CMS-2279-P-75 Medicaid Graduate Medical Education

Submitter : Mrs. Nancy Payne **Date & Time:** 06/21/2007

Organization : Allina Hospitals and Clinics

Category : Hospital

Issue Areas/Comments
GENERAL

GENERAL

Please see attachment.

CMS-2279-P-75-Attach-1.DOC

#75

Allina Hospitals & Clinics
Compliance and Regulatory Affairs
PO Box 43 Mail Route 10105
Minneapolis, MN 55440-0043

ALLINA
Hospitals & Clinics

June 21, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-P
P.O. Box 8011
Baltimore, MD 21244-1850

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

Dear Ms. Norwalk;

On behalf of Allina Hospitals & Clinics (Allina), I appreciate the opportunity to comment on the proposed rule changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs. Allina is a family of urban and rural hospitals, clinics, and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy, durable medical equipment, home care and hospice services. Allina serves communities around Minnesota and western Wisconsin. Additionally, Allina hospitals and clinics facilitate three residency programs focused on internal medicine, family practice and podiatry, graduating 19 new physicians annually. Our hospitals and clinics also provide a learning environment for numerous residents from affiliated residency programs in the Minneapolis/St. Paul metropolitan area.

We have grave concerns regarding the impact that elimination of the federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments will have on our ability to continue to play a key role in medical education. Finalizing this rule would erode the financial condition of our teaching hospitals and jeopardize our ability to continue to fulfill this important mission.

Hospitals are the backbone of America's health care safety net, providing care to all patients who come through our doors, regardless of ability to pay. As all health care providers, Allina faces financial challenges related to caring for the growing population of uninsured patients, for which we provided over $47 million through free care and uninsured discount programs in 2006. In addition, Medicaid shortfalls accounted for over $41 million. As a not-for profit organization, the health of the communities in which we

operate is essential to Allina's mission and strategy. In total for 2006, we provided over $396 million in benefit to our communities. Any reduction in Medicaid funding will have a detrimental impact on our ability to continue to support the communities we serve at the same rate.

With a growing population of Medicaid patients as well the uninsured nationally, funding of federal dollars must be preserved to assure that all states can meet its health care obligations to the neediest in our society. 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.

The Medicaid program is already underfunded. We request the Centers for Medicare & Medicaid Services (CMS) rescind the May 23, 2007 proposed rule.

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 are essential to our mission of providing the clinical education of future physicians. Medicare GME payments compensate teaching hospitals for the direct costs of their educational activities by measuring the number of medical residents trained. These medical residents work within a supervised patient care team of health care professionals, providing needed care to Medicare and Medicaid 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.

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.

We urge CMS to rescind this proposed rule. Given our important role in medical education 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. The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs, which through their function, provide care to some of our most vulnerable populations.

The gravity of this change may severely impact our continued role in providing the highly skilled professionals essential to meeting the health needs of our society. If you have any questions regarding these remarks, please feel free to contact me at 612-262-4912.

Sincerely,

Nancy G. Payne

Nancy G. Payne, RN, MA
Director Regulatory Affairs

CMS-2279-P-76 Medicaid Graduate Medical Education

Submitter : Mr. R. Edward Howell **Date & Time:** 06/21/2007

Organization : University of Virginia Medical Center

Category : Hospital

Issue Areas/Comments
GENERAL

GENERAL

See Attachment

CMS-2279-P-76-Attach-1.PDF

#76

UNIVERSITY of VIRGINIA HEALTH SYSTEM

VICE PRESIDENT *and* CHIEF EXECUTIVE OFFICER
of the MEDICAL CENTER

June 20, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of The University of Virginia Health System 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 not only our hospital, but all teaching hospitals 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. The Commonwealth of Virginia has long funded GME payments, and the UVA Medical Center receives approximately $12 million per year in Medicaid GME funding. We and other 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 forecasting a physician shortage in the near future. We currently provide

