Submitter : Ms. Katherine Stephens **Date:** 06/22/2007

Organization : Palmetto Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-203-Attach-1.DOC

#203

PALMETTO HEALTH

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of Palmetto Health to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Palmetto Health sponsors 17 residency programs comprising 225 future physicians. Over half of these future physicians are being trained in primary care specialties, most of which are underrepresented in many areas of South Carolina. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **On behalf of Palmetto Health, we urge the Agency to rescind the proposed rule.**

Sincerely,

Katherine G. Stephens, MBA, FACHE
Vice President, Medical Education
Palmetto Health

Submitter : Mr. Santiago Munoz **Date:** 06/22/2007

Organization : University of California, Office of the President

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#204

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Leann Chilton **Date:** 06/22/2007

Organization : BJC Healthcare-Children's Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-205-Attach-1.PDF

#205

Children's
HOSPITAL • ST. LOUIS

One Children's Place
St. Louis, Missouri 63110-1077
stlouischildrens.org

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of St. Louis Children's Hospital to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. While some of the reimbursement formulas have changed over the years, Missouri Medicaid has included the costs of approved intern-resident training as an allowable component of its cost reimbursement methodology. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

On page 28931 of the subject proposed rule, CMS presents an interesting analysis that would revise history and redefine terms, as commonly understood in the health care industry, and we believe, by Congress. In enumerating the "care and services" that may be included in approved State Medicaid plans, it is stated "Graduate medical education

(GME) is not included in this list of care and services within the scope of medical assistance." This is true, because until this proposed rule was released, the costs of approved training programs for interns and residents have never been characterized as a "service," but only as a "component cost" of services provided to patients.

On page 28932, CMS quotes section 1886(a)(4) of the Act, which describes the "operating costs" which can be included in the determination of the basic payment amounts under Medicare's prospective payment system (PPS) for inpatient hospital services, and implies that the exclusion of "costs associated with educational activities from the operating costs that can be included in the cost base used to develop the basic payment amounts" somehow changes the "character" of such costs.

While it is clear that Congress and the Medicare program separated the costs of approved educational activities from the PPS base costs, it is also clear that this "cost separation" was for the purpose of reimbursing these approved education costs differently than the other operating costs and to facilitate imposing limits on such costs for improved budgetary control. Historically, this treatment is not that different from the isolation of "inpatient routine service costs" for purpose of imposing reimbursement limitations on such "inpatient routine service costs" under the historical "cost" reimbursement methodology. The segregation of such costs did not change their character. Thus, even though GME costs have been separated from other operating costs for differing payment methods under the Medicare inpatient PPS and associated payment methods, such GME costs remain "component costs" of patient care services, especially for those reimbursement systems which continue to use the historical "cost" reimbursement method, which include Missouri and many other state Medicaid programs.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Each year St. Louis Children's Hospital provides education for over 200 future doctors training in 5 primary specialty programs (including anesthesiology, emergency medicine, and pediatrics) and 20 sub-specialty programs (which includes16 pediatric sub-specialty programs, such as pediatric cardiology, pediatric endocrinology, and pediatric pulmonology). Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more pediatric physicians are needed throughout the country.

St. Louis Children's Hospital is one of the largest volume providers of Medicaid days in the State of Missouri and is one of the principal pediatric referral centers for the metropolitan St. Louis area. St. Louis Children's Hospital is the only pediatric hospital in the metropolitan St. Louis area that is a designated Level I Trauma Center. Annually through the use of our Pediatric residents and other health care professionals our Hospital provides care to over 25,000 Medicaid and charity pediatric patients, which includes approximately 38,000 inpatient days of care to Medicaid and Charity pediatric patients.

It must be observed that interns and residents, especially those who have completed their initial year of training, are an important part of overall patient care staffing. If GME programs are reduced or discontinued as a result of inadequate funding, to maintain the same volume of patients and quality of care, teaching hospitals would be required to employ many more registered nurses and nurse practitioners at compensation levels that are significantly greater than the stipends paid to interns and residents.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,
For St. Louis Children's Hospital

Lee Fetter
President
St. Louis Children's Hospital

Submitter : Leann Chilton **Date:** 06/22/2007

Organization : BJC Healthcare-Barnes Jewish Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-2279-P-206-Attach-1.PDF

#206

BARNES-JEWISH Hospital

Andrew A. Ziskind, MD
President

June 22, 2007

Leslie Norwalk, Esq.
Acting Adminstrator
Herbert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of Barnes-Jewish Hospital to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. While some of the reimbursement formulas have changed over the years, Missouri Medicaid has included the costs of approved intern-resident training as an allowable component of its cost reimbursement methodology. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

On page 28931 of the subject proposed rule, CMS presents an interesting analysis that would revise history and redefine terms, as commonly understood in the health care industry, and we believe, by Congress. In enumerating the "care and services" that may be included in approved State Medicaid plans, it is stated "Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance." This is true, because until this proposed rule was released, the costs of approved training programs for interns and residents have never been characterized as a "service," but only as a "component cost" of services provided to patients.

On page 28932, CMS quotes section 1886(a)(4) of the Act, which describes the "operating costs" which can be included in the determination of the basic payment amounts under Medicare's prospective payment system (PPS) for inpatient hospital services. This implies that the exclusion of "costs associated with educational activities from the operating costs that can be included in the cost base used to develop the basic payment amounts" somehow changes the "character" of such costs.

While it is clear that Congress and the Medicare program separated the costs of approved educational activities from the PPS base costs, it is also clear that this "cost separation" was for the purpose of reimbursing these approved education costs differently than the other operating costs and to facilitate imposing limits on such costs for improved budgetary control. Historically, this treatment is not that different from the isolation of "inpatient routine service costs" for purpose of imposing reimbursement limitations on such "inpatient routine service costs" under the historical "cost" reimbursement methodology. The segregation of such costs did not change their character. Thus, even though GME costs have been separated from other operating costs for differing payment methods under the Medicare inpatient PPS and associated payment methods, such GME costs remain "component costs" of patient care services, especially for those reimbursement systems which continue to use the historical "cost" reimbursement method, which include Missouri and many other state Medicaid programs.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Each year Barnes-Jewish Hospital provides education for over 700 future doctors training in 19 primary specialty programs (including internal medicine, emergency medicine, neurological surgery, obstetrics and gynecology, diagnostic radiology, and general surgery) and over 20 sub-specialty programs (including cardiovascular disease, gastroenterology, hematology/oncology, nephrology, vascular and interventional radiology, and cardiothoracic surgery). Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. Barnes-Jewish Hospital is the largest volume provider of Medicaid days in the State of Missouri and is THE "safety net hospital" for the metropolitan St. Louis area. Annually, our Hospital provides care to over 54,000 Medicaid and charity patients, which includes approximately 69,000 inpatient days of care to Medicaid and Charity patients. The proposed reduction of funding of Medicaid services, regardless of what it is called, significantly increases our Hospital's challenge to meet the hospital care requirements of

our area's neediest patients, that is, Medicaid recipients and those with no health insurance of any kind.

It must be observed that interns and residents, especially those who have completed their initial year of training, are an important part of overall patient care staffing. If GME programs are reduced or discontinued as a result of inadequate funding, to maintain the same volume of patients and quality of care, teaching hospitals would be required to employ many more registered nurses and nurse practitioners at compensation levels that are significantly greater than the stipends paid to interns and residents.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,
For Barnes-Jewish Hospital

Andrew Ziskind, M.D.
President
Barnes-Jewish Hospital

Submitter : Dr. Peter Densen **Date:** 06/22/2007

Organization : University of Iowa Hospitals and Clinics

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-207-Attach-1.PDF

#207

UNIVERSITY of IOWA
CARVER COLLEGE
OF MEDICINE

University of Iowa Health Care

Office of the Dean

University of Iowa Roy J. and Lucille A. Carver College of Medicine
Office of the Executive Dean
218 Medicine Administration Building
Iowa City, IA 52242-1101
319-335-9825 Tel
319-353-5617 Fax
www.medicine.uiowa.edu

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of the University of Iowa Carver College of Medicine to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule will erode the financial condition of teaching hospitals and jeopardize their ability to continue to fulfill important teaching and patient care roles.

If the proposed rule is not rescinded, this revision will represent a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. Here in Iowa, for example, in FY 07 the State provided the UIHC with $2,311,677 for direct medical education expenses and $4,084,034 for indirect medical education expenses. When federal matching dollars of $3,915,902 and $6,918,214 respectively are combined, Medicaid support for graduate medical education at the UIHC totals $17,229,827. We rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Given the numerous studies predicting a physician shortage in the near future, educating future physicians and other health care professionals has never been more important.

The University of Iowa Hospitals and Clinics and Carver College of Medicine teaches about 582 medical students and trains more than 600 residents in various specialties and

subspecialties. Half of all physicians in Iowa completed medical school or graduate training at the University of Iowa. The state of Iowa has an immediate demand for physicians in the specialties of psychiatry, neurosurgery and general surgery. We anticipate future demand for general internal medicine, cardiology, internal medicine and family practice specialists. A change such as the one being proposed could cripple our graduate medical education programs at a time when more physicians are needed in Iowa and throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In our own case, approximately 57% of the UIHC's payer mix falls outside of commercial or Blue Cross.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment. With residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Our institution is unique in many of the services we provide to both the community and the state of Iowa as a whole. FY 05-06 saw 35,069 visits to our Emergency-Trauma Center, which is the only level 1 trauma center in the state. We also have the only burn center and the only neonatal intensive care unit statewide. The Holden Comprehensive Cancer Center at the University of Iowa is the single cancer center in Iowa with prestigious "comprehensive" status from the National Cancer Institute. We have a full range of cardiovascular specialists who use the latest techniques and technologies to provide premier heart care.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. We strongly urge CMS to rescind the proposed rule.

Sincerely,

Peter Densen, M.D.
Executive Dean
University of Iowa Roy J. and Lucille A. Carver College of Medicine

Submitter : Mr. Santiago Munoz **Date:** 06/22/2007

Organization : University of California, Office of the President

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-208-Attach-1.PDF

#208

UNIVERSITY OF CALIFORNIA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

OFFICE OF THE PRESIDENT –
CLINICAL SERVICES DEVELOPMENT

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1111 Franklin Street
Oakland, CA 94607-5200
Phone: (510) 987-9071
Fax: (510) 763-4253
http://www.ucop.edu

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

SUBJECT: **CMS-2279-P**, Medicaid Program; Graduate Medical Education Program

Dear Administrator Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule CMS-2219-P which would eliminate federal financial participation (FFP) for graduate medical education (GME) expenses incurred by hospitals in furnishing care to Medicaid patients. These comments are submitted on behalf of the University of California (UC) Health System and its academic medical centers (AMCs) located at Davis, Los Angeles, Irvine, San Diego, and San Francisco. We respectfully urge withdrawal of the proposed rule given that it would impede access to care for vulnerable Medicaid patients and is inconsistent with the Medicaid statute.

The UC clinical enterprise is the fifth largest healthcare delivery system in California and provides patient care services valued at over $4 billion. In alignment with their patient care work, the UC AMCs play a critical role in achieving a number of broad public-policy goals, including the education of health professionals and the advancement of medical science through cutting-edge research.

Specifically, the UC AMCs offer services that are essential to the health and well being of Medicaid beneficiaries and all Californians including a broad array of highly specialized services, such as trauma, neo-natal intensive care, cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, world class primary and preventive care, and extensive sub-specialties often available only in an academic setting. Moreover, UC AMCs sponsor more than 300 residency training programs in all of the

recognized specialties and subspecialties of medicine and surgery — nearly 4,000 residents participate annually in these programs.

Medicaid and uninsured patients represent nearly 30 percent of the patient population at the UC AMCs. We rely heavily on Medicaid GME to help ensure access to this patient population and also provide a learning venue for the nation's future physicians. This is especially important considering that we attract the highest resource-intensive patients who require specialty, tertiary and quaternary care. Quite simply, a significant number of our Medicaid patients have medical conditions that can only be managed in a tertiary referral hospital such as an academic medical center. The complexity of our patient population is reflected in the specialty and regional nature of the care we provide. Notwithstanding the provision of these essential services, we estimate that the UC AMCs would lose at least $16 million per year under the proposed rule.

