Submitter : Mr. Kenneth Raske

Organization : Greater New York Hospital Association

Category : Health Care Professional or Association

Date: 06/05/2006

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1531-IFC-1-Attach-1.PDF

Attachment #1

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

June
Five
2006

Mark McClellan, MD
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8011
Baltimore, MD 21244-8011

RE: CMS-1531-IFC: Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations

Dear Dr. McClellan:

Greater New York Hospital Association (GNYHA), which represents approximately 100 teaching hospitals in the metropolitan New York region, including hospitals in New York, New Jersey, Connecticut, and Rhode Island, is pleased to provide these comments on *Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations*, which was published in the *Federal Register*, vol. 71, no. 70, on April 12, 2006, as an interim final rule with comment period.

Need for the Emergency Area Graduate Medical Education Regulations

GNYHA agrees with the Centers for Medicare & Medicaid Services (CMS) that special regulations are needed to accommodate the special circumstances faced by teaching hospitals in a situation where an area is declared a Section 1135 emergency area under the Social Security Act. As was quickly evident in the aftermath of Hurricanes Katrina and Rita, the most important priority is to address the drastic public health emergency that might arise in such an area. Our hospitals colleagues in the regions affected by those disasters have done an outstanding job dealing with these extraordinary situations. Because caring for victims of a disaster should take center stage, a standing policy is needed to ensure that educational issues for physician residents can be accommodated without distracting from these critical concerns. GNYHA commends CMS for recognizing the need for a set of regulations so that affected hospitals, and the academic medicine community in areas unfortunate enough to have to face this kind of a situation in the future, can look to a policy so that academic issues, and their associated financial implications, can be addressed without delay.

Because these rules only apply in very limited circumstances and in the case of an extraordinary situation, GNYHA offers these comments within what we believe should be a

context of the government's desire to grant maximum latitude to organizations affected by an extraordinary situation. This desire for accommodation should extend to the needs of teaching hospitals to ensure that the education of physician residents is continued with minimal disruption. As the agency develops its policy, GNYHA urges CMS to carefully weigh the necessity of imposing any regulatory or administrative limitation that serves in any way to create a barrier to physician residents being able to complete their education with minimal disruption or delay.

Constraints Imposed by the BBA Resident Cap

According to the rule, hospitals that take over the training of displaced residents ("host hospitals") would be eligible for an adjustment to their resident cap for both direct GME and indirect medical education (IME) payment purposes. GNYHA recognizes that CMS does not have the authority under the current statute to grant a general exception and permit an increase to the resident caps for hospitals that take over the training of residents displaced as the result of a Section 1135 emergency without an associated decrease in another hospital's resident caps. The development of these emergency regulations and the need to work around an outdated law is illustrative of just how problematic and potentially damaging the resident cap imposed by the Balanced Budget Act (BBA) can be. In the context of an emergency situation, it is striking to consider how constrained CMS is by the BBA resident cap, and how the imposition of these caps can wreak so much havoc for physician residents seeking to complete their education in the context of a natural disaster. CMS has done an admirable job working within the constraints imposed by the statute, but the agency has been forced to create significant administrative hurdles on teaching hospitals that would not be necessary absent this outdated section of the BBA.

For reasons such as this, GNYHA continues to recommend that Congress eliminate, or at least update, the statute establishing the resident caps so that the academic medicine community can educate the physicians of tomorrow without hindrance and the country can benefit from the talented physician workforce it deserves and will need as the population ages.

Retroactive Application of the Rule

GNYHA commends CMS for presenting this rule with a retroactive effective date of August 29, 2005 (the date that Hurricane Katrina occurred). GNYHA recognizes that CMS has limited ability to do retroactive rulemaking but agrees that the issues presented by Hurricanes Katrina and Rita necessitate a rule that would benefit teaching hospitals and physician residents affected by those natural disasters. The number of questions that have been asked since shortly after these terrible occurrences illustrate the need for the emergency regulations and the importance of making the rule retroactive.

Requirements for Emergency Medicare GME Affiliated Group

GNYHA appreciates that CMS decided to waive certain requirements in use for a standard Medicare GME affiliated group for these special situations, specifically that the hospitals that are party to these emergency agreements must a) be located in the same or contiguous areas and b) have a shared rotational arrangement. On the other hand, GNYHA does not believe it is appropriate in the context of an emergency situation to "test" whether a hospital located in a Section 1135 area qualifies for application of this rule. In particular, GNYHA does not

believe it is appropriate to review inpatient occupancy at a hospital located in a Section 1135 area in consecutive weeks to determine whether there has been at least a 20% drop in inpatient occupancy to determine eligibility. Hospitals in a Section 1135 emergency area may experience an *increase* in inpatient occupancy as a result of an emergency situation but still decide that its physician residents are better served in being placed in another teaching hospital for a period of time or the duration of the residents' training. The complexity inherent in dealing with an emergency situation should not be hampered by administrative rules that are simply not appropriate in extraordinary situations. Therefore, GNYHA recommends that CMS state unequivocally that any teaching hospital located in a Section 1135 emergency area is eligible to be considered a home hospital under these regulations.