P.O. Box 800809 • Charlottesville, VA 22908-0809
434-243-9308 • Fax: 434-243-9328

training for over 750 residents and fellows and support over 100 training programs. Our programs offer excellent opportunities to become a competent and caring physician in dozens of specialties, including many where physician shortages have been noted. These include Obstetrics and Gynecology, which provides care to many high-risk pregnant patients who have been left without options given the current malpractice crisis in our area. In addition, we train child and adolescent psychiatrists; this is an area of severe physician shortage as recently noted by the Commonwealth of Virginia. In addition, we have training programs in many pediatric subspecialty areas, including urology, nephrology, cardiology, and endocrinology, which is particularly important given the current epidemic of childhood obesity and diabetes. We have recently added fellowship positions in Infectious Diseases and Nephrology to accommodate the growing number of HIV-positive patients, as well as those with chronic kidney disease, whose numbers have increased dramatically in our geographic area. 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. At the UVA Medical Center, we have approximately 39,600 Medicaid inpatient days and 5,900 Indigent Care inpatient days per year. This volume of care demonstrates our commitment to helping the underserved in our community – a commitment that would be severely hampered if we faced a large loss of GME funding.

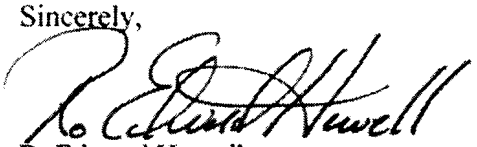
Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, 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 University of Virginia Health System plays a unique role in Central Virginia. We not only serve as a tertiary care health care provider, we are also seen as the community hospital for the city of Charlottesville and several surrounding counties. We provide care for a large number of low income and uninsured patients. Our Medical Center offers unique

specialty services, including world renowned expertise in neurosurgery, cardiothoracic surgery, endocrinology, and others. We also provide crucial care to a large geographic area with our trauma unit, burn unit, neonatal intensive care unit, and community psychiatric services. Additionally, we sponsor training programs that offer expert and caring services in both primary, preventive, and palliative care and act as a key referral service for hard-to-access specialty care services, particularly for the uninsured. Many of our residents and physicians staff the Free Clinic of Charlottesville and Albemarle County, which provides medical care to the many un- or underinsured patients in our area. Furthermore, a large number of our residents and fellows participate in RAM (Remote Area Medical Program), which annually provides care to the uninsured patients living the Appalachian region of Southwest Virginia.

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. Edward Howell
Vice President and Chief Executive Officer

cc: E. Darracott Vaughan, Jr., M.D., Chair, Medical Center Operating Board
Mr. Leonard W. Sandridge, Executive Vice President
Sharon L. Hostler, MD, Interim Vice President and Dean, School of Medicine
Susan E. Kirk, MD, Associate Dean, Graduate Medical Education

CMS-2279-P-77 **Medicaid Graduate Medical Education**

Submitter : Mr. Kevin Kinsella **Date & Time:** 06/21/2007

Organization : Hartford Hospital

Category : Hospital

Issue Areas/Comments
GENERAL

GENERAL

See attachment

CMS-2279-P-77-Attach-1.DOC

#77

June 21, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of Hartford 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. In Connecticut, only direct GME payments associated with inpatient services are provided by the Department of Social Services ("DSS"). For Hartford Hospital, this amounts to approximately $1.1 million per year associated with approximately 2,600 State cases annually. 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. As a major urban teaching hospital, Hartford Hospital enrolls 228 residents in various teaching programs. Such programs are critical in order to service the health care needs of the community. Hartford Hospital in

particular, consistently treats the most complicated cases among hospitals in the State as measured by the case-mix index. The Hospital's commitment to the existing teaching programs has allowed Hartford Hospital to service this population. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

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

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

Medicaid reimbursement to hospitals must be reasonable and adequate to meet the costs incurred by efficiently operated hospitals providing quality services. There is no question that Hartford Hospital provides its services efficiently and in conformity with State and Federal conditions of participation for quality and safety. However, there continues to be a huge gap between the Hospital's costs to provide services and reimbursement. Factors contributing to the Hartford Hospital's increased costs in caring for the Medicaid population include:

a) an increase in acuity of Medicaid cases as demonstrated by the rise in case-mix index;
b) increased consumption of Hospital services by Medicaid patients; advances in medical technology that have produced more expensive, but necessary, medical supplies and technologies;
c) Hartford Hospital is the largest provider of services to Medicaid and SAGA patients residing in Hartford;
d) Hartford Hospital has the second largest volume of Medicaid inpatient cases in the State; and
e) The Hospital is the largest provider of outpatient services to Medicaid and SAGA patients in the State which contributes greatly to the growth in the Hospital's inpatient population.