- Role of Teaching Programs

We are concerned that adoption of the proposed rule would, over time, undermine physician teaching programs, gradually lead to physician shortages, and thereby impede access to care for the most vulnerable patient populations.

The UC AMCs and their counterparts throughout the country rely on interns and residents to expand access to high-quality patient care. For example, interns and residents often perform the initial assessment of an incoming patient and prepare the patient's plan of care. While these assessments and care plans are reviewed by the teaching physicians, the contributions of the interns and residents in this area and other areas are critical. Furthermore, the interns and residents provide a great deal of care during evenings, nights and weekends, and therefore contribute greatly to the ability of the UC AMCs to provide quality care around the clock.

Many of the UC AMC interns and residents are in fellowship programs leading to a second or even third board certification in various subspecialty areas. The UC AMCs provide an ideal environment for these subspecialty programs because of the complex medical services provided and the extensive experience of the teaching physicians. The patient care services provided by fellows in these advanced residencies are critical to the ability of the UC AMCs to provide services in these highly complex areas. Moreover, these physicians are well trained to serve their communities throughout their careers.

Generally, GME programs operate on a principle of progressive responsibility. Depending on their medical training, interns and residents can provide a range of services. As an intern or resident becomes more skilled, he or she takes on greater responsibility for patient care. While interns and residents are carefully supervised by

teaching physicians, there is no doubt that the volume of care provided through GME programs throughout the country would decline significantly if teaching physicians at AMCs were required to provide all aspects of patient care directly. Replacing this volume of care and ensuring coverage in certain clinical areas may be extremely costly and may be impossible in many locations.

In short, the proposed rule fails to recognize that the GME costs represent services rendered to Medicaid recipients by interns and residents and supervised by teaching physicians.

- GME as a Covered Service

In the preamble, CMS notes that GME is not specifically included in the list of care and services covered within the scope of medical assistance in Section 1905(a) of the Medicaid statute. CMS relies on this fact to conclude that GME is not a service covered by the Medicaid program. While CMS is correct that GME is not listed as a service, its absence is not surprising because medical education is not itself a service. Instead, GME costs represent the direct health care provided by interns and residents that constitute a necessary component of listed services, such as inpatient hospital services. Indeed, federal and state administrators have recognized this fact since the inception of the Medicaid program.

The GME costs that would be eliminated from payments to Medicaid providers represent direct costs of providing direct health care services to Medicaid recipients in a teaching setting. Providers are entitled to payment for the essential and cost-effective services provided to Medicaid patients by interns and residents. We believe that the continued recognition of GME as a component of provider payments is necessary to ensure compliance with the Medicaid statute.

- Medicare Precedent

We are concerned with CMS' use of various Medicare provisions to support its assertion that GME is not a "health service." In the preamble, CMS indicates that Medicare reimbursement distinguishes between "basic" payments for operating and capital costs of inpatient hospital services, which are then "supplemented" by payments for GME and indirect medical education (IME). CMS points to Section 1886(a)(4) of the Medicare statute, which identifies the "operating costs of inpatient hospital services" that are reimbursed by Medicare under the Inpatient Prospective Payment System (IPPS), and notes that the costs of approved educational activities are excluded from this definition of "operating costs of inpatient hospital services."

The fact that the Medicare program reimburses hospitals for GME costs through a per-resident payment methodology and not as part of its IPPS rate provides no support for CMS' conclusion that the cost of direct medical services provided by interns and residents should be excluded from consideration in the Medicaid payment process. The Medicare program has, since its inception, recognized that medical education costs are allowable inpatient hospital costs and that these services contribute to the quality of care.

The Medicare statute at Section 1861(b) lists the services that are included in the definition of "inpatient hospital services." These services expressly include services provided by interns and residents under an approved teaching program. Consequently, it is our belief that Medicare does not support the assertion that intern and resident services are not health care services or are not inpatient hospital services.

Instead of following Section 1861(b), which clearly shows that intern and resident services are included in Medicare's definition of inpatient hospital services, CMS in its preamble relies upon the definition of "inpatient operating costs" in Section 1886(a)(4). While it is true that Section 1886(a) (4) excludes educational costs, its intent is to clarify that the Medicare program does not reimburse hospitals for GME costs through the IPPS payments. Medicare excludes educational costs from the IPPS, as these costs are reimbursed through separate GME payments. It is imperative to note that the GME payment for each hospital is, in fact, based on its actual costs incurred in a base year. While GME and IME are "supplemental" payments, they represent payment for the actual costs of furnishing patient care.

- Compliance with Medicaid Statute

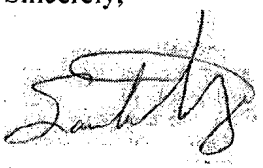
We do not believe that CMS has provided a basis to conclude that the proposed rule is in compliance with Section 1902(a)(30)(A) of the Medicaid statute, which requires that Medicaid inpatient hospital payment rates bear a reasonable relationship to an efficient and economical hospital's costs of providing quality services. In particular, CMS has not provided an analysis in support of its apparent conclusion that GME programs are an inefficient and uneconomical means of providing Medicaid services, and the proposed rule provides no explanation as to how the exclusion of intern and resident costs will bear a reasonable relationship to costs.

Lastly, although the proposed rule characterizes the elimination of GME Medicaid costs as a "clarification," it actually represents a major reversal of the long-standing Medicaid policy to pay for the costs of direct patient services. For decades, most state Medicaid programs, including California's, have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments.

Given the important role of UC's teaching programs and the teaching programs at other California hospitals, it is critical that California's Medicaid program continue to receive federal matching assistance for GME. We therefore respectfully urge CMS to rescind the proposed rule.

Thank you for the opportunity to comment on this proposal. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,



Santiago Muñoz, Associate Vice President
Clinical Services Development

cc: Medical Center CFOs

Submitter : Mr. Donald Yearsley **Date:** 06/22/2007

Organization : Department of Public Welfare

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-209-Attach-1.PDF

#209

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

JUN 2 2 2007

Michael Nardone
Acting Deputy Secretary
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Telephone: (717) 787-1870
Fax: (717) 787-4639
www.dpw.state.pa.us/omap

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, Maryland 21244-8016
Attention: CMS-2279-P

Dear Sir or Madam:

The Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs (OMAP) is submitting comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicaid Program; Graduate Medical Education," published in the Federal Register, Volume 72, Number 99, Pages 28930-28936, on May 23, 2007.

Pennsylvania is concerned that adoption of this rule could compromise access to care for our most vulnerable citizens and for this reason, we oppose it. Teaching hospitals deliver a significant share of the inpatient medical care provided to Medical Assistance (MA) consumers in the Commonwealth, particularly in the urban markets of Philadelphia and Pittsburgh. Maintaining the high level of program participation by these institutions is essential to effective operation of our MA Program. Given the tight budgetary climate in Pennsylvania and nationwide, state MA programs and providers alike rely on all funding sources to maintain an adequate availability of hospital services. Graduate medical education (GME) payments supplement the MA rates for our teaching hospitals, reimbursing these institutions for the added costs associated with residency training programs. Absent this funding source, hospitals will be increasingly hard-pressed to serve the MA population.

Furthermore, funding of GME promotes the delivery of quality medical care. A comprehensive review of literature demonstrated the quality of care provided at teaching institutions in treating a range of complex conditions prevalent among the poor and elderly.[1] Pennsylvania, like most other states, is actively engaged in efforts to improve the quality of care provided to our Medical Assistance consumers and we rely on the expertise of teaching hospitals as part of this endeavor.

[1] "Quality of Care in Teaching Hospitals," by Dr. Joel Kupersmith for the Association of American Medical Colleges, 2003

The Medicaid program was conceived as a federal-state partnership, where each state was given the opportunity to design a program that suited the needs of its citizens. By recognizing the high degree of variability in health care provision nationwide and the different geographic needs of individuals, Medicaid programs have successfully tailored programs to local needs. States should continue to have maximum flexibility to design their MA payment methodology and the option to choose whether to provide funding for GME under the Medicaid State Plan.

Pennsylvania's approved State Plan has authorized funding for GME for more than twenty years. In State Fiscal Year (SFY) ended June 30, 2006, Pennsylvania Medical Assistance paid a total of $77.298 million to 86 hospitals with teaching programs. These GME payments have helped to ensure that MA recipients in Pennsylvania continue to have access to the critical services provided by teaching hospitals.

Loss of federal revenue to support these services will create additional fiscal burdens for states at a time when states are already under pressure to contain burgeoning Medicaid costs. States, like Pennsylvania, may be forced to reduce or eliminate payments made to hospitals, thereby discouraging hospitals from serving MA recipients. In the alternative, states will be forced to sacrifice in other ways to finance the federal share of GME payments.

An independent analysis conducted by the Medicare Payment Advisory Commission (MedPAC) in August of 1999 recognized that the higher patient costs of teaching hospitals reflect a number of factors that "are likely to strengthen the clinical care that Medicare beneficiaries...receive." These include undertaking more applied clinical research, furnishing broader and more technically sophisticated services, and providing care that is more complex. MedPAC also recognized that GME and other educational activities tend to enhance care because the "team" approach to care strengthens clinical decision-making and provides additional quality oversight. MedPAC recommended that Medicare should pay for these costs because of the benefits they provide to the Medicare population. Likewise, Medicaid patients benefit from the teaching and clinical mission of these institutions, and states should have the flexibility to recognize these costs in its hospital payment methodology.

Concerns recently expressed by the medical education community over the potential loss of federal funding for GME, specifically Direct Medical Education (DME) payments, also underscore how critical GME payments are to these hospitals. Darrell G. Kirch, M.D., President of the Association of the American Medical Colleges, shared his thoughts on the issue earlier this year. He pointed out that "These institutions and the medical school physicians who work in them are committed to caring for Americans who have nowhere else to turn for medical treatment. While major United States teaching hospitals represent just six percent of the nation's hospitals, they provide

almost 50 percent of all the charity care in this country. If these institutions lose federal support, it will stretch the already taut health care safety net to the breaking point."[2]

Based on the aforementioned reasons, the Pennsylvania Medical Assistance Program respectfully requests that CMS reconsider the decision to preclude federal financial participation for State Medicaid DME payments.

Thank you in advance for your careful consideration of these comments. If you have any further questions, please do not hesitate to contact Ms. Leesa Allen of my staff at (717) 772-6341.

Sincerely,

Michael Nardone

Michael Nardone

[2] Press release dated January 26, 2007 from Darrell G. Kirch, M.D., President of the Association of American Medical Colleges, an organization representing nearly 400 major teaching hospitals and physicians at the nation's 125 medical schools.

Submitter : **Ms. Mary Edwards** **Date: 06/22/2007**

Organization : **Fairview Health Services**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-210-Attach-1.DOC

#210

FAIRVIEW

Fairview Health Services

2450 Riverside Ave.
Minneapolis, MN 55454
612-672-6300

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of Fairview Health Services to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support their critical functions.

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, these medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

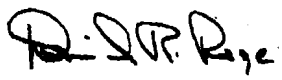
Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take

place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,



David R. Page
President and CEO
Fairview Health Services

Submitter : Anthony Rodgers **Date:** 06/22/2007

Organization : AHCCCS

Category : State Government

Issue Areas/Comments

GENERAL

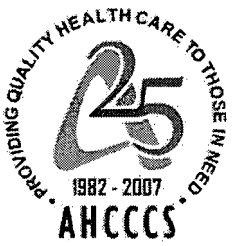
GENERAL

See Attachment

CMS-2279-P-211-Attach-1.DOC

#211

Janet Napolitano, Governor
Anthony D. Rodgers, Director



801 E. Jefferson, Phoenix, AZ 85034
P.O. Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

June 22, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-2279-P

Thank you for the opportunity to review and comment on the proposed rules prohibiting the use of federal Medicaid funds to support graduate medical education (GME) as published in the Federal Register on May 23, 2007 (72 Fed. Reg. 28930). The State of Arizona strongly supports CMS continuing to allow states to utilize Medicaid funds to support GME programs' direct and indirect costs. State Medicaid programs cannot assure adequate health care access without strategic policy tools like GME.

