Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400 F 202 828 1125
www.aamc.org

Via e-mail: Andy.Slavitt@cms.hhs.gov

March 18, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Acting Administrator Slavitt:

As the Centers for Medicare and Medicaid Services (CMS or the Agency) prepares to release the FY 2015 Hospital Inpatient Prospective Payment System (IPPS) Notice of Proposed Rulemaking, the Association of American Medical Colleges (AAMC) would like to take the opportunity to share with the Agency our priorities and positions on some of the key issues we expect the Agency to address in the upcoming rulemaking.

The AAMC's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the IPPS. The Association also represents all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

On behalf of this membership, the AAMC urges CMS to consider and adopt the following policies, discussed in more detail below:

- Replace the "Two Midnights" policy with a return to clinical judgment;
- Carefully consider alternate short stay payment policies that continue to incentivize efficiency;
- Extend the "Two Midnights" enforcement moratorium and "probe and educate" program;
- Repeal the 0.2% reduction to the standardized amount;
- Implement meaningful recovery audit contractor (RAC) program reform;
- Update guidance to allow residents to write inpatient orders;
- Clarify that de minimus rotations of medical residents to non-teaching hospitals will not trigger a hospital's per resident amount or cap-building window;
- Adjust the Uncompensated Care Disproportionate Share (UC DSH) methodology to account for the appeals backlog;
- Implement a floor on weighted direct graduate medical education (DGME) caps to prevent penalizing hospitals training additional fellows above their 1996 caps; and
- Modify quality performance programs to reduce the disproportionate penalty for major teaching hospitals.

REPLACE THE TWO MIDNIGHT RULE WITH A RETURN TO CLINCIAL JUDGMENT

The AAMC remains extremely concerned about the impact of CMS's "two midnights" policy on hospitals that treat our nation's most medically complex patients. While we acknowledge that the Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A, finalized in the FY 2014 IPPS rule, were an attempt to provide a bright line for determining the appropriateness of inpatient stays, we cannot support a policy that, with few exceptions, defines inpatient care on the basis of length of stay irrespective of the severity of a patient's medical needs and the intensity of services required to meet them.

The complex and difficult clinical decision to admit a patient to the hospital does not lend itself to a time-based, bright-line rule regarding which stays are appropriately categorized as inpatient for reimbursement purposes. The AAMC continues to believe that a short hospitalization should be reimbursed as an inpatient stay if the physician believes that admitting his or her patient best serves that patient's medical needs.

The Two Midnight Rule's largely arbitrary approach to reimbursing short inpatient stays is detrimental to Medicare beneficiaries, the hospitals who treat a high proportion of complex cases, and to Medicare's entire system for efficiently reimbursing for inpatient care:

- **Medicare beneficiaries** are left with confusing and costly Part B copayments, despite receiving an intensity of services in the hospital of an inpatient stay;
- **Hospitals** serving a disproportionate share of patients with complex medical and sociodemographic needs are undercompensated for carefully monitoring their patients with potentially escalating comorbidities and are penalized for innovating to allow for shorter hospital stays. Teaching hospitals face unwarranted cuts to their IME and DSH payments even though the costs of their teaching and indigent care missions are unchanged;
- **The medical-severity diagnosis related group (MS-DRG) system**, predicated on a balance of averages, is undermined by removing the short hospital stays that naturally balance the costs of atypical long stays. The MS-DRG system has proven effective in reducing overall spending for Medicare, and across the health system, and should not be sacrificed.

These damaging consequences of the Two Midnights policy will only worsen as it is more fully implemented. Though CMS succeeded in implementing a clear and intuitive guideline for when a long observation stay should be considered inpatient, the Two Midnight policy's approach to short stays is untenable and does not resolve the primary issue that prompted the policy change: aggressive RAC review. In the sections that follow, the AAMC offers specific RAC reform proposals and examines possible alternate short stay policies. Underlying all of these policy solutions our fundamental policy principle is the same: physician clinical judgment must be paramount in the decision to admit a patient for an inpatient stay.

Though Imperfect, CMS Should Consider Alternative Short-Stay Payment Methodologies

The AAMC maintains that the simplest and most equitable policy solution is to repeal the short stay portion of the Two Midnight Rule, return to the longstanding deference to medical judgment that is well-documented in the medical record, and implement comprehensive RAC reforms described below. That said, the immediate and clear priority is to alleviate the most onerous effects of the Two Midnight rule and with that goal in mind the AAMC has undertaken careful analysis of alternate short stay payment policies. An alternative short stay payment policy would at least respect clinical judgment regarding the inpatient admission by ensuring that these stays are properly characterized as inpatient stays for reimbursement and beneficiary liability purposes. Adopting a short stay payment policy would also curtail the most confusing and detrimental aspects of the Two Midnight rule.

The AAMC focused its analysis on two approaches that create separate weights for short stays, either for all MS-DRGs or for targeted MS-DRGs.[1] For the purposes of these models, a short stay was identified as having a length of stay shorter than two days. For the targeted DRG approach, we started with the 93 MS-DRGs suggested by MedPAC. The 93 MS-DRGs were then collapsed into 43 DRGs based on similarity of conditions. The impact of each of these models on our members was fairly comparable, as shown in the table below. The impact is estimated using 2013 inpatient Standard Analytical Files and is budget neutral to the inpatient PPS. The impact analysis does not reflect changes implemented due to or incurred after the two-midnight policy.

Impacts (percentage) of alternative short-stay payment methodologies by teaching status

Teaching Status	Separate short stay DRGs for all DRGs	Separate short stay DRGs for targeted DRGs
Major Teaching	-0.13%	-0.12%
Minor Teaching	0.09	0.04
Non-Teaching	0.00	0.05

The targeted DRG approach would likely require more frequent review because the criteria used to create the targeted list of MS-DRGs (high volume of short stays and observation stays, or RAC denials) would change over time. Under the dual weighting approach for all DRGs, we encountered the issue that high severity DRGs had lower weights than low severity DRGs in the same DRG family or short stay DRGs were weighted higher than non-short stay DRGs split from the same DRG.

For each of these models, the changes to the MS-DRG system necessary to create short stay MS-DRGs also are administratively burdensome to hospitals and present them with planning challenges. Despite these significant shortfalls, each of these short stay payment methodologies would reduce provider and beneficiary confusion around inpatient admissions and would appropriately defer to clinical judgment

[1] The AAMC model used the list of 93 MS-DRGs from MedPAC and split these DRGs into short stay and non-short stay cases. The MedPAC MS-DRGs were based on those existing in 2014. The MedPAC list was compared to Table 5 in the Final Rule to identify changes to the MS-DRG codes in FY 2015. Three DRGs that were deleted in 2015 were excluded and another three DRG codes were added to replace these three DRGs. The 93 DRGs were collapsed into 43 based on similarity of conditions (i.e., family of MS-DRGs).

regarding the inpatient admission. Accordingly, the targeted short stay DRG and DRG refinement approaches that the AAMC modeled make more policy sense and are preferable to the Two Midnight rule as it pertains to inpatient stays that do not meet the two midnight benchmark.

Other hospital associations have modeled additional applications of short stay DRGs. These variations include creating short stay DRGs for each Major Diagnostic Category (MDC); creating separate short stay DRGs for all medical DRGS within an MDC and for all surgical DRGs within an MDC; and assigning inpatient stays shorter than two days to the base DRG for which that DRG belongs. Of these variations, the least desirable is creating a short stay DRG for each MDC because this is the most redistributive and therefore, would be most difficult for hospital planning and could create a high level of instability.

