CMS-2279-P-16 Medicaid Graduate Medical Education

Submitter : Dr. John Monroe **Date & Time:** 06/18/2007

Organization : Good Samaritan Family Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The limitations of funding for postgraduate education for physicians would adversely affect the quality of medicine in an already cripled healthcare system. John Monroe, MD

CMS-2279-P-17 **Medicaid Graduate Medical Education**

Submitter : Mr. Ron Girotto **Date & Time:** 06/18/2007

Organization : The Methodist Hospital System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2279-P-17-Attach-1.PDF

#17

Methodist The Methodist Hospital System

Ronald G. Girotto
President
Chief Executive Officer

6565 Fannin, D200
Houston, Texas 77030-2707
713-441-3366
Fax: 713-790-2605
E-mail: rgirotto@tmh.tmc.edu
www.methodisthealth.com

June 15, 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 Methodist Hospital System* (TMHS) to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule seeking 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 Texas does not access Medicaid GME, it remains an important issue to us as a means to reduce the future physician shortage the entire county is facing. We struggle with the financial realities of health care and the responsibilities faced to ensure that care will be available to future generations. We face the tremendous challenge of training and retaining qualified physicians in our state. We know the serious consequences of loss of Medicaid GME funding. We urge reconsideration.

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 critical functions.

Medicaid GME payments help teaching hospitals sustain 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.

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,

R. G. Girotto
President
Chief Executive Officer

RGG:cjb

CMS-2279-P-18 **Medicaid Graduate Medical Education**

Submitter : Sally Enevoldson **Date & Time:** 06/18/2007

Organization : University of Kansas Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2279-P-18-Attach-1.DOC

#18

June 18, 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:

The University of Kansas Hospital (KUH) appreciates the opportunity to comment on CMS's proposed Medicaid graduate medical education rule. We are a 508-bed teaching hospital with approximately 437 residents. KUH requests that the Centers for Medicare & Medicaid Services (CMS) 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. 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. KUH provides inpatient services to over 14,900 Medicaid patients and 10,900 uninsured patients a year. These services represent over $240 million in charges.

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.

KUH operates the only Level I Trauma Center on the Kansas side of the Kansas City metropolitan area and provides presentations to local schools on injury, alcohol and drug use prevention. The Rural Trauma Team Development, composed of KUH nurses and physicians, travels to rural hospitals and provides a morning of lectures followed by an afternoon of skills stations that focus on stabilization and transfer of a trauma patient.

KUH operates the only Burn Center in the Kansas City area. KUH provides burn prevention and fire safety education programs to the community, supports young burn patients with school reentry programs and burn camps and meets the educational and emotional needs of patients post discharge through burn survivor support groups.

KUH has operated the Mid-America Poison Control Center, which serves the State of Kansas, for the past 25 years. KUH is also taking the lead in the Kansas City area in emergency preparedness through the purchase of the area's only decontamination trail, through disaster preparedness conferences and through the employment of a hazardous materials operation level team in the Emergency department.

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 CMS to rescind the proposed rule. In the event that CMS chooses to finalize this rule, however, we would assert that Medicare indirect medical education payments should be included in the Medicaid UPL calculation, as these payments help cover the increased costs of patient care in teaching institutions.

Sincerely,

Sally Enevoldson

CMS-2279-P-19 Medicaid Graduate Medical Education

Submitter : Dr. Alan Leibowitz **Date & Time:** 06/18/2007

Organization : Banner Good Samaritan Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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 Banner Good Samaritan/Phoenix VA internal medicine program 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,

Alan I. Leibowitz, MD
Chairman, Department of Medicine
Director of Internal Medicine Programs
Banner Good Samaritan Medical Center
Associate Head, Department of Medicine-Phoenix
Professor of Internal Medicine
University of Arizona College of Medicine

602-239-2296
alan.leibowitz@bannerhealth.com

CMS-2279-P-20 Medicaid Graduate Medical Education

Submitter : Mr. Peter Grollman **Date & Time:** 06/18/2007

Organization : The Children's Hospital of Philadelphia

Category : Health Care Provider/Association

Issue Areas/Comments
GENERAL

GENERAL

Dear Administrator Norwalk:

I am writing on behalf of The Children's Hospital of Philadelphia 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,

Peter M. Grollman, Legislative Affairs Director
The Children's Hospital of Philadelphia

CMS-2279-P-21 Medicaid Graduate Medical Education

Submitter : Dr. Peter McKellar **Date & Time:** 06/18/2007

Organization : Banner Good Samaritan Medical Center Phoenix

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 Banner Good Samaritan Medical Center 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. I urge the Agency to rescind the proposed rule.

Sincerely,

Peter McKellar, MD

CMS-2279-P-22 **Medicaid Graduate Medical Education**

Submitter : Dr. Gary Wainer **Date & Time:** 06/18/2007

Organization : MacNeal Hospital

Category : Hospital

Issue Areas/Comments

Background

Background

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).

GENERAL

GENERAL

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 MacNeal 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. 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,

Dr. Gary Wainer
Vice President

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see above

CMS-2279-P-23 **Medicaid Graduate Medical Education**

Submitter : Dr. Peter Deckers **Date & Time:** 06/18/2007

Organization : UConn School of Medicine

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-23-Attach-1.PDF

CMS-2279-P-23-Attach-2.PDF

#23

University of Connecticut Health Center

Office of the
Executive Vice President for
Health Affairs

Dean, School of Medicine

June 18, 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 ***John Dempsey Hospital at the University of Connecticut Health Center*** 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

An Equal Opportunity Employer

263 Farmington Avenue
Farmington, Connecticut 06030-1920
Telephone: (860) 679-2594
Facsimile: (860) 679-1255

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,

Peter Deckers MD

Peter J. Deckers
Executive Vice President
Dean of the School of Medicine

#23-b.

University of Connecticut Health Center

Office of the
Executive Vice President for
Health Affairs

Dean, School of Medicine

June 18, 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 ***John Dempsey Hospital at the University of Connecticut Health Center*** 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

263 Farmington Avenue
Farmington, Connecticut 06030-1920
Telephone: (860) 679-2594
Facsimile: (860) 679-1255

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,

Peter J. Deckers
Executive Vice President
Dean of the School of Medicine

CMS-2279-P-24 **Medicaid Graduate Medical Education**

Submitter : Mr. Joseph R. Horton **Date & Time:** 06/18/2007

Organization : Intermountain Healthcare

Category : Health Care Industry

Issue Areas/Comments
GENERAL

GENERAL

See Attachment

CMS-2279-P-24-Attach-1.DOC

#24

COMMENTS DUE BY 5 PM (EST) OR 3 P.M. (MST) JUNE 22

[DATE]

[FOR OVERNIGHT OR EXPRESS MAIL]
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2279—P
Mail Stop C4—26—05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attn: CMS—2279--P
Medicaid Program; Graduate Medical Education

Dear Sir/Madam:

On behalf of the Intermountain Healthcare teaching hospitals, I would like to submit comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid proposed rule on Graduate Medicaid Education (GME) published in the May 23rd *Federal Register*. Without the Federal match for direct GME Medicaid funding, the ability of teaching hospitals to train providers will be seriously threatened. Therefore, we believe CMS should rescind the proposed rule.

