

**Submitter :** Dr. Daniel Jones

**Date:** 06/22/2007

**Organization :** University of Mississippi Medical Center

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2279-P-231-Attach-1.DOC

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

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Office of Strategic Research Alliances

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June 22, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of the University of Mississippi 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.

Administrator Norwalk

June 22, 2007

Page 2

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, takes 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,

Daniel W. Jones, M.D.  
Vice Chancellor for Health Affairs  
Dean, School of Medicine  
Langford Professor of Medicine

Submitter : Ms. Julie Windom  
Organization : Georgia Alliance Of Community Hospitals  
Category : Health Care Professional or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

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June 22, 2007

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

Attention: CMS-2279--P

Dear Administrator Norwalk:

I am writing on behalf of the Georgia Hospital Safety Net Coalition, which consists of ten hospitals throughout the state, including the major teaching hospitals. The Coalition urges 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 (Sec 72 Fed. Reg. 28930). Finalizing this rule would erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

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

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 provided occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources.

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,

Georgia Hospital Safety Net Coalition  
Julie Ellen Windom, ESQ  
Director of Governmental Affairs  
Georgia Alliance of Community Hospitals

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Atlanta, GA 30309  
404 509 3573  
404 249 9434 (fax)  
jwindom@gach.org

Submitter :

Date: 06/22/2007

Organization :

Category : Individual

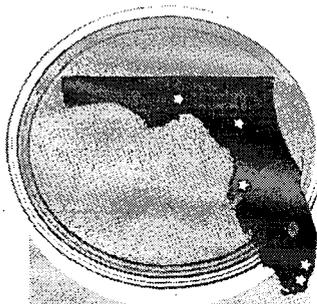
Issue Areas/Comments

GENERAL

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See Attachment

CMS-2279-P-233-Attach-1.PDF



# COUNCIL OF FLORIDA MEDICAL SCHOOL DEANS

United for Excellence in Medical Education, Research, and Health Care

June 22, 2007

## DEANS:

Pascal J. Goldschmidt, M.D.  
University of Miami  
School of Medicine

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Florida State University  
College of Medicine

Stephen K. Klasko, M.D.  
University of South Florida  
College of Medicine

Anthony J. Silvagni, D.O.  
Nova Southeastern University  
College of Osteopathic Medicine

C. Craig Tisher, M.D.  
University of Florida  
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Leslie Norwalk, Esq.  
Acting Administrator  
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Hubert H. Humphrey Building  
Room 445-G  
200 Independence Ave. SW  
Washington, DC 20201

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

Dear Administrator Norwalk:

The Council of Florida Medical School Deans (the Council) urges 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.<sup>1</sup> First and foremost, the rule should be rescinded given the subsequent passage of moratorium language, which negates the rule. Finalizing this rule would erode the financial condition of Florida's medical schools and teaching hospitals. The rule, if promulgated, will jeopardize our ability to continue to fulfill important teaching, patient care, education, and research missions.

The Council is comprised of Florida's accredited medical schools, which are Florida State University, Nova Southeastern University, University of Florida, University of Miami, and University of South Florida. At the present time, there are approximately 256 accredited allopathic residency programs and 42 osteopathic programs with up to 3,200 and 450 resident positions, respectively, in Florida. Council members in conjunction with our teaching hospital partners provide Florida's GME; and in the process training and educating Florida's future workforce, the Council's faculty and resident physicians provide significant levels of care to Medicaid and charity patients.

<sup>1</sup> 72 Federal Register 28930 (May 23, 2007)

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.

Florida is among the majority of states that support GME - and the state has been very progressive in doing so. Consistent with the prevailing federal regulations, Florida pays faculty physicians enhanced rates<sup>2</sup> and hospitals are paid hospital-specific per diem rates based on audited cost reports, and included in those costs are the costs associated with GME.<sup>3</sup> In addition, the role of teaching hospitals has been acknowledged in Florida's disproportionate share, upper payment limit, and low-income pool programs. GME has been a recognized and reimbursed cost for over twenty years. Florida's medical schools and teaching hospitals rely on these and other Medicaid payments to support critical access.

