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January 31, 2020

Ms. Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

**RE: Medicaid Program; Medicaid Fiscal Accountability Regulation
(CMS-2393-P)**

Dear Administrator Verma:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS's or Agency's) proposed rule entitled, "Medicaid Fiscal Accountability Regulation" 84 *Fed. Reg.* 63722 (November 18, 2019), also referred to as MFAR. **Because we believe the proposed changes do not comply with the law, and for other reasons discussed in detail below, the AAMC strongly urges CMS to withdraw the proposed rule.**

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their 173,000 full-time faculty members, 89,000 medical students, and 129,000 resident physicians. Together, these institutions and individuals are the American academic medicine community.

Current Medicaid rules allow states substantial flexibility to determine Medicaid benefits and to fund their Medicaid programs in order to meet states' needs and the needs of Medicaid beneficiaries. In addition, states have the flexibility to supplement providers' base rates with reimbursements that bring payments closer to what Medicare pays. The MFAR would modify that balance to grant CMS unprecedented authority to dictate current state decisions to the detriment of the states and providers, and most importantly Medicaid beneficiaries.

Supplemental payments are a long-standing and essential part of the Medicaid program, making up a quarter of all Medicaid payments to hospitals nationwide and being a significant source of

funding for teaching hospitals as well as many physicians who practice at teaching hospitals and medical schools who provide significant care for Medicaid beneficiaries. These payments have been used to ensure access to Medicaid beneficiaries, including the disabled, children and many in rural communities. Examples of programs at academic medical centers supported by the supplemental program include telehealth services, telepsychiatry, access to complex cancer care, and ambulatory clinics. These programs work to improve preventive services, which result in reduced visits to emergency departments and fewer hospital admissions. This benefits not only Medicaid beneficiaries, but also the fiscal soundness of the Medicaid program for both states and the federal government. As the Government Accountability Office (GAO) recently reported, “new or increased supplemental payments helped mitigate the increasing gap between Medicaid base payments and hospital costs. These payments have been essential in improving access to both hospitals and physicians. While supplemental payments increased, the number of states reducing or freezing base payments to hospitals has increased, in part because states reported challenges paying the nonfederal share with state general funds.”¹ Given the importance of supplemental payments, any reforms must be made thoughtfully and cautiously, and with an awareness of the impact on beneficiary access to care. As described below, the ripple effects of the proposed rule will be devastating.

CMS writes “the goal of this proposed rule is to strengthen the overall fiscal integrity of the Medicaid program.” (p. 63722) The AAMC is fully supportive of fiscal integrity. However, this proposed rule will cause significant reductions in the program, effectively eliminating Medicaid coverage for millions of vulnerable patients. CMS estimates that the cap on physician supplemental payments alone will be a “reduction of \$222 million in total computable Medicaid reimbursements.” (p. 63773) This figure was arrived at by what can only be described as a rough calculation that likely grossly underestimates the actual impact and gives no indication of where the impact will be most severe. As for the rest of the rule, CMS does not even attempt to provide an impact of the reductions, though outside estimates are that it will be tens of billions of dollars. By severely, unevenly, and haphazardly constraining sources of financing for the program, the proposed rule would dramatically reduce access for the individuals who rely on Medicaid for their health care coverage, undermining the program’s primary purpose. The financing mechanisms that the rule proposes to change are authorized by statute and are relied on by states as the best way to pay for care to Medicaid beneficiaries by balancing fiscal constraints with the need to ensure adequate access to necessary care, the cornerstone of Medicaid. The changes that will occur as a result of this proposed rule change are too great for the system to withstand without significant harm to patients and providers. Therefore, we strongly recommend as stated above that the rule be withdrawn.