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,

J. Kevin Kinsella
Vice President

CMS-2279-P-78 **Medicaid Graduate Medical Education**

Submitter : **Date & Time:** **06/21/2007**

Organization :

Category : **Physician**

Issue Areas/Comments
GENERAL

GENERAL

See Attachment

CMS-2279-P-78-Attach-1.DOC

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 as the Program Director of the Internal Medicine Residency Training Program at the University Hospital and the University Of Cincinnati College Of Medicine to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching and patient care missions.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. In 2006, University Hospital received $17 million in support of its care of the Medicaid population. 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. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In 2006, University Hospital admitted 10,000 Medicaid patients for inpatient services and provided care for an additional 77,000 Medicaid patients in outpatient settings. This is in addition to the 4,000 indigent care patients admitted for inpatient services and the 111,000 treated in outpatient settings. In 2006, as defined by the Catholic Healthcare Initiative, University Hospital provided over $71 million in community benefit. This figure is by far the largest in our region and one of the top three among providers in the State of Ohio.

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.

University Hospital and the University of Cincinnati College of Medicine work collaboratively in graduate medical education as well as medical student education. A high percentage of physicians practicing in the greater Cincinnati area received residency training at University Hospital. University Hospital is a major resource to the community. It houses the city's major trauma center with AirCare helicopter transport as a key component. University Hospital is the site of the regional adult burn unit. University Hospital and the faculty of the College of Medicine are major referral sites for tertiary and quaternary care in many areas such as Neurology and Neurosurgery. University Hospital maintains the area's only Psychiatric Emergency Services Unit. The Center for Emergency Care is one of the busiest in the region and serves as a major resource for the regional emergency response system. The University Hospital outpatient clinic system provides high quality primary care to the indigent population and the specialty clinics serve as a key referral source for the indigent population. University Hospital maintains a high risk obstetric service and a Newborn Intensive Care Unit. In summary, University Hospital is a significant community resource offering a wide range of primary care and specialty care services to patients of all demographics and payment status. University Hospital has been recognized for quality of care while fulfilling its mission as a safety net hospital.

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,

Gregory W. Rouan, MD
Richard and Sue Vilter Professor of Medicine
Associate Chairman for Medical Education
Internal Medicine

CMS-2279-P-79 Medicaid Graduate Medical Education

Submitter : Dr. Jeffrey Goldsmith **Date & Time:** 06/21/2007

Organization : University Hospital

Category : Hospital

Issue Areas/Comments
GENERAL

GENERAL

see attachment

CMS-2279-P-79-Attach-1.DOC

#79

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**

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Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. In 2006, University Hospital received $17 million in support of its care of the Medicaid population. 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. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In 2006, University Hospital admitted 10,000 Medicaid patients for inpatient services and provided care for an additional 77,000 Medicaid patients in outpatient settings. This is in addition to the 4,000 indigent care patients admitted for inpatient services and the 111,000 treated in outpatient settings. In 2006, as defined by the Catholic Healthcare Initiative, University Hospital provided over $71 million in community benefit. This figure is by far the largest in our region and one of the top three among providers in the State of Ohio.

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University Hospital and the University of Cincinnati College of Medicine work collaboratively in graduate medical education as well as medical student education. A high percentage of physicians practicing in the greater Cincinnati area received residency training at University Hospital. University Hospital is a major resource to the community. It houses the city's major trauma center with AirCare helicopter transport as a key component. University Hospital is the site of the regional adult burn unit. University Hospital and the faculty of the College of Medicine are major referral sites for tertiary and quaternary care in many areas such as Neurology and Neurosurgery. University Hospital maintains the area's only Psychiatric Emergency Services Unit. The Center for Emergency Care is one of the busiest in the region and serves as a major resource for the regional emergency response system. The University Hospital outpatient clinic system provides high quality primary care to the indigent population and the specialty clinics serve as a key referral source for the indigent population. University Hospital maintains a high risk obstetric service and a Newborn Intensive Care Unit. In summary, University Hospital is a significant community resource offering a wide range of primary care and specialty care services to patients of all demographics and payment status. University Hospital has been recognized for quality of care while fulfilling its mission as a safety net hospital.

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,

Gregory W. Rouan, MD
Richard and Sue Vilter Professor of Medicine
Associate Chairman for Medical Education
Internal Medicine

CMS-2279-P-80 **Medicaid Graduate Medical Education**

Submitter : Sarah deLone **Date & Time:** 06/21/2007

Organization : Center on Budget and Policy Priorities

Category : Other

Issue Areas/Comments

Background

Background

See attached.

GENERAL

GENERAL

See attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached.

CMS-2279-P-80-Attach-1.DOC

CMS-2279-P-80-Attach-1.DOC

CMS-2279-P-80-Attach-1.DOC

#80

Center on Budget and Policy Priorities

820 First Street NE ■ Suite 510 ■ Washington DC 20002
(202)408-1080 ■ fax (202)408-1056 ■ center@cbpp.org ■ www.cbpp.org

June 21, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017

ATTN: CMS-2279-P

RE: Comments on Medicaid Program; Graduate Medical Education (CMS-2279-P)

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, DC. Founded twenty-five years ago, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting low- and moderate-income families and individuals. We appreciate the opportunity to comment on the proposed rule on the Medicaid Program and Graduate Medical Education, which was published in the Federal Register on May 23, 2007. We are particularly concerned about the impact of the proposed rule on Medicaid beneficiaries and the uninsured.[1]

1. The financial impact of the proposed rule on medical teaching facilities, and therefore on the patients they serve, would be significant.

It is hard to precisely quantify the financial impact that the elimination of Medicaid GME payments would have on teaching hospitals. A recent survey conducted for the Association of American Medicaid Colleges reported that, as of 2005, 47 states and the District of Columbia provided GME payments under Medicaid. Medicaid GME payments that year totaled $3.2 billion, representing roughly 7 percent of total Medicaid inpatient hospital expenditures.[2]

In addition to precluding states from using Medicaid funds to support GME, the proposed regulation would require states to exclude "direct graduate medical education" (DGME) payments made under Medicare from their calculation of the upper payment limit (UPL), established under CMS regulations, for hospitals under Medicaid. In the preamble to the proposed rule, CMS solicits

[1] As you know, under Section 7002 of the 2007 supplemental appropriations (Public Law 110-28), there is a one-year moratorium on the promulgation or implementation of rules regarding payments for Medicaid graduate medical education. We assume that the Centers for Medicare and Medicaid Services (CMS) is still accepting comments on this proposed regulation, although it cannot promulgate final rules until May 26, 2008 at the earliest.

[2] Tim M. Henderson, "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey," Association of American Medical Colleges, November 2006.

comments on whether or not states also should be required to exclude the "indirect medical education" (IME) payments made under Medicare from the hospital UPL.[3]

We estimate that the exclusion of Medicare DGME payments from the Medicaid upper payment limit would effectively lower the cap on Medicaid hospital payments by at least $7.2 billion over five years.[4] If Medicare IME payments are also excluded, this would lower the cap on Medicaid hospital payments by $19.5 billion over five years, for a total reduction in the cap of $26.7 billion. We realize that many states do not reach the upper payment limit in Medicaid payments to hospitals, so the actual payment reduction would be less than the reduction in the caps, estimated above.

Thus, although the financial impact cannot be precisely predicted, there is no question that the proposed rule would have a significant impact (1) on the financial viability of teaching hospitals — particularly public and non-profit hospitals — and other health care facilities that provide graduate medical training and that rely on this source of revenue; (2) on the ability of such facilities to provide care to Medicaid beneficiaries and the uninsured; and (3) insofar as it reduces training for physicians and other health professionals, on the quality of care received by other patients as well.

2. The proposed rule would prohibit a widespread practice of making Medicaid GME payments, which has been sanctioned by CMS for over 40 years.

Within broad federal guidelines, states have considerable discretion in administering their Medicaid programs. As acknowledged by CMS in the preamble to the proposed rule, such discretion includes the establishment of Medicaid provider payment rates, including those for hospital services. Thus, unless specifically limited by federal statute or regulation, states are permitted to develop reimbursement methodologies that meet the needs and policy goals of their Medicaid programs.

There are two federal statutory provisions which establish the boundaries of state flexibility to establish hospital payment rates: (1) section 1902(a)(13) of the Social Security Act ("Act"), which requires states to engage in a public process in developing and publishing the payment methodologies and rates for various institutional services, including hospital services; and (2) the requirement in section 1902(a)(30)(A), applicable to all provider payment rates, that states establish rates that "are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[5]

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[3] DGME payments compensate teaching hospitals for the direct costs of their educational activities, as measured by the number of residents being trained and the historic costs associated with such training. IME payments reflect additional costs that teaching hospitals incur in providing patient care to Medicare beneficiaries — e.g., salaries and fringe benefits for medical residents and teaching faculty. Graduate medical education payments are not defined under the Medicaid statute. Consequently, the GME expenses for which states provide reimbursement under Medicaid, and the methodology used by each state to determine such reimbursement amounts, varies from state to state. Some states borrow the concepts of direct versus indirect costs from Medicare. Others do not make this distinction.

[4] These estimates are based on DGME and IME payments in Medicare, as estimated in CBO's March 2007 baseline, and the ratio of Medicaid to Medicare hospital expenditures, as projected by the Office of National Health Estimates at CMS, from 2008 to 2012.

[5] In addition, federal regulations establish an "upper payment limit" for Medicaid payment rates for inpatient hospital and long-term care services. The upper payment limit (UPL), defined at 42 CFR 447.272, refers to a reasonable estimate of the amount that would be paid for the services provided under Medicare. In general, Medicaid payments to three

For over 40 years — since the inception of the Medicaid program itself — states have been exercising the flexibility afforded to them under the statute to include the costs of GME in their determinations of hospital payment rates, and virtually all states do so today. Further, CMS consistently has approved rate-setting methodologies which take GME expenses into account. Indeed, current federal regulations require that states specify the methods and standards used to determine inpatient hospital payment rates in their state plan."[6] Thus, before considering GME expenses in determining Medicaid hospital payment rates, states must obtain CMS approval.

Other than a general statement that there is "no express authority" in Title XIX to support Medicaid payments for GME, CMS gives no explanation for this dramatic policy reversal. Express authorization, however, is not required. Given the broad discretion states have to set hospital rates under the federal statute and regulations, all that is required is that GME payments fall within the bounds of states' discretion. It simply defies credulity that, after over 40 years of approving GME payments in as many as 47 states and the District of Columbia, that CMS now has come to the realization that such payments fall beyond the discretion afforded states under the statute.

Because Medicaid GME payments clearly are permitted under federal law and are consistent with the purposes of the Medicaid program, the Secretary should rescind this proposed rule, and leave intact the agency's longstanding interpretation of the statute to permit these payments.

3. IME and DGME adjustments under Medicare should not be excluded from the upper payment limit.

As noted above, CMS specifically solicits comments on the propriety of including Medicare indirect medical education (IME) adjustments paid by Medicare from the calculation of the upper payment limit for hospitals under Medicaid. As also noted above, the exclusion of DGME could reduce the cap on Medicaid hospital payments by at least $7.2 billion over five years. The exclusion of IME could lower the cap by an additional $19.5 billion. This would substantially reduce states' abilities to improve Medicaid hospital payments to levels comparable to Medicare and would establish federal rules that lock in Medicaid as a poor payer to all participating hospitals (both teaching and non-teaching hospitals).