All of the short stay payment methodologies upset the MS-DRG system and shift the payment differential between observation and inpatient to a new differential between short and non-short stays. As the AAMC noted above, none of these approaches are optimal ways to resolve the underlying issues that CMS identified as the justification for implementing the Two Midnight rule. However, the Association also recognizes that the onerous operational challenges, inadequate payment, and confusion created by the Two Midnight rule demand an immediate solution and as discussed above, some proposed alternatives are better than others.

The AAMC maintains that these are imperfect solutions. The need for an alternative payment policy only emerged after an even more flawed policy - the Two Midnight rule - was implemented. Accordingly, the AAMC would find each of these models preferable to the Two Midnight Rule because they would: restore deference to medical judgment, reduce provider and patient confusion, and prevent inadequate reimbursement for the resources hospitals use to treat patients whose conditions demand an inpatient level of care for short stays.

Extend the partial enforcement delay until the later of October 1, 2015 or CMS implementation of a short stay payment policy

CMS' prohibition on recovery audit contractors (RACs) conducting post-payment patient status reviews for claims that would be subject to the Two Midnight rule expires March 31, 2015. The AAMC strongly urges extension of this moratorium. The Two Midnight rule has been extremely challenging to operationalize and given the critical need to replace this policy, and the ongoing legislative and regulatory debate about the best way to do so, the enforcement delay must be extended until a new policy is put in place and providers have an adequate opportunity to implement it.

Repeal the 0.2 percent reduction to the standardized amount that was implemented in FY 2014

CMS has never shared the assumptions and analysis that led the Agency to reduce IPPS payments by 0.2% to offset expected shifts in utilization between inpatient and outpatient settings. The AAMC continues to believe and has data analysis to support that CMS' projected net shift in volume from the outpatient to inpatient setting did not occur; instead the Two Midnight rule resulted in a decrease in inpatient short-stay claims and an increase in outpatient observation claims. The Association's analysis

(see attached tables) suggests a dramatic drop in short stays in the first quarter of FY 2014, which was concurrent with a dramatic increase in observation stays. This suggests that the implementation of the Two Midnight rule caused a net outflow of inpatient short-stay claims to outpatient observation. Given that this directly counters CMS' original projection that was used to justify the 0.2 percentage point negative adjustment to the update factor starting FY 2014, the AAMC believes CMS should revisit the original assumptions and repeal the 0.2 percent reduction.

Implement Meaningful RAC Reform to Reduce Administrative Burden and Decrease the Appeals Backlog

Overly aggressive RAC denials are a major source of the untenable number of appeals and will continue to be until adequate reforms are instituted. The fact that sixty-eight percent of RAC denials are overturned on appeal does not suggest that medical judgment or a misplaced payment incentive are to blame for the unmanageable appeals backlog.[2] Rather it suggests that RACs are often aggressively denying these claims irrespective of the medical necessity of the inpatient admission.

The Association supports CMS' December 2014 RAC improvements, particularly the following:

- Limiting the RAC look-back period to 6 months from the date of service of patient status reviews, in cases where the hospital submits the claim within 3 months of the date of service.
- Imposing a 30 day waiting period on RACs to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.
- Ensuring that RACs will not receive a contingency fee until after the second level of appeal is exhausted. Previously RACs were paid immediately upon denial and recoupment of the claim.
- Requiring that RACs maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. Failure to do so will result in CMS placing the RAC on a corrective action plan that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected.

The AAMC urges CMS to include these improvements in RAC contracts without further delay. In the same vein, the AAMC supports MedPAC's draft recommendation to hold RACs accountable for improper claim denials by reducing RAC contingency fees if their denial rate exceeds a certain threshold. We object, however, to recommendations that would undermine physician judgment and discourage innovation by targeting hospitals with penalties based solely on their volume of short inpatient stays compared to that of other hospitals.

[2] *See* Sheehy, et. al., "Recovery Audit Contractor Audits and Appeals at Three Academic Medical Centers," Journal of Hospital Medicine. "These data also show continued aggressive RAC audit activity despite an increasing overturn rate in favor of the hospitals in discussion or on appeal each year (from 36.0% in 2010 to 68.0% in 2013)."

Update Hospital Inpatient Admission Order and Certification Guidance to Allow Residents to Write Inpatient Orders Consistent with Longstanding Hospital Practice

The Association again urges CMS to update guidance implementing the Two-Midnight Rule entitled "Hospital Inpatient Admission Order and Certification,"[3] because this guidance excludes most residents from the list of medical professionals who can furnish orders for admission without the added step of tracking down the attending physician for a countersignature. The following modifications in the guidance would ensure that residents are allowed to write orders on behalf of attending physicians who supervise them, consistent with longstanding hospital practice:

1) States generally grant licenses to practice medicine, rather than licenses to admit inpatients to hospitals. Therefore, CMS should change the *Hospital Inpatient Order and Certification* guidance language requiring that "[t]he order must be furnished by a physician or other practitioner ("ordering practitioner") who is (a) licensed by the state to admit inpatients to hospitals" [4] to "(a) ***licensed by the state to practice medicine***."

2) Residents at most teaching hospitals are rarely granted their own admitting privileges as they are not considered to be part of the medical staff. Instead, hospitals' by-laws allow these residents to write orders on behalf of the attending physicians who supervise them. Therefore, CMS should change the *Hospital Inpatient Order and Certification* guidance language requiring that "[t]he order must be furnished by a physician or other practitioner ("ordering practitioner") who is…(b) granted privileges by the hospital to admit inpatients to that specific facility" to "(b) ***granted privileges by the hospital to write inpatient admission orders***."

Consistent with these suggested modified qualifications of the ordering/admitting practitioner, the AAMC also encourages CMS to modify paragraph B.2.a of the *Hospital Inpatient Order and Certification* guidance document. This would allow these individuals to act as proxy for the ordering practitioners without the difficult and confusing step of countersigning the order. These changes are particularly necessary, because it remains unclear how and where this countersignature should be included in the electronic medical record. The following modified language would resolve this confusion:

> Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located ***to practice*** medicine, and are allowed by hospital by-laws or policies to ***furnish orders***. The admitting practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the admitting practitioner approves and accepts responsibility for the admission decision as demonstrated by documentation in

[3] *Hospital Inpatient Oder and Certification*, CMS, 1 (Jan. 30, 2014). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf.
[4] *Id*.

the medical record, such as progress notes, prior to discharge. ***In this case a countersignature of the order is not needed.***

CLARIFY THAT DE MINIMUS ROTATIONS OF RESIDENTS TO NON-TEACHING HOSPITALS WILL NOT TRIGGER SETTING THE HOSPITAL'S PER RESIDENT AMOUNT (PRA) OR CAP-BUILDING WINDOW

The AAMC urges CMS to bring clarity and resolution to a particularly vexing and ambiguous problem new teaching hospitals face: prior acceptance of small numbers of resident rotators from other hospitals inadvertently triggered setting their per-resident amount (PRA) and/or their cap-building window.

To date, CMS has not offered any clear public guidance that would indicate whether the presence of a small number of FTE resident rotators triggers the setting of a hospital's per resident amount (PRA) for DGME purposes or DGME and IME caps under the new program regulations (42 C.F.R. § 413.79). Through this letter, the AAMC requests that CMS publish in the proposed rule a clear statement that neither a hospital's PRA nor its cap-building window is triggered by the presence of a small number of residents performing brief rotations at the hospital. The attached legal memorandum explains in detail why CMS does in fact have the legal authority to issue such a clarification.