As Director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single State Medicaid Agency, I submit the following comments pertaining to those rules.

Summary of policy rationale to oppose the proposed rule changes.

1. **Consistency with Medicare**. CMS has historically allowed states to financially support GME programs through both direct and indirect cost reimbursement methodologies. This is a beneficial strategy to reduce manpower shortages and is consistent with authority under Medicare.
2. **Discretion to the states**. Medicaid is a federal/state partnership that allows states discretion in establishing service and program reimbursement methodologies consistent with program goals and that assures maintenance of effort within budget neutrality targets. GME falls within this discretionary authority.
3. **Meeting Federal requirements**. Federal requirements for state Medicaid programs include access to care and cost effectiveness. GME programs enhance service capacity and cost savings through physician residents at teaching hospitals and ambulatory care clinics assuring the state's supply chain of future providers.
4. **Provider shortages increase costs**. The Medicaid program has grown, increasing the demand for primary and specialty medical care. It is antithetical to reduce financial support to a program like GME, which is critical to meet this growing demand. Moreover, it is well documented that provider shortages in public programs leads to higher emergency room and inpatient utilization by Medicaid beneficiaries.

Medicaid GME funding has been recognized implicitly since the program's inception.

I disagree with the assertion that it is inconsistent with the Medicaid statute to pay for direct costs associated with GME. Arizona's utilization of Medicaid funds as a source of program revenue to finance GME is well-grounded. While there is, in fact, no statutory requirement for states to make GME payments, the Centers for Medicare and Medicaid Services (CMS) has recognized its implicit authority to make federal financial participation available for direct GME costs both in its rulemaking, as expressed in the current 42 C.F.R. §§ 438.6 and 438.60, and in its approval of Arizona's state plan amendments in 1993, 1998, and 2000.

Acting on approval by CMS, other states have made GME payments under their Medicaid programs since the beginning of the program. Medicaid payments for GME have been recognized and reviewed by the Office of Inspector General and the General Accountability Office. And despite this long history, Congress has never intervened to end CMS' authority to approve the use of Medicaid funds for GME program support.

Medicare's underlying policy rationale for GME is applicable to Medicaid today.

In addition, while the Medicaid statute does not explicitly authorize the expenditure of federal funds, the rationale for providing the express authority in Medicare also applies to Medicaid. In providing the explicit authority in Medicare, Congress was responding to general concerns that the nation was suffering from a shortage of physicians. Congress believed that educational activities contributed to the quality of care within institutions, and such activities were necessary to meet community needs for trained personnel. While it is true that Congress decided Medicare should only participate until communities shouldered the costs in some other fashion, Congress has not acted to substantially limit or eliminate Medicare subsidies for GME.

Arizona, as the nation's fastest growing state, is facing an imminent physician workforce crisis. Recently, researchers at the Arizona State University and the University of Arizona published the *Arizona Physician Workforce Study, Part I*, which found that Arizona had 20.7 physicians per 10,000 people – substantially below the national average of 28.3. The study also found a disturbing misdistribution of physicians, ranging from a high of 27.6 in urban Pima County to a low of 4.8 in rural Apache County.

Arizona is taking action to address this workforce crisis. With the recent opening of the joint University of Arizona-Arizona State University medical school in Phoenix, Arizona now has two allopathic and two osteopathic schools of medicine. Researchers have demonstrated that there are clear connections between locations of medical schools and residency training, and between residency training and initial practice locations. Simply put, states with a higher percentage of physician residents from in-state medical schools are more likely to retain in-state graduates for residency; likewise, states with a higher percentage of physician residents from in-state medical schools are more likely to retain physicians of all specialties in all geographic locations. Therefore, Arizona's expansion of in-state medical school capacity can expand Arizona's physician workforce, *but only if* Arizona has sufficient capacity of in-state graduate medical education programs to accept more in-state graduates. Medicaid GME funds are a critical tool

for maintaining and expanding physician capacity. Medicaid, as a payer for 18% of all Arizonans, is a vital component of the healthcare fabric of this state.

GME programs add directly to the state's service capacity by providing clinical services to Medicaid beneficiaries. Additionally, GME programs train the next generation of providers, which assures not only future capacity but also providers who are up-to-date with the changes in evidence-based medicine and the access and quality of care requirements of public programs that have been part of their training program.

Address accountability concerns through regulation and guidance.

Reviewing the notice and proposed rule, it appears that CMS has significant concerns regarding accountability in the use of Medicaid GME funds. The notice asserts that traditional Medicaid financing of GME

> assures Federal participation, but does not provide clear accountability. Funding intended by the States to support GME often becomes subsumed within MCO or hospital rates (including supplements to these rates) or inpatient disproportionate share hospital (DSH) payments. As a result, it is difficult to quantify Medicaid GME payments or monitor and measures the effect of Medicaid payments on GME programs.

72 Fed. Reg. 28930, 28932 (May 23, 2007). Although there are some challenges of accountability regarding the use of federal matching funds for GME, the solution is not to scrap the program altogether, removing billions of dollars from the nation's teaching hospitals and medical education training programs. Rather, steps should be taken at the federal level to link Medicaid GME financing to the achievement of specific workforce objectives while continuing to provide states with flexibility to demonstrate innovative ways to meet those objectives.

As an example, by linking GME funding to the achievement of the state's workforce objectives, and to serving Medicaid-eligible persons, Arizona is holding teaching programs – and itself – more accountable for the use of GME funds. Traditionally, Arizona has modeled Medicaid GME payments after Medicare's payments, providing no restriction on specialties of physicians being trained and providing little assistance to cover the costs of training physicians in rural and non-hospital settings. Recently, however, Arizona has altered its Medicaid GME program to link payments directly to its workforce objectives.

In 2006, Arizona Governor Janet Napolitano secured an additional $12 million for the expansion of existing residency programs and for the development of new residency programs. This year, Governor Napolitano requested an additional $9 million in total funding for GME. The Governor's proposal explicitly links the new funding to the achievement of the state's physician workforce objectives by directing funds toward new teaching programs in rural counties, new residency positions that include rural county rotations, and to programs that encourage residents to establish permanent practices in rural counties. Programs receiving GME funding in either

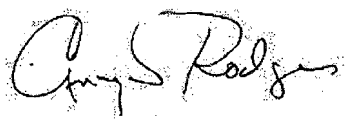
year, must identify and report the number of new residency positions created, including positions in rural areas.

Arizona goes beyond merely recognizing that financing physician training benefits all members of a community. In Arizona, explicit funding for GME is linked to the provision of services to Arizona's Medicaid members. AHCCCS has established a Memorandum of Understanding (MOU), voluntarily entered into between AHCCCS, a teaching program, and a Medicaid managed care organization. Upon entering into the MOU, AHCCCS and the Medicaid MCO work together to ensure that a sufficient number of Medicaid members are assigned to the teaching program to support that teaching program. Teaching programs in Arizona have as many as 7,000 assigned Medicaid members. In this way, GME funding directly benefits the many AHCCCS members who receive care at the teaching program. In turn, teaching programs provide educational opportunities for residents to familiarize themselves with principles of managed care and encourage residents to locate practices in Arizona.

With millions of dollars at stake, Arizona has a substantial interest in Medicaid GME funding. The abrupt and arbitrary elimination of this funding jeopardizes Arizona's efforts to address its workforce crisis, and the loss of funds will impact access to care, quality of care and preventive medicine at the very time that the President and Secretary are urging transparency and value driven health care decisions.

As a public servant, I share CMS' concerns regarding the accountability of public funds and take very seriously our fiduciary responsibility to taxpayers. It appears that due to these concerns, CMS wants to terminate GME funds putting at risk the ability of our state to build the physician workforce needed for the future. For these reasons, I respectfully request CMS to rethink this decision and work with its state partners to create the appropriate level of accountability necessary to maintain this vital program.

Sincerely,



Anthony D. Rodgers
Director

Submitter : **Dr. Rhonda Medows** **Date: 06/22/2007**

Organization : **Georgia Department of Community Health**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-212-Attach-1.DOC

#212

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

June 22, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2279–P
P.O. Box 8016
Baltimore, MD 21244–8016

*Re: (*CMS–2279–P*) Medicaid Program; Graduate Medical Education, (Vo. 72, N0. 99, May 23, 2007)*

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. Medicaid support of Graduate Medical Education (GME) facilitates continuing access to care for Medicaid members. Medicaid, like other payers, should continue to recognize the cost to hospitals that support teaching programs and play a proportionate role in the financial support of these facilities. Many states, like Georgia, already face shortages in physicians. The loss of Medicaid funding for hospital-based teaching programs will result in hospitals scaling down or closing their programs. This will only exacerbate the shortage problem and in the long-term, diminish access to care…not only for Medicaid members, but for all citizens.

I respect that CMS has some concerns about the current use of Medicaid funds to support GME programs. Instead of completely eliminating federal financial participation for GME, CMS should instead consider the following to address some of those concerns:

- Target GME funding based on a need for additional physicians in each state.
- Require periodic reporting from states on GME payments by provider.
- Require state Medicaid agencies to distribute managed care GME funds directly to the provider and carve them out of managed care arrangements.

CMS and its predecessor agencies have been funding the Medicaid share of GME expenses for more than 40 years. In the absence of statutory direction, CMS should continue to provide its federal funds for the Medicaid share of GME expenses.

Sincerely,

Rhonda M. Medows, M.D.

Submitter : Dr. David Stern

Date: 06/22/2007

Organization : University of Cincinnati College of Medicine

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-213-Attach-1.PDF

Given the important role of University Hospital, and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs continue to receive federal matching assistance for GME. Therefore, we urge the Agency to rescind the proposed rule.

Sincerely,

David Stern

David M. Stern, MD
Christian R. Holmes Professor
and Dean, College of Medicine

Submitter : Mr. John Bluford **Date:** 06/22/2007

Organization : Truman Medical Centers

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-214-Attach-1.PDF

#214

TMC
TRUMAN MEDICAL CENTERS
Better. For Everyone.

Office of the President

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of Truman Medical Centers to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their ability to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC) in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. The Missouri Medicaid Program for many years has recognized the key role of Medicaid graduate medical education at Truman Medical Centers and other Missouri teaching hospitals. Truman Medical Centers and other Missouri teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future.

At Truman Medical Centers there currently are 306 residents and fellows in training, including the following specialties: Anesthesiology, Community and Family Medicine, Sports Medicine, General Dentistry, Oral & Maxillofacial Surgery, Emergency Medicine, Internal Medicine, Infectious Diseases, Medicine/Pediatrics, Gastroenterology, Critical

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,

John W. Bluford
President/CEO

First, if CMS applies its rationale for not recognizing GME costs to other costs defined in the implementing regulations (42 C.F.R. Part 440), but not listed in Medicaid statute (Section 1905(a)), some significant costs would now be classified as ineligible for purposes of FFP. Examples include durable medical equipment (DME), and transportation and other travel expenses.

Second, even if CMS were correct in reasoning that FFP should be available only for the items and services listed in the Medicaid statute, FFP would still be available for GME because it is part of inpatient and outpatient hospital services. CMS states in the proposed rule that the Medicaid statute permits States flexibility to develop their own methods and standards for determining payment requirements for covered hospital services **within reasonable estimates of what Medicare would have paid for the services**. Since Medicare pays for GME as a hospital service, State Medicaid payments for inpatient and outpatient hospital services that include GME costs are eligible for FFP.

The fact that the GME payment is separate from the PPS payment is irrelevant to whether GME is a reimbursable hospital cost under Medicare. Capital costs, for example, are paid outside the inpatient operating PPS, yet they are clearly reimbursable by Medicare as a hospital cost.

NJHA has attempted to show that CMS' reversal of long-standing policy acknowledging GME as an allowable cost is based on flawed reasoning. By failing to justify termination of the federal funds supporting Medicaid GME programs, CMS should permanently withdraw this proposed rule. The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs, which, through their teaching function, provide care to some of our most vulnerable populations.