GNYHA also recommends that CMS modify the documentation submission requirements associated with the resident displacement. Rather than requiring that the home and host hospital submit an agreement by July 1 for each of the upcoming residency training years when a resident has been displaced to a host hospital, GNYHA recommends that the hospitals be required to submit these documents by 180 days *after the end of the relevant academic year*. GNYHA can think of no valid reason for home and host hospitals dealing with an emergency situation to have to scramble to generate prospective agreements for displaced residents in the context of dealing with residents displaced from the area.

Limitation of Effective Period to Three Years

GNYHA is dismayed to read in the interim final rule that an arbitrary limit of three years was included as the effective period of any application of the rule. This unexplained limitation strikes GNYHA as contrary to the intent of the regulation, which is to deal with extraordinary emergency situations and permit displaced physician residents to complete their training program with minimum disruption. As CMS knows, a residency program can take from one year (for transitional year programs and certain fellowship programs) to five years (for certain core specialty programs, such as general surgery) to complete. It would make much more sense for CMS to adopt a rule that permits a host hospital to receive a cap adjustment for up to five years, in recognition that this is the outer limit of residency program length. GNYHA appreciates that this would create more of a documentation and auditing burden for the fiscal intermediary, but we believe that is a small price to pay in the interest of protecting a resident's educational pathway.

Also, since the rule is structured so that the home hospital must agree to lower its Medicare resident cap in order for *any* host hospital to receive an increase to accommodate a displaced resident, there is no reason not to grant maximum flexibility for the home and host hospitals to decide whether to continue an arrangement for the benefit of the displaced resident. GNYHA expects that virtually all affected hospitals would execute year-to-year renewable affiliation agreements, so any potential negative effect on the home hospital is completely eliminated. If a multi-year agreement between a home hospital and a host hospital was executed, the agreement could easily be structured to include a clause indicating that the agreement shall remain in effect unless terminated by either party. Inclusion of such a clause would prevent the home hospital from being disadvantaged in terms of "reclaiming" its residents.

Multiple Host Hospitals
GNYHA recommends that CMS affirmatively state in the final rule that eligibility for an adjustment applies to any hospital that accepts a resident who has been displaced from a Section 1135 area and that there is no requirement that the resident be transferring directly from the home hospital. As an illustration, CMS should state that if a resident transfers from the home hospital in a Section 1135 area to Host Hospital A for a period of time, and the resident then decides to transfer to Host Hospital B to continue training, Host Hospital B would be eligible for an adjustment to both its direct GME and IME caps even though the resident did not transfer directly from the home hospital to Host Hospital B.

Application of the Three-year Rolling Average
According to the rule, for the balance of the resident's first training year being displaced, the host hospital would be allowed to receive an adjustment to its resident cap for both direct GME and IME purposes outside of the three-year rolling average. As of the first July 1 after the resident begins training at the host hospital, a displaced resident would be included in the host hospital's calculation of its three-year rolling average. GNYHA does not believe a hospital that is willing to take over the training of a resident displaced from a hospital located in a Section 1135 area should be disadvantaged in this way. We note that the regulations specifying the rules for a hospital taking over the training of a resident from a closed hospital or a closed program permit the displaced resident to be kept outside the three-year rolling average for resident count purposes for the time period that the resident needs to complete his or her training. GNYHA recommends that CMS treat the displaced residents in these emergency situations in the same manner.

Closure of a Hospital Located in a Section 1135 Emergency Area
Given the nature of a Section 1135 emergency, it is possible that a hospital located in that area would be forced to close, or a home hospital would be forced to close a residency program, after its residents have been placed in host hospitals. GNYHA recommends that CMS state in the final rule that should a home hospital be closed after residents have been transferred, the host hospitals would be granted an automatic increase in their resident caps to allow the residents displaced from the closed hospital to complete their training. In particular, CMS should indicate how the documentation requirements associated with the transition to the resident being from a Section 1135 emergency area to a closed hospital or closed program should be handled by the host hospitals and the fiscal intermediary.

Should you or your staff have any questions regarding these comments, please contact Tim Johnson of my staff at 212-506-5420 or tjohnson@gnyha.org.