The AAMC believes that CMS has informally interpreted the new program regulations such that a hospital triggers its PRA anytime a single resident rotates to the hospital, no matter how short the rotation, and that the hospital begins to build a resident cap if it hosts rotating residents from any new medical residency training program, regardless of whether the hospital that sponsors the program and other participating hospitals are in a cap-building period, and no matter how fleeting the hospital's participation in the program.

The following two examples serve to illustrate the problem, though there are many variations:

> **Example 1:** Hospital A, an existing teaching hospital, has had an internal medicine program for 30 years. Hospital A decides to rotate two medical residents from that internal medicine program to Hospital B, a non-teaching community hospital, each for a 4-week rotation. Hospital A continues to pay the residents' stipends and benefits during the 4-week rotation.
>
> Under CMS' informal interpretation, the fact that a resident rotated to a community hospital from an existing teaching program would trigger the establishment of a PRA for the community hospital. If the community hospital does not incur or record costs for those residents on the hospital's Medicare cost report, it will be assigned a PRA amount of $0 and will never be eligible to receive Medicare DGME funding. This severely limits the non-teaching hospital's ability to become a teaching hospital and begin a community training program in future years.
>
> **Example 2:** Hospital X, an existing teaching hospital, has never had a psychiatry residency program before but decides to open one on July 1, 2013 to help alleviate a psychiatry shortage in its region. One resident from the new psychiatry program rotates to Hospital Y, a non-teaching community hospital, for a two-month rotation in August 2015.

> If Hospital Y only trained two months' worth of resident rotators in each of the remaining three years of the cap-building window, Hospital Y would be given a permanent cap of less than one FTE and would never be eligible to receive funding for a bigger residency training program.

Because of the lack of publicly available information on these informal interpretations, hospitals, through no fault of their own, have not been aware that their ability to receive DGME and IME funding in the future was being curtailed. Hospitals that are just now discovering that their PRA and cap-building windows were inadvertently triggered have been required to halt efforts to establish robust new teaching programs that are desperately needed to combat current and impending physician shortages.

Community hospitals should be encouraged to host resident rotators, not penalized. A policy that allows hospitals to test the waters by hosting brief rotations from established teaching institutions ensures they are fully prepared for and capable of undertaking a teaching mission and can remain viable over the long term. Additionally, a policy that allows a hospital to set its PRA only when it begins its cap-setting process – and not earlier – encourages resident rotations to take place at the most academically and clinically appropriate clinical training sites.

The AAMC urges CMS to publish a formal interpretation in the proposed rule that neither a hospital's per resident amount nor its cap-building window will be triggered by the presence of a small number of residents performing brief rotations at the hospital. As outlined in the attached legal memorandum, the Social Security Act gives CMS broad discretion to adopt these clarifications, and they are critical to ensuring a sufficient physician workforce.

Finally, if CMS determines that hospitals have in the past inadvertently triggered a PRA or a cap adjustment based on CMS' unpublished, informal policy, the AAMC encourages CMS to offer these hospitals a one-time opportunity to set a PRA and obtain a future cap adjustment.

ADJUST THE UC DSH POOL PROJECTION METHODOLOGY TO ACCOUNT FOR THE APPEALS BACKLOG

During the FY 2015 IPPS rule-making process, the Uncompensated Care Disproportionate Share Hospital (UC DSH) payments varied substantially (by more than 10%) between the proposed and final rules. This suggests that the historical data used to determine the DSH pool estimate was not a reliable proxy upon which to base estimates for future DSH payments.

One factor affecting the projection's accuracy is the exclusion of appeals claims from the UC DSH projection. Before 2013, the majority of appeals were decided within a year. As a result, the majority of the appealed claims were included in the rate setting process. In contrast, in 2013, a significant number of claims were caught in the appeals backlog for longer than a year.

The claims that are held up in the appeals backlog are taken out of the system as soon as the claim is denied. CMS has indicated that the claim is returned to the system only when it is reversed, even though

sixty-eight percent of appeals were overturned in favor of the hospitals in 2013.[5] Many of these appeals were not adjudicated within the timeframe necessary for the denied claim to be put back into the system and included in the rate-setting process.

Excluding claims held up in the appeals process exaggerated the projected loss of FY 2013 volume, and therefore had a negative effect on the FY 2015 UC DSH pool. If the sixty-eight percent of claims that were successfully appealed were added back in to the claims data, the decrease in volume in FY 2013 would be smaller.

The Global Settlement Offer also added to the exaggerated projected decline in volume.[6] Any claims included in the Global Settlement Offer remain denied in CMS' data set and would be treated accordingly. Therefore, the UC DSH projections and pool would be negatively affected even for hospitals that did not accept the settlement offer. The settlement agreement was that sixty-eight percent of the value of these claims would be paid, including all the add-on payments. Accordingly, these claims should not be entirely excluded from the UC DSH pool estimate. The settlement was intended to address the appeals backlog, not to reduce the UC DSH pool.

The AAMC encourages CMS to use a settlement process that relies on more current data to ensure a more reasonable estimate of the UC DSH pool. Specifically, we suggest CMS implement a settlement of each fiscal year's DSH pool amount when the current year uninsured/insurance coverage data, Medicaid utilization data, and Medicare inpatient claim data become available. This settlement would include two parts:

1) Replace the Congressional Budget Office (CBO) insurance enrollment projection with real insurance coverage data; and

2) Update DSH pool estimates based on current year claims data and current year Medicaid utilization data. Claims held up in the appeals backlog should be **included** in the DSH pool estimate, as should claims from hospitals that accepted the appeals settlement offer.

Claims data does not currently include denied claims that were contested but have not been adjudicated. Therefore, we suggest that the projections include claims that were not addressed within the year. This would provide an incentive to address the backlog, and eliminate inequities that result when claims are excluded from the DSH pool projections simply because they are held up in the prolonged appeals process.

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[5] *See supra*, note 2

[6] If there were no settlement offer, a large portion of the appealed claims may have been successfully appealed and added back to the FY 2013 claim data the following year, which would have increased FY 2013 volume. The FY 2016 UC DSH projection will be estimated using DSH payments reported on the 2012 cost report and trending forward to FY 2016. The increase of FY 2013 volume would be reflected in a higher UC DSH projection in FY 2016. If a portion of hospitals accepted the settlement offer, though, the FY 2013 appeals claims would be forever treated as denied claims and never added back to the claim data, which means the FY 2013 volume projection would not be corrected in the future.

IMPLEMENT A FLOOR FOR THE WEIGHTED DGME CAP TO ENSURE THAT HOSPITALS ARE NOT UNFAIRLY PENALIZED WITH A CAP BELOW THEIR 1996 WEIGHTED CAPS FOR ADDING TO THE NUMBER OF FELLOWS THEY ARE TRAINING OVER THE CAP

In determining a hospital's current DGME cap, CMS applies a formula to weight the cap based on the number of residents training within their initial residency period (IRP) (which are each counted as one FTE) and the number of residents training beyond their IRP (which are counted as 0.5 FTEs). While this weighting of residents within their IRP and those beyond their IRP is statutorily required, the amount of additional residents that a hospital is training **above that hospital's 1996 cap** should not decrease its weighted cap below that hospital's 1996 weighted cap.

Contrary to this principle, the weighting methodology used to convert the unweighted DGME cap to a weighted cap disadvantages hospitals whose proportion of fellows compared to the total number of residents has increased compared to the base year when the caps were set. This was not the intention of the policy that established the caps.

For example:

Hospital A has an unweighted cap of 150 and its 1996 weighted cap was 140.

