospitals would be at or near pre-Katrina capacity), the IRB ratio cap would be adjusted so that the numerator of the prior year IRB ratio would be set at a pre-Katrina/pre-transfer FTE count. FAH requests two or three years of such IRB ratio cap relief.

PROVISIONS OF THE INTERIM FINAL RULE

Section 412.105(a)(1)(i) (IRB ratio cap exemption):

FAH interprets CMS's proposed revision to this section as providing the emergency Medicare GME affiliated group the same treatment given to the regular Medicare GME affiliated group and new programs with regard to the application of the IRB ratio cap.

FAH recommends, however, that CMS discuss this in more detail and provide examples to illustrate the implementation of this policy. This is an area subject to misunderstanding by both intermediaries and providers alike.

The section reference of 413.97(f) should read 413.79(f).

Section 413.75 (b) Definitions

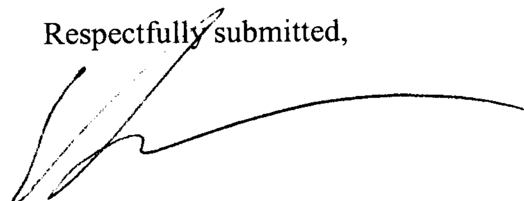
FAH suggests adding a regulatory definition of "new host teaching hospitals".

As discussed at page 18661, "new host teaching hospitals" were previously non-teaching hospitals that will become new teaching hospitals once they begin to train displaced residents from home hospitals as part of an approved medical residency program.

* * * *

FAH appreciates CMS's review and careful consideration of the comments in this letter, and would be happy to meet, at your convenience, to discuss them. If you have any questions, please feel free to contact Steve Speil, Senior Vice President at 202-624-1529.

Respectfully submitted,



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Jordan J. Cohen, M.D.
President

VIA HAND DELIVERY

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, S.W.
Washington, DC 20201

Attention: **CMS-1531–IFC**

Dear Administrator McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) Interim Final Rule entitled *"Medicare Program: Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations"* 71 Fed. Reg. 18654 (April 12, 2006). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; 90,000 full-time clinical faculty, and the nation's medical students and residents.

We would like to thank Agency staff for developing this rule in such an expeditious timeframe. This rule provides important flexibility to the Medicare direct graduate medical education (DGME) and indirect medical education (IME) resident limit policies when teaching hospitals undergo substantial disruption during major emergencies and disasters. Because CMS established an effective date retroactive to August 29, 2005 these regulations also provide needed regulatory relief to "host" hospitals that took on residents displaced from their "home" hospitals due to hurricanes Katrina and Rita.

At the same time, however, we believe modifications to the interim final rule are needed to ensure that during periods of emergency, residency education can continue with minimal disruption and is not compromised – goals that are shared by both the government (as evidenced by these regulations) and the academic medical community.

We all hope that this will be a "one time" rule that will address the situations resulting from last year's hurricanes and that will never be needed again. However, in what assuredly will be very limited circumstances in cases of extraordinary situations, we believe it is vital that Medicare's regulatory framework ensure that those hospitals that "step up to the plate" and take on displaced residents during a time of state or national emergency will receive needed financial support from the Medicare program.

Brief Summary of the Interim Final Rule

In general, current law limits the number of allopathic and osteopathic residents that Medicare may recognize for DGME and IME payment purposes to the number of residents reflected on hospitals' 1996 Medicare cost reports.

In rare emergencies in which hospitals are severely impacted, it may be necessary for residents in hospitals in the affected areas (referred to as "home" hospitals in the interim final rule) to temporarily transfer their residents to other hospitals ("host" hospitals) so that their residency training can continue with as little disruption as possible. Depending on the extent of the emergency and the residents' training needs, the residents may be displaced to teaching hospitals throughout the country. For host hospitals that are already training residents at or above their caps, taking on the displaced residents raises the question of how Medicare can help ensure that these hospitals will receive the financial support needed to train the additional residents.