These programs and specifically the supplemental payments to faculty physicians have been adopted by the state Legislature and approved and allowed by CMS. Eliminating FFP for state Medicaid agency payments for GME could cripple our GME programs at a time when more physicians are needed throughout Florida and the country.

Medicaid GME payments help medical schools and 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.

Florida consistently ranks among the lowest in the country in terms of residency positions per 100,000 population. With only 19 medical residents per 100,000 in population, Florida ranks 44th in residents per capita. Studies have shown that place of residency is a determinant factor in ultimate practice location. By placing additional financial constraints on medical school and teaching hospitals, it will become difficult to maintain the residency programs and positions in place, let alone expand as needed to meet Florida's growing population demands.

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<sup>2</sup> 42 CFR § 447.304

<sup>3</sup> 42 CFR § 447 Subpart C

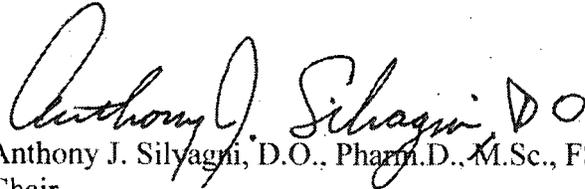
Florida's physician workforce has not kept pace with the state's booming population growth; Florida general and physician populations are aging. One-fourth of Florida's licensed physicians are over the age of 65 and half are over age 50; only 10% of Florida's working physicians are under the age of 35.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

A GME funding cut could also affect services offered to Medicaid and other patients by reducing medical school and teaching hospital financial resources because academic providers serve a great percent of our state's uninsured and underinsured. Florida's teaching and safety net hospitals provide in excess of 50% of the charity care and most of those patients are cared for by faculty physicians and residents.

Medical schools and 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. In partnership with the medical schools, Florida's teaching and safety net hospitals also offer access to tertiary services providing 99% of the state's burn care, 2 out of every 3 organ transplants, and represent all of the state's designated Level I trauma centers. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals are able to care for the nation's sickest patients. Most recently, faculty physicians and 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 medical schools and hospitals with residency programs, it is important that state Medicaid programs receive federal matching assistance for GME. **We urge the Agency to rescind the proposed rule.**

Sincerely,

  
Anthony J. Silvagni, D.O., Pharm.D., M.Sc., FSACOFP *dist.*  
Chair

**Submitter :** Mr. Larry Gage  
**Organization :** National Association of Public Hospitals  
**Category :** Health Care Provider/Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

Background  
See Attachment.

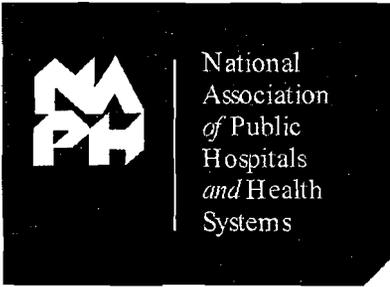
**GENERAL**

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See Attachment.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule  
See Attachment.

CMS-2279-P-234-Attach-1.PDF



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June 22, 2007

Ms. Leslie V. Norwalk, Esq.  
 Acting Administrator  
 Centers for Medicare and Medicaid Services  
 Department of Health and Human Services  
 Hubert H. Humphrey Building, Room 445-G  
 200 Independence Avenue, SW  
 Washington, D.C. 20201

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

Dear Ms. Norwalk:

The National Association of Public Hospitals and Health Systems (NAPH) writes to express our grave concern about the impact that the proposed elimination of Medicaid payments for graduate medical education (GME) will have on our nation's health care system. As you know, Congress has prohibited the Centers for Medicare and Medicaid Services (CMS) from taking any steps to implement this proposal until May 25, 2008. Through the submission of these comments, NAPH does not concede that CMS has the authority to receive or review comments during the period of the moratorium. Moreover, we believe that if the moratorium were to expire without further legislation by Congress, CMS would be required to re-solicit comments at that time before finalizing the regulation.