Sincerely,

Kenneth E. Raske
President

cc: Liz Richter
Tzvi Hefter

Submitter : Mrs. Peggy Robison

Organization : Mrs. Peggy Robison

Category : Individual

Date: 06/09/2006

Issue Areas/Comments

GENERAL

GENERAL

I believe it would be terrible to cut the funding for our teaching schools. The Tax dollars that we Americans pay, surely could be used to benefit some or all of our society. The communities are becoming more and more in need of well trained Doctors. There seems to be a shortage. Please consider this issue to the greatest links!!

Thanks,
Peggy Robison

Submitter : Dr. Kathleen Santi **Date:** 06/09/2006

Organization : Halifax Medical Center F P Residency Training Pgm

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As usual congress is doing everything it can to decrease the number of primary care providers. We are already short enough and with the impending changes in medicare reimbursement, will only get shorter.

Submitter : Dr. Rick Miles **Date:** 06/12/2006

Organization : Richard S Miles PSC and KAFP

Category : Physician

Issue Areas/Comments

Provisions of the Interim Final Rule

Provisions of the Interim Final Rule

Family Medicine is the cost effective answer to the rising costs of medical care in this country. Where the family doctor is prevalent the cost of care is lower and the quality of care is higher in study after study.

The new Medicare rules will decrease payment to residencies that are already struggling financially. Since family physicians are reimbursed less anyway it will be harder for the residencies to stay open.

We already produce half of the FP residents that we produced in the 1980's. As the residencies fail fewer Family Physicians will result in higher medical costs.

The didactic teaching is essential to producing quality physicians and an integral part of the residency. Not reimbursing for that is like telling government workers that we will buy cars but will not pay for the gas.

Please reconsider your payment scheme for residencies- especially Family Medicine where 95% of the graduates actually do Primary Care and do not go into subspecialties unlike Pediatrics and Internal Medicine. We need Primary Care i.e. Family Medicine to deliver cost effective medical care in the USA.

Thanks Rick Miles, M.D.

124 Dowell Rd.
Russell Springs,KY
42642

Vice President, Finance Vice President, Government Relations
Ochsner Clinic Foundation Ochsner Clinic Foundation

Teaching Hospitals Affected by a Disaster

Teaching Hospitals Affected by a Disaster

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

Attention: CMS-1531-IFC

Dear Administrator McClellan:

Ochsner Clinic Foundation appreciates the opportunity to comment on the 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). Ochsner operates a major teaching hospital within the designated New Orleans emergency area, offering 16 Ochsner sponsored programs of graduate medical education to over 200 physician residents and fellows and 4 programs that are jointly sponsored with Louisiana State and Tulane Universities serving 112 residents and fellows. Further, there are 31 residents and fellows participating in 13 additional training programs at Ochsner under affiliation arrangements with local medical schools and hospitals.

In the post-storm environment, Ochsner has played a major role in providing essential medical services to local residents and emerged as the largest academic medical center in the region. In addition, Ochsner has been actively engaged in efforts to stabilize local programs of graduate medical education that have been severely disrupted by storm damage inflicted on key hospital training sites. Going forward, Ochsner s ability to reconfigure graduate medical education programs with LSU and Tulane University will be a critical factor in preserving Louisiana s medical education infrastructure.

While the interim final rule provided some important measures of geographic flexibility and short-term financial relief for graduate medical education programs and teaching hospitals, several regulatory problems should be addressed to facilitate the implementation of the Emergency Medicare GME Affiliated Group Provisions. More specifically, Ochsner encourages CMS to reconsider the interim final rules associated with the three-year rolling average calculation, duration and time frames for submission of affiliation agreements, and resident specific documentation requirements that must be provided to Medicare fiscal intermediaries.

CMS-1531-IFC-13-Attach-1.DOC

6

Submitter : Mr. Mark Beckstrom **Date:** 06/12/2006

Organization : Ochsner Clinic Foundation

Category : Hospital

Issue Areas/Comments

Application of the Interim Final Rule

Application of the Interim Final Rule

APPLICATION OF EXISTING RULES: ADJUSTMENTS TO THE 3-YEAR ROLLING AVERAGE CALCULATION

One major barrier to reconfiguring local graduate medical education programs involve the use of the 3-year rolling average resident count for the purposes of establishing DGME and IME payment calculations. Hurricane Katrina caused massive financial losses for all hospitals in the emergency area including over $60 million in operating losses sustained by Ochsner Clinic Foundation between the end of August and the end of February. If Ochsner and other host hospitals participate in emergency GME affiliation agreements under the 3-year rolling average calculation, they will sustain additional near term losses that are untenable in the post-storm environment. CMS should adopt a provision similar to the mechanism found in the closed program regulation, which establishes a regulatory precedent in providing an exemption from the 3-year rolling average for host hospitals that accept residents from closed programs. More specifically, Ochsner recommends that home and host hospitals be provided with the ability to transfer current resident FTE counts as part of an emergency affiliation agreement. This arrangement represents a reasonable and practical solution to extraordinary near term financial problems that threaten the survival of key GME training programs.

Provisions of the Interim Final Rule

Provisions of the Interim Final Rule

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION: DURATION OF AFFILIATION AGREEMENTS

The interim final rule states that the emergency affiliation provisions will expire on June 30, 2008 afterwhich the flexibility granted under these agreements will no longer exist. As a practical matter, it is highly doubtful that all pre-storm home hospital facilities and GME programs will return to their previous forms and scale within 3 years. Further, it is possible that some facilities and programs may not reopen or be sustained. It may also be useful to note from a facility reconstruction perspective that the new Veterans Administration hospital is scheduled to be rebuilt within a 5 to 7 year time period. The rule should provide for at least a 5-year agreement, which is the maximum time period allowed under Medicare for initial residency periods. There should also be a mechanism for a permanent affiliation agreement between home and host hospitals that allows for a transition to what appears will be a dramatically altered healthcare system and demographic landscape in the New Orleans emergency area.

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION: TIME FRAME FOR SUBMISSION OF AFFILIATION AGREEMENTS

According to the interim final rule, an emergency GME affiliation agreement must be in place by the later of 180 days after the emergency period begins or June 30th of the relevant training year. It should also be recognized, however, that the interim rule was published on April 12, 2006, leaving less than 90 days to negotiate and complete an extraordinary array of affiliation agreements among hospitals. Further, the post-storm challenges and problems confronting local hospitals remain daunting. Under these circumstances, Ochsner believes that CMS should extend the deadline for submission of initial emergency affiliation agreements for an additional 180 days from the April 12th publication of the rule or, at a minimum, 180 days from the end of the emergency period. The agreements should also be made retroactive to July 1, 2006, which is the beginning of the academic year.

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION: DOCUMENTATION REQUIREMENTS FOR DISPLACED RESIDENTS

Under the emergency affiliation provisions, host hospitals are required to provide the Medicare fiscal intermediary documentation of each displaced resident s name, social security number, program sponsor, and hospital from where the resident was displaced. Ochsner has affiliation contracts, however, that are based on the number of residency positions and are not individual or resident specific. As a result, a host hospital can prove that the number of residents in training exceeds their contractual obligation due to an influx of displaced residents, but may have considerable difficulty identifying specific displaced residents from those that are training at the hospital under normal circumstances. Ochsner recommends that these individual identification requirements for affiliation agreements be modified to allow home and host hospitals to report the total number of residents training in their facilities within the parameters of established Medicare resident FTE caps.

Conclusion

Once again, Ochsner appreciates the opportunity to comment on the interim final rule governing graduate medical education and emergency Medicare GME affiliation agreements. Our staff is available to provide you with further information about our programs and these aforementioned issues and concerns.

Thank you for your attention and consideration.

Sincerely,

Jody Ohlmeyer Mark Beckstrom

Attachment #6

Ochsner
CLINIC FOUNDATION

June 15, 2006

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

Attention: CMS-1531-1FC

Dear Administrator McClellan:

Ochsner Clinic Foundation appreciates the opportunity to comment on the 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). Ochsner operates a major teaching hospital within the designated New Orleans emergency area, offering 16 Ochsner sponsored programs of graduate medical education to over 200 physician residents and fellows and 4 programs that are jointly sponsored with Louisiana State and Tulane Universities serving 112 residents and fellows. Further, there are 31 residents and fellows participating in 13 additional training programs at Ochsner under affiliation arrangements with local medical schools and hospitals.

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While the interim final rule provided some important measures of geographic flexibility and short-term financial relief for graduate medical education programs and teaching hospitals, several regulatory problems should be addressed to facilitate the implementation of the Emergency Medicare GME Affiliated Group Provisions. More specifically, Ochsner encourages CMS to reconsider the interim final rules associated with the three-year rolling average calculation, duration and time frames for submission of affiliation agreements, and resident specific documentation requirements that must be provided to Medicare fiscal intermediaries.

APPLICATION OF EXISTING RULES: ADJUSTMENTS TO THE 3-YEAR ROLLING AVERAGE CALCULATION

One major barrier to reconfiguring local graduate medical education programs involve the use of the 3-year rolling average resident count for the purposes of establishing DGME and IME payment calculations. Hurricane Katrina caused massive financial losses for all hospitals in the emergency area including over $60 million in operating losses sustained by Ochsner Clinic Foundation between the end of August and the end of February. If Ochsner and other host hospitals participate in emergency GME affiliation agreements under the 3-year rolling average calculation, they will sustain additional near term losses that are untenable in the post-storm environment. CMS should adopt a provision similar to the mechanism found in the "closed program" regulation, which establishes a regulatory precedent in providing an exemption from the 3-year rolling average for "host" hospitals that accept residents from closed programs. More specifically, Ochsner recommends that "home" and "host" hospitals be provided with the ability to transfer current resident FTE counts as part of an emergency affiliation agreement. This arrangement represents a reasonable and practical solution to extraordinary near term financial problems that threaten the survival of key GME training programs.

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION: DURATION OF AFFILIATION AGREEMENTS

The interim final rule states that the emergency affiliation provisions will expire on June 30, 2008 afterwhich the flexibility granted under these agreements will no longer exist. As a practical matter, it is highly doubtful that all pre-storm home hospital facilities and GME programs will return to their previous forms and scale within 3 years. Further, it is possible that some facilities and programs may not reopen or be sustained. It may also be useful to note from a facility reconstruction perspective that the new Veterans Administration hospital is scheduled to be rebuilt within a 5 to 7 year time period. The rule should provide for at least a 5-year agreement, which is the maximum time period allowed under Medicare for initial residency periods. There should also be a mechanism for a permanent affiliation agreement between "home" and "host" hospitals that allows for a transition to what appears will be a dramatically altered healthcare system and demographic landscape in the New Orleans emergency area.

OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION: TIME FRAME FOR SUBMISSION OF AFFILIATION AGREEMENTS

According to the interim final rule, an emergency GME affiliation agreement must be in place by the later of 180 days after the emergency period begins or June 30th of the relevant training year. It should also be recognized, however, that the interim rule was published on April 12, 2006, leaving less than 90 days to negotiate and complete an extraordinary array of affiliation agreements among hospitals. Further, the post-storm challenges and problems confronting local hospitals remain daunting. Under these circumstances, Ochsner believes that CMS should extend the deadline for submission of initial emergency affiliation agreements for an additional 180 days from the April 12th publication of the rule or, at a minimum, 180 days from the end of the emergency period. The agreements should also be made retroactive to July 1, 2006, which is the beginning of the academic year.

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Under the emergency affiliation provisions, "host" hospitals are required to provide the Medicare fiscal intermediary documentation of each displaced resident's name, social security number, program sponsor, and hospital from where the resident was displaced. Ochsner has affiliation contracts, however, that are based on the number of residency positions and are not individual or resident specific. As a result, a "host" hospital can prove that the number of residents in training exceeds their contractual obligation due to an influx of displaced residents, but may have considerable difficulty identifying specific displaced residents from those that are training at the hospital under normal circumstances. Ochsner recommends that these individual identification requirements for affiliation agreements be modified to allow "home" and "host" hospitals to report the total number of residents training in their facilities within the parameters of established Medicare resident FTE caps.

Conclusion

Once again, Ochsner appreciates the opportunity to comment on the interim final rule governing graduate medical education and emergency Medicare GME affiliation agreements. Our staff is available to provide you with further information about our programs and these aforementioned issues and concerns.

Thank you for your attention and consideration.

Sincerely,

Jody Ohlmeyer
Vice President, Finance
Ochsner Clinic Foundation

Mark Beckstrom
Vice President, Government Relations
Ochsner Clinic Foundation

Submitter : Ms. Danielle Lloyd **Date:** 06/12/2006

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1531-IFC-14-Attach-1.DOC

Attachment # 7

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1531--IFC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

***RE: CMS-1531--IFC, Medicare Program; Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations,* Vol. 71 No. 70 Fed. Reg. 18654 (April 12, 2006).**

Dear Dr. McClellan:

On behalf of the American Hospital Association's (AHA) 4,800 member hospitals, health care systems and other health care organizations, and our 35,000 individual members, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the *Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations* interim final rule.

The AHA supports CMS' proposal to establish in regulation exceptions to the Medicare direct graduate medical education (DGME) and indirect medical education (IME) resident-limit policies for hospitals that experience emergency situations requiring the relocation of their interns and residents to "host" hospitals, as this will ensure minimal disruption to the interns' and residents' training. We further support the application of this regulation retroactively to August 29, 2005 in order to provide needed regulatory relief to "host" hospitals that took on residents displaced from their "home" hospitals by hurricanes Katrina and Rita.

Under such extreme circumstances, we agree that it would be appropriate to lift the requirement that affiliation agreements only occur between hospitals that are located in contiguous areas and have shared rotational arrangements. However, we believe that this waiver should apply to all affected hospitals, not just those that experience a 20 percent or greater decrease in inpatient volume. If some hospitals in a disaster area close, hospitals remaining open may see a temporary increase in volume. Nevertheless, a hospital may believe that it is advisable to relocate its interns and residents due to structural damage or a lack of other local services, among other reasons. The

fundamental goal of this policy change should be to reduce the red tape for such hospitals, which need to spend their time and resources caring for their communities.

The interim final rule requires both the "home" and "host" hospital to submit an affiliation agreement to CMS within 180 days of the *start* of the emergency or by June 30 of the relevant training year. This does not give hospitals, who are clearly contending with significant hurdles to maintain basic daily operations, sufficient time to officially finalize an affiliation agreement. It would make more sense to require hospitals to turn in the agreement within 180 days *after* the emergency ends or by June 30, whichever is later.

CMS proposes to limit these affiliation agreements to three years. The AHA believes this time period is insufficient and recommends that CMS extend it to five years, the maximum-allowable residency period. Once interns and residents are situated at "host" hospitals, which may be located halfway across the country, it is unreasonable to force them to return to their "home" hospitals for their last year or two of training. The "home" hospitals cannot fill those residency slots until the residents finish the program. Therefore, there is no increased cost to Medicare, and those hospitals' resident caps are not permanently affected.

The resident caps are calculated based on a three-year, rolling average. In the case of hospitals affected by hurricanes Katrina and Rita, CMS proposes to give an adjustment for the remainder of the year to "host" hospitals. However, CMS then proposes to apply the three-year, rolling average policy to hospitals facing similar situations in the future. The current policy for closed programs allows displaced residents to be counted outside of the three-year, rolling average. We would support the application of the same policy to "host" hospitals under this regulation. In addition, the AHA recommends that CMS allow "host" hospitals to receive an automatic increase in their resident caps if the "home" hospital associated with a transferred resident permanently closes.

While we are very supportive of CMS' move to provide flexibility for hospitals experiencing extreme circumstances, we believe that CMS should refrain from imposing arbitrary eligibility thresholds, time limits and documentation requirements. The "home" hospitals have no control over their situation, and "host" hospitals are doing a service by taking on these displaced residents. We believe the rules should be structured to provide maximum flexibility.

The AHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Danielle Lloyd, senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : **Dr. Mark Boyd** **Date: 06/12/2006**

Organization : **St Elizabeth medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Keep GME monies for Graduate Medical Education

Submitter : **Ms. Barbara Peck** **Date: 06/12/2006**

Organization : **American College of Surgeons**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1531-IFC-16-Attach-1.PDF

Attachment 9

American College of Surgeons

Washington Office: 1640 Wisconsin Avenue, NW • Washington, DC 20007 • 202/337-2701 • FAX 202/337-4271
e-mail: postmaster@facs.org ACS Web site: http://www.facs.org

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: File Code CMS 1531-IFC

Dear Dr. McClellan:

On behalf of the 71,000 Fellows of the American College of Surgeons, I am pleased to provide comment on the Centers for Medicare and Medicaid Services proposed rule entitled Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations, published April 12, 2006. The surgical community greatly appreciates the accommodations CMS has made to ensure medical residents displaced by Hurricanes Katrina and Rita have been able to continue their medical training in reasonable and effective manner.

We have numerous comments on the proposed rule. In general, we believe the accommodations CMS has proposed are just and equitable and will go a long way toward helping rebuild the medical community in the gulf coast region. All of our comments have one overriding theme: Ensuring residents in training receive high quality training in an appropriate and edifying environment.

Background

In the proposed rule, CMS identifies and defines both "home" hospitals and "host" hospitals. It is our belief that there is a third invaluable player in this equation and that is the "sponsoring" organization. CMS recognizes that residency programs vary greatly and that many residents train at multiple hospitals and facilities throughout their training program. Traditionally, it is the resident's sponsoring program, not the individual hospitals, that arrange for and are responsible for these transfers between facilities. It is the sponsoring organizations that are accountable to the Accreditation Council for Graduate Medical Education (ACGME) and Residency Review Committees and must ensure the quality, vigor and

cohesiveness of each resident's training. For this reason, we propose that CMS assign the sponsoring organizations as the coordinating authority between the home and host hospitals and require sponsoring organization approval before any cap transfers are made.

We believe involvement of the sponsoring organizations will help ensure that the GME funds provided by CMS will be used for their intended use – to make certain medical residents receive high-quality training and are, therefore, able to provide high-quality care to program beneficiaries. Our primary concern at this point is that many of the medical centers, and their respective medical departments, have been left in shambles since Hurricanes Katrina and Rita. Entire medical and surgical departments have temporarily been dislocated or are operating on a minimalist level. While many gulf coast hospitals are making valiant efforts to rebuild their facilities and need the funds and manpower that come along with medical residents, there is no guarantee that there are qualified personnel available to actually teach and mentor these residents. Just because a home hospital claims it is ready to bring back residents, does not mean the resident is qualified and prepared to return to that particular hospital environment. Medical residencies are extremely structured and rigorous with residents learning and mastering specific skill sets in a defined order. The resident's sponsoring program director is the only person in a position to understand and evaluate a particular resident's skill set and needs and must be involved in the decision to transfer residents between facilities. We feel this is particularly true in this instance because the training of many residents has already been disrupted and residents may already be "off track" and in need of individualized restructuring and attention that can only be done by a program director.

Overview of the Emergency Medicare GME Affiliated Group Provision

At this point, we feel there is a question about the timeframe for the effective period for the emergency. Under the proposed rule, the term for the effective period to allow temporary affiliated agreements will end in June 2008. We do not feel that we, or anyone else, can reasonably comment on whether this is enough time to allow the healthcare system in the gulf coast to be rebuilt. It is our understanding that several major healthcare institutions in the New Orleans area will have to be rebuilt from the ground up, if they are rebuilt at all. We request that CMS reevaluate the situation in late 2007 to determine whether the temporary affiliation agreements need to be extended, or if the resident slots need to be permanently reassigned.

We do not feel it is likely the residency programs in the gulf coast area will be up and running at full capacity by June 2008. Many surgical residency programs run

between five to seven years and residents who started in the gulf coast pre-Katrina will still be in the midst of their training in June 2008. Many of these residents would have started their training in New Orleans, been relocated to a host facility for almost three years, and then will have to return to New Orleans, or find another facility to complete their training. If some facilities do not rebuild or do not rebuild to full capacity, it is entirely possible there will be no place for these residents to return to after the three-year temporary affiliation program expires. We request that CMS reserve the right to build some flexibility into the system once more information is available regarding the rebuilding of facilities in the gulf coast. In addition, considering that it appears quite likely that the facilities in the gulf coast will be unable to rebuild to their pre-hurricane level and support their pre-hurricane levels of residents, we request CMS consider a method for reallocating those residency spots to other areas. Various sources have predicted an impending physician workforce shortage and many medical schools have or will be increasing enrollment as a result. "Losing" residency spots after June 2008 will only aggrevate this problem.

Emergency Medicare GME Affiliated Group Provisions – Application of Existing Rules

We urge CMS to reconsider its position on the application of the three-year rolling average for both home and host hospitals. The waiver of this provision in the wake of the hurricanes created a willingness by facilities to accept residents from the gulf coast area in an expedited and efficient manner. Applying the three-year average rule on July 1, 2006, will likely cause many host facilities to drop residents on July 1 out of financial necessity. Many host facilities have taken on large numbers of uncompensated or poorly compensated care caused by the relocation of citizens from the gulf coast region and cannot afford to take on the training of residents without immediate compensation. Therefore, we urge CMS to waive the three-year rolling average and reimburse host facilities directly for their costs.

We also have concerns about applying the three-year rolling average to the home institutions. As CMS points out, it could help facilities initially, but having a "zero" or other low number in the calculation with throw off the average for several years. This could be a devastating blow to facilities that are attempting to rebuild and bring back residents, but have to wait several years for their GME payments to "catch up." In addition, while the average will help facilities in the early years, these facilities are not likely to have large numbers of Medicare billings at this time and, therefore, will not benefit from the higher payments as a result of the indirect GME payments.

Conclusion

We greatly appreciate CMS' willingness to provide accommodations for the medical facilities affected by Hurricanes Katrina and Rita. We believe it is essential to rebuild the healthcare system in the affected areas and believe a fair and reasonable GME policy will ensure beneficiaries will have access to high quality healthcare. We appreciate the opportunity to provide input on these important issues and we look forward to working with CMS.

Sincerely,

Cynthia A. Brown

Cynthia A. Brown
Director
Division of Advocacy and Health Policy

Submitter : Mr. Wade Gillham **Date:** 06/12/2006

Organization : East Jefferson General Hospital

Category : Hospital

Issue Areas/Comments

Teaching Hospitals Affected by a Disaster

Teaching Hospitals Affected by a Disaster

APPLICATION OF EXISTING RULES
Will a host hospital that accepts residents as a result of a 1135 emergency still be subject to the lesser of the current and prior period rules on the IME ratio?