Sincerely,

Sean J. Hopkins
Senior Vice President, Health Economics

Submitter : **Date: 06/22/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-216-Attach-1.PDF

#216

SNHA Safety Net Hospital Alliance of Florida

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of the Safety Net Hospital Alliance of Florida (the "Alliance") to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments.[1] First and foremost, the proposed rule should be withdrawn in light of the subsequent passage of congressional moratorium language making promulgation of the rule incongruous during the moratorium period. Finalizing this rule would erode the financial condition of Florida's teaching and safety net hospitals that have made an investment in educating and training our future physicians. The rule, if promulgated, will jeopardize their abilities to continue to fulfill important teaching, patient care, education, research missions.

There are 14 Alliance hospitals, which represent a small fraction of the hospitals in Florida; however, this group of hospitals provides over 80% of the GME programs and positions in the state. These hospitals are the primary teaching facilities for the state's medical schools; 2,156 residents were educated and trained in 196 accredited programs during 2006/07. In addition to their education mission, these hospitals provide over half of the state's charity care hospital days.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs.

[1] 72 Federal Register 28930 (May 23, 2007)

101 N. Gadsden Street · Tallahassee, FL 32301 · Office: 850.201.2096 · Fax: 850.201.2078
www.snhaf.net

Florida's physician workforce has not kept pace with the state's booming population growth; Florida general and physician populations are aging. One-fourth of Florida's licensed physicians are over the age of 65 and half are over age 50; only 10% of Florida's working physicians are under the age of 35. Now, is not the time to further jeopardize Florida's physician workforce by making it increasingly difficult for hospital to sponsor needed medical resident programs and positions.

Teaching and safety net hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Florida's teaching and safety hospitals provide 99% of the state's burn care, two out of every three organ transplants performed in Florida, and represent all of the state's designated Level I trauma centers. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals assure continuous access to critical care. Most recently, teaching and safety net hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching and safety net hospitals with residency programs, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,

Anthony P. Carvalho

Anthony P. Carvalho
President

Cc: Florida Congressional Delegation
Teaching Hospital Council of Florida Board of Directors
Safety Net Hospital Alliance of Florida Board of Directors

101 N. Gadsden Street · Tallahassee, FL 32301 · Office: 850.201.2096 · Fax: 850.201.2078
www.snhaf.net

Submitter : Ms. Donna Sollenberger **Date:** 06/22/2007

Organization : University of Wisconsin Hospital and Clinics

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-217-Attach-1.PDF

CMS-2279-P-217-Attach-2.PDF

#217

June 21, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

University of Wisconsin Hospital and Clinics four-part mission includes a commitment to educate the next generation of medical professionals. As such, we urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (see 72 Fed. Reg. 28930). Finalizing this rule would jeopardize our ability to continue this important mission which not only has an impact on the future of these important education programs, but also directly impacts patient care in the rural and underserved areas of our state.

The Wisconsin Idea, is an ideal designed to improve the lives of all of our residents. UW Hospital and Clinics GME program is directly involved in that ideal with its innovative programs. UW Hospital and Clinics has been long recognized as a national leader in many specialized fields of medicine, including cancer treatment, pediatrics, ophthalmology, surgical specialties and organ transplantation. The hospital is frequently sited in publications rated as the nation's best medical facilities. This level of expertise translates directly to the supervised patient care team of health care professionals, medical residents who provide needed care to Medicaid and other patients as part of their training programs.

Our 530 residents, in 56 different specialty programs train and participate heavily in the care of underinsured and governmental programs. For example, our resident clinic in psychiatry is one of the only two providers of services to Dane County. Our residents have a strong presence in our ambulatory pediatric

and internal medicine clinics where we see a high number of Medicaid patients, and we have extensive affiliations with hospitals in both rural and metropolitan settings across the state. And UW Hospital and Clinics is the only hospital in the state of Wisconsin offering a Level One Trauma Center for both Adult and Pediatrics and a verified burn center and that our residents are critical to this program.

Being a part of the state university system translates to a high number of applicants from the smaller rural communities. We are able to train them in the context of their own community, and again, linking to the Wisconsin Idea, many of them choose to return to those communities. These highly trained specialty and sub-specialty physicians are filling the needs in many Wisconsin communities. It is clear that eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout our own state and the country.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. In the case of the UW Hospital and Clinics, the state of Wisconsin Medic aid Program currently proves an annual GME reimbursement of $2.6 million dollars. This reimbursement has been provided for over 10 years.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. UW Hospital and Clinic treats 2200 Medicaid inpatients a year and provides 34,000 Medicaid outpatient visits a year, at a cost that exceeds reimbursement by $20 million dollars per year. It also provides charity care to thousands of patients per year at an annual cost approximately $13 million dollars a year.

We provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac

care, and transplant services take place. We offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, we are caring for some of the sickest patients.

We urge the Agency to closely evaluate the important role that GME plays in the future of quality health care, and to rescind the proposed rule which would have a negative impact on our own and other programs that receive federal matching assistance for GME.

Sincerely,

Donna K. Sollenberger

Donna K. Sollenberger
President & CEO

CMS-2279-P-218

Submitter : Mr. Steven Renne **Date:** 06/22/2007

Organization : Missouri Department of Social Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attached file.

CMS-2279-P-218-Attach-1.DOC

#218

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

In the Matter of	)
	)
Proposed Medicaid Program Rules on	)
	)
GRADUATE MEDICAL EDUCATION	)
	)
CMS-2279-P	)
	)

COMMENTS OF THE MISSOURI DEPARTMENT OF SOCIAL SERVICES

The Missouri Department of Social Services submits these comments in response to the proposed regulations, published May 23, 2007, that would eliminate Medicaid reimbursement for direct Graduate Medical Education (GME) costs. Missouri has also joined in the Joint Comments, submitted on behalf of a group of states in opposition to the proposed rules, that explain why the proposal is not supported by the law and is bad public policy.

With 35 teaching hospitals in the State, reimbursement for GME costs is an important component of Missouri inpatient hospital reimbursement. The Centers for Medicare & Medicaid Services ("CMS") has repeatedly (and recently) approved plan amendments that expressly reimburse for those costs. The per diem rate paid to hospitals includes a component for graduate medical education costs (SPA 00-15, approved Aug. 28, 2001); the Direct Medicaid add-on payment pays for a number of unreimbursed Medicaid costs, including specifically medical education costs, that are not covered by the per diem (SPA 05-04, approved Apr. 24, 2006); and the plan provides for a quarterly GME payment to account for medical education expenses attributable to hospital services provided to enrollees of managed care plans (SPA 05-04. approved Apr. 24, 2006). The State also makes an annual enhanced GME payment to reflect

the fact that the Medicare calculation of GME costs (which is used for the State's other GME payments) has not kept pace with the inflation of health care costs (SPA 00-10, approved Aug. 28, 2001).

These payments result in reimbursements of over $130 million annually to the hospitals that incur expenses in training the next generation of health care professionals, out of $2.2 billion total Medicaid reimbursement to these hospitals. The impact of eliminating this reimbursement to Missouri teaching hospitals will be grave. Nor can Missouri increase its hospital payments to help alleviate the loss in revenue because elimination of GME reimbursement from the Medicare UPL calculation will drive down the aggregate cap on hospital reimbursement.

CMS's position that it is "clarifying" that these are not reimbursable costs related to the provision of hospital services is not supported by the statute or the history of GME reimbursement, as set forth in the Joint Comments that Missouri has joined. CMS's own repeated actions in approving plans such as Missouri's that expressly provide for reimbursement of GME expenses also rebuts the position taken in the proposed rules. Moreover, CMS's own rules have recognized the centrality of GME to hospital reimbursement. For example, Missouri's quarterly and enhanced GME payments are paid in accordance with CMS rules at 42 C.F.R. 438.60 that "[t]he State agency must ensure that no payment is made to a provider than the the MCO . . . except when . . . the State agency has adjusted the capitation rates paid under the contract . . . to make payments for graduate medical education."

Teaching hospitals are some of the most critical providers to Missouri's Medicaid program, and supporting the training physicians who are treating the State's most fragile and

disadvantaged citizens is an important goal that should be promoted, not weakened, by its federal partners.

For these reasons, and the reasons set forth in the Joint Comments, we urge that the proposal be rejected in its entirety.

Submitter : Dr. Robert Golden **Date:** 06/22/2007

Organization : UW-Madison School of Medicine and Public Health

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter

CMS-2279-P-219-Attach-1.PDF

#219

University of Wisconsin
SCHOOL OF MEDICINE
AND PUBLIC HEALTH

Administration

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of the University of Wisconsin School of Medicine and Public Health to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007, proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care, and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support their critical functions.

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, these medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

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UW Health
UW School of Medicine and Public Health
UW Hospital and Clinics
UW Medical Foundation

Because half of all Medicaid discharges are from the nation's nearly 1,100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources.

Teaching hospitals provide an environment in which clinical research can flourish and where highly-specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,

Robert N. Golden

Robert N. Golden, M.D.
Dean, School of Medicine and Public Health
Vice Chancellor for Medical Affairs
University of Wisconsin-Madison

Cc: Gordon Ridley
Carl Getto, M.D.

Submitter : Mr. Charles N. Kahn III **Date:** 06/22/2007

Organization : Federation of American Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-220-Attach-1.TXT

#220

June 22, 2007

VIA HAND-DELIVERY

The Honorable Leslie V. Norwalk, J.D.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS Proposed Rule with Comment Period, Medicaid Program; Graduate Medical Education; CMS-2279-P; Federal Register (May 23, 2007)

Dear Ms. Norwalk:

The Federation of American Hospitals ("FAH") is the national representative of investor owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, long-term care, rehabilitation, and psychiatric hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule ("Proposed Rule") regarding Medicaid funding of graduate medical education ("GME") programs.

FAH urges CMS to rescind the May 23, 2007 Proposed Rule that seeks to eliminate federal financial participation ("FFP") matching funds associated with Medicaid GME. Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their ability to continue to fulfill important teaching and patient care missions.

Although characterized by CMS as a "clarification," the Proposed Rule actually represents a reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS has approved and matched these payments. Indeed, in the Proposed Rule, CMS indicated that it "has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services." 72 Fed. Reg. 28,930, 28,931 (May 23, 2007).

FAH respectfully points out that CMS should not be concerned that it seemingly lacks express Congressional approval to provide FFP for GME costs. First, as CMS acknowledged, states have a great deal of flexibility in establishing hospital payment rates and are not expressly prohibited from including GME costs or payments in that computation. Given that the Medicare program considers GME payments to be a critical source of funding for teaching hospitals, it would not be unexpected or unreasonable for states to follow suit and provide additional funding for teaching hospitals. Further, Congress can certainly be deemed to have acquiesced in CMS's long-standing policy of allowing the inclusion of GME costs in FFP payments to states.

According to a study commissioned by the Association of American Medical Colleges ("AAMC"), 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Significantly, FAH believes it might well be administratively difficult for states and hospitals to separate out payments for direct medical education from those related to indirect medical education. The states' methods of providing medical education payments may not be that specific. Thus, the Proposed Rule could create a new, extreme and costly administrative burden on states and Medicaid providers.

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals are a critical component of the health care safety net. Moreover, like

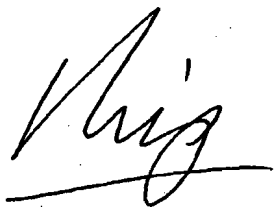
all full service community hospitals, teaching hospitals are looked to as front-line responders in the event of a pandemic or terrorist threat.

Given their important roles and the current and future financial uncertainty for America's hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. FAH urges CMS to rescind the Proposed Rule.

****

FAH and its members greatly appreciate the opportunity to submit these comments. If you have any questions, please do not hesitate to contact me or Steve Speil, Senior Vice President, Health Finance and Policy, at (202) 624-1529.

Respectfully Submitted,



Submitter : Ms. Tonya Nottmeier **Date:** 06/22/2007

Organization : Trinity Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-221-Attach-1.PDF

#221

TRINITY HEALTH
Novi, Michigan

June 21, 2007

Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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www.trinity-health.org

REF: Re: (CMS-2279-P) Medicaid Program; Graduate Medical Education (Vol. 72, No. 99), May 23, 2007

Dear Ms. Norwalk:

On behalf of our 31 acute care hospitals operating in Maryland, Ohio, Michigan, Iowa, Indiana, Idaho, Nebraska, and California, Trinity Health appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rulemaking changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs. **As you know, the proposed rule is subject to a yearlong moratorium secured by P.L. 110-28.**

Trinity Health respectfully submits these comments with strong opposition to the policy changes proposed in this rule. The proposed rule substantially departs from long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs. Although CMS claims this rule clarifies existing GME policy, it completely reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The agency's recent decision will result in a cut of nearly $2 billion in federal funds out of the program. **Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.**

For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. **All teaching hospitals rely on these and other Medicaid payments to support critical functions.**

At Trinity Health, we have GME programs at eleven of our acute care facilities. Medicaid GME payments for these programs are nearly $7 million each year. These GME payments are used to offset the cost of the teaching programs. Even after offsetting our costs with GME payments from Medicaid and Medicare, we estimate that the annual net cost to us of educating physicians is $24 million.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. At Trinity Health, our teaching hospitals provided $75 million of Charity Care (at cost) and contributed $71 million toward the cost of caring for the Medicaid patients (net of Medicaid payments). **Implementation of the proposed Medicaid GME payment reductions would be harmful to our institutions.**

At Trinity Health our conviction that health care is a basic human right drives us to seek out the most needy in our communities even if they don't show up at our hospital doors. Our teaching

hospitals provided more than $33 million in direct outreach programs to the uninsured and indigent (this amount is **exclusive** of Charity Care and the Unpaid Cost of Medicaid reference earlier in the letter). These programs include: free or low-cost prescription medications, free-standing community clinics, hospice care, and mobile units. **If the GME Medicaid payments are discontinued, the impact on our available financial resources would jeopardize the future of such programs and the health of this vulnerable population.**

Medicaid GME payments help our teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. **Eliminating FFP for state Medicaid agency payments for GME could be detrimental to our graduate medical education programs at a time when more physicians are needed throughout the country.**

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. We urge the Agency to rescind the proposed rule.

Sincerely,

Timothy Eckels, VP Public Policy
eckelst@trinity-health.org

Paul Sahney, VP Revenue Management
sahneyp@trinity-health.org

Submitter : Lisa Brandenburg **Date:** 06/22/2007

Organization : University of Washington Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-222-Attach-1.PDF

#222

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of University of Washington Medical Center (UWMC) to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (72 Federal Register 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care, and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support our critical functions. Through components of our Medicaid rates and additional supplemental payments UWMC receives approximately $8.5 million and $9.7 million, per year, for direct and indirect medical education, respectively.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. The University of Washington is the only accredited medical school in a five state area encompassing Washington, Alaska, Idaho, Montana, and Wyoming. UWMC trains over 300 residents in over 50 disciplines annually, and is by far the largest residency

Lisa Brandenburg, Interim Executive Director
1959 N.E. Pacific Street, Room BB318 Box 356151 Seattle, WA 98195-6151 206-598-4465 Fax 206-598-6292 lisab@u.washington.edu

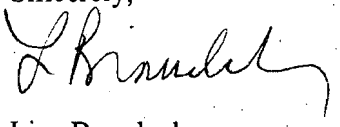
program in the state. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Nearly 30 percent of UWMC's discharges are for Medicaid clients. A GME funding cut will affect our ability to provide all services to Medicaid and other patients, completely eliminating our operating margin. As an academic medical center, our teaching function is integral to operations and cannot be considered unrelated to patient care.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care takes place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment, caring for the sickest patients. At UWMC our neonatal intensive care, oncology, cardiology, and transplant programs are advancing the state of care in across the nation.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,



Lisa Brandenburg
Interim Executive Director
UW Medical Center

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Submitter : Joseph Zambuto **Date:** 06/22/2007

Organization : Covington & Burling LLP

Category : State Government

Issue Areas/Comments

Background

Background

See Attachment.

GENERAL

GENERAL

See Attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment.

CMS-2279-P-223-Attach-1.PDF

#223

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

In the Matter of	)
	)
Proposed Medicaid Program Rules on	)
	)
GRADUATE MEDICAL EDUCATION	)
	)
CMS-2279-P	)
	)

JOINT COMMENTS OF TWENTY STATES AND STATE MEDICAID AGENCIES

These comments on the above-captioned proposed rule are submitted on behalf of the agencies and officials responsible for administering the Medicaid program in the States of Alaska, Connecticut, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, North Carolina, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, and Washington ("Commenting States") in response to the proposed rule on Medicaid reimbursement of Graduate Medical Education (GME), published May 23, 2007, at 72 Fed. Reg. 28,930.

The "clarification" that costs and payments associated with GME programs are not expenditures for medical assistance for which federal reimbursement is available under the Medicaid program is an unsupportable interpretation of Title XIX that flies in the face of forty years of approved reimbursement practices in virtually every State. The unjustified prohibition of these costs as Medicaid reimbursable will substantially reduce payments to the nation's teaching hospitals, which tend to be the most critical providers of hospital care for Medicaid and other indigent patients. That result cannot be squared with the responsibility of the States -- shared by the federal government through its federal financial participation -- to pay rates that

are consistent with "quality of care" and that assure "access to care." The proposal's attempt to distinguish Medicare and Medicaid is fundamentally flawed and cannot explain why costs reimbursed for treating the nation's elderly should not also be reimbursed for care provided to its poorest and most fragile citizens. The proposal is without merit and without basis in the statute and should be withdrawn in its entirety.

I. BACKGROUND TO THE PROPOSED RULE

In the 1965 Amendments to the Social Security Act, Congress authorized federal funding to the States for programs providing medical assistance to the needy. Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1901-1905 (1965). Section 1903(a)(1) of the Act stipulated that federal funding would be available for a percentage of amounts "expended...for medical assistance under the State plan." Section 1905(a) named "inpatient hospital services" as one constituent of "medical assistance" that must be covered by State Medicaid plans in order for them to be eligible for FFP. The term "inpatient hospital services" was not defined in the portions of the 1965 Social Security Amendments dealing with Medicaid. *See id.*

The same Act of Congress established the Medicare program, which provided funding for a package of medical services to the elderly, also including "inpatient hospital services." That term was defined in section 1861(b) of the Act to include "services provided by interns or residents in training under approved teaching programs." Pub. L. No. 89-97, § 1861(b). In 1970, the Health Care Financing Agency ("HCFA") promulgated regulations to guide States in the construction of their Medicaid plans. 45 C.F.R. § 250 (1970). These regulations dictated that for the purposes of assessing payments to a hospital for "inpatient hospital services," States must "apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment current used in computing reimbursement...under [Medicare]." 45 C.F.R. § 250.30(b)(1). Among the Medicare regulations specifically cited in that paragraph

(20 C.F.R. § 405.415–405.429 (1970)) was the section affirming Medicare's commitment to funding medical education and stating that "[a]n appropriate part of the net cost of approved educational activities is an allowable cost." 42 C.F.R. § 405.421 (1970).

When HCFA revised these regulations in 1978, 42 C.F.R. §447.261(b) (1978), they retained the reference to Medicare's payment principles but added a subsequent subparagraph, 42 C.F.R. § 447.261(c)(1), specifically excluding one of them (*i.e.*, the "inpatient routine nursing salary cost differential"). The fact that HCFA did *not* choose at that time to exclude the principle providing for medical education costs confirms that the agency purposefully included medical education as a reimbursable cost of inpatient hospital services under Medicaid. In the early 1980s, Congress implemented a new prospective payment system ("PPS") for assessing hospital costs for the purposes of Medicare reimbursement. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607 (1983). The new system "shifted the basic unit of reimbursement from 'the hospital' to national average rates imposed on all hospitals alike, adjusted for variations recognized to be 'legitimate.'"[1] Among those items that came to be treated as "legitimate variations" were several categories of costs that had previously been treated as elements of inpatient hospital costs, including indirect medical education ("IME") and direct graduate medical education ("DGME") expenses, *id.* at 140-41. Medicare continued to reimburse hospitals for these costs, but they were assessed separately and added to the base PPS calculation.

[1] David M. Frankford, *The Complexity of Medicare's Hospital Reimbursement System: Paradoxes of Averaging*, 78 IOWA L. REV. 517, 522 (1993).

With this proposed rule, CMS seeks to "clarify" that costs associated with DGME are not reimbursable expenditures for "medical assistance" under the Medicaid program. 72 Fed. Reg. 28,930 (May 23, 2007). It argues that the exclusion of direct GME costs from Medicare PPS system is grounds for the conclusion that "GME is outside the scope of medical assistance, and that GME funding is not an allowable component of payment methodologies included in a State's approved Medicaid State Plan or in any Medicaid managed care payment." *Id.* at 28,933.

As shown above, there is nothing in the statute or the history of either the Medicare or Medicaid program to support that conclusion.

II. COMMENT

A. GME is a Cost of Providing Care in Teaching Hospitals.

The fact that GME is not listed in section 1905(a)(1) is insignificant and has been treated as such for as long as the Medicaid program has existed. GME has always been treated, under both Medicare and Medicaid, as a part of inpatient care, which is the very first service listed under "medical assistance" in section 1905(a)(1). Pub. L. No. 89-97, § 1905(a)(1).

It is irrelevant that Title XIX does not identify GME as a component cost of inpatient hospital services. Unlike the Medicare program design, which expressly identifies the costs to be reimbursed, and lays out a methodology for doing so, the States have had flexibility to design their Medicaid reimbursement methodologies for hospitals. That flexibility has steadily increased -- from the "reasonable cost" mandate of 1965; to the responsibility in 1972 to develop "methods and standards" for making payments on reasonable cost basis; to the 1981 Boren Amendment directive to make "findings" and "assurances" that payment rates were reasonable and adequate to meet the costs of efficiently and economically operated facilities; to the current requirement, put in place in 1997, that there be a public process for determination of hospital payment rates. *See* Pub. L. 89-97, § 121(a) (1965); Pub. L. No. 92-603, § 232(a) (1972);

Pub. L. No. 97-35, § 2173 (1981); Pub. L. No. 105-33, Title IV, Subtitle H, Ch. 2, § 4711(a) (1997). Under each of those statutory regimes, States have had approved methodologies in their State plans that included, as part of the cost of inpatient hospital services in teaching hospitals, the costs of GME.

The States' flexibility in setting hospital payment rates has, for decades, been constrained by the rates that would be paid under Medicare payment principles.[2] *See* 42 C.F.R. § 337.261 (1978), 42 C.F.R. § 447.272(b)(1) (1987). The architects of the Medicare program clearly regarded GME as "an element in the cost of patient care", S. Rep. No. 89-404, at 36 (1965), and they treated it as such in the design of the program. According to the 1965 Social Security Amendments that enacted the original Medicare program, "inpatient hospital services" included "services provided by interns or residents in training under approved teaching programs." Pub. L. No. 89-97, § 1861(b). Reports from both houses of Congress supported the inclusion, H.R. Rep. No. 89-213, at 5 (1965); S. Rep. No. 89-404, at 27 (1965), with the Senate Finance Committee offering the following rationale:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes the bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

S. Rep. No. 89-404, at 36 (1965). In the original regulations governing the implementation of Medicare, the Secretary echoed this rationale, writing that "these programs contribute to the

[2] As noted in Part I of these Comments, HCFA's 1970 Medicaid regulations mandated that States reimburse providers according to Medicare's payment principles, including the regulation committing Medicare to reimburse costs of medical education. Later, they were given the option either to employ Medicare's payment principles or to regard them as an "upper limit." *See* 45 C.F.R. § 250.30(b) (1970); 42 C.F.R. § 450.30 (a)(2)(i) (1977); 42 C.F.R. § 447.261 (1978); 42 C.F.R. § 447.272 (1981).

quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel," and that "until communities undertake to bear these costs, the program will participate appropriately in the support of these activities." 20 C.F.R. § 405.421 (1967).[3]

There is no basis for CMS's apparent assumption that Medicare's adoption of the prospective payment system ("PPS") in 1983 invalidated the premise that GME was "an element in the cost of patient care" in the Medicare program, or that these costs could be "borne to an appropriate extent by the hospital insurance program" but not by the Medicaid program. It is true that when Congress adopted PPS in 1983, it continued to reimburse the "direct" costs of GME by the traditional cost-based method, while creating a novel method for calculating the "indirect" costs. *See* S. Rep. No. 98-25, pt. 1, at 140-41 (1983). The preamble to the proposed rule contends that, since these costs--and particularly the direct GME costs--came to be calculated in a different manner from the prospective payment system's basic determination of inpatient costs, they are not to be regarded as covered inpatient services. *See* 72 Fed. Reg. at 28,932. But there is nothing in the legislative history of the 1983 amendments to support that view. In fact, the Committee report accompanying the bill suggests that Congress excluded GME and other categories of inpatient costs from the PPS system because of concerns that the new system would not adequately account for them. *See* H.R. Rep. 98-25, pt. 1, at 135, 140-141 (1983).[4] The Committee even "emphasizes its view" that a special IME adjustment is necessary

[3] This language remained in the Code of Federal Regulations until the year 2000. Originally codified as 20 C.F.R. § 405.421 (1967), it was later recodified as 42 C.F.R. § 405.421 (1977), and then as 42 C.F.R. § 413.85 (2000).

[4] *See also* Medicare Payment Advisory Commission ("MedPAC"), *Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals* 5 (1999) [hereinafter MedPAC, *Rethinking Medicare*]; Joseph P. Newhouse & Gail R. Wilensky, *Paying for Graduate* (continued...)

because "such expenses are not to be subjected to the same standards of 'efficiency' implied under the DRG prospective system." H.R. Rep. No. 98-25, pt. 1, at 140 (1983). Thus, exceptional treatment under the new regime was certainly not a sign of decreased significance or obsolescence.

Nowhere in Congress's discussion of the decision to separate GME from the PPS system is it suggested that GME or the other costs excluded from the basic PPS calculation (such as DSH adjustments or outlier payments) were not legitimate components of reimbursement inpatient care. *See id.* Rather, the changes reflect a different *method* of reimbursing for those different components.

Neither does the legislative history support a distinction between IME and DGME with respect to eligibility for reimbursement as a cost of inpatient hospital services. In a 1999 report analyzing Medicare's GME reimbursement, the Medicare Payment Advisory Commission ("MedPAC") concluded that the distinction between "direct" and "indirect" GME expenses is "an accounting artifact,"[5] left over from the era when all inpatient services were reimbursed according to cost, and assessing those costs required segregating different kinds of activities.[6] Even under the cost-based system when such segregation was necessary, MedPAC points out, Congress reimbursed both direct and indirect GME costs "based on the belief that '...these activities enhance the quality of care in an institution'."[7] With the transition from cost

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Medical Education: The Debate Goes On, 20 HEALTH AFF. 136, 138 (2001) (suggesting that Congress felt it necessary to decide "whether and how to account for teaching hospitals' higher costs").

[5] MedPAC, *Rethinking Medicare*, *supra* note 5, at xii.

[6] *See id.* at 4-5.

[7] *Id.* at 4 (citing H.R. Rep. No. 89-213).

accounting to PPS, the accounting distinction between DGME and IME was simply preserved as a convention; there was no implication that the new accounting methodologies reflected different degrees of relationship to inpatient care.

Medicare's current treatment of IME and DGME confirms that both are constituents of the cost of inpatient services. Each of them does have a unique accounting methodology; neither is part of the basic PPS calculation of inpatient hospital services. Nonetheless, they are both, as the preamble to the proposed rule acknowledges, treated as supplements to the basic inpatient hospital service payment rate. *See* 72 Fed. Reg. at 28,933.

The preamble to the proposed rule states that "[d]irect graduate medical education is specifically prohibited as part of the inpatient PPS rate at § 412.2(2)(e)[sic]," while "[i]ndirect medical education is separately identified as a payment adjustment based on a formula at § 412.105." 72 Fed Reg. at 28,932. That construction of the Medicare regulations is both incomplete and incorrect. DGME costs *for nursing and allied health professions* are "excluded" at § 412.2(e)(2), whereas DGME and IME for physicians are both listed in the subsequent subparagraph, § 412.2(f), as "additional payments to hospitals." 42 C.F.R. § 412.2(f). Other "additional payments" include DSH and outlier payments, both of which are treated as component costs of inpatient hospital care. *See id.* Thus, contrary to CMS's account in the preamble, physician DGME is not "specifically prohibited" but is merely described as an "additional payment" to the PPS payment, along with IME, DSH and outlier payments.

Finally, to call IME an "adjustment" and DGME a "supplement" obscures the more fundamental economic reality that both numbers represent additional costs of inpatient services at teaching facilities. According to MedPAC, the cost of residents' salaries are not "costs of training," to be contrasted with costs of better patient care:

> Residents earn a stipend because they provide patient care and perform other services that are of value to the hospital. Other things being equal, this stipend reflects the value of the services residents furnish minus the cost of their training. The direct cost of their training is reflected in the remaining direct GME expenses for faculty supervision, administrative staff, and facility overhead. In principle then, the direct GME costs that hospital report on their Medicare cost reports represent the net value of the patient care services residents provide.[8]

Based on this economic analysis, MedPAC concludes that "the distinction between the direct and indirect costs of training programs is artificial.... In the analytic framework of economics, the direct and indirect costs associated with training programs are indistinguishable; both represent costs of providing patient care."[9]

B. To Ensure Access to Care and Quality of Care, States Need the Flexibility to Consider GME Costs in Setting Hospital Payment Rates

While States are not required to reimburse teaching hospitals for the cost of GME in providing hospital services, virtually every State with a teaching hospital has elected to do so, to some degree. The responsibilities imposed on States by Title XIX require that they continue to have the discretion to recognize these costs in setting hospital payment rates.

Title XIX requires State Medicaid plans to ensure that Medicaid payments are consistent with "economy, efficiency and quality of care" and "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." SSA § 1902(a)(30)(A). Similarly, state plans must ensure that "care and services will be provided in a manner consistent with simplicity of administration and the best interests of recipients."

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[8] MedPAC, *Rethinking Medicare*, *supra* note 5, at 7-8.

[9] *Id.* at 6.

SSA §1902(a)(19). States may not be able to live up to these obligations if they are prohibited from considering GME costs in setting payment rates for hospital services, or if they are required to cut payments in order to satisfy the proposed lowering of the Medicare upper payment limit.

State policymakers may well determine that payment for GME is necessary to advance the objectives of "economy, efficiency and quality of care." Studies have concluded that teaching hospitals are particularly well-equipped to handle certain conditions prevalent among the poor and elderly. For example, according to one study published in *The American Journal of Medicine*, in-hospital death rates for patients admitted with heart failures, heart attacks, and strokes are lower at major teaching hospitals than non-teaching hospitals.[10] Likewise, another study in *The New England Journal of Medicine* concluded that care at major teaching hospitals for hip fractures, strokes, coronary heart disease, and congestive heart failure was costlier but led to better overall survival.[11]

State policymakers also need the authority to reimburse for GME costs if they conclude such payments are necessary to assure access to care. It is well established that teaching hospitals "play a prominent role as providers of specialty care to the poor."[12] Most teaching hospitals are located in urban and economically depressed inner-city areas,[13] and

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[10] Carisi A. Polanczyk, et. al, *Hospital Outcomes in Major Teaching, Minor Teaching, and Nonteaching Hospitals in New York State*, 112 AM. J. MED. 255 (2002).

[11] Donald H. Taylor, et. al, *Effects of Admission to a Teaching Hospital on the Cost and Quality of Care for Medicare Beneficiaries*, 340 NEW. ENG. J. MED. 293 (1999).

[12] Joel S. Weissman, et. al, *Limits to the Safety Net: Teaching Hospital Faculty Report on Their Patients' Access To Care*, 22 HEALTH AFF. 156, 157 (2003).

[13] *See* Mustafa Z. Younis, *A Comparison Study of Urban and Small Rural Hospitals Financial And Economic Performance*, ONLINE J. OF RURAL NURSING & MED. CARE (2003), http://www.rno.org/journal/issues/Vol-3/issue-1/Younis.htm

individuals in the poorest neighborhoods are most likely to choose a teaching hospital for their medical needs.[14]

Teaching hospitals provide a disproportionate level of care to Medicaid patients when compared to their non-teaching counterparts.[15] For example, public teaching hospitals are more likely to admit poor-paying transfer patients than other private hospitals.[16] The unique role of teaching hospitals is best illustrated by one recent study that analyzed how hospitals treated breast cancer for Medicaid-insured women. While teaching hospitals diagnosed just 12.5 percent of the cases, they cared for 21.3 percent of the Medicaid patients being treated for breast cancer.[17] In short, even if teaching hospitals do not make an initial diagnosis, they often end up being the ultimate health care provider for poverty-level patients.

Additionally, many teaching hospitals are children's hospitals providing critically needed services to Medicaid-enrolled children. From 2002 to 2006, the number of Medicaid-covered children, and the severity of their illnesses, increased at children's hospitals when compared to non-Medicaid children.[18] State policymakers may therefore reasonably determine that a GME payment component is important in order to assure continued access to specialty care for children.

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[14] *See* Eugene C. Rich, et. al, *Medicare Financing of Graduate Medical Education*, 17 J. GEN. INTERNAL MED. 283 (2002).

[15] *See, e.g.*, John K. Iglehart, *Teaching Hospitals*, 329 NEW. ENG. J. MED. 1052 (1993).

[16] *See* Adrienne Green, et. al, *The Relationship of Insurance Status, Hospital Ownership, and Teaching Status With Interhospital Transfers in California in 2000*, 80 ACAD. MED. 774 (2005).

[17] Lisa C. Richardson, et. al, *The Roles of Teaching Hospitals, Insurance Status, and Race/Ethnicity in Receipt of Adjuvant Therapy for Regional-Stage Breast Cancer in Florida*, 96 AM. J. PUB. HEALTH 160 (2006).

[18] *See* National Association of Children's Hospitals, *FAQs on Children's Hospitals*, (2006) http://www.childrenshospitals.net/AM/Template.cfm?Section=FAQs_on_Children_s_Hospitals.

Some States also have exercised their discretion, and should be able to continue to do so, to tie GME reimbursement to the accomplishment of specific policy objectives designed to improve access to care in Medicaid, such as encouraging more primary care training, more training outside the hospital, and more training in underserved areas.[19]

The proposed rule pays lip service to the States' "flexibility, subject to a reasonable estimate of what Medicare would have paid for the services, to develop their own methods and standards to determine the price they will pay for Medicaid covered services," but then takes the position that including payment for GME is not within that authority because "it is difficult to quantify Medicaid GME payments or monitor and measure the effect of Medicaid payments on GME programs." There is no requirement in Title XIX to "quantify" one cost item of a payment rate or to "monitor and measure" the effects of including it. Rather, the standard for assessing Medicaid payment rates -- established by Congress -- is one of efficiency, economy, access to care and quality of care based on overall payments. SSA § 1902(a)(30)(A). Nowhere in the proposed rule does CMS explain how its new interpretation can be reconciled with that standard, nor can it.

Conclusion

The proposed rule is ill-conceived. It is not based on any reasonable construction of the statute, and is in fact contrary to the statutory directives granting States the flexibility to set payment rates to achieve the objectives of quality of care and access to care. The premise that the costs of GME can only be appropriately considered in Medicare and not Medicaid is

[19] *See* Tim M. Henderson, *Medicaid's Role in Financing Graduate Medical Education*, 19 HEALTH AFF. 221, 225 (2000).

unfounded, as is the attempted distinction between IME and DGME payments. For these reasons, the proposed rule should be withdrawn.

Respectfully submitted,

/s/

Caroline M. Brown
Charles A. Miller
Joseph Zambuto, Jr.

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1201 Pennsylvania Ave., NW
Washington, DC 20004
(202) 662-6000

For the following States and State Medicaid Agencies:

Alaska Department of Health and Social Services
Connecticut Department of Social Services
State of Hawaii
Idaho Department of Health and Welfare
State of Illinois
Kansas Health Policy Authority
Kentucky Cabinet for Health and Family Services
Louisiana Department of Health and Hospitals
State of Maine
Michigan Department of Community Health
Missouri Department of Social Services
North Carolina Department of Health and Human Services
Ohio Department of Job and Family Services
Oklahoma Health Care Authority
Pennsylvania Department of Public Welfare
South Dakota Department of Social Services
Tennessee Bureau of Tenncare
Utah Department of Health
Office of Vermont Health Access
State of Washington

Submitter : **Mr. Don Snell** **Date: 06/22/2007**

Organization : **MCG Health, Inc.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS has proposed to no longer pay for the cost of training physicians to treat Medicaid patients.