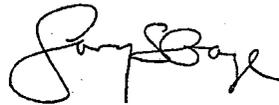
The proposal -- CMS-2279-P -- Medicaid Program; Graduate Medical Education (the Proposed Rule) -- is premised on a flawed interpretation of the Medicaid and Medicare statutes, defies over 26 years of unambiguous congressional intent, and will seriously undermine the vital services that teaching hospitals provide to Medicaid recipients, to local communities, and to our nation as a whole. NAPH urges CMS to withdraw the Proposed Rule.

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. One way in which many of our members serve their communities is through the training of future physicians and nurses. Eighty-five percent of NAPH members are teaching hospitals (as defined by the Accreditation Council for Graduate Medical Education (ACGME)) and 51 percent are academic medical centers (as defined by the Council of Teaching Hospitals of the Association of American Medical Colleges (COTH)). NAPH members train approximately 18 percent of the doctors who receive their training at acute care facilities nationwide and play an even larger role in their

respective communities, training 35 percent of the medical and dental residents. Teaching hospitals, including our members, also provide specialized care generally unavailable at other acute care hospitals and are often the largest employers in their respective communities. Our member hospitals are heavily reliant on government payors, receiving on average approximately 35% of their net revenue from Medicaid and another 20% from Medicare.

The attached comments detail our specific policy and legal concerns about the Proposed Rule. Fundamentally, we oppose the Proposed Rule because it will severely restrict access to care for Medicaid recipients and undermine the already precarious financing of our nation's system of medical education. We urge CMS to withdraw the Proposed Rule. If you have any questions regarding these comments, please contact Barbara Eyman or David Gross at NAPH counsel Powell Goldstein (202) 347-0066.

Sincerely,

A handwritten signature in cursive script, appearing to read "Larry S. Gage".

Larry S. Gage  
President



National  
Association  
of Public  
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and Health  
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June 22, 2007

**COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS  
AND HEALTH SYSTEMS ON PROPOSED RULE: CMS-2279 – P – Medicaid  
Program; Graduate Medical Education**

**Prepared on behalf of NAPH by Powell Goldstein, LLP**

The National Association of Public Hospitals and Health Systems (NAPH) is deeply concerned about the Centers for Medicare and Medicaid Services' (CMS') proposal to terminate Medicaid support for graduate medical education (GME) -- CMS-2279 – P – Medicaid Program; Graduate Medical Education (the Proposed Rule).<sup>1</sup> CMS is incorrect in declaring that it does not have legal authority to provide federal financial participation for Medicaid GME payments; indeed, it is the agency's unilateral reversal of decades of Medicaid policy that lacks legal authorization. But aside from the proposal's legality, the policy choice it represents is extremely shortsighted. CMS proposes to abruptly withdraw longstanding support for the training of our future doctors, without regard to the real world impact on the health care system.

Medicaid has, for decades, provided essential financial support for clinical medical education programs in the United States, and the programs have evolved in reliance on that financial support. States have overwhelmingly opted to provide such support because they recognize what this Proposed Rule ignores – the crucial link between GME programs and the success of Medicaid in ensuring access to care for low income populations. This rule would result in markedly reduced access by withdrawing support for the programs that ensure an adequate ongoing supply of well-trained high quality health care professionals available to serve Medicaid recipients. And it would do so at a time when our population continues to age and to grow and the demand for medical services is expected to increase substantially.