Because no other current regulations fully address resident cap slots when displaced residents must train at another hospital as a result of an emergency situation, CMS issued the emergency Medicare GME affiliation agreements interim final rule. This rule is based on the current Medicare GME affiliation agreement regulations which allow hospitals to aggregate their resident limits and redistribute them among themselves pursuant to an agreement. However, it differs in several important, and beneficial, ways:

- Unlike non-emergency affiliation agreements, there is no requirement that the members of the affiliated group be in the same geographic area, be under common ownership, or be jointly listed in the Graduate Medical Education Directory, and

- Hospitals that are members of an emergency Medicare GME affiliated group do not need to have shared rotational arrangements.

These regulations would only become applicable when the President of the United States declares an emergency pursuant to the National Emergencies Act. Hospitals that enter into these agreements will still be required to submit significant documentation to CMS and their respective fiscal intermediaries in order for the host hospitals to receive the additional cap slots.

This Rule Would Be Unnecessary If the Medicare Resident Caps Were Lifted

At the outset, we would like to note that this rule would be unnecessary if the Medicare resident caps were lifted. The purpose of the rule is to allow the temporary transfer of resident cap slots from hospitals in emergency situations to "host" hospitals that take on the displaced residents so that the host hospitals may receive DGME and IME payments associated with these residents. While we appreciate the Agency's efforts to use its regulatory authority to work within what is obviously an extraordinarily stringent legislative policy, the process is still unnecessarily cumbersome and burdensome. Moreover, to the extent a home hospital is training residents in excess of its cap, there will not be enough cap slots to give to host hospitals.

The Medicare resident caps (or limits) have been in place since FY 1998 when they were mandated by the Balanced Budget Act of 1997. This policy, which essentially "freezes" the number of residents that are associated with Medicare reimbursement, has generated significant problems for teaching hospitals and medical schools that sponsor and conduct graduate medical education programs. The resident limits have now been in place for over eight years. Over that time period, there have been numerous examples of the resident caps posing detrimental barriers and penalties to sound educational policies and decisions. The inability of "host" hospitals to receive Medicare support for training additional residents during times of national emergencies without invoking a complex regulatory mechanism to comply with the cap policy is another example of why this legislative policy must be readdressed.

In other areas, decisions to impose a "freeze" are temporary in nature. In health care, and in Medicare in particular, we are unaware of policies that have not factored in the need for modifications after a certain period of time. In sum, we believe it is time to reconsider the resident limits policy. We urge CMS' office of legislation to convey the regulatory difficulties associated with continued implementation of the resident caps to Congress so that this policy may be addressed.

The June 30, 2006 Deadline Must Be Extended

Under the interim final rule, host hospitals that trained (or are training) displaced residents from hurricanes Katrina and Rita must submit emergency GME affiliated group agreements by this June 30 if they wish to receive additional cap slots that would allow them to receive DGME and IME payments. We urge the Agency to do a one-time extension for this year.

The situation in Louisiana is still very tenuous. Louisiana teaching hospitals are still in the midst of regaining patient operations capacity. Because of these critical patient care responsibilities, pursuing GME affiliation agreements has, by necessity, not been a top priority. We can think of no reason for not extending the June 30 deadline. If, however, CMS believes this deadline cannot be extended, we urge the Agency to give hospitals and

fiscal intermediaries the flexibility to address incomplete documentation issues associated with those agreements that were submitted by the deadline.

"Host" Hospitals Should Be Exempt from the Three-Year Rolling Average Calculation

Ordinarily, Medicare policy requires that hospitals' resident count for purposes of IME and DGME payment calculations be based on a three-year rolling average resident count. This policy extends to those hospitals in GME affiliation agreements, and the interim final rule would retain the policy for hospitals in emergency GME affiliation agreements.[1] For "home" hospitals, this policy provides an important financial cushion, because the reduced DGME and IME payments associated with the reduced resident count due to the emergency situation will be spread out over a three-year period. However, for emergency "host" hospitals, this policy means that the Medicare DGME and IME payments associated with these additional residents also will be spread out over three years.

In the final rule, we urge the Agency to provide for an exception to the three-year rolling average for "host" hospitals. Such an exception would allow these hospitals to receive full payments during the most critical time – when the residents are actually training at their institutions. The current "closed program" regulations are an important precedent. Under these regulations, hospitals that take on residents from other hospitals when a residency program is closed before all the residents have finished their training are exempt from the three-year rolling average. In implementing the exemption, CMS recognized that hospitals that take on displaced residents due to program closures incur the full costs of those residents during the displacement period, yet receive only partial Medicare DGME and IME payments for the first two years (see 66 Fed. Reg. at 39990-91 (August 1, 2001)).