We submit these comments even though we believe the moratorium included in the FY 2007 Iraq War Supplemental Appropriation Bill (H.R. 2206) precludes CMS from "taking any action (through promulgation of rule, issuance of regulatory guidance or other administrative action)," including closing or enforcing the comment period on the Medicaid GME rule. Further, we believe that CMS does not have the authority to review or in any way act on any comments provided until the moratorium ends. However, because CMS intends to implement the comment period and the significance of this issue to the Intermountain Healthcare teaching hospitals, we submit the following substantive comments to ensure they are considered when the moratorium ends.

Comments on Proposed Rule on Medicaid Direct GME

CMS' proposal to reduce Medicaid education reimbursement conflicts with Congress' recent action to expand Medicare education reimbursement. In S.588, Congress proposes to increase the Medicare caps on GME positions for States with a shortage of residents. This legislation was proposed in recognition of the fact that almost half of the States in the country presently do not train a sufficient number of physicians to meet the needs of their current populations.

Furthermore, the proposed rule disproportionately affects hospitals who treat the most acute and vulnerable populations of Medicaid patients (e.g., neonates, children, cardiac patients, transplant patients, etc.).

Intermountain's four teaching hospitals, which include the only pediatric teaching hospital between Denver and the West Coast, provide critical levels of care that community hospitals are unable to provide. Without sufficient funding to insure that physicians can continue to be trained in these high tertiary settings, the most vulnerable patients from both teaching and smaller community hospitals will be left without an adequate number of providers to treat them.

We recommend rescission of the proposed rule for several reasons:

- **CMS plans to end the Federal match for Medicaid direct GME funding without adequate justification, despite permitting the practice for decades.** For decades, States, with the approval of CMS or its predecessor the Health Care Financing Administration, have used Medicaid dollars to support graduate medical education. Despite this long history, the proposed regulation asserts that Medicaid does not have the authority to provide funding for direct graduate medical education. To support this argument, CMS says that direct graduate medical education costs are specifically prohibited as part of Medicare's inpatient prospective payment rate. However, CMS ignores the fact that direct GME costs are not part of Medicare's diagnosis-related group (DRG) payments because Congress passed legislation to require that those costs be reimbursed through a formula that uses per resident amounts and Medicare utilization.

  Medicare makes separate payments for direct GME costs to insure that Medicare education payments are appropriately only made to teaching hospitals. If CMS has a concern that Medicaid direct GME payments are not currently linked to teaching hospitals in all States, it should publish guidance to help States link the reimbursement to only teaching hospitals as Medicare has done. In Utah, this has already been done. The direct GME funds are a separate pool of dollars that are paid out only to teaching hospitals based on the combination of the hospitals' number of residents and its corresponding Medicaid utilization.

  In summary, the regulation does not adequately explain the abrupt change in longstanding policy that has provided critical support for teaching hospitals.

- **The loss of Medicaid direct GME funding would threaten our teaching hospitals' ability to train the next generation of providers not only for Utah, but also for other western states who either refer patients to our facilities or who receive pediatric providers from the GME training programs in our children's hospital.** Intermountain's teaching facilities receives nearly $5.5 million in Utah Medicaid GME funding. It provides critical support to our training programs. Without this dedicated funding, the costs of our training program would not be fully covered. If the Federal

match for Medicaid GME funding ends, we will have to make serious decisions about the ability to sustain our current training programs.

- **Ending Medicaid direct GME funding could worsen existing shortages of pediatric subspecialists.** Intermountain's children's hospital (i.e., Primary Children's) trains pediatricians and subspecialists who care for all children. Primary is the only source of this training for a large multi-state area. A recent survey of acute care and specialty children's hospitals conducted by the National Association of Children's Hospitals and Related Institutions found critical shortages of pediatric providers, particularly pediatric subspecialists, throughout the country. This is certainly the case in Utah and in other western states. Therefore, any cut in direct GME funding provided through Medicaid could exacerbate existing shortages. These shortages affect all children, not just children insured by Medicaid.

- **The proposed rule would shift costs to the States and providers.** Under the proposed rule, our State Medicaid program could continue to pay for GME with State-only funds. This means that the State could shoulder all of the cost, reduce funding, or end direct GME funding completely. Any reduction in GME funding by our State would shift costs of training to the teaching hospitals. As previously mentioned, teaching hospitals provide high tertiary services that community hospitals are unable to provide. As a result, any attempts to cut back or end support for direct GME programs could have dire effects on the country's health care workforce for the most acutely ill patients. Having the Federal government simply shift the costs for direct GME to States and providers is not fair.

- **The proposed rule contradicts the significant flexibility States are currently allowed under the Medicaid program.** Since the repeal of the Boren amendment in 1997, the Federal government has given States significant flexibility to set provider reimbursement rates. This proposed regulation contradicts earlier policies allowing substantial flexibility in Medicaid payment to providers by prohibiting a Federal match for direct graduate medical education in Medicaid programs.

Due to the concerns expressed above, we believe CMS should rescind the proposed rule. We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Bill Barnes at 801-442-3240 bill.barnes@intermountainmail.org or Kathy Konishi at 801-442-2847 Kathy.Konishi@intermountainmail.org. Thank you for your consideration of these comments.

Sincerely,

Joseph R. Horton
Senior Vice President, Hospital Operations

CMS-2279-P-25 Medicaid Graduate Medical Education

Submitter : Dr. John Ferrara **Date & Time:** 06/18/2007

Organization : Phoenix Integrated Surgical Residency

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 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,

John J. Ferrara, MD
Program Director, Phoenix Integrated Surgical Residency
Program Director, Level I Trauma Center, Banner Good Samaritan Medical Center
Arizona State Chair, American College of Surgeons Committee on Trauma
University of Arizona
Associate Department Head, Surgery
Professor of Clinical Surgery

CMS-2279-P-26 **Medicaid Graduate Medical Education**

Submitter : Mr. G. Richard Hastings **Date & Time:** 06/18/2007

Organization : Saint Luke's Health System

Category : Hospital

Issue Areas/Comments
GENERAL

GENERAL

See Attachment

CMS-2279-P-26-Attach-1.DOC

Saint Luke's
Health System
saintlukeshealthsystem.org

June 18, 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

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

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the proposed rule cited above (CMS-2279-P). I submit these comments on behalf of Saint Luke's Health System (SLHS) in the Kansas City Metropolitan Region. SLHS consists of eleven hospitals, several physician groups, and other medical services organizations in both Missouri and Kansas. Saint Luke's Hospital of Kansas City (SLH), our largest facility with 629 beds, is a tertiary referral center, and the largest teaching facility for the University of Missouri – Kansas City School of Medicine. SLH was the recipient of the Malcolm Baldrige National Quality Award in 2003. As a system, we also received the 2006 Missouri Quality Award, based on the Malcolm Baldrige principles of quality.