CMS' decision to move forward administratively with this proposal is particularly perplexing. Congress has never questioned either the legality or the underlying policy of CMS' longstanding practice of providing financial support for Medicaid GME payments. Indeed, when the Administration first announced its intent to eliminate Medicaid GME earlier this year, Congress reacted swiftly by beginning work on a moratorium to *prohibit*

<sup>1</sup> 72 Fed. Reg. 28930 (May 23, 2007).

the adoption of any such policy.<sup>2</sup> Nonetheless, CMS rushed to publish the Proposed Rule before the moratorium could take effect. Given the undeniable impact the Proposed Rule would have on medical education programs, it is mystifying as to why CMS would move forward to change the policy administratively when it clearly does not have the authority to adopt alternative GME funding mechanisms or otherwise mitigate the impact of its actions. If CMS had legal or policy concerns about Medicaid GME, it should have taken its concerns to Congress and sought to work cooperatively with its legislative partners to fashion an appropriate response. In insisting on unilateral policymaking on an issue as important as this, CMS is displaying disregard for Congress and its role in formulating Medicaid policy.<sup>3</sup>

The Proposed Rule will leave teaching hospitals in an untenable position; they will be forced either to cut back on their teaching programs, depriving the next generation of Medicaid recipients (and all Americans) of a sufficient number of health care providers, or to stop offering other essential services to the communities in which they are located. Regardless, teaching hospitals, their communities, and the nation as a whole, all will be irreparably harmed by this shortsighted policy decision. NAPH urges CMS to withdraw the Proposed Rule.

NAPH's comments are organized into two major categories. After a brief summary of our arguments, we first lay out our major policy concerns about the Proposed Rule. Second, we explain in detail why we believe the CMS proposal is without legal basis. Finally, we request clarification on one aspect of the Proposed Rule.

#### **I. Summary of Comments:**

NAPH has serious concerns with respect to the policy implications of this ill-considered Proposed Rule as well as CMS' legal authority to preclude federal financial participation (FFP) for GME expenses. On a preliminary level, the Proposed Rule is premised on a misconception of what clinical medical education is. CMS has based these drastic payment cuts on an understanding of GME activities as separate and distinct from the provision of health services. In practice, this understanding is incorrect, as GME costs are incurred to provide patient care.

The proposed cuts would seriously undermine the infrastructure of the American health care system in the present and for years to come. These cuts would stifle medical education, leaving future Medicaid enrollees, along with the rest of the population, with an inadequate supply of health professionals. These cuts also would directly limit access

<sup>2</sup> H.R. 2206, 110th Cong., enacted into law by reference in Pub. L. No. 110-28, § 7002(a).

<sup>3</sup> This is not the first time this year that CMS has openly defied Congress' role in Medicaid policymaking. NAPH notes the parallels between this proposed GME rule, and CMS' proposal to overhaul the financing of state Medicaid programs, CMS-2258-P. In that case, CMS ignored Congress' clear and repeated bipartisan opposition to administrative policymaking, going so far as to issue a final rule *after* Congress had adopted a moratorium prohibiting such action but a few hours *before* the President signed the moratorium legislation giving it legal effect. Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

to care for current Medicaid enrollees, as the availability of medical students to treat these individuals is reduced and as hospitals absorb the cuts by limiting their services. The impact of the proposal would most severely be felt by safety net teaching hospitals, which rely to a greater degree than other teaching hospitals on Medicaid funding and which are located in already underserved communities.

The Proposed Rule is a dramatic departure from longstanding CMS policy, which has permitted Medicaid GME funding to become a critical pillar of teaching hospital support. The Proposed Rule removes this financial support suddenly and CMS does not, because it cannot, offer any alternative funding. Further, the cuts will result in a significant, and unjustified, cost shift from the federal government either to states or, more likely, to teaching hospitals themselves. A policy decision of this magnitude should only be made with congressional input.

From a legal standpoint, CMS does not have the authority to deny FFP for state Medicaid program GME expenses. Medicaid payment of GME expenses is expressly authorized under a natural reading of Section 1905(a) of the Social Security Act as payment for inpatient and outpatient hospital services. Reference to the Medicare statute validates this interpretation. Section 1861 expressly defines inpatient hospital services to include most GME activities, and Section 1886 includes all GME reimbursement under the payment methodologies for inpatient hospital services. Further, a historical review of the Medicaid and Medicare statutes indicates that, prior to 1981, inpatient hospital services were reimbursed by Medicaid under a reasonable cost methodology and included GME activities. No congressional action has stripped CMS of this authority.