4. The proposed rule would place the quality of medical care for Medicaid patients and the uninsured at greater risk, particularly for those with more complex medical problems.

By effectively requiring states to reduce Medicaid payments to teaching facilities, the proposed rule also would effectively reduce Medicaid funding available for patient care and/or for the training of graduate physicians, nurses and other health professionals. As noted above, the AAMC survey indicated that the Medicaid GME and IME payments average about 7 percent of total inpatient hospital expenses, with levels substantially higher in a number of states. It is difficult to believe that hospitals can sustain such deep losses without having an impact on the quality of medical care provided. (The effect of other changes in Medicaid cost limits to government providers could

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different groups of facilities specified in the regulations (state government-owned or operated facilities, non-state government-owned or operated facilities, and privately-owned and operated facilities) may not exceed the UPL.

[6] 42 CFR 447.253(i).

further compound these problems.) To the extent that patients at teaching hospitals are sicker, with more complex medical conditions, it places a particularly severe burden on those patients. The proposed rule offers no rationale for such a policy, nor does it suggest how states or hospitals might ameliorate these effects. It seems likely that this will lead to lower quality care and greater morbidity and mortality among low-income patients.

Again, thank you for the opportunity to comment on this interim regulation. If you have any questions, please do not hesitate to contact Leighton Ku or Sarah deLone at 202-408-1080.

Sincerely,

/s/

Leighton Ku
Senior Fellow

/s/

Sarah deLone
Senior Policy Analyst

CMS-2279-P-81 Medicaid Graduate Medical Education

Submitter : Dr. Debra Fiser **Date & Time:** 06/21/2007

Organization : UAMS College of Medicine

Category : Academic

Issue Areas/Comments
GENERAL

GENERAL

see attachment

CMS-2279-P-81-Attach-1.DOC

CMS-2279-P-81-Attach-2.DOC

#81

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

Attention: CMS-2279-P

Dear Administrator Norwalk:

We in the University of Arkansas for Medical Sciences (UAMS), College of Medicine (COM), appreciate the opportunity to provide comments on the above CMS rule to clarify that reimbursement would no longer be provided for Graduate Medical Education under the rules governing the Medicaid Program, and further request that you rescind the May 23, 2007 proposed rule.

Characterized as a clarification this is clearly a reversal of long-standing Medicaid policy. Clearly for decades state Medicaid programs have recognized and supported the higher costs of teaching hospitals. This action had CMS approval since this these payments were matched with federal funds. Teaching hospitals clearly need added support from GME and IME to support their critical functions.

These payments help the University of Arkansas for Medical Sciences, Medical Center sustain their responsibility in assisting the COM in providing clinical education to future physicians. University Hospital serving as the safety net hospital for Arkansas and seeing a disproportionate share of the Medicaid patients in Central Arkansas as well as from all corners of the state is a vital partner in patient care provided by supervised residents as part of their training program. With the numerous studies calling for a near crisis in physicians in the near future it seems short sighted to now cut the educational support necessary to increase the number of physicians. AAMC calls for increasing our numbers of enrolled students by as much as 30%, a task almost impossible to implement without continued FFP for hospitals participating in the training and expansion.

Serving as the States only teaching hospital for the only state medical school, our citizens are afforded highly specialized services which if not provided in Arkansas would require additional resources to be sought out of state, increasing the cost to both Medicaid and Medicare. Supporting these physicians and residents with the most state of the art equipment and services, providing around the clock coverage, is not inexpensive and without CMS support for the extra cost of teaching all programs would suffer tremendously. Our hospital provided a vital services to the victims of both Katrina and Rita, and are expected to be the first responder in the event of biological, chemical or nuclear attack, all done in partnership with the COM and the resident force supported through these funds.