The policy for including an exception to the three-year rolling average under the closed program regulations is equally applicable to emergency situations. These hospitals should not be penalized for taking on displaced residents, nor should they be discouraged from accepting these residents because they will not receive timely payments. Just as hospitals continue to bear the obligation for training residents, even when emergencies make it necessary to change the location of the training, Medicare should continue to bear its obligation to pay for this training at the time the payment is needed most.

The Inpatient Volume Reduction Requirement Should Be Eliminated

Under the interim final rule, only hospitals that are in a nationally declared emergency area and have a reduction in their inpatient volume of 20 percent may enter into emergency GME affiliation agreements. We believe the inpatient volume requirement is

[1] However, there is a time-limited (August 29, 2005 through June 30, 2006) exception to the three-year rolling average for hospitals that took on residents displaced due to hurricanes Katrina and Rita because of issues associated with a Katrina "Question and Answer" that CMS posted to its web site in the fall.

unnecessary and could be detrimental. First, adding a requirement that goes beyond the national emergency declaration may reflect a concern that hospitals would otherwise arbitrarily or improperly transfer residents to other hospitals. This is certainly not the case. Teaching hospitals and their academic leaders make every effort to maintain high quality, stable learning environments for their residents. A decision to transfer residents in an emergency situation would not be entered into lightly. Using a nationally declared emergency as the sole trigger for this rule will be sufficient to prevent any possible abuses.

Second, it is possible that during an emergency situation, a hospital's inpatient volume could actually increase, yet for a variety of reasons the hospital believes that their residents should be relocated. A volume reduction requirement in these situations would run counter to the flexibility that CMS is trying to provide through these regulations.

More Flexibility Is Needed in Submission and Duration Time Frames

Under the interim final rule, both home and host hospitals must submit a copy of the emergency GME affiliation agreement to CMS and their respective fiscal intermediaries (FIs) by the later of 180 days after the emergency period begins or June 30 of the relevant training year. Coping with an emergency will place extraordinary demands on hospitals and may make it impossible to meet this deadline. At a minimum, we believe that hospitals should have at least 180 days after the emergency period ends, rather than begins.

We also believe that the limitation on the maximum period for which the emergency affiliation agreement may be in place – the remainder of the academic year during which the emergency began plus two additional years – is unnecessary and too restrictive. At a minimum, a reasonable maximum would be five years, the maximum period for which Medicare recognizes initial residency periods.

Clarifying the Juxtaposition Between the Emergency GME Affiliation Agreement and Closed Program/Closed Hospital Regulations

As CMS uses this opportunity to consider the implications of the Medicare resident cap regulations during an emergency situation, we urge the Agency to also consider appropriate Medicare policy if a hospital in an emergency area is no longer able to continue operations and closes or if a residency program permanently closes while displaced residents are training at other hospitals.

We believe that a straightforward solution would be to grant the host hospitals an automatic increase in their resident caps to allow the residents displaced from the closed hospital or program to complete their training without incurring additional documentation requirements.

New Teaching Hospitals and Resident Cap Policy

We appreciate CMS' recognition that during emergency periods it may be necessary for a home hospital to send its residents to nonteaching hospitals to continue their training. Because these hospitals have no resident caps, their ability to receive DGME and IME payments is entirely dependent on obtaining temporary cap slots from the home hospital via a GME emergency affiliation agreement.

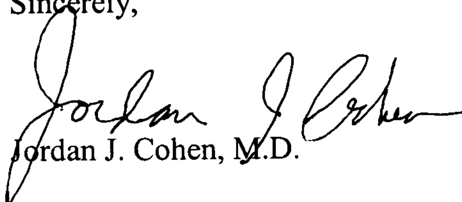
In the final rule, we ask that CMS confirm that, like nonteaching hospitals that enter into affiliation agreements in non-emergency situations, nonteaching hospitals that participate in emergency GME affiliation agreements do not lose their "nonteaching" status for purposes of obtaining their own, permanent resident cap at some point in the future if they choose to start new residency programs.

Conclusion

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

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, Health Care Affairs, or Karen Fisher, Senior Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,



Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC