American Hospital Association

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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