On the same campus as our largest facility, SLH, we also have the Saint Luke's Community Service Clinics. These clinics provide comprehensive health care services in the Multi-Specialty Clinic, the Women's Health Care Center, and the Family Care Clinic. Each clinic team operates independently by providing specialty care for patients. Each clinic is well defined in its scope of service. The role of the Multi-Specialty Clinic is providing specialized services including Internal Medicine, Cardiology, Pulmonology, Psychiatry, Surgery, Gastroenterology, Endocrinology, and INR Clinics. The Women's Health Care Center provides obstetrical and gynecological services including a full range Teen Center. The Family Care Clinic provides primary care to all ages from newborns to seniors. What truly makes these clinics special is they are set up to care specifically for Medicaid patients and uninsured patients, and are staffed by medical residents and interns with supervising physicians. Furthermore, these clinics are primarily funded through Graduate Medical Education payments.

These clinics are a critical component of the healthcare safety net in the Kansas City Metropolitan area. Within our own health system, we direct uninsured and Medicaid patients to the Community Service Clinics to ensure they receive primary care services in a cost-effective setting. It is our goal to help these patients avoid the emergency departments in the area and foster in them the security of knowing they have a medical home, regardless of their ability to pay for services, unlike many traditional physician offices.

After careful examination of CMS-2279-P, we have come to the conclusion that if the proposed rule is implemented as written, the financial impact to SLH is approximately $3,000,000 annually. To compensate for such a large financial hit to the Graduate Medical Education

program on this campus, we will have to significantly cut back on the operation of the Community Service Clinics, and potentially eliminate them from the services altogether. The level of funding from Medicare and Medicaid payments are not sufficient to support hiring staff and physicians to care for this population at the same level of the Community Service Clinics, a vital component of the healthcare safety net. Interns and residents are the only financially feasible option to care for this section of the community on such a large scale. With one employed staff physician for every four residents, we save over $350,000 in salaries that it would take in a private office to provide the same level of service the clinics provide, currently in excess of over 40,000 visits annually.

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. Without the support from GME payments, these services are in jeopardy.

Although CMS has characterized CMS-2279-P as a "clarification," in reality, this is 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. Teaching hospitals such as SLH rely on these and other Medicaid payments to support our critical functions. GME payments help us sustain two of our core responsibilities: providing the clinical education of future positions, and caring for the community regardless of their financial situation.

If the proposed rule is implemented, the impact to the Kansas City Metropolitan area is virtually unimaginable. The three remaining providers of healthcare in the urban core of Kansas City depend on GME payments to provide care for the Medicaid and indigent populations. The ability to see these patients in a primary care setting will be at risk, and possibly no longer available. Many patients will be forced to utilize emergency departments for all of their medical needs. As a result, the actual cost of treating the exact same patients will grow immensely, and the costs will spread throughout the community. The impact to the cost of healthcare for the nation will be exponentially higher.

Given the important role teaching facilities play in the quality of healthcare, and the future of healthcare in this nation, it is important that state Medicaid programs receive federal matching assistance for Graduate Medical Education. We strongly urge you to rescind the proposed rule.

Should you have any questions or would like further information, please do not hesitate to contact me, or Scott Pester, SLHS Reimbursement Director, at 816-932-5734.

Sincerely,
G. Richard Hastings
President & CEO, Saint Luke's Health System

CMS-2279-P-27 **Medicaid Graduate Medical Education**

Submitter : **Dr. Vikram Deka** **Date & Time:** **06/19/2007**

Organization : **Phoenix Integrated Surgical Residency**

Category : **Physician**

Issue Areas/Comments
GENERAL

GENERAL

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 a resident in training in surgery, and I am writing on behalf of Phoenix Integrated Surgical Residency 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,
Vikram J Deka, MD

CMS-2279-P-28 **Medicaid Graduate Medical Education**

Submitter : **Mr. Edward Karlovich** **Date & Time:** **06/19/2007**

Organization : **UPMC**

Category : **Hospital**

Issue Areas/Comments
GENERAL

GENERAL

See Attachment for CMS-2779 -P Medicaid Program Graduate Medical Education Proposed Rule

CMS-2279-P-28-Attach-1.DOC

CMS-2279-P-28-Attach-2.DOC

28

June 18, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Via: UPS Delivery and
http://www.cms.hhs.gov/eRulemaking

ATTENTION: CMS-2279-P

RE: CMS-2279-P
Medicaid Program; Graduate Medical Education; Proposed Rule
(Federal Register/Vol.72 No.99/May 23, 2007 pages 28930-28936)

Dear Sir or Madam:

On behalf of the University of the Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (Federal Register / Vol. 72, No. 99 / May 23, 2007 pages 28930 - 28936) "Medicaid Program; Graduate Medical Education". We also are submitting these comments electronically to http://www.cms.hhs.gov/eRulemaking.

The following summarizes our comments and concerns regarding these proposed GME rules, and why we urge CMS to withdraw these proposed rules.

CMS Proposal to Eliminate Federal Financial Participation (FFP) in State Medicaid Programs for Graduate Medical Education (GME) Program Costs (FR page 28931)

Proposed CMS Rules: CMS indicates in this 30-day proposed rule that costs and payments associated with Graduate Medical Education programs are not authorized expenditures for medical assistance and as such are not federally reimbursable under the Medicaid program. This notice is to clarify that point, and to welcome comments, while CMS modifies current regulations and policies regarding Medicaid State Plan requirements. These modifications would indicate:

- GME cannot be included as part of any payment methodology in the Medicaid State Plans, so a federal match would not be allowed
- CMS would modify current rules to ensure when calculating a States Medicaid upper payment limit (UPL) that it must exclude all Medicare payments associated with direct GME. (Note: Currently under UPL regulations States must demonstrate the rates they reimburse Medicaid hospitals do not in the aggregate, and within three provider categories (government, non-State government, or private), exceed a reasonable estimate of what Medicare would have paid for the same services using Medicare payment principles.)