We have focused our specific comments on the following issues:

¹ *States’ Use and Distribution of Supplemental Payments to Hospitals*, GAO-19-603, July 2019, page 10

- The proposed rule does not pass legal muster. It is impermissibly vague, introduces inconsistencies with existing regulatory language, and violates the Administrative Procedures Act. In addition, it does not include the impact analysis that is required by law to assess the consequences of such a dramatic rule change.
- The proposal is not sufficiently informed by data, nor does it make a compelling case for such a sweeping change in the Medicaid program. CMS does not provide adequate information to allow for a full understanding of the impact on access and patient care. The proposed rule only includes an estimate of the potential reduction in physician payments without address reductions caused by the rest of the proposals. In short, this proposed rule will severely impact beneficiaries, as well as the hospitals and physicians who treat them.
- The terms “net effects” and “totality of circumstances” on which CMS relies are unworkable. They are so vague that neither states nor providers will have any assurance that their intergovernmental transfers (IGTs) and supplemental payments will meet the new criteria.
- The definition of “appropriated funds” which can be used for IGTs is too narrow. Hospitals, and in particular state university teaching hospitals, should be able to use all non-federal funds for IGTs to avoid reducing the funds available to ensure access to beneficiaries.
- Limitations on Medicaid funding for graduate medical education (GME) will destabilize GME programs, which will, in turn, limit access to Medicaid providers and hamper states’ ability to use this funding to support state workforce goals. If CMS finalizes the rule, GME payments should be excluded from the definition of supplemental payments and all provisions that newly apply to supplemental payments.
- The changes would require states to revise long-standing arrangements that have evolved to meet state and local needs to care for their Medicaid population. In addition, the balance between federal oversight and state responsibility would be altered in such a way that would harm states’ ability to oversee and develop state Medicaid programs.

The Proposed Changes Do Not Pass Legal Muster

While the Medicaid law gives CMS clear statutory authority to permit the policies currently in place, CMS has proposed a number of changes that would sharply curtail states’ ability to use these financing arrangements. In general, CMS would grant itself unfettered discretion to assess whether a financing arrangement is permissible. In order to do this, the Agency uses the “net effect” standard based on “the totality of circumstances.” These new, vague terms without defined criteria would impermissibly create confusion and uncertainty for states, hospitals, and

physicians. The proposed rule would violate the Medicaid statute by requiring only a “reasonable expectation” that the taxpayer may be held harmless, rather than a “guarantee,” as required by the statute. This rule also would introduce inconsistencies with existing regulatory language and violate the Administrative Procedure Act because it is changing policy and guidance upon which states and providers have long relied without adequate rationale. CMS also has made no attempt to assess the impact of the proposed changes even though the Agency is required to do so. Finally, the proposal is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers

The Proposed Rule is not Sufficiently Informed by Data, Particularly as it Relates to the Impact on Beneficiary Access and the Providers Who Treat Them

It should be noted the AAMC opposes reducing the monitoring requirements on states since monitoring is a key element to ensuring adequate access for Medicaid beneficiaries. Nonetheless, it is worth noting that in July 2019, CMS described a thoughtful approach to Medicaid rulemaking when it issued the proposed rule, *Methods for Assuring Access to Covered Medicaid Services—Rescission* (84 Fed Reg 33722) and stated the following:

We are renewing our efforts and commitment to develop a data-driven strategy to understand access to care in the Medicaid program across fee-for-service and managed care delivery systems, as well as in home and community-based services waiver programs. This new strategy will focus on developing a more uniform methodology for analyzing Medicaid access data for all states and **will be led by us working in partnership with states and other stakeholders. We will use this analysis to inform our approval decisions and to set out new policies, as necessary, to improve beneficiary access to care and services in the Medicaid program.** (emphasis added, p. 38724)

The proposed MFAR rule fails that commitment. Rather than working in partnership, determining the data that needs to be collected, undertaking the actual data collection, analyzing the data, and using a carefully considered process to propose policy changes, CMS prejudices the data it proposes to collect and proposes substantial and uninformed policy changes. This is both irresponsible and denies public stakeholders the opportunity to comment on the true impact of the proposed regulation.

CMS abdicates its responsibility to even attempt to evaluate the fiscal impact of the proposed rule. According to CMS, “[t]he fiscal impact on the Medicaid program from the implementation of the proposed rule is unknown.” (p. 63773) While CMS invites comments on the estimates and potential state responses to these provisions, it is the obligation of the Agency to prepare a Regulatory Impact Analysis (RIA). The Office of Information and Regulatory Affairs provides

an extensive checklist² for agencies to use in preparing an RIA, including whether the RIA quantifies and monetizes the benefits and the costs of the regulatory action and an explanation of why this action is preferable to alternatives. The proposed MFAR rule fails to meet even the most basic requirements of impact analysis and thereby denies the public a meaningful opportunity to comment.