Given the important role 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,

Debra H. Fiser, M.D.
Dean, College of Medicine
Vice Chancellor, UAMS

CMS-2279-P-82 Medicaid Graduate Medical Education

Submitter : Mr. James Kingsbury **Date & Time:** 06/21/2007

Organization : University Hospital-Cincinnati

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-82-Attach-1.DOC

#82

University Hospital

Health Alliance™

June 20, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of University Hospital and the University Of Cincinnati College Of Medicine to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule 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. In 2006, University Hospital received $17 million in support of its care of the Medicaid population. 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. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In 2006, University Hospital admitted 10,000 Medicaid patients for inpatient services and provided care for an additional 77,000 Medicaid patients in outpatient settings. This is in addition to the 4,000 indigent care patients admitted for inpatient services and the 111,000 treated in outpatient settings. In 2006, as defined by the Catholic Healthcare Initiative, University Hospital provided over $71 million in community benefit. This figure is by far the largest in our region and one of the top three among providers in the State of Ohio.

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.

University Hospital and the University of Cincinnati College of Medicine work collaboratively in graduate medical education as well as medical student education. A high percentage of physicians practicing in the greater Cincinnati area received residency training at University Hospital. University Hospital is a major resource to the community. It houses the city's major trauma center with AirCare helicopter transport as a key component. University Hospital is the site of the regional adult burn unit. University Hospital and the faculty of the College of Medicine are major referral sites for tertiary and quaternary care in many areas such as Neurology and Neurosurgery. University Hospital maintains the area's only Psychiatric Emergency Services Unit. The Center for Emergency Care is one of the busiest in the region and serves as a major resource for the regional emergency response system. The University Hospital outpatient clinic system provides high quality primary care to the indigent population and the specialty clinics serve as a key referral source for the indigent population. University Hospital maintains a high risk obstetric service and a Newborn Intensive Care Unit. In summary, University Hospital is a significant community resource offering a wide range of primary care and specialty care services to patients of all demographics and payment status. University Hospital has been recognized for quality of care while fulfilling its mission as a safety net hospital.

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,

James Kingsbury
Executive Director
University Hospital

CMS-2279-P-83 Medicaid Graduate Medical Education

Submitter : Mr. John Stephen **Date & Time:** 06/21/2007

Organization : NH Department of Health and Human Services

Category : State Government

Issue Areas/Comments
GENERAL

GENERAL

See Attachment

CMS-2279-P-83-Attach-1.DOC

#83

June 20, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
P. O. Box 8016
Baltimore, MD 21244-1016

Re: CMS-2279-P Medicaid Program; Graduate Medical Education

Dear Sir/Madam:

The State of New Hampshire Department of Health and Human Services appreciates the opportunity to submit comments on CMS-2279-P regarding Medicaid Program; Graduate Medication Education (GME) payments. New Hampshire is anticipating paying participating hospitals approximately $850,000 for Direct Medical Education (DME) and approximately $3 Million for indirect medical education (IME) on an annual basis beginning July 1, 2007 as stipulated in the current version of the State Budget for the new biennium.

We concur with the notion that general medical education payments are no longer necessary to support the State's medical education systems, nor do we believe that the payments directly benefit Medicaid recipients as perhaps originally intended, as follows:

1) Of the 26 general hospitals that operate in New Hampshire, this proposal affects only four hospitals, with one hospital being the primary beneficiary of GME payments. These four hospitals are in good financial condition, with all four showing profitability and positive financial health.

2) As implemented in New Hampshire, GME is an entitlement program. Hospitals receiving GME payments are not held accountable for any education, workforce, or other objectives deemed in the State's interests.

3) DME payments do not directly benefit Medicaid patients since reimbursement is not dependent on direct services to Medicaid recipients.

4) IME payments may compensate hospitals in excess of their actual medical education costs.

5) Medicare supports NH teaching hospitals through DME and IME payments.

Discontinuation of the current Medicaid GME program as we presently know it would provide value to the New Hampshire taxpayer.

The New Hampshire Department of Health and Human Services appreciates the opportunity to submit these comments on the Proposed Rule regarding Graduate Medical Education. If you have any questions about these comments, please contact James Fredyma, Controller, at 603-271-4333.

Your consideration on this matter is appreciated.

Sincerely,

John A. Stephen
Commissioner