These rules would be implemented in the first full State fiscal year following the effective date of the subsequent final rule.

CMS provides the following reasons as the basis for this new position:

- Title XIX of the Social Security Act (SSA or Act) authorizes federal grants for States with Medicaid programs, operated by the State under approved State plans
- State plans provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities
- The care and service that may (or in some cases, must) be included within the scope of medical assistance under a Medicaid State plan are generally set forth in section 1905(a) of the Act. ... and include inpatient and outpatient hospital services
- Graduate Medical Education (GME) is not included in this list of care and services within the scope of medical assistance
- Section 1902(a)(30) of the Act requires States to develop payment methodologies for services that are consistent with economy, efficiency and quality of care
- While CMS has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services they will no longer do so, since:
    - GME is not a health service that is included in the authorized coverage package
    - Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services

Response: UPMC respectfully disagrees with the new position taken by CMS in this proposed rule and urges CMS to withdraw these proposals since the reality is the proposed rule represents a major reversal of long-standing Medicaid policy and not a clarification of policy intent. If approved, these proposed rules would further erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions which benefits needy individuals including low income families, the elderly and persons with disabilities.

Four brief reasons why UPMC believes the proposed rules should not be adopted include:

1. GME has been historically recognized, accepted and paid by the Federal and State governments as a legitimate component of inpatient & outpatient hospital cost of care for teaching providers, since Title XIX (Medical Assistance) was enacted in 1965
2. GME has been historically recognized as a necessary and proper cost of teaching providers that is related to patient care and has been recognized as a component cost of inpatient and outpatient hospital services
3. The Federal Government's attempt to shift a portion of their financial responsibility for a component of teaching facility cost and treatment to other payers

4. Short and Long-term consequences to the proposed discontinuation of federal financial participation in the training of qualified physicians, through GME programs, that could potentially lead to reduced quality of care and services for our disadvantaged MA patient populations and ultimately, other payers

More detailed explanations on why UPMC does not support the adoption of the proposed new MA GME rules are described in the following four sections:.

1. GME Has Been Historically Recognized and Accepted by the Federal and State Governments as a Legitimate Part of Patient Care Cost for Teaching Providers, Since the Enactment of Title XIX Medical Assistance in 1965:

- *Enactment of Title XIX Medical Assistance (MA) in 1965* - Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
- *Federal Government has Accepted GME Costs as Part of Patient Care Cost for 42 Years* – Since the inception of MA in 1965 the Federal government and State government have participated in a share of net approved medical education activities in order to enhance and improve the quality of patient care and as a necessary part of the efficient delivery of needed health care. This is documented in the background portion of the final GME rule published in the Federal Register of September 29, 1989. It states:

> "Medicare has historically paid a share of the net cost of approved medical education activities. Our regulations at 42 CFR 413.85(b) currently define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. These activities include approved training programs for physicians, nurses, and certain paramedical health professionals (sometimes referred to as allied health professionals), for example, physical therapists. The allowable costs of these activities include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appropriately allocated to the particular medical education cost center." ...
>
> "The Medicare program has shared in the costs of approved medical education activities, as defined above, on a reasonable cost basis. Section 1861(v)(1)(A) of the Social Security Act (the Act) defines reasonable cost as the cost actually incurred, excluding any cost unnecessary in the efficient delivery of needed health services to Medicare beneficiaries. Section 413.85 of the regulations further specifies that the allowable cost of approved educational activities is the net cost, which is determined by deducting tuition revenues from total costs."

While the method of payment, from Federal and State governments, for approved GME program costs have changed over these 42 years, it has always been recognized as a legitimate teaching provider cost subject to reasonable cost principles under section 42 CFR 413. As such, this proposed rule is not a clarification of the state Medicaid plan rule, but a clear attempt to change historic policy.

- *GME Payment Method by Federal Government Under Medicare*:
  - From 1965 through 1984 Medicare paid hospitals for their portion of GME costs under "reasonable cost principles"
  - From 1985 through today Medicare pays hospitals for GME costs on a hospital specific average per resident amount per direct GME payment regulations § 413.76 through 413.83. This payment is a separate Medicare payment over and above the inpatient operating and capital DRG payment for teaching providers.
- *GME Payment Method by State Government Under Medical Assistance:*
  - From 1965 through 1984 Pennsylvania Medical Assistance (MA) paid hospitals for their portion of GME costs under "reasonable cost principles"
  - From 1985 through 1993 Pennsylvania Medical Assistance (MA) paid hospitals for GME costs based on the lower of actual medical education pass through cost or a hospital specific base year cost rolled forward with an inflation factor
  - From 1994 through today Pennsylvania Medical Assistance (MA) paid hospitals for GME costs based on a contracted prospective payment rate (which was based on the preceding years approved GME limit with occasional contract negotiated inflators)

As the above payment notations prove, GME costs while not paid under the Medicare Inpatient Prospective Payment System (IPPS) DRG operating and capital payment formulas, are still being recognized and paid under a different Medicare "pass through" payment methodology. As such the implied position taken in the proposed rule, that these GME costs are not recognized costs of inpatient or outpatient hospital services is incorrect. They are just paid under a different Medicare computational payment formula which recognizes that allowable GME costs apply to multiple provider service areas such as inpatient PPS, sub-provider units (psychiatric or rehabilitation), outpatient services and as such cannot be included solely in the operating costs of the Inpatient PPS (IPPS-DRG) service payment rates. So the exclusion of these GME costs from IPPS payments does not mean, as implied in the proposed rule, that these GME costs are not recognizable and legitimate inpatient service costs, it just means that these GME costs cannot be included 100% in the inpatient perspective payment rates since they do not solely apply to inpatient services.

- This proposed notice (FR 5-23-2007 page 28931), clearly acknowledges that "CMS has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services."

2. GME Has Been Historically Recognized as a Necessary and Proper Cost for Teaching Providers that is Related to Patient Care and Has Been Recognized as a Component Cost of Inpatient and Outpatient Hospital Services:

As noted above, for 42 years Medicare has recognized a portion of net GME costs as necessary cost "related to patient care", and has paid for these costs under different payment methodologies with various reasonable cost limits and exclusions. (i.e. exclusions include elimination of research, non-patient care activities, etc.). While this term and principle "related to patient care" was more commonly referenced and applied under the older "reasonable cost based reimbursement" payment methodology in effect from 1965 through 1984, it still conceptually applies today and when Medicare established its current direct GME payment methodology in 1985. Under this direct GME payment approach, Medicare established direct GME per-resident-average base rates for 1985 based on the allowable portion of GME costs divided by the number of allowable residents, as determined at audit. These base rates adjusted for inflation and budget neutrality adjustments are multiplied by the allowable resident GME counts for gross allowable GME payments. This gross amount is then multiplied by Medicare's actual utilization percentage for Medicare's portion of GME cost. While this may sound simple this latest methodology was quite complex and refined, with various limits and restrictions. As a result these direct GME payments were limited to those activities related to patient care. Therefore, even these current GME pass-through payments had a foundation in the following guiding principles:

- Costs related to patient care (42 CFR § 413.9):
  - *"Principle* - All payments to providers of services must be based on reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost..."
  - *"(1) Reasonable Cost* - Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an

accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year."