Since the IME ratio is limited to the lesser of the current or prior cost report year, please explain how the IME intern-to-bed ratio will be adjusted in the period prior to the academic year in which the section 1135 emergency period began. When performing this comparison, will the host hopsital's IME ratio for the prior period be adjusted for the displaced residents in a similar manner as the section 1135 year?

Submitter : Mr. Paul Salles **Date:** 06/12/2006

Organization : Louisiana Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1531-IFC-18-Attach-1.DOC

Attachment #11

LOUISIANA HOSPITAL ASSOCIATION

JOHN A. MATESSINO
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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, SW
Washington, DC 20201

Attention: **CMS-1531-IFC**

Dear Administrator McClellan:

The Louisiana Hospital Association (LHA) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 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 LHA represents over 180 hospitals in Louisiana, including major teaching hospitals and health systems impacted by hurricanes Katrina and Rita last year.

We would like to thank CMS 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 are affected by 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 because of hurricanes Katrina and Rita.

While the LHA supports many of the rule's provisions, we believe modifications to the interim final rule are needed to ensure the present and future of residency education in the disaster region.

It is critical that Medicare's regulatory framework ensures that hospitals that take on displaced residents during a time of state or national emergency will receive needed financial support from the Medicare program. In addition to financial support, we believe that flexibility is critical, as "host" and "home" hospitals work with each program's academic sponsor to maintain vital residency programs.

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 report.

When hospitals and the populations they serve are significantly impacted by a disaster, 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 or previously non-teaching hospitals in other parts of a state, or throughout the country for long periods of time. 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.

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. With this purpose in mind, we would like to offer the following comments.

"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 continue this policy beginning July 1, 2006. For "home" hospitals, this policy provides an important financial cushion, because the reduced DGME and IME payments associated with the reduced resident count caused by 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 will be spread out over three years.

In the final rule, we urge CMS to provide for an exception or option to the three-year rolling average calculation. Both "host" and "home" hospitals should have the option of using current year resident counts (instead of the three-year rolling average) provided they both agree to do so under the emergency affiliation agreement. This would ensure that the total resident counts remain within the established caps, and Medicare reimbursement to be allocated more directly to the "host" hospital currently training the

resident. Such an option 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 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. This level of flexibility is necessary as "home" and "host" hospitals work with their academic sponsors in developing these emergency affiliation agreements.

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 unnecessary and could be detrimental. Adding a requirement that goes beyond the national emergency declaration is unnecessary and may actually be harmful as teaching hospitals and their academic leaders make every effort to maintain high quality, stable learning environments for their residents. Using a nationally declared emergency as the sole trigger for this rule should be sufficient.

Additionally, 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 the effects of hurricanes Katrina and Rita has placed extraordinary demands on all hospitals in Louisiana, and may make it impossible to meet this deadline. In this instance, the interim final rule was published on April 7, 2006, leaving just 84 days to negotiate and finalize agreements between hospitals and academic sponsors. At a minimum, we believe that hospitals should have at least 180 days after the initial publication of the emergency rule to submit copies of the emergency GME affiliation agreements.

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. During this time period, there should also be a mechanism for a permanent affiliation agreement between "home" and "host" hospitals that allows for a permanent transition of resident caps. This would help to ensure the ongoing viability of residency training based on new geographic and demographic realities.

New Teaching Hospitals Resident Cap and Base Year Policy

We appreciate CMS' recognition that during emergency periods it may be necessary for a "home" hospital to send its residents to non-teaching 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 non-teaching hospitals that enter into affiliation agreements in non-emergency situations, non-teaching hospitals that participate in emergency GME affiliation agreements do not lose their "non-teaching" status for purposes of obtaining their own, permanent resident cap at some point in the future if they choose to start new residency programs. We also ask that CMS clarify the impact on a non-teaching hospital's base year calculation for DGME reimbursement for non-teaching hospitals that participate in emergency GME affiliation agreements.

Documentation Requirements for Displaced Residents

Under the emergency affiliation provisions, "host" hospitals are required to provide the Medicare fiscal intermediary documentation of each displaced resident's name, social security number, program sponsor, and hospital from where the resident was displaced. As a result, a "host" hospital can prove that the number of residents in training exceeds their contractual obligation because of an influx of displaced residents, but may have difficulty in identifying specific displaced residents from those that are training at the hospital under normal circumstances. We recommend that the individual identification requirements for affiliation agreements be modified to allow "home" and "host" hospitals to report the total number of residents training in their facilities within the parameters of established Medicare resident caps. Please clarify CMS's need for this additional administrative requirement, and explain how the fiscal intermediaries will be instructed to implement this provision.

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 me at (225) 928-0026.

Thank you for your consideration

Sincerely,

Paul A. Salles

Paul A. Salles
Vice President of Health Reimbursement Policy