- Scenario 1: Hospital A is training:
  - 150 residents within their IRPs (WIRPs), and
  - 50 residents beyond their IRP (BIRPs)
  - Hospital A's unweighted count = 200
  - Hospital A's weighted count = 175
  - 175 (weighted count) ÷ 200 (unweighted count) x 150 (unweighted cap)= 131.25 (current weighted cap)

- Scenario 2: Hospital A is training:
  - 150 WIRPs, and
  - 100 BIRPs
  - Hospital A's unweighted count = 250
  - Hospital A's weighted count = 200
  - 200 (weighted count) ÷ 250 (unweighted count) x 150 (unweighted cap) = 120 (current weighted cap)

In each of these scenarios, Hospital A is training the **same** number of WIRPs. The difference is that in Scenario 2, Hospital A doubles the number of BIRPs trained. Even though Hospital A trains the same number of WIRPs and more residents in total in Scenario 2, its weighted cap decreased compared to Scenario 1. Simply, adding more fellows penalizes Hospital A.

CMS can, and should, resolve this problem by adding a weighted cap floor to ensure that a hospital's weighted cap is no less than that of 1996. This can be done through revisions to the Medicare hospital

cost report Worksheet E4 to incorporate a floor for the weighted cap based on the 1996 level of the weighted cap.

This summary of suggested changes is detailed in the attached spreadsheet, with additions highlighted in red:

- Add line 8.1 to reported weighted 1996 FTE cap.
- Add line 9.1, if current weighted cap is less than 1996 weighted cap, use 1996 weighted cap and prorate weighted cap for primary and other based on share of primary and other in total weighted count reported in line 8.
- Add line 9.2, apply the adjusted weighted FTE cap (line 9.1) to the weighted FTE count (line 8).
- Modify instruction of line 11 to use the adjusted cap (line 9.2).

The AAMC believes these changes are necessary to prevent penalizing hospitals training over their caps that increase their complement of fellows without any reduction to the number of residents the hospital trains within their IRPs. There is no policy justification for such a penalty, and, therefore, the Association strongly urges CMS to make these cost report revisions to be more consistent with the intent of the law. If CMS makes these recommended changes, the AAMC urges the Agency to apply them to the prior and penultimate FTE counts as well as the current year counts.

MODIFY QUALITY PERFORMANCE PROGRAMS TO REDUCE THE DISPROPORTIONATE PENALTY FOR MAJOR TEACHING HOSPITALS

AAMC members are committed to improving quality outcomes for their patients, but limitations in the quality measures and scoring and benchmark methodologies are creating a systematic bias against teaching hospitals. Major teaching hospitals are not being measured solely on the quality of their care but on the complications inherent in the complex services they provide and complex patients they serve. In FY 2015, major teaching hospitals are being disproportionately penalized across all three hospital quality pay-for-performance programs (see Figure 1). Examples of the payment disparity include:

- In the Hospital Value Based Purchasing (VBP) Program, the odds of major teaching hospitals receiving a loss compared to a bonus are the opposite of non-teaching hospitals. (34.4% of major teaching hospitals earned a bonus compared to 59.9% experiencing a loss. For non-teaching hospitals, 52.8% earned a bonus compared to 33.3% experiencing a loss.)
- For the Hospital Readmissions Reduction Program (HRRP), 90.4% of major teaching hospitals were penalized, compared to 73.8% of non-teaching.
- In Hospital Acquired Conditions Reduction Program (HACRP), major teaching hospitals are **almost three times** as likely to be penalized compared to non-teaching (47.4% to 16.1% respectively.)

Figure 1: FY 2015 Impact of Hospital Value Programs on Hospitals by Teaching Status

	Major Teaching	Other Teaching	Non-Teaching	All Hospitals
Total Number of Hospitals	302	753	2,421	3,476
Hospitals with VBP Bonus	**34.4%**	43.8%	**52.8%**	49.3%
Hospitals with VBP Loss	**59.9%**	51.5%	**33.3%**	39.6%
Hospitals with HRRP Reduction	**90.4%**	76.6%	**73.8%**	75.9%
Hospitals with HACRP Penalty	**47.4%**	25.5%	**16.1%**	20.9%

Source: AAMC Analysis of FY2015 Medicare IPPS Final Rule and Supplemental Files

The Association urges CMS to reduce this bias against major teaching institutions by adopting the following changes.

- **Use Hospital Peer Cohorts to Determine Overall Performance in the HACRP**
  CMS should ensure an apples-to-apples comparison among all hospitals by measuring performance within specific peer cohorts so that hospitals with similar characteristics and risk profiles are compared to each other.

- **Ensure Appropriate Sociodemographic Status (SDS) Adjustment for Certain Accountability Measures**
  The AAMC recognizes that CMS is conducting research on the influence of socioeconomic status (SES) and demographic factors (collectively referred to as sociodemographic status factors) on various quality measures. In a recent notice on changes to Medicare Advantage (MA), CMS acknowledged the correlation of SES factors to performance for plans serving vulnerable populations and proposed to lower the weighting for certain measures impacted by SES. CMS' proposal to take immediate – even if interim – action to mitigate the effects of such bias in the MA is promising, and should be replicated for other programs, including HRRP, in the Agency's proposed Inpatient Prospective Payment System rule.

- **Lower the Medicare Spending Per Beneficiary (MSPB) Measure Weight and Revisit the Scoring Methodology in the VBP Program**
  MSPB is the only measure in the VBP Program's efficiency domain, which encompasses 25 percent of an institution's total score in FY 2016. A recent technical panel on 5-stars rating for Hospital Compare noted that MSPB is "'non-directional' meaning that a higher or lower score is not necessarily better."[7] However, in the VBP program, lower MSPB scores translate into maximum achievement. The AAMC asks CMS to revisit the scoring methodology for MSBP and, in the interim, to reduce the weight of this measure.

- **Ensure Hospitals Have Access to Validated Performance Results Before Incorporating Measures Into a Payment Program**

[7] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html.

Hospitals need to receive feedback and have sufficient time to improve performance before their payment is affected. In addition, stakeholders need an opportunity to identify and resolve any implementation issues with the measures that could affect performance measurement. For instance, CMS has been implementing measures directly into HRRP without providing this basic data to providers. AAMC believes all measures need to be publicly reported a minimum of one year and asks that CMS provide feedback before the performance period begins in any pay-for-performance program.