- *"(2) Necessary and Proper Costs* - Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity."

We contend, as previously recognized by Medicare, that the GME expenses apportioned to Medical Assistance and patient care activities would have met these guiding principles and should still be recognized as "costs related to patient care" and should continue to be recognized as a component part of the mandated patient service cost for the following reasons:

- GME costs are necessary and proper because they are costs incurred that are common and accepted treatment costs in teaching hospitals
- Interns/residents are performing direct patient care (inpatient, outpatient, psychiatric, rehabilitation, ancillary, etc.) activities in accordance with their approved GME training program requirements
- GME costs were limited over the years through various means (by Medicare and State government) to assure the reasonableness of the GME costs
- All hospital specific MA GME base limits applied in Pennsylvania were determined through true step down allocation methodology approaches to assure that net GME costs related to patient care were allocated to appropriate patient service areas and that the MA GME amount was based on the proportion of actual medical assistance patient utilization
- Historically both Medicare and Medical Assistance have recognized GME costs as necessary and proper costs of teaching providers and have paid for their share of these costs under different payment methodologies over 42 years
- The proposed rule attempts to portray GME expenses as a "specific health service" and not recognize it as a component part of every patient service. Residents and their supervising physicians are critical parts of the treatment teams (in teaching providers) rendering all types of needed services to all patients (Medicare, MA and all other patients).
- GME costs are the "hands on" resident and supervising physician costs associated with actual patient care. The AAMC describes Graduate medical education (GME) as:

> "...the second phase of the formal educational process that prepares doctors for medical practice. GME is required of all medical school graduates seeking full medical licensure and board certification in one of the specialties and/or subspecialties of medicine. This phase of medical education is, of necessity,

conducted primarily in clinical settings, and requires direct participation by residents in the delivery of patient care services."

- The proposed rule indicates that because GME expenses are excluded from Inpatient PPS DRG payments, then they must not be recognized as a component of inpatient hospital services. When in reality, GME expenses are excluded from IPPS operating costs because these GME costs are not 100% inpatient costs. Resident GME costs can relate to various service areas such as inpatient, ancillary, outpatient, psychiatric units, and rehabilitation units. As such these costs and payments are paid for as a separate Medicare pass-through payment. Thus the exclusion of GME from inpatient operating IPPS payment DOES NOT MEAN it is not a recognized cost of inpatient or outpatient care.

As we have attempted to show, GME is a necessary and proper expense of a teaching facility in the production and delivery of required services to MA beneficiaries by residents in training. As such it would never be listed as "a service" since it is part of 'all services" in a teaching setting. For instance, the authorized coverage package under the Medicaid statute does not list "nursing" as a separate health service but their cost is being recognized as a component part of the inpatient or outpatient service. It is no different for resident GME costs; they are also part of the treatment team rendering the service to the MA or Medicare beneficiary. We urge CMS to drop this proposal and return to the long standing recognition that GME is part of a teaching providers patient care service cost.

3. Attempt by Federal Government to Shift a Portion of Their Financial Responsibility for a Component of Teaching Facility Cost and Treatment to Other Payers:

As previously noted, Title XIX of the Social Security Act enacted in 1965 requires the Federal government to jointly finance with the State governments medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. Within broad Federal rules, each state decides eligible groups, types and range of services, and payment levels for services. For 42 years the Federal government has historically recognized and accepted that GME activities are a recognized component part of the cost of inpatient and outpatient hospital services to Medical Assistance patients. As a component cost of the required MA patient services the States were able to obtain a Federal match on these GME expenditures.

Under this proposed rule GME expenditures will not be eligible for a federal match on the basis that GME is not a health service within the scope of MA services and that GME is not recognized under Medicaid statute as a component of MA inpatient and outpatient hospital services.

UPMC disagrees with these findings as discussed above. The Federal government is attempting to reduce its portion of the required Federal match by proposing that GME

expenditures are not a component part of the MA inpatient and outpatient hospital service cost. CMS also indicates that the States have the option of replacing these lost federal funding dollars with State-only dollars, obtain private sector funds, or increase taxes to provide funding for the lost federal share of graduate medical education (GME) dollars. We contend that this proposal is a form of cost shifting which is contrary to several of the guiding principles that Medicare has traditionally observed, and have tried to recognize in the development of their various payment systems. They include:

> (42 CFR § 413.5 Cost Reimbursement: General (a)) "In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program," ... "All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution."

We contend that this proposed rule to stop funding of Medical Assistance GME expenditures is contrary to this guiding Medicare principle which has been historically followed by Medicare. The Medical Assistance portion of GME costs for teaching providers will now have to be borne by other patients or other tax payers. Clearly this proposal is not fair to these other patients, taxpayers or to teaching providers. Again we urge CMS to rescind this proposed rule.

4. Short and Long-term Consequences to the Proposed Discontinuation of Federal Financial Participation in the Training of Qualified Physicians, Through GME Programs, that Could Potentially Lead to Reduced Quality of Care and Services for our Needy MA Patient Populations, and Ultimately Other Payers

If this proposed rule to eliminate all Federal financial participation in Medical Assistance GME expenditures is not withdrawn then it will have an immediate negative impact on all State governments and teaching providers. Long-term consequences will clearly impact all patients through a decline in the caliber of its physicians, an unavoidable decline in the quality of care, possible slow-down in long-term clinical innovations and or a general cut in patient services. While teaching hospitals and State governments will clearly attempt to continue their training programs the challenges of finding other GME funding sources will clearly place significant financial stress on all involved. While some states may decide to increase taxes to fund the lost federal match, others will not and may drop Graduate Medical Education (GME) funding all-together. These GME funding shortfalls will place an immediate financial and administrative burden on teaching providers who have limited short term options in dealing with revenue shortfalls. 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. Short-term remedies would require immediate reduction in hospital staffing,

reduced or closed clinic hours, and planned reductions in residency programs or FTEs would also be required. All these options clearly reduce quality, the educational opportunities for residents, and patient care options and services, to the detriment of all patients.

