



**Association of
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April 3, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

The Greater New York Hospital Association (GNYHA) and the Association of American Medical Colleges (AAMC) appreciate the efforts made by the Centers for Medicare & Medicaid Services (CMS) thus far to issue Section 1135 waivers and implement regulatory flexibilities to help hospitals and health systems respond to the 2019 novel coronavirus (COVID-19). We write to request that CMS confirm – through interim regulatory guidance or Section 1135 waiver – that the addition of temporary hospital beds to respond to the pandemic will not negatively impact a teaching hospitals' indirect medical education (IME) payments.

GNYHA represents 160 voluntary and public hospitals and health systems in New York, New Jersey, Connecticut, and Rhode Island. The vast majority of GNYHA members are teaching hospitals, including some of the most outstanding academic medical centers in the world. Although the pandemic is quickly spreading across the country, the downstate New York region, where the majority of GNYHA are located, has become the current epicenter of the virus. GNYHA members are battling the epidemic on multiple fronts and their doctors and nurses are heroically caring for those afflicted with the virus.

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 155 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 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

We are hearing concerns from many member hospitals that are adding temporary inpatient beds and utilizing non-traditional patient care areas to expand care for COVID-19 patients that doing so could have a negative effect on the intern-and-resident to bed (IRB) ratio used to calculate the IME adjustment. Our members believe that a dramatic increase in the number of temporary beds during the pandemic, if not

excluded from the denominator of the IME ratio, will dramatically lower IME payment to hospitals. **As we discuss below, we believe that based on the regulation and manual instruction, the increase in temporary beds in response to this public health crisis should not be included in the IRB ratio as part of the calculation of Medicare's IME payments. We ask that CMS promptly confirm this interpretation by issuing guidance, through the use of the 1135 Waiver, or an interim final rule.**

CMS Has the Regulatory Authority to Exclude COVID-19-Related Surge Beds from the IRB Ratio Used to Calculate IME Payments

Under current CMS IME payment regulations, the number of beds in a hospital is “determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.” 42 C.F.R. § 412.105(b). The regulation excludes various types of beds from the count of available bed days, including, for instance, beds in excluded distinct part units. Part I, Section 2405.3(G) of the Medicare Provider Reimbursement Manual (PRM) further excludes beds in various hospital units and defines available beds as those that are “permanently maintained for lodging inpatients... [and] available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds).”

To expand capacity, hospitals will likely set up new beds in existing hospital space, as well as non-hospital buildings and space. We believe that these pandemic-related “temporary beds” are excluded from the IME bed count under the current regulatory guidance. For instance, hospitals housing inpatients in excluded distinct part units—pursuant to the blanket waiver issued by CMS on March 13—are not required to count these beds under 42 C.F.R. § 412.105(b). Similarly, under the current PRM guidance, any beds added in response to COVID-19—including those within the hospital and those constructed in alternative care sites, such as hotels, gymnasiums, tents or other temporary shelters—should be considered temporary and excluded from the bed count.

We ask CMS to confirm this understanding by quickly issuing interpretive guidance or an FAQ clarifying that teaching hospitals may exclude from the bed count for IME payment purposes any beds added on a temporary basis in response to the public health emergency.

CMS Could Also Hold Hospitals Harmless by Issuing a Section 1135 Waiver that Changes the Definition of an “Available Bed” During This Emergency

Alternatively, we request a Section 1135 waiver to temporarily modify the determination of bed count and available beds set forth in the regulation at 42 C.F.R. § 412.105(b). To ensure that health care providers are reimbursed for services provided during a public health emergency, Section 1135 authorizes CMS to temporarily waive or modify regulations pertaining to “conditions of participation or other certification requirements” or “program participation.”

The SSA permits CMS to define the meaning of “available beds.” Section 1886(d)(5)(B) requires CMS to make IME payments to teaching hospitals based on the IME adjustment factor, calculated by using a hospital’s IRB ratio and a multiplier set by Congress. The IRB ratio is based in part on a “hospital’s

available beds (*as defined by the Secretary*)” (emphasis added). As discussed above, CMS promulgated rules in 42 C.F.R. § 412.105(b) and subregulatory guidance defining available beds and instructing hospitals how to determine the number of beds. Given the broad authority under Section 1135 and the statutory delegation given to CMS to define available beds, we believe that CMS has the authority to issue a waiver to temporarily modify the regulatory definition of available beds.

CMS has already issued similar Section 1135 waivers during this public health emergency. On March 13, CMS issued a blanket waiver allowing long-term care hospitals (LTCHs) to exclude patient stays from the 25-day length of stay requirement, when the LTCH admits or discharges patients to meet the demands of the emergency. As with the IME payment statutory provision, the SSA sets forth the 25-day average length of stay requirement, but tasks CMS with determining how to calculate it. That CMS has issued a Section 1135 waiver to permit hospitals to modify how they calculate the length of stay demonstrates that the Agency also has the authority to issue a waiver to modify how hospitals determine the number of beds for IME payment purposes.

By issuing interpretive guidance or a Section 1135 waiver permitting hospitals to exclude beds added in response to the public health emergency, CMS will give teaching hospitals the assurance that they will have the funding necessary to respond to the pandemic. We appreciate CMS’s consideration and, in light of its urgent nature, request a response to this letter as soon as possible.

Should you need more information regarding this request, please contact Tim Johnson at GNYHA (tjohnson@gnyha.org) or Ivy Baer at AAMC (ibaer@aamc.org).

Sincerely,



Kenneth E. Raske
President
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David J. Skorton, MD
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