Further, it is notable that in the preamble to the proposed rule, CMS repeatedly mentions programmatic efficiency and economy but makes no attempt to assess the rule's impact on access. The Agency has a legal obligation to:

“assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available [...] at least to the extent that such care and services are available to the general population in the geographic area.”³(emphasis added)

In proposing significant changes to Medicaid financing rules and provider payments without an analysis of the impact on access to care, CMS disregards its responsibility to ensure access and denies the public any meaningful opportunity to comment on whether the efficiency and economy that CMS seeks to achieve can be done without undermining its other legal obligations to provide equal access to care.

The Impact of the Rule on Teaching Hospitals and the Physicians Who Care for Medicaid Beneficiaries Will be Significant, Affecting Access to Care

The AAMC is particularly concerned about the effect this proposed rule will have on patients who rely on teaching hospitals and teaching physicians for their care. These patients, many of which have complex medical conditions, are unable to have their medical needs taken care of elsewhere. While AAMC member hospitals make up just 5 percent of all short-term general acute care hospitals, they account for 26 percent of Medicaid discharges. Our member hospitals are major providers of many of the medical services that are essential for addressing the needs of the Medicaid population. For example, 68 percent of AAMC member hospitals have Level 1 Trauma Centers, compared to 3 percent for hospitals overall; 18 percent have inpatient care for drug dependency, compared to 5 percent overall; and 23 percent offer outpatient substance abuse disorder (SUD) treatment, compared to 14 percent overall. The patients at our member hospitals are treated by teaching physicians who also provide a significant amount of care to the Medicaid population.

During an MFAR discussion that occurred at the December 2019 meeting of the Medicaid and CHIP Payment and Access Commission (MACPAC), staff noted that:

² https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/inforeg/inforeg/regpol/RIA_Checklist.pdf; accessed 1/13/2020

³ *ibid*

. . . we can't really go behind the numbers to see who would be affected [by MFAR]. A few years ago MACPAC did do a compendium of physician payment policies in fee-for-service, and so we have a sense of the different types of providers that are targeted by supplemental payments . . . At least the state plans just generally describe academic medical centers more broadly and don't tie it to particular services they provide, but obviously many of these academic medical centers do provide a lot of complex care for kids as well as adults.⁴

The limitations on sources of non-federal share funding proposed in the MFAR rule will inevitably lead to significant reductions in payments to hospitals and physicians, particularly teaching hospitals and physicians who are essential providers to Medicaid patients. These reductions also will lead to the elimination of programs, requiring states to renegotiate with stakeholders, pass new legislation, and undergo a lengthy and unpredictable federal approval processes. As a result, there will likely be years in which providers will face unstable and unpredictable payments, which will affect physician participation in a program. Medicaid beneficiaries already face challenges accessing care. Further instability in the program can only lead to substantial challenges that will affect the care of vulnerable individuals.

In particular, the Agency's proposal to limit supplemental payments to physicians and practitioners to no more than 50 percent of base payments (75 percent in rural areas) will limit access to care. A primary reason for choosing supplemental payments rather than increasing base payments is to target payments to physicians, many of whom work at academic medical centers, that are most critical to the Medicaid program, such as physicians serving in underserved areas and specialties that have high Medicaid volumes. Typical of AAMC members is one that informed us that in their state "supplemental funding has been instrumental in supporting the implementation of initiatives that are evidence-based and scalable." Among the many improvements that have resulted from this support, including in rural areas, are more accurate and timely diagnosis of developmental issues, training of individuals who can work on approaches to suicide prevention, and improved addiction treatment, to name just a few. The actual list of benefits is extensive and covers such services as ambulatory clinics and telehealth programs to improve access to urban and rural patients. These clinics have been developed with current upper payment level (UPL) payments. Cuts to the UPL will have an immediate impact on access to care.