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 UPMC's education and research missions, we offer the most advanced, state-of-the- art services and equipment; and with residents and supervising physicians available around-the-clock, UPMC is looked to as a front-line responder in the event of a local and/or national disaster and have implemented plans to fulfill that role. If this FFP funding for GME payments is removed it hinders UPMC's ability to continue to fulfill these missions.

We again urge CMS to withdraw this proposed rule as reductions in federal financial participation in MA resident training programs hurts teaching providers immediately, but in the long-term it will negatively affect all of us.

Conclusion

We appreciate the opportunity to submit these comments on your proposed changes to the "Medicaid Program; Graduate Medical Education" and hope they are considered before any final rule is adopted.

Sincerely,

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

CC: Concordia, Elizabeth
Farner, David M..
Huber, George
Kennedy, Robert A.
Lewandowski, C.
Stimmel, P.
System CFO's
Zerega, Dennis

#28

June 18, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Via: UPS Delivery and
http://www.cms.hhs.gov/eRulemaking

ATTENTION: CMS-2279-P

RE: CMS-2279-P
Medicaid Program; Graduate Medical Education; Proposed Rule
(Federal Register/Vol.72 No.99/May 23, 2007 pages 28930-28936)

Dear Sir or Madam:

On behalf of the University of the Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (Federal Register / Vol. 72, No. 99 / May 23, 2007 pages 28930 - 28936) "Medicaid Program; Graduate Medical Education". We also are submitting these comments electronically to http://www.cms.hhs.gov/eRulemaking.

The following summarizes our comments and concerns regarding these proposed GME rules, and why we urge CMS to withdraw these proposed rules.

CMS Proposal to Eliminate Federal Financial Participation (FFP) in State Medicaid Programs for Graduate Medical Education (GME) Program Costs (FR page 28931)

Proposed CMS Rules: CMS indicates in this 30-day proposed rule that costs and payments associated with Graduate Medical Education programs are not authorized expenditures for medical assistance and as such are not federally reimbursable under the Medicaid program. This notice is to clarify that point, and to welcome comments, while CMS modifies current regulations and policies regarding Medicaid State Plan requirements. These modifications would indicate:

- GME cannot be included as part of any payment methodology in the Medicaid State Plans, so a federal match would not be allowed
- CMS would modify current rules to ensure when calculating a States Medicaid upper payment limit (UPL) that it must exclude all Medicare payments associated with direct GME. (Note: Currently under UPL regulations States must demonstrate the rates they reimburse Medicaid hospitals do not in the aggregate, and within three provider categories (government, non-State government, or private), exceed a reasonable estimate of what Medicare would have paid for the same services using Medicare payment principles.)

These rules would be implemented in the first full State fiscal year following the effective date of the subsequent final rule.

CMS provides the following reasons as the basis for this new position:

- Title XIX of the Social Security Act (SSA or Act) authorizes federal grants for States with Medicaid programs, operated by the State under approved State plans
- State plans provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities
- The care and service that may (or in some cases, must) be included within the scope of medical assistance under a Medicaid State plan are generally set forth in section 1905(a) of the Act. ... and include inpatient and outpatient hospital services
- Graduate Medical Education (GME) is not included in this list of care and services within the scope of medical assistance
- Section 1902(a)(30) of the Act requires States to develop payment methodologies for services that are consistent with economy, efficiency and quality of care
- While CMS has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services they will no longer do so, since:
    - GME is not a health service that is included in the authorized coverage package
    - Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services

Response: UPMC respectfully disagrees with the new position taken by CMS in this proposed rule and urges CMS to withdraw these proposals since the reality is the proposed rule represents a major reversal of long-standing Medicaid policy and not a clarification of policy intent. If approved, these proposed rules would further erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions which benefits needy individuals including low income families, the elderly and persons with disabilities.

Four brief reasons why UPMC believes the proposed rules should not be adopted include:

1. GME has been historically recognized, accepted and paid by the Federal and State governments as a legitimate component of inpatient & outpatient hospital cost of care for teaching providers, since Title XIX (Medical Assistance) was enacted in 1965
2. GME has been historically recognized as a necessary and proper cost of teaching providers that is related to patient care and has been recognized as a component cost of inpatient and outpatient hospital services
3. The Federal Government's attempt to shift a portion of their financial responsibility for a component of teaching facility cost and treatment to other payers

4. Short and Long-term consequences to the proposed discontinuation of federal financial participation in the training of qualified physicians, through GME programs, that could potentially lead to reduced quality of care and services for our disadvantaged MA patient populations and ultimately, other payers

More detailed explanations on why UPMC does not support the adoption of the proposed new MA GME rules are described in the following four sections:.

1. GME Has Been Historically Recognized and Accepted by the Federal and State Governments as a Legitimate Part of Patient Care Cost for Teaching Providers, Since the Enactment of Title XIX Medical Assistance in 1965:

- *Enactment of Title XIX Medical Assistance (MA) in 1965* - Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
- *Federal Government has Accepted GME Costs as Part of Patient Care Cost for 42 Years* – Since the inception of MA in 1965 the Federal government and State government have participated in a share of net approved medical education activities in order to enhance and improve the quality of patient care and as a necessary part of the efficient delivery of needed health care. This is documented in the background portion of the final GME rule published in the Federal Register of September 29, 1989. It states:

> "Medicare has historically paid a share of the net cost of approved medical education activities. Our regulations at 42 CFR 413.85(b) currently define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. These activities include approved training programs for physicians, nurses, and certain paramedical health professionals (sometimes referred to as allied health professionals), for example, physical therapists. The allowable costs of these activities include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appropriately allocated to the particular medical education cost center." ...
>
> "The Medicare program has shared in the costs of approved medical education activities, as defined above, on a reasonable cost basis. Section 1861(v)(1)(A) of the Social Security Act (the Act) defines reasonable cost as the cost actually incurred, excluding any cost unnecessary in the efficient delivery of needed health services to Medicare beneficiaries. Section 413.85 of the regulations further specifies that the allowable cost of approved educational activities is the net cost, which is determined by deducting tuition revenues from total costs."

While the method of payment, from Federal and State governments, for approved GME program costs have changed over these 42 years, it has always been recognized as a legitimate teaching provider cost subject to reasonable cost principles under section 42 CFR 413. As such, this proposed rule is not a clarification of the state Medicaid plan rule, but a clear attempt to change historic policy.