CMS-2279-P-224-Attach-1.PDF

#224

Don Snell
President and Chief Executive Officer

MCG Health System

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Re: CMS-2279 - P

Dear Ms. Norwalk:

I am writing on behalf of MCG Health, Inc. (MCGHI). MCGHI is a 632 bed, two (2) hospital, public teaching hospital / safety net hospital (Level I Trauma Center, Level III NICU, only private Psychiatric service in the region), that serves the patients and families of Georgia, South Carolina, and much of the Southeast. I am writing to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Currently, MCGHI receive $908.44 for each Medicaid discharge for medical education. Approximately 60% of these Medicaid funds are federal funds. In FY 2006, MCGHI had 5,284 Georgia Medicaid discharges, which means we received $4.8 MM from Medicaid for medical education in FY 2006. If only the federal matching part of these funds is withheld, our reimbursement would decrease by $2.9MM. If, however, the state also chooses to withhold its Medicaid medical education funds, MCGHI will lose approximately $5,000,000 in much needed funding to support its critical role as a teaching hospital.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. MCGHI trains over 330 interns / residents / fellows each year in 39 physician training programs in a state (Georgia) that is already facing a shortage of doctors. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed in Georgia and throughout the country. In fact, CMS's position is a total administrative disconnect from recent federal health policy discussions calling for an increase in physician manpower by 30% or more over the next five (5) years. It does not make sense to call for such an increase and eliminate funds needed to pay for the increase at the same time.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. With a "payor mix" of 30% Medicaid, and 10% self-pay, MCGHI would experience reimbursement reductions that would force it to re-evaluate and reduce services it could provide to this population. This would have a significant impact on Medicaid patients in this region as we are the region's largest provider of services to the Medicaid population and uninsured (2nd in the state only to the Grady Health System).

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role. Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,

Don Snell
President and CEO
MCG Health, Inc.

MCG Health, Inc.
1120 15th Street, BA-3306, Augusta, GA 30912 MCGHealth.org
Medical College of Georgia Health System

Submitter : Mr. Richard Pierson **Date:** 06/22/2007

Organization : UAMS Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-225-Attach-1.DOC

#225

UAMS Medical Center

4301 W. Markham Street
Little Rock, Arkansas 72205-7199
501-686-7000

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave., SW
Washington, D.C. 20201

June 22, 2007

Attention: **CMS-23279-P**

Re: CMS-2279-P, Medicaid Program; Graduate Medical Education; Proposed Rule (Vol. 72, No. 99), May 23, 2007

Dear Administrator Norwalk:

The UAMS Medical Center appreciates the opportunity to provide comments on CMS's proposed rule to clarify that reimbursements for Graduate Medical Education under the Medicaid Program would be not allowed. The UAMS Medical Center (the "Hospital") is part of the University of Arkansas Medical Sciences (UAMS), which is located centrally in the state of Arkansas in the city of Little Rock. UAMS serves as the state's only academic health center. As such, the UAMS College of Medicine is the sole institution in the state which educates medical students to become future physicians. Additionally, UAMS Medical Center serves as the primary teaching hospital for the College of Medicine for its graduate medical education residency programs, training over two hundred and twenty five residents each year in most specialties. The Hospital's support of these residency programs depends heavily on these funds received through the Medicaid Program. If these reimbursements were to be eliminated as proposed, it would seriously jeopardize the Hospital's ability to continue to support these residencies. The consequences of this on the long term supply of physicians in the state of Arkansas would be dramatic and dire, and would be contrary to the current reality of the need for even more physicians in the future given the projected needs of the state. We believe this would negatively impact, in a substantial way, the access to, and the provision of, health care services for the needy individuals which the Medicaid Program indeed exists to assist. We think this is an unintended, but ironically, a very real consequence of this proposal.

Besides the residency programs supported directly by UAMS Medical Center, this proposal would significantly impact in a negative way, the long term supply of primary care physicians in rural areas of the state. UAMS, through its residency education programs operated at the UAMS Area Health Education Centers (AHECs) located in several areas throughout the state, trains over sixty family practice residents in those remote locations throughout the state in conjunction with local area hospitals. These residents go on to become a significant source of primary care physicians living in, and serving, some of the most rural areas of the state. The proposed cuts would no doubt affect the ability of those affiliated hospitals to continue to support these very needed primary care residencies of the AHECs.

We acknowledge CMS's discussion of the wording of the original statute with regards to intent vis-à-vis graduate medical education and the apparent vagueness of the UPL allowance which gave rise to much of

the current interpretation. However, it might be argued that CMS's long standing allowance of these funding mechanisms has already provided the clarity of treatment that this proposed rule now seeks to make. Regardless, to simply eliminate these funds without some alternative replacement source of funding would be crippling to our institution. In the proposed rule, CMS makes reference to the policy intent of the original Medicare GME support provisions, alluding to such timeframe as "until communities shouldered the costs in some other fashion." If this is a hint as to what the reasoning is in this regard, we believe it to be inconsistent with Medicare treatment and somewhat unrealistic with already strapped budgets of state and local governments. Whatever the reasoning, the immediate impact would be punitive to the hospital providers.

In the proposed rule, CMS also asked for specific comment on the propriety of including Medicare IME adjustments as part of the UPL calculation. For all the reasons stated above, and additionally recognizing that these costs relate to the operating costs of providing patient care, we feel that the Medicare IME should be retained as part of the UPL calculation.

We appreciate your consideration of our responses and feedback to the proposed rule, and respectfully urge CMS to reconsider and rescind the proposed rule.

Sincerely,

Richard A. Pierson
Chief Executive Officer

Submitter : Mr. Don Faulk **Date:** 06/22/2007

Organization : Medical Center of Central Georgia

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-226-Attach-1.DOC

#226

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

I am writing on behalf of The Medical Center of Central Georgia (MCCG) and the 670,000 residents of our 29 county, Central Georgia service area to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," the reality is the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Currently, the GME budget at the Medical Center of Central Georgia is approximately $11.75 million. The proposed rule would result in a loss of $2 million, a 17% reduction in GME funds. Teaching hospitals, specifically MCCG, rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future.

MCCG, in affiliation with the Mercer University School of Medicine (MUSM), hosts five residency programs - Family Practice, General Surgery, Internal Medicine, OB/GYN, and Pediatrics. Over the last five years, the MCCG residency programs have produced 125 physicians. Among those graduates, 31 have gone on to fellowships, 5 have pursued academics, 78 have entered private practice, all within Georgia, and 32 of those 78 private physicians are associated with MCCG. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care provided occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In FY 2006, MCCG treated 7,630 Medicaid inpatients, 89,242 Medicaid outpatients, 1572 indigent inpatients and 64,110 indigent outpatients at a **cost** of $134,682,770.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized, tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

The Medical Center of Central Georgia is a 501(c)(3) not-for-profit hospital of the Central Georgia Health System. Located in Macon, GA, the original hospital opened on March 27, 1895. Today, MCCG is the second largest hospital in Georgia with 603 beds and routinely treats residents from more than 50 counties in Central and South Georgia and a population of more than 670,000 in the immediate 29 county area. Our payor mix is Medicare 30%, Medicaid 21%, Insured 33%, and Self pay/other 16%.

Medical Center services and centers of excellence include

- Central Georgia's only Level I Trauma Center – one of only four in the state, treating over 48,000 patients in FY 2006
- Albert L. "Buddy" Luce, Jr. Heart Institute at the Georgia Heart Center
- The Central Georgia Breast Care Center
- The Ambulatory Surgery Center
- The Family Birth Center
- Diabetes Healthways
- The Cancer Life Center
- The Georgia Neuro Center
- The Children's Hospital (including a 42 bed NNICU)
- The W. T. Anderson Health Center (serving the uninsured)

The Medical Center offers a wide-variety of off-campus services such as

- Urgent Care centers – Med Centers North, East, and Northwest offering non-emergent care for minor illnesses and injuries.
- Neighborhood Healthcare Centers – primary care offices located in lower socio-economic neighborhoods providing non-urgent medical services.
- The Wellness Center and Macon Health Club
- Heartworks Cardiac Rehab
- Central Georgia Diagnostics – an offsite facility offering radiology and laboratory services

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. **I urge the Agency to rescind the proposed rule.**

Sincerely,

Don Faulk, FACHE
President and CEO
Medical Center of Central Georgia

Submitter : Dr. Barbara Atkinson **Date:** 06/22/2007

Organization : University of Kansas Medical Center

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-227-Attach-1.PDF

#227

KU THE UNIVERSITY OF KANSAS
Medical Center

June 21, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

On behalf of the University of Kansas Medical Center, I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to rescind the May 23, 2007, proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching and patient care missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support their critical functions.

The KU School of Medicine is the only medical school in Kansas, and we are therefore very committed to our responsibility to train physicians for our state. We sponsor over 400 residents in the Kansas City region, the majority of which are at the University of Kansas Hospital in Kansas City, Kansas. In addition, our affiliates in Wichita, Wesley Medical Center and Via Christi Health System, provide graduate medical education to over 250 residents. These 650-plus residents represent the future of not only the physician workforce in Kansas, but also the physician workforce for our region.

Medicaid GME payments help all teaching hospitals – in Kansas and across the nation – sustain one of their core responsibilities: providing clinical education to future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care

Office of the Executive Vice Chancellor
Mail Stop 2015 | 3901 Rainbow Blvd. | Kansas City, KS 66160 | (913) 588-1440 | Fax (913) 588-1412 | www.kumc.edu

to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting an impending physician shortage. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. The University of Kansas Hospital alone provides inpatient services to over 14,900 Medicaid patients and 10,900 uninsured patients a year. These services represent over $240 million in charges. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given their important roles and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. On behalf of the University of Kansas Medical Center and the University of Kansas School of Medicine, **I urge the Agency to rescind the proposed rule.**

Sincerely,

Barbara Atkinson MD

Barbara Atkinson, MD
Executive Vice Chancellor
Executive Dean, School of Medicine

Submitter : **Christine Bronson** **Date: 06/22/2007**

Organization : **Minnesota Department of Human Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2279-P-228-Attach-1.PDF

#228

Minnesota Department of **Human Services**

June 22, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
PO Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8016

Minnesota Department of Human Services Comments on:
Docket: CMS-2279-P, Graduate Medical Education

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the proposed rule. Minnesota shares the goal of promoting fiscal integrity in the Medicaid program. However, we have concerns about several aspects of the Medicaid payment policy the Centers for Medicare & Medicaid Services (CMS) is proposing and strongly recommend that you refrain from finalizing this proposed regulation following the one year moratorium period.

CMS should not withdraw support for Medicaid payments for graduate medical education (GME). Medicaid has an obligation to pay reasonable and efficient rates, and training costs in teaching hospitals is clearly part of the cost of care. Also, an adequate supply of physicians is a public good worthy of state and federal support. Federal support of Medicaid GME payments benefits both the Medicaid program and the beneficiaries it serves and should be sustained and encouraged, not prohibited. The agency's proposed policy will serve as a disincentive for other payers to contribute their share of the costs of producing an adequate supply of well-trained providers. CMS' proposal is particularly troubling given the current issues regarding access to medical care and the increasing need for medical practitioners as the population ages.

Medicaid beneficiaries, in particular, are best served when there is an adequate supply of medical practitioners. Because Medicaid payment rates are generally below those of Medicare and private plans, any shortfall in the provider workforce would likely be felt first by our most vulnerable population. In addition, Title XIX imposes responsibility on states to ensure access to care. Prudent funding of GME is an important part of meeting that responsibility.

We are also concerned about the precedent this rule sets with regard to CMS oversight of Medicaid payment rates. Congress very clearly gave the states the right and responsibility to set payment rates within broad parameters. If CMS intends to begin disallowing *component parts* of payment rates that are in compliance with the broad parameters established by Congress, it leaves states with no rate-setting

authority and limited ability to further state policy goals. This result is inconsistent with Medicaid payment regulations, the basic principles of the Medicaid program and the aims of the federal-state partnership.