CONCLUSION

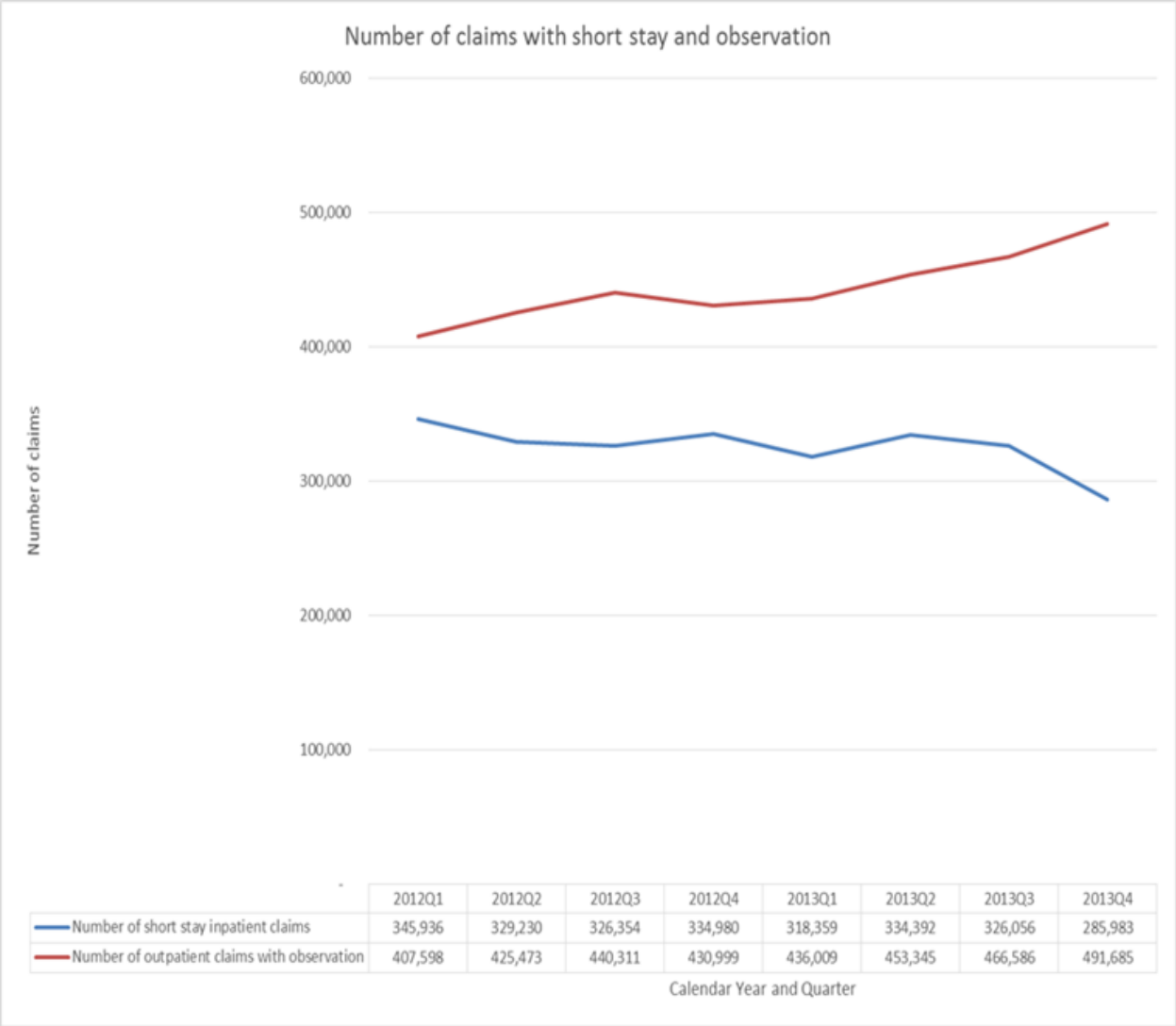
Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medical center community. If you have questions regarding hospital payment issues please feel free to contact Lori Mihalich-Levin, J.D., at 202-828-0599 or at lmlevin@aamc.org or Allison Cohen, J.D. at 202-862-6085 or at acohen@aamc.org. For questions regarding the quality program issues please contact Mary Wheatley, M.S., at 202-862-6297 or at mwheatley@aamc.org.

Sincerely,

Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

Utilization Trend of Inpatient Stay and Outpatient Observation Before and After the Two Midnight Rule[1]

	Volume Change Compared to The Same Quarter in 2012			
Calendar Year and Quarter	Total IP volume	IP Short Stays	OP Obervation	IP Non-Short stays
2013Q1	-4%	-8%	7%	-4%
2013Q2	-2%	2%	7%	-2%
2013Q3	-2%	0%	6%	-3%
2013Q4	-6%	-15%	14%	-5%



[1] The chart and table are summarized based on Greg Watson's analysis of 100% inpatient and outpatient standard analytical files for calendar years 2012 and 2013. The data analysis was restricted to IPPS providers. One major limitation of the analysis is we only have one quarter of data in the post two midnight rule period.

- There is an aggregate decrease in IPPS volume and we are still investigating the reasons (e.g. whether there is an increase in denied claims).
- We see a dramatic drop in short stays in the first quarter of FY 2014 which was concurrent with a dramatic increase in observation stays.
- Non-short stays also decreased in a similar manner while overall volume changed.
- This suggests that the implementation of the Two Midnight rule caused a net outflow of inpatient short-stay claims to outpatient observation. This runs counter to CMS' original projection that was used to justify the .2 percentage point negative adjustment to the update factor starting FY 2014.
- For these reasons, we believe CMS should revisit the original assumptions and estimate. As we discussed, we also encourage CMS to share any assumptions that the Agency relied upon and any new data (e.g. 2014 outpatient data when CMS releases FY2016 proposed rule). We would be happy to continue to share our analysis as well so that we can develop a solution.

Eyman Associates, PC
beyman@eymanlaw.com
smutinsky@eymanlaw.com
(202) 567-6203
www.eymanlaw.com

MEMORANDUM

To: Association of American Medical Colleges

From: Barbara Eyman, Esq.
Eva Johnson, Esq.

Date: March 1, 2015

Re: **CMS Legal Authority to Determine a New Teaching Hospital's Resident Cap and Per Resident Amount**

The Association of American Medical Colleges (AAMC) has learned, through discussions with members and the Centers for Medicare & Medicaid Services (CMS), that CMS has informally interpreted its graduate medical education (GME) regulations such that a non-teaching hospital can inadvertently trigger a resident cap and per resident amount (PRA) simply by accepting resident rotators. Under CMS' current interpretation, a cap and PRA are established no matter how fleeting a hospital's participation in training, and even if the rotations are from a program of a long-established teaching institution (one with a permanent cap and PRA).

AAMC has expressed concern with these interpretations on a number of legal and policy grounds. We do not repeat those concerns here. Rather, AAMC urges CMS to change its policies prospectively as they apply to resident rotators, such that a hospital's acceptance of a small number of rotators ("de minimis" rotations) would no longer trigger a cap or PRA, and has asked for our analysis of the agency's legal authority to do so. This memorandum examines the statutes that authorize CMS to adopt rules for adjusting the caps and PRAs of new teaching hospitals, and concludes that CMS has ample legal authority to limit cap and PRA adjustments for resident rotators.

I. CMS Authority to Establish Resident Caps for New Programs

A. Statute and Legislative History

Congress made sweeping changes to GME reimbursement in the Balanced Budget Act of 1997 (BBA), capping for the first time the total number of residency positions that Medicare would support. For hospitals training residents at that time, full-time equivalent (FTE) resident counts for each individual hospital were frozen at 1996 levels.[1] At the same time, Congress recognized that some hospitals not engaged in training at that time would later become teaching hospitals. Seeking to accommodate training at those hospitals, Congress granted CMS broad authority in the BBA to determine the rules that apply in assigning resident caps for medical residency programs established on or after January 1, 1995, stating simply in a provision governing "[n]ew facilities" that:

> The Secretary shall, consistent with the principles [in the same subsection governing resident caps], prescribe rules for the application of [resident caps] in the case of medical residency training programs established on or after January 1, 1995.[2]

The conference report accompanying the BBA confirmed Congress' intent to grant CMS broad authority with respect to new programs. There, Congress acknowledged that establishing caps at a national and a facility level "raise[s] complex issues," and therefore deemed it appropriate to "provide for specific authority for the Secretary to promulgate regulations to address the implementation of [the resident cap] section." In fact, Congress singled out the impact of the cap freeze on future teaching hospitals as an issue for which the Secretary should have "proper flexibility" to apply the caps: "Among the specific issues that concerned the Conferees was application of a limit to new facilities, that is, hospitals or other entities which established programs after January 1, 1995." The Conferees therefore contemplated that such hospitals "would be permitted to receive an increase in payments" for a "period of time . . . before a cap was applied."[3] Notably, Congress explicitly rejected a House bill provision that set a national aggregate cap but did not require the Secretary to establish rules for new programs.[4]