CMS' statutory analysis also contradicts congressional intent and its own interpretation of the Medicaid statute. Over the past 26 years, Congress has repeatedly indicated its intent for the Medicaid program to reimburse GME activities, through legislative history, congressional publications, and recent legislation. CMS has never before interpreted the Medicaid statute to preclude payment for GME activities, and it permits FFP for many activities that, similar to GME, can be characterized as not "expressly authorized" under Section 1905(a).

Finally, CMS has requested comments on its decision to allow states to retain indirect medical education (IME) payments in their calculation of the upper payment limit (UPL). We believe that legally CMS has no choice but to maintain such a policy and urge CMS to clarify, notwithstanding its misguided direct graduate medical education (DGME) policy, that IME payments are eligible for FFP.

In light of these serious policy and legal concerns, we urge CMS to withdraw the Proposed Rule.

## II. Major Policy Concerns:

### 1. *The centerpiece of the training of future physicians is clinical experience.*

The teaching hospital is the centerpiece of the American model of medical education. 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. While providing this care under physician supervision, the residents gain practical experience, unavailable in the classroom, to prepare them for the independent practice of medicine. CMS' proposal to discontinue support for medical education through the Medicaid program is not merely a payment cut to teaching hospitals as individual providers; it represents a CMS policy decision to stifle medical training and restrict the supply of future physicians.

### 2. *Residents provide a significant amount of patient care.*

While receiving clinical training in graduate medical education programs, interns and residents provide a significant amount of direct patient care under the supervision of physicians, including care to Medicaid recipients. In underserved communities, the role of the resident in providing patient care is particularly critical in ensuring adequate access to health care services. CMS ignores this critical patient care role in assuming that all GME is not a health service and not reimbursable as a component of inpatient or outpatient hospital care. And it ignores the direct impact that the Proposed Rule will have on access to care for Medicaid recipients if funding for a substantial portion of the caregivers in teaching hospitals is eliminated.

### 3. *Teaching programs ensure an adequate future supply of health care professionals to serve Medicaid recipients.*

It is entirely consistent with the goals and purposes of the Medicaid statute for states to support clinical programs that are training future medical professionals to serve the Medicaid population. Indeed, the 1994 report by the Office of the Inspector General cited by CMS recommended adjustments to Medicare GME payment mechanisms to account for the then-prevailing oversupply of physicians.<sup>4</sup> That oversupply has evolved into a projected significant shortfall,<sup>5</sup> and it is entirely reasonable for states to seek to address that shortfall through reimbursement policies that will ensure robust clinical training programs.

Instead, CMS is proposing to withdraw all Medicaid support for GME. The result will be shrinking teaching programs, fewer medical education graduates and ultimately a physician workforce that is insufficient to meet the health care needs of the population.

<sup>4</sup> Office of the Inspector General of the Department of Health and Human Services, *A Study of Graduate Medical Education Costs*, July 28, 1994.

<sup>5</sup> For example, in a 2005 report, the Council on Graduate Medical Education (COGME) predicted that by 2020, there will be a shortage of physicians in the range of 65,000 to 150,000. COGME, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, January 2005.

Medicaid recipients will likely be hardest hit by such a shortfall as many physicians, confronted by high demand for their services, will prioritize care to patients covered by more lucrative commercial insurance and Medicare.

4. *Teaching hospitals are reliant on Medicaid to help finance the clinical education of future health care professionals.*

Medicaid payments are a critical pillar of support for GME activities throughout the country. As CMS itself notes in the preamble to the Proposed Rule, 47 states and the District of Columbia use Medicaid funds to make GME Payments.<sup>6</sup> As of 2001, Medicaid GME payments provided approximately 10 percent of the GME financing for teaching hospitals.<sup>7</sup> Second only to Medicare GME payments, Medicaid GME support has evolved as a crucial financial underpinning of our nation's teaching programs. Unfortunately, private payers generally have not followed suit in providing direct support for clinical education provided by teaching hospitals. And while some communities do provide support, they cannot be expected to replace the funding that would be cut by this regulation. Nor is it realistic to assume, as CMS does in the Regulatory Impact Statement section, that a significant number of states may choose to assume the federal share of GME payments at their current levels through state-only funding. The loss of Medicaid funding if this rule is ever implemented would be devastating to teaching hospitals.

5. *Teaching hospitals provide essential medical services not generally available in other hospitals.*

The benefits that teaching hospitals provide to their communities extend beyond clinical education to future physicians. Most teaching hospitals offer specialized services that are not otherwise available at other hospitals. For example, 25.9 percent of teaching hospitals perform organ transplants, 50.9 percent operate certified trauma centers, and 49.4 percent provide neonatal intensive care. The percentage of all other hospitals providing these services was 2.0 percent, 30.2 percent, and 12.1 percent respectively.<sup>8</sup> Teaching hospitals also provide a substantial amount of primary care to their communities through the operation of community clinics in underserved areas. 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.

All of these high-cost and under-reimbursed community services are offered in spite of the fact that teaching hospitals operate at margins well below the industry norm.

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<sup>6</sup> 72 Fed. Reg. at 28932; Association of American Medical Colleges, *Direct and Indirect Graduate Medical Education Payments by State Medicaid Programs*, November 2006 at 2.

<sup>7</sup> National Health Policy Forum, *Federal and State Perspectives on GME Reform*, June 22, 2001 at 2 (the NHPF Report).

<sup>8</sup> Association of American Medical Colleges, *Analysis of Fiscal Year 2005 American Hospital Association Data*.

Through the Proposed Rule, CMS has presented teaching hospitals with an ultimatum, and either option is a losing proposition. Because teaching hospitals do not have the revenue to subsidize both their community services and their GME activities, funding cuts will have to be made. And as a result, the medical infrastructure of the next generation will be severely weakened or the communities in which teaching hospitals are located will be deprived of essential medical services. Under either scenario, Medicaid recipients are certain to be harmed.

6. *The Proposed Rule will disproportionately impact safety net teaching hospitals.*

The proposed cuts will cause the greatest amount of harm to safety net teaching hospitals, which serve a disproportionately large share of Medicaid patients. As compared to the average teaching hospital, these safety net hospitals, many of them NAPH members, rely to a much greater extent on the Medicaid program to reimburse their teaching expenses. Medicare GME payments are based on the volume of Medicare services provided, and safety net teaching hospitals serve a much lower proportion of Medicare beneficiaries than the average teaching hospital. As a result, safety net teaching hospitals must rely to a much greater extent on Medicaid GME reimbursement, as their Medicaid patient population is generally much greater proportionally than that of their non-safety net counterparts.<sup>9</sup> NAPH member hospitals, which serve the greatest number of Medicaid recipients with the most complex medical needs, will therefore suffer the heaviest blow from these proposed payment cuts.

7. *The removal of DGME from the UPL will reduce Medicaid reimbursement to all acute care hospitals.*

By removing DGME from the inpatient hospital UPL, the impact of the Proposed Rule would be felt in some states by non-teaching hospitals as well as teaching hospitals. Under 42 C.F.R. § 447.272(b), the UPL amount is "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles." The UPL represents the total amount of federal funds available to the states to make payments to hospitals for inpatient services, and all of these funds are crucial in ensuring adequate hospital reimbursement for the treatment of Medicaid recipients. As CMS notes in the Proposed Rule, "States routinely make payments to hospitals up to the maximum level permitted under the UPL." The removal of DGME from the UPL does not just affect GME payments to teaching hospitals; it would lower the limit on payments to all hospitals within a state. The lower limit will impact not only GME payments to teaching hospitals, but could also reduce payments to non-teaching