Minnesota's Support for GME

Minnesota's payment policies have long recognized that a high-quality medical education system is key to ensuring the high quality of health care and ensuring access to that care. Minnesota is also committed to a training system that prepares providers to work where the need is, in terms of both geographical setting (urban and rural) and specialty areas. Minnesota, like many states, faces significant shortages of psychiatric and behavioral health providers. Given the limited coverage of mental health benefits by other payers, Medicaid serves as a critical safety net to ensure access to these services. CMS' proposed GME policy would eliminate one of the few mechanisms we have to encourage medical students to pursue careers as mental health providers.

General Comments on the Proposed Regulation

CMS' general arguments for eliminating payments for graduate medical education are as follows:

- GME is not specifically mentioned as a covered service in Title XIX;
- GME is not recognized as a component of the cost of Medicaid inpatient or outpatient hospital services;
- Direct medical education costs are not included in the Medicare prospective rates, the implication being that GME is not recognized as health care by Medicare, and therefore would represent an unreasonable payment in Medicaid;
- Payments incorporated into the Medicaid payment rates do not allow for clear accountability of payment for medical education; and
- There is no assurance that GME payments are actually effective in supporting these programs.

None of these arguments support the elimination of GME payments from the Medicaid program. The fact that GME is not specifically mentioned as a covered service in Title XIX of the Social Security Act, or as a component of the cost of Medicaid hospital services in specific sections of Title XIX or the related regulations is irrelevant. Title XIX does not define hospital services at all. The regulation, at 42 CFR §§440.10 and 440.20, defines inpatient and outpatient hospital services very generally. Nowhere in statute or regulation does Congress or CMS attempt to identify each of the component parts of a hospital service, or any other outpatient service for that matter. Nursing care, food service, housekeeping, supplies, support staff, etc. are not identified either. The fact that medical education is equally unmentioned provides no support for its elimination.

In its discussion, CMS explains the history of Medicare payment methodology at great length, in an effort to establish that the inclusion of GME payments in Medicaid is inconsistent with the upper payment limit principles. Basically, CMS argues that because GME is excluded from the costs used to develop the Medicare PPS rates, even though direct GME is paid for by Medicare as a separate payment, the Medicaid upper payment limit calculation should exclude Medicare payments for direct GME. In addition, CMS argues that the inclusion of Medicare GME in the UPL calculation would result in payment rates that are inconsistent with efficiency and economy. We believe the reverse to be true. Congress has consistently and explicitly recognized that training programs enhance the quality of care and allowed for Medicare reimbursement. It would be patently unfair and unreasonable to not recognize Medicare's GME payments in the Medicaid upper limits. All components of the Medicare payment should be included in the UPL calculation.

CMS' characterization of GME as something other than a health care service is out of step with more recent research and the day-to-day realities of how teaching hospitals are staffed. As early as 1999, the Medicare Payment Advisory Committee (MedPAC) recognized that the direct costs of operating approved medical residency programs are payment for patient care[1].

CMS also argues that GME payments incorporated into the Medicaid payment rates do not allow for clear accountability of payment for medical education, and that there is no assurance that GME payments are actually effective in supporting these programs. Neither of these arguments supports the *elimination* of GME payments. In addition, the same could be said for any component cost of a hospital or other Medicaid service. Minnesota pays its clinics based on aggregate submitted charges. It is impossible to track the *component* of that payment that relates to, for example, the costs of nursing staff at the clinic. That does not invalidate the need to pay clinics adequately for their nursing costs.

There are many reasons why CMS should support reasonable and responsible Medicaid payments for medical education. The flexibility granted to states by Congress permits states to set Medicaid payment rates that reflect state policy goals. The cost of care delivered in teaching hospitals is higher for a number of reasons, including the fact that teaching hospitals offer a broader and more complex array of medical services. Given the complex medical needs of many Medicaid beneficiaries, it is imperative that states retain the ability to recognize the higher costs of teaching hospitals and set reimbursement levels sufficient to ensure continued access to these needed services.

Medicaid payments for GME also represent a significant opportunity for states to implement policy goals that uniquely benefit the Medicaid population. In its October, 2006 projections of physician supply and demand, HRSA projected inadequacies in the supply of certain specialties important to Medicaid beneficiaries including general surgery, cardiology, radiology and psychiatry.[2] States can and do use Medicaid support for GME to encourage and enhance the development of training opportunities in specialties for which the Medicaid demand is not being met. As noted earlier, GME payments are an important tool states use to meet their statutory obligations to assure reasonable access to providers.

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[1] MedPAC. Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals. Report to Congress. August, 1999.
[2] HRSA. Physician Supply and Demand: Projections to 2020. October, 2006.

Provisions of the Proposed Rule

Throughout the preamble and regulatory text of the proposed rule, CMS has consistently failed to clarify whether the proposed changes to the GME policy apply to direct graduate medical education costs, indirect graduate medical education costs, or both. It is also unclear whether CMS intends to preclude Medicaid payments for GME from all rates, from only cost-based rates, or to only preclude states from explicitly recognizing GME as a component of a payment rate.

Part 438 – Managed Care
CMS intends to delete references to GME costs in the managed care regulations. It is unclear from the proposed regulatory changes whether or not CMS intends to require states to recalculate their capitation rates. States set payment rates based on a number of factors, including historical payments and costs. Is it the agency's intention to require states to make adjustments to managed care capitation rates even if GME costs were never explicitly factored into the rate setting calculations?

Part 447 – Payments for Services
As noted above, it is unclear if CMS intends to preclude FFP for only those GME costs that are explicitly accounted for (in either prospective rates or cost-based rates), to preclude FFP for GME costs only when providers are paid on a cost basis, or to preclude FFP for all GME costs in all rates whether explicitly recognized or not. The revisions proposed at §447.257(b) and §447.304(b) are especially unclear because they state only that FFP is not available for graduate medical education, without distinguishing direct from indirect GME, and without distinguishing between cost-based and other payment methodologies.

In closing, contrary to CMS' argument, it is necessary, efficient and fair for state Medicaid programs to pay for some medical education costs, to the extent that payments support service delivery to Medicaid patients. The proposed regulation is inconsistent with Title XIX and not based on supportable policies. For these reasons, we recommend that CMS refrain from finalizing this proposed rule.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

Submitter : Ms. Joy Wilson **Date:** 06/22/2007

Organization : National Conference of State Legislatures

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-229-Attach-1.PDF

#229

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

Leticia R. Van de Putte, R. Ph.
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Texas
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Stephen R. Miller
Chief, Legislative Reference Bureau
Wisconsin
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William T. Pound
Executive Director

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Re: (CMS-2279-P) Proposed Rule---Medicaid Program; Graduate Medical Education (Vol.72, No.99)

Dear Ms. Norwalk:

On behalf of the National Conference of State Legislatures (NCSL), I would like to take this opportunity to express our concerns regarding the proposed rule, published in the *Federal Register* on May 23, 2007, that would eliminate federal reimbursement under Medicaid for payments and costs associated with Graduate Medical Education (GME).

It is imperative for states to have stability in the financing of the Medicaid program. NCSL vigorously opposes the continuation of the regulatory activism that has become the rule in the U.S. Department of Health and Human Services, and that threatens any hope of program stability. In the case of Graduate Medical Education (GME), the proposed rule would essentially repeal a key component of the Medicaid program without any input from Congress. Graduate Medical Education plays an important role in the Medicaid program and should be retained. It appears that the primary argument to eliminate federal reimbursement is a technical one regarding whether or not GME is specifically authorized in the Medicaid statute. Since it has not been a problem in the past, the logical solution upon finding this technical glitch would be to ask Congress to fix it. The elimination of GME as an allowable cost is certainly an overreaction to a technical drafting error.

We are pleased that the Congress imposed a one-year moratorium on the implementation of this proposed rule in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28) and look forward to a full and productive discussion in Congress that will lead to the withdrawal of this proposal.

NCSL supports a full and healthy debate on Medicaid reforms and will continue to oppose the initiative of major Medicaid reforms by administrative rule. As always, we look forward to working with you and your staff towards making Medicaid a stronger program that provides the highest quality to low-income individuals and families.

Sincerely,

Carl Tubbesing
Deputy Executive Director

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Submitter : Dr. Fred Sanfilippo, MD, PhD **Date:** 06/22/2007

Organization : Ohio State University Medical Center

Category : Hospital

Issue Areas/Comments

Background

Background

See attachment

GENERAL

GENERAL

See attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

CMS-2279-P-230-Attach-1.DOC

#230

June 20, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
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Washington, DC 20201

Attention: **CMS-2279--P**

Dear Administrator Norwalk:

We are writing on behalf of the Ohio State University Medical Center to strongly urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of our teaching hospital and jeopardize our ability to continue to fulfill our teaching and patient care missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments as a part of the cooperative policy and financing arrangement that recognizes joint responsibility for the vulnerable populations covered by the Medicaid program According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support our critical functions. **For example, in FY06, the OSU Medical Center received approximately $13.8 million through the Ohio Medicaid program for GME purposes. This represents nearly a third of the total GME funding that we receive from governmental sources. The loss of this funding would necessitate a significant financial crisis within our GME programs.**

In the short term, a disruption in GME training programs could cause a major access problem for wide variety of patient populations – including patients covered by the Medicaid program. Working under the supervision of our faculty, our residents and fellows provide necessary healthcare services to Medicaid beneficiaries and other patients who often have no other access to care. If we have to decrease the size of our training programs, there may be less access to certain healthcare services and unnecessary delays in care for these patients. As you are aware, on the national level, approximately half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions. A GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. **For example, in FY06, the OSU Medical Center provided nearly 10,000 inpatient admissions (18% of our total admissions), over 44,000 outpatient visits (nearly 9% of our total outpatient visits) and over 11,000 Emergency Department visits (just over 15% of our total ED visits) to patients covered by the Medicaid program. Residents and fellows are an integral part of the care team that provides healthcare services to these patients. The loss of Medicaid GME funding would cause a major disruption to our training programs, and an access problem for services in the future.**

In the long-term, Medicaid GME payments help teaching hospitals sustain one of our core responsibilities by helping provide for the clinical education of future physicians. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Over the past year, the Ohio Board of Regents has been working with a variety of stakeholders to outline the specialty-specific and geographic disparities in physician supply and distribution within our state. Needless to say, the results of that study showed many "gaps" in the capacity of our current and projected physician supply to provide the healthcare that will be needed by the citizens of Ohio.

Eliminating FFP for state Medicaid agency payments for GME will cripple graduate medical education programs at Ohio State and at other teaching hospitals in Ohio at a time when more physicians are needed in Ohio and throughout the country. **During FY08, we will have approximately 650 MD, DO, DPM and DDS trainees enrolled in over 70 specialty and subspecialty training programs within the Medical Center. We have increased our number of trainees by approximately 130 positions in the past five years – despite the fact that we have been over our GME "caps" since FY06. A major decrease in funding of this magnitude would certainly curb any future growth in our programs and most likely would necessitate decreasing either the size or the number of our training programs at OSU. This is not a good long-term strategy for our Medical Center, our community or our state.**

Given the access to care that we provide to patients covered by the Medicaid program and our role in the development of the next generation of physicians, the continuation of federal matching assistance to Ohio's investment for GME in our state Medicaid program is critical to preserve the clinical and education missions of the OSU Medical Center. **We strongly urge the Agency to rescind the proposed rule.**

Sincerely,

Fred Sanfilippo, MD, PhD
Senior Vice President for Health Sciences
CEO, OSU Medical Center

Wiley W. "Chip" Souba, Jr., MD, ScD
Dean, OSU College of Medicine

Peter Geier, CEO
OSU Health System

Hagop S. Mekhjian, MD
Associate Vice President, Health Sciences
Chief Medical Officer, OSU Health System

Andrew M. Thomas, MD, MBA
Associate Dean for Graduate Medical Education
Associate Medical Director, University Hospital

CC: Hon. George Voinovich
Hon. Sherrod Brown
Hon. David Hobson
Hon. Deborah Pryce
Hon. Pat Tiberi
Hon. Ted Strickland