B. CMS Has Routinely Exercised Its Broad Authority to Interpret the Cap Rules for New Programs Without a Statutory Directive

Over the years, CMS has exercised its authority to amend and refine its definition of "new" programs and the methodology for calculating cap adjustments for new programs in its regulations at 42 C.F.R. § 413.79, without any statutory directive to do so. In a controversial

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[1] 42 U.S.C. § 1395ww(h)(4).
[2] 42 U.S.C. § 1395ww(h)(4)(H)(i).
[3] House Rpt. 105-217, Balanced Budget Act of 1997, Conference Report to Accompany H.R. 2015, 105th Cong. 1st Sess., at 821-22 [hereinafter "House Rpt. 105-217"]. In the Conference Report, Congress placed only one limitation on CMS' flexibility, requiring that CMS adopt policies consistent with Congress' purpose in freezing caps at 1996 levels – "to end the implicit incentive for hospitals to increase the number of FTE residents." 77 Fed. Reg. 53258, 53416 (Aug. 31, 2012); *see also infra* notes 9-11 and accompanying text.
[4] House Rpt. 105-217 at 821.

2009 rule, for example, CMS imposed new factors for assessing the status of "new" programs that significantly narrowed the circumstances under which programs were treated as "new."[5] In doing so, CMS brushed off concerns that "there [was] no legal authority for the proposal in relevant statutes and legislative history, and that no change in law or regulation [had] prompted" the change in policy. In response to these concerns, CMS stated, "We . . . disagree with the commenter's suggestion that we lack the legal authority to implement this policy. The BBA and our regulations provide that hospitals are permitted to receive an FTE cap increase in order to start new programs, and *CMS is the agency charged with administering these provisions*. As such, it is our responsibility to provide guidance when we believe clarification is needed."[6]

More recently, in 2012, CMS extended the cap-building period for new programs from 3 to 5 years. The change was prompted not by a statutory amendment, but by CMS' desire to achieve certain policy objectives. More specifically, in extending the cap-building period to five years, CMS sought to respond to provider "concerns about teaching hospitals having insufficient time to 'grow' their new residency training programs and to establish an appropriately reflective permanent FTE resident cap."[7] Again, CMS relied on the broad authority granted to it under the BBA to amend the new program rules.[8]

Throughout the course of implementing and amending its new program regulations, CMS has identified only one limiting principle from the BBA – that "the aggregate number of FTE residents should not increase *unnecessarily* over the numbers of residents being trained at the time the BBA was passed."[9] Notably, CMS itself has recognized that it is not statutorily required to ensure that the aggregate cap remains constant.[10] Rather, CMS must ensure that any increase to the aggregate cap caused by cap adjustments for new programs is "warranted" by policy considerations.[11] CMS' recent extension of the cap-building period from 3 to 5 years, for example, likely resulted in an increase in the number of Medicare-funded training slots. Yet, CMS adopted the extension because there were compelling policy justifications for doing so: among other reasons, CMS agreed with commenters that a three-year window was incompatible with program accreditation requirements in some instances, that staggering the start dates of training programs helped hospitals gain important experience in residency

[5] 74 Fed. Reg. 43754, 43908 et seq. (Aug. 27, 2009).
[6] *Id.* at 43911 (emphasis added).
[7] 77 Fed. Reg. 53258, 53416 et seq. (Aug. 31, 2012).
[8] *See id.* at 53416 (referencing the BBA as the source of the GME cap provisions in section 1886(h)(4) of the Social Security Act, which include the provision for new programs now codified at 42 U.S.C. § 1395ww(h)(4)(H)(i)).
[9] 74 Fed. Reg. 43910 (emphasis added).
[10] Indeed, the mere existence of a regulation allowing any cap adjustments for new programs—which is statutorily required—necessarily results in an aggregate cap increase.
[11] 74 Fed. Reg. 43911 ("FTE cap adjustments, which *could increase the number of Medicare-funded training slots in the aggregate,* will only be granted to qualifying teaching hospitals *when warranted*") (emphasis added).

training, and that a longer cap-building period would be more reflective of the number of FTE residents that a hospital would actually train once its programs were fully grown.[12]

C. CMS Has Broad Statutory Authority to Conclude that De Minimis Rotations Do Not Trigger a Cap

In the BBA, Congress did not define what constitutes a new residency program or dictate a methodology for determining cap adjustments for new programs.[13] Rather, Congress left those decisions for CMS to address through rulemaking, desiring that CMS have "proper flexibility" in implementing rules for new programs.[14] And CMS has exercised that flexibility on numerous occasions in the past, acknowledging that it "is the agency charged with administering" the rules for new programs.[15] CMS clearly has broad latitude to define what constitutes a new program and the circumstances under which a hospital's cap is adjusted for new programs, and therefore, the extent to which resident rotations trigger a cap adjustment. Nothing in the statute itself or the legislative history would preclude CMS from withholding cap adjustments for de minimis rotations.

Importantly, the BBA does not require that CMS apply resident caps in all instances for all residency training programs established on or after January 1, 1995. Rather, the statute simply states that CMS must prescribe rules for applying resident caps in the case of programs established on or after January 1, 1995. CMS may choose not to apply caps in certain instances, and many CMS policies do in fact limit the circumstances under which cap adjustments are available. For example, hospitals with caps set in the 1996 base year do not get a cap increase for programs that are established on or after January 1, 1995, even though those programs are "new."[16] Similarly, CMS' 2009 rule identifying criteria for assessing whether programs are "truly new" significantly limited the availability of cap adjustments.[17] And in at least one instance, CMS has even concluded that rotations do not trigger a cap adjustment—when hospitals accept rotations through an affiliation agreement.[18] Surely CMS believes these policies to be consistent

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[12] 77 Fed. Reg. 53416-17.
[13] The concept of a "new medical residency training program" is itself a regulatory construct, defined by CMS at 42 C.F.R. § 413.79(l).
[14] House Rpt. 105-217 at 822.
[15] 74 Fed. Reg. 43911.
[16] 77 Fed. Reg. 53416 ("Once a hospital's FTE resident cap is established, no subsequent cap adjustments may be made for new programs unless the teaching hospital is a rural hospital.").
[17] 74 Fed. Reg. 43909.
[18] 64 Fed. Reg. 41490, 41524 (Jul. 30, 1999) ("Consistent with our regulations at § 413.86(g)(6)(i) [now codified at 42 C.F.R. § 413.79(e)], a nonteaching hospital that participated (or participates) in an affiliated group for purposes of establishing an aggregate FTE cap does not forego its opportunities to later establish new residency programs and accordingly receive an adjustment to its individual FTE cap."); 70 Fed. Reg. 47278, 47452 (Aug. 12, 2005) (providing an example in which a hospital accepting rotations through an affiliation agreement later started its own new residency training program and received a permanent cap adjustment for that program, despite the earlier rotations).

with its authority under the BBA, or CMS would not have adopted them. Likewise, CMS has the authority to conclude that de minimis rotations do not trigger a cap.

The only possible limit on CMS' discretion to alter the treatment of de minimis rotations is the directive that CMS "adhere to the principles of the base-year FTE resident caps."[19] But even if withholding adjustments for de minimis rotations were to increase the number of Medicare-funded slots by some amount, an increase would be warranted by policy considerations and thus consistent with CMS' statutory authority.[20] If caps for de minimis rotations were eliminated, new GME funding would be distributed in a more focused manner to hospitals taking on a meaningful and intentional role in teaching.[21] Under CMS' current policy, by contrast, scarce new GME funds are supporting individual rotations that are scattered across the country. A more focused distribution of funds for new programs would better address our nation's growing physician and residency shortages, ultimately improving access to care and health outcomes.