What states pay in supplemental payments to physicians is based on a complex set of considerations that should not be undermined by the imposition of an arbitrary cap. In many states, physician payments in Medicaid are strikingly low, falling below half of Medicare payments for equivalent services. This causes fewer physicians to participate in Medicaid than in Medicare, commercial, and employer-sponsored insurance. Patients with complex care needs or

⁴ Transcript, MACPAC Public Meeting, December 12, 2019; <https://www.macpac.gov/wp-content/uploads/2018/03/December-2019-Meeting-Transcript.pdf>

rare conditions often need to see highly specialized providers who may only be available at academic medical centers. States must then negotiate exceptions to their fee schedule, which are paid as supplemental payments atop base payments. CMS's proposal would deny these patients access to care. Alternatively, it would require a state to elevate base payments to all providers to an acceptable level. If states are not able to do this, there likely would be a limitation on access to ambulatory care, which in turn would lead to increased visits to emergency departments and more inpatient stays, representing an avoidable increased cost to state Medicaid programs. We note, moreover, because the new proposed limit is calculated from a state's base payments, providers in the states with the lowest base payments will feel the most severe impact.

Finally, the Agency's presumption that states will choose to increase base payments if supplemental payments are reduced is unsupported by history and by data. The reality is the burden will fall on beneficiaries. As referenced above, GAO has found a clear trend over time: the majority of states are reducing or freezing hospital base payments and have been doing so continually and increasingly for over a decade. Given the magnitude of supplemental payments – up to 60 percent of total hospital payments in some states – it is unreasonable to imagine that states will reverse their own history and magically find new budgetary room for significant state general fund investments in Medicaid. It is more reasonable to conclude that as sources of non-federal share dollars are disallowed or curtailed and physician supplemental payments substantially reduced, access will be threatened. We have seen hospital closures, especially in rural areas. The reduction of payments will likely accelerate this trend.

The Proposed Rule Will Destabilize Graduate Medical Education Programs and Impede Physician Training

Many state Medicaid programs provide funding for graduate medical education (GME), which supports training for the next generation of physicians while also providing funds that help provide care to the Medicaid population. As written, it appears the proposed rule would harm GME programs in at least two ways. First, it will constrain the financing mechanisms that states use. The second is that by requiring periodic review and reapproval, hospitals will not have a reliable source of funding and will be unable to make decisions about whether they can continue physician training at the same level. The most recent survey by the AAMC shows that 42 states and the District of Columbia make GME payments through their Medicaid programs.⁵ GAO found that in FY 2017 these investments in physician training totaled approximately \$2 billion.⁶ Proposals that would undermine GME funding include inaccurate data collection, disruption of supplemental payments through added frequency of re-approvals, and limitations on sources of non-federal share for GME investments.

⁵ AAMC. *Medicaid Graduate Medical Education Payments: Results from the 2018 50-State Survey*. July 2019. https://store.aamc.org/downloadable/download/sample/sample_id/284/

⁶ *States' Use and Distribution of Supplemental Payments to Hospitals*, GAO-19-603, July 2019

States have developed GME funding streams that provide needed funds for physician residency programs and ensure that physician training occurs in settings where residents will have the benefit of treating the unique needs of Medicaid beneficiaries. At a time of physician shortages, it is untenable to put at risk money that states have decided should be made available to teaching hospitals and physicians. To have these funding sources put in jeopardy will be a blow to the health of the communities the hospitals serve and to the physicians whose training is supported by Medicaid GME payments.

According to MACPAC, GME payments “can reflect both the direct costs of training (e.g., residents’ salaries) as well as indirect costs associated with a more severe case mix.”⁷ Some states make GME payments as supplemental payments while others account for GME costs in the base payments calculated for teaching hospitals. The variety of mechanisms for state investments in GME means that the supplemental payment data collection proposed in the MFAR rule would capture only some GME investments, making cross-state comparisons inaccurate.

Further, many states make GME payments through both fee-for-service payments and through managed care. To collect data only on fee-for-service GME payments, as CMS proposes, would make comparisons across hospitals within a state misleading. For example, many states carve children with complex conditions out of their Medicaid managed care programs. This means children’s hospitals receive more of their payments, including GME payments, through fee-for-service than other hospitals who see more adults and therefore more managed care payments. As currently proposed, CMS’s data collection would likely show children’s hospitals receiving a disproportionate amount of GME payments – even if this is not true.