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<sup>9</sup> A comparison of the utilization data of NAPH members (85 percent of whom are teaching hospitals) with the overall major teaching hospital average provides an indication of the disproportionate reliance on Medicaid by safety net teaching hospitals. The average NAPH member's inpatient population, as measured by discharge volume, is 38 percent Medicaid and 21 percent Medicare, as compared to 20 percent Medicaid and 34.4 percent Medicare for the average major teaching hospital. See National Association of Public Hospitals and Health Systems, *American's Public Hospitals and Health Systems, 2004*; Association of American Medical Colleges, *Analysis of Fiscal Year 2005 American Hospital Association Data*.

hospitals and non-GME payments to teaching hospitals. As a result, access for Medicaid recipients will be reduced in both teaching and non-teaching hospitals.

8. *All GME payments relate to the provision of inpatient hospital services.*

We strongly object to CMS' assertion that "GME is not a health service."<sup>10</sup> This characterization fails to grasp the nature of GME activities, and the teaching methodologies employed in teaching hospitals. Under the Medicare program, GME costs are separated into two components, DGME costs and IME costs. Contrary to CMS' understanding, both DGME and IME activities are health services.

DGME payments compensate hospitals for resident and teaching physician salaries and benefits, as well as teaching program overhead. The DGME payments are incurred by teaching hospitals in the course of providing patient care, as clinical education occurs primarily through the provision of medical services by the residents and teaching physicians. In fact, the presence of a strong clinical training program is a prerequisite for teaching program accreditation.<sup>11</sup> The Third Circuit has concluded similarly, noting that residents spend the vast majority of their time administering patient care and that DGME reimbursement "is in a large part a reimbursement for patient care."<sup>12</sup>

IME payments are provided to reimburse hospitals for extra expenses that are incurred as a result of having a teaching program (e.g., for the treatment of high-acuity patients; for additional diagnostic tests ordered by residents who lack the diagnostic skills of a seasoned physician). As CMS notes in the Proposed Rule, the "IME adjustment is intended to compensate teaching hospitals for the additional costs they incur when providing hospital services versus non-teaching hospitals."<sup>13</sup> CMS' contention that all GME activities are not health services has no basis in fact and cannot support the conclusion that there is no statutory authorization for Medicaid GME funding.

9. *The Proposed Rule irresponsibly shifts costs to states and teaching hospitals.*

To the extent that states, communities, and teaching hospitals decide that their GME programs must continue even in the face of the Proposed Rule, they will have to find a way to replace the federal funding that CMS is withdrawing. Indeed, it appears that CMS is counting on these other entities to pick up the federal government's share as there is no discussion in the preamble to the Proposed Rule of the impact of shrinking the nation's GME programs. Such a massive cost-shifting to states and/or other entities is an inappropriate step for an agency to take without congressional authorization. As

<sup>10</sup> 72 Fed. Reg. at 28931.

<sup>11</sup> The Accreditation Council for Graduate Medical Education (ACGME) evaluates and accredits medical residency programs in the United States. One of the core competencies for all residency programs listed in its "Common Program Requirements" is "practice-based learning and improvement," or clinical experience.

<sup>12</sup> *West Virginia University Hospital, Inc. v. Casey*, 885 F.2d 11, 27 (3d Cir. 1989) (*WVUH*) (noting that residents spend approximately 75 percent of their time providing patient care).

<sup>13</sup> 72 Fed. Reg. at 28932 (*emphasis added*).

explained in more detail below, Congress has long authorized the two major governmental health care programs – Medicare and Medicaid -- to assume a share of the cost of graduate medical education as part and parcel of payment for hospital services. For CMS to decide to shirk the federal government's share of Medicaid's portion of those costs is unfair to those entities that will be forced to find replacement funding and is an irresponsible exercise of federal regulatory authority.