- *GME Payment Method by Federal Government Under Medicare*:
  - From 1965 through 1984 Medicare paid hospitals for their portion of GME costs under "reasonable cost principles"
  - From 1985 through today Medicare pays hospitals for GME costs on a hospital specific average per resident amount per direct GME payment regulations § 413.76 through 413.83. This payment is a separate Medicare payment over and above the inpatient operating and capital DRG payment for teaching providers.
- *GME Payment Method by State Government Under Medical Assistance:*
  - From 1965 through 1984 Pennsylvania Medical Assistance (MA) paid hospitals for their portion of GME costs under "reasonable cost principles"
  - From 1985 through 1993 Pennsylvania Medical Assistance (MA) paid hospitals for GME costs based on the lower of actual medical education pass through cost or a hospital specific base year cost rolled forward with an inflation factor
  - From 1994 through today Pennsylvania Medical Assistance (MA) paid hospitals for GME costs based on a contracted prospective payment rate (which was based on the preceding years approved GME limit with occasional contract negotiated inflators)

As the above payment notations prove, GME costs while not paid under the Medicare Inpatient Prospective Payment System (IPPS) DRG operating and capital payment formulas, are still being recognized and paid under a different Medicare "pass through" payment methodology. As such the implied position taken in the proposed rule, that these GME costs are not recognized costs of inpatient or outpatient hospital services is incorrect. They are just paid under a different Medicare computational payment formula which recognizes that allowable GME costs apply to multiple provider service areas such as inpatient PPS, sub-provider units (psychiatric or rehabilitation), outpatient services and as such cannot be included solely in the operating costs of the Inpatient PPS (IPPS-DRG) service payment rates. So the exclusion of these GME costs from IPPS payments does not mean, as implied in the proposed rule, that these GME costs are not recognizable and legitimate inpatient service costs, it just means that these GME costs cannot be included 100% in the inpatient perspective payment rates since they do not solely apply to inpatient services.

- This proposed notice (FR 5-23-2007 page 28931), clearly acknowledges that "CMS has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services."

2. GME Has Been Historically Recognized as a Necessary and Proper Cost for Teaching Providers that is Related to Patient Care and Has Been Recognized as a Component Cost of Inpatient and Outpatient Hospital Services:

As noted above, for 42 years Medicare has recognized a portion of net GME costs as necessary cost "related to patient care", and has paid for these costs under different payment methodologies with various reasonable cost limits and exclusions. (i.e. exclusions include elimination of research, non-patient care activities, etc.). While this term and principle "related to patient care" was more commonly referenced and applied under the older "reasonable cost based reimbursement" payment methodology in effect from 1965 through 1984, it still conceptually applies today and when Medicare established its current direct GME payment methodology in 1985. Under this direct GME payment approach, Medicare established direct GME per-resident-average base rates for 1985 based on the allowable portion of GME costs divided by the number of allowable residents, as determined at audit. These base rates adjusted for inflation and budget neutrality adjustments are multiplied by the allowable resident GME counts for gross allowable GME payments. This gross amount is then multiplied by Medicare's actual utilization percentage for Medicare's portion of GME cost. While this may sound simple this latest methodology was quite complex and refined, with various limits and restrictions. As a result these direct GME payments were limited to those activities related to patient care. Therefore, even these current GME pass-through payments had a foundation in the following guiding principles:

- Costs related to patient care (42 CFR § 413.9):
    - *"Principle* - All payments to providers of services must be based on reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost..."
    - *"(1) Reasonable Cost* - Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an

accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year."

- *"(2) Necessary and Proper Costs* - Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity."

We contend, as previously recognized by Medicare, that the GME expenses apportioned to Medical Assistance and patient care activities would have met these guiding principles and should still be recognized as "costs related to patient care" and should continue to be recognized as a component part of the mandated patient service cost for the following reasons:

- GME costs are necessary and proper because they are costs incurred that are common and accepted treatment costs in teaching hospitals
- Interns/residents are performing direct patient care (inpatient, outpatient, psychiatric, rehabilitation, ancillary, etc.) activities in accordance with their approved GME training program requirements
- GME costs were limited over the years through various means (by Medicare and State government) to assure the reasonableness of the GME costs
- All hospital specific MA GME base limits applied in Pennsylvania were determined through true step down allocation methodology approaches to assure that net GME costs related to patient care were allocated to appropriate patient service areas and that the MA GME amount was based on the proportion of actual medical assistance patient utilization
- Historically both Medicare and Medical Assistance have recognized GME costs as necessary and proper costs of teaching providers and have paid for their share of these costs under different payment methodologies over 42 years
- The proposed rule attempts to portray GME expenses as a "specific health service" and not recognize it as a component part of every patient service. Residents and their supervising physicians are critical parts of the treatment teams (in teaching providers) rendering all types of needed services to all patients (Medicare, MA and all other patients).
- GME costs are the "hands on" resident and supervising physician costs associated with actual patient care. The AAMC describes Graduate medical education (GME) as:

> "...the second phase of the formal educational process that prepares doctors for medical practice. GME is required of all medical school graduates seeking full medical licensure and board certification in one of the specialties and/or subspecialties of medicine. This phase of medical education is, of necessity,

conducted primarily in clinical settings, and requires direct participation by residents in the delivery of patient care services."

- The proposed rule indicates that because GME expenses are excluded from Inpatient PPS DRG payments, then they must not be recognized as a component of inpatient hospital services. When in reality, GME expenses are excluded from IPPS operating costs because these GME costs are not 100% inpatient costs. Resident GME costs can relate to various service areas such as inpatient, ancillary, outpatient, psychiatric units, and rehabilitation units. As such these costs and payments are paid for as a separate Medicare pass-through payment. Thus the exclusion of GME from inpatient operating IPPS payment DOES NOT MEAN it is not a recognized cost of inpatient or outpatient care.

As we have attempted to show, GME is a necessary and proper expense of a teaching facility in the production and delivery of required services to MA beneficiaries by residents in training. As such it would never be listed as "a service" since it is part of 'all services" in a teaching setting. For instance, the authorized coverage package under the Medicaid statute does not list "nursing" as a separate health service but their cost is being recognized as a component part of the inpatient or outpatient service. It is no different for resident GME costs; they are also part of the treatment team rendering the service to the MA or Medicare beneficiary. We urge CMS to drop this proposal and return to the long standing recognition that GME is part of a teaching providers patient care service cost.

3. Attempt by Federal Government to Shift a Portion of Their Financial Responsibility for a Component of Teaching Facility Cost and Treatment to Other Payers:

As previously noted, Title XIX of the Social Security Act enacted in 1965 requires the Federal government to jointly finance with the State governments medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. Within broad Federal rules, each state decides eligible groups, types and range of services, and payment levels for services. For 42 years the Federal government has historically recognized and accepted that GME activities are a recognized component part of the cost of inpatient and outpatient hospital services to Medical Assistance patients. As a component cost of the required MA patient services the States were able to obtain a Federal match on these GME expenditures.