In addition, a change in policy would result in better training opportunities for future physicians. As a result of CMS' current policy, hospitals are turning down resident rotators for fear that they will trigger a permanent cap, even if they can provide the best training environment in a particular geographic area. In some cases, teaching hospitals and medical schools are having difficulty placing residents in the most academically and clinically appropriate training settings. Limiting cap adjustments for rotations would promote training in the best setting.

In sum, CMS clearly has the statutory authority to conclude that rotations do not automatically trigger a cap adjustment under 42 C.F.R. § 413.79. The statute directs CMS simply to "prescribe rules for the application of [resident caps] in the case of medical residency training programs established on or after January 1, 1995."[22] Though CMS must act in a manner that is appropriately restrained to avoid an unwarranted increase in the aggregate number of residency slots, CMS can and has made significant changes to the rules in the past—including changes that result in an aggregate increase—without a statutory amendment. Limiting caps for de minimis rotations would achieve important policy objectives that would warrant an increase (if any) in the national aggregate cap, as with CMS' extension of the cap-building period from 3 to 5 years, and clearly would be within the bounds of CMS' broad authority.

II. CMS Authority to Establish Per Resident Amounts for New Programs

A. Statute and Legislative History

In shifting Medicare from cost-based reimbursement to prospective payment systems in 1984, Congress also altered the methodology for calculating GME payments, requiring for the first time that CMS

[19] 74 Fed. Reg. 43909.
[20] *See supra* notes 9-11 and accompanying text.
[21] A policy withholding cap adjustments for de minimis rotations would give meaning to Congress' title for the new program statute—"New facilities." 42 U.S.C. § 1395ww(h)(4)(H)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(H)(i).

determine a fixed per resident amount for hospitals that had training programs at that time based on their reported costs in the 1984 base year.[23] In doing so, Congress sought to tie GME payments to historical amounts as a cost control measure. As with resident caps, Congress granted CMS broad authority in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to determine how the PRA should be set for hospitals without training programs at that time:

> In the case of a hospital that did not have an approved medical residency training program or was not participating in [Medicare] for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating [in Medicare], provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.[24]

Congress went on to define an "approved medical residency training program" as "a residency or other postgraduate medical training program, participation in which may be counted toward certification in a specialty or subspecialty."[25]

Notably, Congress explicitly directed that the PRA for new teaching hospitals be set "*as the Secretary determines to be appropriate*."[26] Not surprisingly, given this explicit grant of discretion to the Secretary, Congress did not provide further guidance in the legislative history on how this provision was to be interpreted, leaving CMS with broad latitude to determine what level of participation in training triggers a new teaching hospital's PRA.[27]

B. CMS Has Routinely Exercised Its Broad Authority to Interpret the PRA Rules for New Programs Without a Statutory Directive

CMS' interpretation of its PRA rules for hospitals without programs in the 1984 base year (at 42 C.F.R. § 413.77(e)) also has evolved over time. And once again, CMS never has questioned its authority to interpret the PRA rules as it "determines to be appropriate" pursuant to its statutory directive.

In fact, when CMS first promulgated rules to implement the PRA provisions for new teaching programs in 1989, CMS adopted the same language as Congress, requiring that a hospital "have" a "program" in

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[23] 42 U.S.C. § 1395ww(h)(2).
[24] 42 U.S.C. § 1395ww(h)(2)(F).
[25] 42 U.S.C. § 1395ww(h)(5)(A) (emphasis added).
[26] 42 U.S.C. § 1395ww(h)(2)(F) (emphasis added); *see also* 54 Fed. Reg. 40286, 40287 (Sept. 29, 1989) ("Section 1886(h)(2)(E) of the Act provides that if a hospital did not have an approved GME program or did not participate in Medicare for its cost reporting period beginning in FY 1984, then the Secretary is to determine an appropriate per resident amount."). Contrast this language with the Secretary's authority to set PRAs in the 1984 base year, for which Congress was much more prescriptive: "The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount . . . as follows . . . ." 42 U.S.C. § 1395ww(h)(2) (emphasis added).
[27] *See* Conference Rpt. 99-453, Consolidated Omnibus Budget Reconciliation Act of 1985, Conference Report to Accompany H.R. 3128, 99th Cong. 1st Sess., at 102-08 (citing the text to be added to the Medicare statute without any explanation).

order to trigger a PRA (language that remains in the regulation unchanged).[28] CMS clearly envisioned at that time that a hospital needed to do more than simply host a handful of rotations to trigger a PRA. As CMS described then, only "hospitals that begin a GME program after the base period" receive a PRA adjustment based on "the first cost reporting period in which residents were on duty in their GME program."[29]

Commentary in the 1989 final rule confirms that at that time, CMS had a different conception of what it means to "have" "program," which would not have included de minimis rotations. Originally, CMS had proposed to use costs in the first program year to establish the PRA for new programs. In response to a commenter's concern that costs in the first program year might not be representative of the program once fully operational, CMS agreed to amend its final rule to calculate the PRA based on the first cost reporting period for which residents in the new GME program were on duty in that program.[30] CMS agreed with the commenter that "all elements of [a] program do not fall into place at the same time" and recognized the need to account for "start-up costs incurred in a cost reporting period before the arrival of residents." This commentary only makes sense if CMS was envisioning more active involvement in the program rather than minor rotations. A hospital accepting a small number of rotations does not have start-up costs, nor is a ramp-up period required to operationalize a small number of rotations. In that same commentary, CMS expressed its view that hospitals would "rare[ly]" begin GME programs after 1984. Again, the commentary is nonsensical if CMS intended for rotations to trigger a PRA at that time. CMS cannot have expected rotations to be a rare occurrence – they have always been a common feature of graduate medical education. Indeed, CMS itself acknowledged in that *same rule* that it expected "fairly constant rotation of residents to other hospitals."[31] By contrast, given the complexity of starting whole new programs (obtaining accreditation, etc.), it was reasonable for CMS to assume that relatively few non-teaching hospitals would start new programs after the 1984 base period.

Over time, CMS has shifted away from the concept that a hospital has to "begin[] a GME program for the first time" after the base period to obtain a PRA. In more recent commentary, CMS has changed its characterization of the rules meaningfully, explaining that "if a hospital did not have residents in the 1984 base period but later participates in teaching activities" a PRA is assigned.[32] Likewise, in providing an example of how PRAs are calculated, CMS used the example of a hospital "that begins training

[28] 42 C.F.R. § 413.77(e) ("if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the based period, but either condition changes . . . the contractor establishes a per resident amount") (emphasis added).
[29] 54 Fed. Reg. 40286, 40310 (emphasis added). Compare with notes 32-33 and accompanying text (describing CMS' evolution away from the use of this terminology).
[30] This comment was the genesis of language that remains in 42 C.F.R. § 413.77 today, directing intermediaries to "establish[] a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period." Importantly, the phrase "on duty" was included in the regulation not to convey that a PRA is triggered as soon as a resident is on duty at a hospital, but to convey that, for hospitals beginning a program, the PRA will not be calculated until residents in that program are on duty during the first month of a cost reporting period.
[31] 54 Fed. Reg. 40286, 40298.
[32] 62 Fed. Reg. 45966, 46004 (Aug. 29, 1997) (emphasis added).

residents for the first time on July 1, 2003."[33] These references have been made in passing as part of discussions of other policy changes. Under these new characterizations, CMS has informally taken the position that a PRA is triggered when any resident is on duty at the hospital, regardless of whether the resident is training in a new program.[34] Notably, CMS never has suggested that these shifts in policy have been required to faithfully execute the PRA statute. Indeed, CMS has never explained its apparent change in policy at all, even though its more recent characterizations diverge significantly from the plain language of the applicable statute and regulation. Clearly, CMS has a history of exercising significant discretion in interpreting the PRA rules for new teaching hospitals, taking advantage of Congress' broad grant of authority under COBRA.