Graduate medical education takes place over years, requiring no less than three years of training in some specialties and many more years for other specialties. In order for an academic medical center to invest in a residency position, it must be assured of stable sources of funding. CMS’s proposal to require states to submit all supplemental payments for approval and re-approval by the federal government every three years would dismantle the payment stability teaching hospitals rely upon to maintain their programs. Resident recruitment, ongoing accreditation, and the ability to place residents in community-based settings for training would all be affected.

CMS has previously recognized the unique importance of supplemental payments for GME, most recently when it allowed states to continue making directed GME payments directly to providers, even when those benefits were covered through managed care. The AAMC believes that no part of the proposed MFAR rule should be finalized. But in the event that CMS finalizes some or all of the rule, **the AAMC urges CMS to exclude GME payments from the definition of supplemental payments and all provisions that newly apply to supplemental payments.**

⁷ *Medicaid Base and Supplemental Payments to Hospitals*, MACPAC Issue Brief, March 2019, page 6

The Proposed “Net Effect” and “Totality of Circumstances” Standards are so Vague as to Mean that Neither States nor Providers Will Have Any Assurance That Their Medicaid Programs Will be Certified

CMS proposes new, discretionary standards for evaluating the validity of supplemental payments, including their adherence with the requirement that provider taxes not include “hold harmless” provisions and be generally redistributive. CMS proposes to consider the “net effect” of any financing arrangement across many quantitative and qualitative factors, and to consider the “totality of circumstances” when evaluating whether or not any providers are “held harmless” in circumstances involving provider taxes and supplemental payments.

While a broad and holistic approach may appear appropriate when taken on face value, replacing the existing statistical tests for adherence with vague subjective standards amounts to CMS giving itself unfettered ability to make decisions, and gives no assurance of fairness or consistency. First, unrestricted and undefined federal discretion in evaluating each supplemental payment arrangement leaves states, hospitals, and physicians with no ability to predict what CMS will find acceptable now or in the future, a situation impossible for state legislatures to navigate. Provider taxes and fees are usually imposed in law, requiring legislatures to engage in complex and often contentious negotiation. They are not able to send their proposed laws to CMS for an evaluation of “the net effect” of their actions. And even if CMS initially signs off on a tax structure, the rules would permit CMS to determine based on a later look at “net effect” that the tax cannot be sustained. Whereas today, states can rely on statistical tests to ensure their changes will meet federal approval, vague standards would lead to delays in both the federal process and in instances where state legislatures (which may meet for only a portion of the year or may only meet every other year) would have to enact new legislation after the Agency’s input. This could become a never-ending process that will leave hospitals and physicians without adequate payment and unable to plan for the future because of unstable funding, and leave beneficiaries with limited or no access to care.

Second, the proposed rule only loosely describes what CMS could consider in evaluating the “totality of circumstances” with respect to pooling and would give the Agency the authority to examine contracts between private entities, grants from foundations, and nearly any other transaction the Agency suspects could be relevant. Not only would this constitute an enormous new administrative burden for states and for any affected provider, and an intrusion of the federal government into private enterprise, it would also place an unreasonable expectation and unfunded mandate on state officials to be aware of every private transaction among Medicaid providers. If two providers make an arrangement, which they do often for many different reasons, and CMS decides that the arrangement suggests an attempt to hold those providers harmless for the taxes paid, the entire tax falls, an extraordinary result with sweeping implications.

For example, Hospital System A participates in Medicaid and receives supplemental funds. It chooses to contribute to a community foundation as part of its commitment to reducing the burden of social determinants of health. The foundation may make a grant to clinics or providers affiliated with Hospital System B to fulfill this mission, without consulting its donors or the state. If the foundation's grantees were part of a system that happened to pay higher provider taxes than those paid by Hospital System A, this could be viewed as somehow holding Hospital System B harmless. But how would Hospital System A (or the state) become aware of this? Is there an expectation that the state will monitor all foundation donations and grantmaking? Could such an arrangement bring down the state's provider tax and jeopardize all supplemental payments for all hospitals? The degree of monitoring necessary to enforce such a rule is unreasonable – and is certainly not appropriately evaluated in any impact analysis included in this proposed rule. The Administration has made significant changes to date to reduce administrative burden. This proposed rule flies in the face of CMS' efforts to date and would lead to significant regulatory burden.