Under this proposed rule GME expenditures will not be eligible for a federal match on the basis that GME is not a health service within the scope of MA services and that GME is not recognized under Medicaid statute as a component of MA inpatient and outpatient hospital services.

UPMC disagrees with these findings as discussed above. The Federal government is attempting to reduce its portion of the required Federal match by proposing that GME

expenditures are not a component part of the MA inpatient and outpatient hospital service cost. CMS also indicates that the States have the option of replacing these lost federal funding dollars with State-only dollars, obtain private sector funds, or increase taxes to provide funding for the lost federal share of graduate medical education (GME) dollars. We contend that this proposal is a form of cost shifting which is contrary to several of the guiding principles that Medicare has traditionally observed, and have tried to recognize in the development of their various payment systems. They include:

> (42 CFR § 413.5 Cost Reimbursement: General (a)) "In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program," ... "All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution."

We contend that this proposed rule to stop funding of Medical Assistance GME expenditures is contrary to this guiding Medicare principle which has been historically followed by Medicare. The Medical Assistance portion of GME costs for teaching providers will now have to be borne by other patients or other tax payers. Clearly this proposal is not fair to these other patients, taxpayers or to teaching providers. Again we urge CMS to rescind this proposed rule.

4. Short and Long-term Consequences to the Proposed Discontinuation of Federal Financial Participation in the Training of Qualified Physicians, Through GME Programs, that Could Potentially Lead to Reduced Quality of Care and Services for our Needy MA Patient Populations, and Ultimately Other Payers

If this proposed rule to eliminate all Federal financial participation in Medical Assistance GME expenditures is not withdrawn then it will have an immediate negative impact on all State governments and teaching providers. Long-term consequences will clearly impact all patients through a decline in the caliber of its physicians, an unavoidable decline in the quality of care, possible slow-down in long-term clinical innovations and or a general cut in patient services. While teaching hospitals and State governments will clearly attempt to continue their training programs the challenges of finding other GME funding sources will clearly place significant financial stress on all involved. While some states may decide to increase taxes to fund the lost federal match, others will not and may drop Graduate Medical Education (GME) funding all-together. These GME funding shortfalls will place an immediate financial and administrative burden on teaching providers who have limited short term options in dealing with revenue shortfalls. 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. Short-term remedies would require immediate reduction in hospital staffing,

reduced or closed clinic hours, and planned reductions in residency programs or FTEs would also be required. All these options clearly reduce quality, the educational opportunities for residents, and patient care options and services, to the detriment of all patients.

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 UPMC's education and research missions, we offer the most advanced, state-of-the- art services and equipment; and with residents and supervising physicians available around-the-clock, UPMC is looked to as a front-line responder in the event of a local and/or national disaster and have implemented plans to fulfill that role. If this FFP funding for GME payments is removed it hinders UPMC's ability to continue to fulfill these missions.

We again urge CMS to withdraw this proposed rule as reductions in federal financial participation in MA resident training programs hurts teaching providers immediately, but in the long-term it will negatively affect all of us.

Conclusion

We appreciate the opportunity to submit these comments on your proposed changes to the "Medicaid Program; Graduate Medical Education" and hope they are considered before any final rule is adopted.

Sincerely,

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

CC: Concordia, Elizabeth
Farner, David M..
Huber, George
Kennedy, Robert A.
Lewandowski, C.
Stimmel, P.
System CFO's
Zerega, Dennis

CMS-2279-P-29 **Medicaid Graduate Medical Education**

Submitter : Mr. Greg Gombar **Date & Time:** 06/19/2007

Organization : Carolinas HealthCare System

Category : Health Care Professional or Association

Issue Areas/Comments
GENERAL

GENERAL

(See attachment)

CMS-2279-P-29-Attach-1.DOC

#29

June 18, 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 Carolinas HealthCare System (CHS) 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. 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. Our major teaching hospital, Carolinas Medical Center (CMC) has been receiving GME funds since the 1960's. CMC relies on these and other Medicaid payments to support our critical functions.

Medicaid GME payments helps CMC sustain its core responsibility of 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. CMC currently trains over 210 physicians in 12 specialties. Many of these physicians upon graduation stay in North Carolina to meet our growing population physician needs. Eliminating FFP for state Medicaid agency payments for GME would devastate CMC's 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. CMC is the largest provider of Medicaid services and uninsured care in NC. Making these huge reductions in GME programs will result in cutbacks in other areas, thus creating access issues and eventually increased costs for all.

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 Medicaid program was essentially modeled after Medicare in the early 1960's from a coverage of costs and methodology basis. Most states modeled their cost findings and payment methods to mirror Medicare. Medicare paid for GME and Medicaid paid for GME. To come in now after the Federal Government has been paying for GME for both Medicare and Medicaid for over 40 years and saying that it is not non-covered is the most inconsistent and inappropriate decision CMS has ever made. Due to the growing number of Medicare, Medicaid and uninsured patients that we, as administrators, have to deal with to provide quality care at lower and lower rates, it is preposterous and out of touch with reality to eliminate these costs after 40 years of funding. If you are going to fix the deficit, don't balance on the backs of those institutions, such as CMC, who are true safety-net providers.

We urge the Agency to rescind the proposed rule.

Sincerely,

Greg A. Gombar
EVP-Administrative Services, CFO

GAG:sd

CMS-2279-P-30 Medicaid Graduate Medical Education

Submitter : Mr. James M. Hill **Date & Time:** 06/19/2007

Organization : Milwaukee County Behavioral Health Division

Category : Psychiatric Hospital

Issue Areas/Comments
GENERAL

GENERAL

see Attachment

CMS-2279-P-30-Attach-1.PDF

#30

DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

ROB HENKEN • Director
JAMES M. HILL • Division Administrator

June 19, 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 Milwaukee County Behavioral Health Division (MCBHD) 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 such as ours, and jeopardize our 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. This tradition is now in jeopardy.

More to the local point, the MCBHD is the public agency serving the mental health and substance abuse treatment needs of a population of 1 million people. Among other services, we operate a 96-bed acute adult inpatient hospital and 24-hour psychiatric crisis service. The majority of our clients are very poor; nearly a third are Medicaid and Medicare-eligible. We have a long-standing relationship with the Medical College of Wisconsin to provide opportunities for individuals to complete their residencies in psychiatry. This collaboration as a teaching hospital to the Medical College enables us to meet our state mandate to serve this population by enabling 24 M.D. residents to fulfill this critical requirement of their medical education. They complete their residencies in our crisis service, which last year assessed and treated over 13,000 individuals in mental health crisis.

We rely significantly on the revenues we receive through our Medicaid DRG rate to make this collaboration possible. Without this fiscal assistance, we would quite literally be unable to meet our mandate.

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

Sincerely,

James M. Hill
Administrator