C. CMS Has Broad Statutory Authority to Conclude that De Minimis Rotations Do Not Trigger a PRA

Congress directed CMS by statute to adopt PRA rules for hospitals without programs in the 1984 base year as CMS "determines to be appropriate."[35] CMS could not have broader authority to interpret the PRA rules for new teaching hospitals. CMS itself has recognized this, adopting policies that have evolved over time, and now diverge significantly from the actual language of the statute, without any concern that doing so exceeds CMS' legal authority.

Both the statute and CMS' implementing regulations state that a PRA will be assigned for hospitals that "have" a "program" for the first time after the 1984 base year.[36] Interpreting these terms more literally, which CMS certainly has the legal authority to do, a hospital's acceptance of de minimis rotations from another hospital's program would not trigger a PRA.[37] That hospital would not "have" a "program" as that term is defined by statute ("a residency or other postgraduate medical training program").[38] At most, the hospital would "have" "resident rotators" or be "participating" in "training activities."

Moreover, the term "program" is a term of art in the GME context, with a widely known and accepted specialized meaning. The Accreditation Council for Graduate Medical Education (ACGME), the primary accrediting body for GME programs (whose accreditation together with a handful of other accrediting bodies is a prerequisite for Medicare GME funding) defines a "program" as "[a] structured educational experience in graduate medical education designed to conform to the Program Requirements of a particular specialty/subspecialty, the satisfactory completion of which may result in eligibility for board

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[33] 67 Fed. Reg. 49982, 50068 (Aug. 1, 2002) (emphasis added).
[34] Renate Dombrowski, CMS, Presentation at the Institute on Medicare and Medicaid Payment Issues (Mar. 20-22, 2013), https://www.healthlawyers.org/Events/Programs/Materials/Documents/MM13/qq_dombrowski_slides.pdf.
[35] 42 U.S.C. § 1395ww(h)(2)(F).
[36] *Id.*; 42 C.F.R. § 413.77(e).
[37] *See, e.g.*, Schreiber v. Burlington Northern, Inc., 472 U.S. 1 (1985) (in applying principles of statutory construction, explaining that the Court's "starting point is the language of the statute," requiring the court to apply a term's "normal meaning"); Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 860 (1984) (in upholding an agency's interpretation of a statute, examining the "ordinary meaning" of a statutory term and concluding the agency's interpretation was "certainly no affront to common English usage" and therefore reasonable).
[38] 42 U.S.C. § 1395ww(h)(5)(A).

certification."[39] Limiting PRA adjustments for de minimis rotations would be consistent with this specialized meaning of "program." Where a word used in a statute is a term of art, as "program" is in the GME context, agencies have clear legal authority to define that term in accordance with its specialized meaning.[40]

Initially, CMS itself appeared to adopt a more literal interpretation of the PRA statute, consistent with the specialized meaning the term "program" has taken on in the GME context. In its 1989 rule, CMS used the exact terminology from the statute ("have" a "program") in its regulation and preamble commentary, stated that new programs would be a rare occurrence (not true of de minimis rotations), and contemplated that hospitals obtaining a PRA adjustment would have start-up costs spanning multiple years (also not true of de minimis rotations). CMS had the legal authority to adopt that policy in 1989, and it has that authority today—the statute has not changed. Though CMS since has adopted a policy that differs meaningfully from the statutory text, stating that a PRA is established if a hospital has "residents" or begins to "participate in training," nothing would preclude CMS from adopting a middle ground policy that eliminates PRA adjustments for de minimis rotations.

In sum, we believe CMS has undeniable legal authority to limit PRA adjustments for de minimis rotations.

III. CMS Has Authority to Change Its Policies through Notice and Comment Rulemaking

Though CMS' position regarding cap and PRA adjustments for rotations never has been explicitly stated, it is AAMC's understanding that CMS views its interpretation as firmly established. As such, there are additional procedural steps that CMS must take to change its policy, namely, CMS must undertake notice and comment rulemaking. Case law clearly establishes that agencies can change their interpretations of the statutes they administer, though they may have to go through notice and comment rulemaking and explain why they are doing so.[41] And CMS itself has many times in the past

[39] ACGME, Glossary of Terms (July 1, 2013), http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf. ACGME has a separate definition for the term "resident," which is "[a]ny physician in an accredited graduate medical education program, including interns, residents, and fellows." *Id.* The American Osteopathic Association (AOA) uses similar, distinct definitions of these terms. *See* AOA, The Basic Documents for Postdoctoral Training (July 1, 2014), http://www.osteopathic.org/inside-aoa/accreditation/postdoctoral-training-approval/postdoctoral-training-standards/Documents/aoa-basic-document-for-postdoctoral-training.pdf.

[40] *See, e.g.*, FAA v. Cooper, 566 U.S. _ (2012) (slip op., at 6) ("[W]hen Congress employs a term of art, it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken" (internal quotation marks omitted)).

[41] *See, e.g.*, *Chevron*, 467 U.S. at 863 ("An initial agency interpretation [of a statute] is not instantly carved in stone. On the contrary, the agency, to engage in informed rulemaking, must consider varying interpretations and the wisdom of its policy on a continuing basis."); Monmouth Med. Ctr. v. Thompson, 257 F.3d 807, 814 (D.C. Cir. 2001) (examining CMS' interpretation of the disproportionate share statute, first through a formal rulemaking and later through an interpretive ruling seeking to rescind the initial interpretation and adopt a new one, and explaining that "under the law of this circuit altering an interpretive rule (interpreting an agency regulation) requires notice and opportunity for comment"); *see also* Alaska Prof. Hunters Ass'n, Inc. v. FAA, 177 F.3d 1030, 1034 (D.C. Cir. 1999) (requiring notice and comment rulemaking for an agency to change its interpretation of a regulation).

issued policy changes through rulemaking.[42] Thus, these procedural steps should not be viewed as an impediment to limiting cap and PRA adjustments for rotations.

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In conclusion, CMS has been granted broad discretion by Congress to adopt rules for new teaching programs. CMS clearly would have legal authority to exercise this discretion and limit cap and PRA adjustments for resident rotations, including by withholding cap and PRA adjustments for de minimis rotations. It is AAMC's understanding, based on informal discussions with staff from CMS and HHS, that CMS is in agreement that its current interpretation of the new program rules has resulted in inequities, and that there are compelling policy reasons to limit cap and PRA adjustments for rotations. CMS has expressed doubt, however, about its legal authority to change the rules. As described above, we believe CMS has undeniable legal authority to withhold cap and PRA adjustments for de minimis rotations, and thus concerns about CMS' legal authority should not be a barrier to a change in policy.

[42] *See, e.g.*, 74 Fed. Reg. 43754, 43908 et seq. (Aug. 27, 2009) (extending the cap-building period for new GME programs from 3 to 5 years); 65 Fed. Reg. 18434, 18504 et seq. (Apr. 7, 2000) (revising the criteria for provider-based status); 66 Fed. Reg. 3148 (Jan. 12, 2001) (establishing separate Medicaid upper payment limits based on three ownership categories: state government-owned and operated facilities, non-state government-owned or operated facilities, and privately-owned and operated facilities).