Finally, even if one were to conclude that CMS's duty to oversee proper payments extended to this type of "totality of circumstances" monitoring, the proposed rule would not achieve these ends as CMS would be examining only that portion of each state's Medicaid program that is subject to this rule. This means that the effect of CMS's new discretionary standard is to increase the administrative burden on hospitals and states dramatically, but not give CMS any meaningful insight into the issues it purports to wish to examine. There also are no assurances that CMS has the capacity to review these state arrangements in a timely and evenhanded way, or that any determination would be "final," all of which leads to uncertainty for states and hospitals and the potential for arbitrary decision-making

For Teaching Hospitals, All Non-Federal Funds Should Be Available to Use for IGTs

CMS proposes that for the state share of financial participation, among the funds that could be used for IGTs would be "funds appropriated to state university teaching hospitals" (42 CFR 433.51(b)(2)). First, CMS should recognize that for a multitude of reasons state university teaching hospitals take many forms and may be considered part of the state or a separate legal entity. It should be a state decision, not a CMS decision, as to which entity should be considered public under state law definitions. Second, CMS should use a broader definition of what will be considered appropriated funds. Each state has a unique set of agencies overseeing health-related functions, as well as a unique set of other governmental actors – counties, parishes, public hospitals, hospital districts, cities, boards of regents, and others – that play a role in delivering health services. Divisions of governmental authority and administration of public duties have evolved locally to meet local needs across a wide range of issues – among which Medicaid is only one. CMS proposes arbitrary definitions as to which entities will or will not be considered "public" and authorized to make IGTs that will force some states to reorganize their agencies and forgoing essential payments. For example, a state may appropriate money to a state mental health

agency which is then provided to the state university teaching hospital for services. Under the proposed rule, these funds would not be considered as the state share for IGTs. States have many ways in which they provide money to their state university teaching hospitals. Non-federal revenue should be able to be used as an IGT since they are funds of a public entity and therefore should be considered public funds.

Should the Rule Be Finalized, A Long Transition Period is Needed

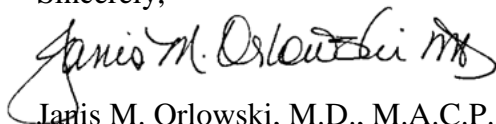
If CMS finalizes this or any portion of this rule, it must provide an adequate transition period. As was described above, it is likely that most states will be unable to meet the requirements of this rule without making significant changes in their Medicaid programs. CMS should acknowledge that changes of this magnitude will require years to implement and must provide a timeline that reflects this reality. The 2016 managed care rule provides precedent for a long transition. CMS gave states a 10-year period to transition pass-through payments to hospitals and five years to eliminate pass-through payments to physicians.

Conclusion

For all of the reasons above, the AAMC reiterates its request that CMS withdraw the MFAR proposed rule. While the issues highlighted here are more than sufficient to warrant a re-examination of the Agency's proposals, discussions with AAMC member institutions have revealed that nearly each state will present unique issues worthy of consideration. States have rightfully designed Medicaid programs to meet the individual needs of their beneficiary populations, provider ecosystems, and budgetary flexibility within already challenging constraints. This means that any significant reform from the federal level must be carefully tailored to meet states' needs – and must start with data collection and analysis to illuminate state-level impacts, importantly on beneficiaries' access to care. The AAMC hopes that CMS will change course to more thoughtfully consider these important issues.

We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact me or Ivy Baer at ibaer@aamc.org or Mary Mullaney, mmullaney@aamc.org, both of whom may be reached at 202-828-0490.

Sincerely,



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

cc: Ivy Baer, J.D., M.P.H, AAMC
Mary Mullaney, AAMC

Administrator Verma

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