10. *CMS improperly has failed to determine the impact of the Proposed Rule.*

CMS improperly fails to evaluate the impact of the Proposed Rule on any of the affected entities, including teaching hospitals and states. In the preamble to the Proposed Rule, CMS declines to undertake a Regulatory Flexibility Act (RFA) analysis of the impact of the regulation on small businesses, including some teaching hospitals. CMS claims that no RFA analysis is necessary because the regulation only affects matching payments to states for GME support and "States may choose to continue to fund direct medical education programs using State-only funding."<sup>14</sup> At the same time, however, for purposes of Executive Order 13132, CMS finds that the rule will have "no substantial effect on State or local government" since states will not be *required* to continue GME payments.<sup>15</sup> Through this slight of hand, CMS appears to have analyzed away *any* impact of the regulation on *any* entity.

11. *It is inappropriate for CMS to undertake this major policy change administratively.*

The Proposed Rule represents an abrupt reversal of long-standing CMS policy. As CMS notes, it "has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services."<sup>16</sup> It is inappropriate for CMS to suddenly reverse this policy, one with significant implications for teaching hospitals, Medicaid recipients, and the nation's health care system as a whole, through the administrative process. Rather, a policy change of this magnitude should be submitted to Congress for approval.

Furthermore, CMS does not appear to object to the existence of hospital-based graduate medical education programs, and presumably would want to see them continue. Yet it has proposed no source of replacement funding for the Medicaid support it is withdrawing -- because it does not have the authority to authorize new funding sources unilaterally. This fact alone -- that it is unable to provide an alternative funding source for an activity whose value is not in dispute -- should have led CMS to seek a legislative, rather than an administrative, solution to its GME policy concerns.

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<sup>14</sup> *Id.* at 28935.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.* at 28931.

### III. Major Legal Concerns:

While the policy choices underlying the Proposed Rule are misguided, the legal foundation of the proposal is simply wrong. Contrary to CMS's purported legal basis, the Medicaid statute does authorize FFP for GME costs. This interpretation is validated by looking to the Medicare statute and legislative activity over the past 26 years. From a legal standpoint, CMS is required to offer FFP to states that reimburse providers for GME activities under their Medicaid programs.

#### 1. *The Medicaid statute authorizes FFP for GME payments.*

Contrary to CMS' assertion, the Medicaid statute provides for Medicaid reimbursement of GME costs through the provision of FFP for inpatient and outpatient hospital services. In the Proposed Rule, CMS sets forth an interpretation of Sections 1903(a) and 1905(a) of the Social Security Act that precludes FFP for costs incurred for GME activities. In particular, CMS claims that FFP is not authorized for GME costs because the Medicaid statute only authorizes FFP for "care and services within the scope of medical assistance," as defined under Section 1905(a), and the definition of medical assistance does not include "express authority" for payments for GME.

CMS' cramped interpretation of Section 1905(a) is contrary to a natural reading of the statute. Section 1905(a) includes in the definition of "medical assistance" for which FFP is available, "payment of part or all of the cost of . . . inpatient hospital services" and "outpatient hospital services."<sup>17</sup> Neither Section 1905(a), nor any other provision of the Medicaid statute, defines inpatient or outpatient hospital services. A natural reading of Section 1905(a) expressly authorizes payment for all costs incurred while providing these services and GME costs are clearly incurred by a teaching hospital while providing inpatient and outpatient hospital services. GME payments are intended to reimburse hospitals for the additional expenses associated with running teaching programs, programs which are comprised of teaching physicians and residents who spend a significant amount of their time providing direct patient care.

Just as "inpatient hospital services" and "outpatient hospital services" are indisputably interpreted to include costs such as capital costs, employee education costs, emergency preparedness costs, administrative overhead, maintenance costs, and all of the other reimbursable costs tracked on hospital cost reports, the costs of graduate medical education are equally a part of the costs of delivering hospital care.<sup>18</sup> There is no legal basis for CMS to single out GME costs as the one component of the costs of delivering hospital care that is not reimbursable. GME costs are clearly encompassed among the costs of delivering inpatient and outpatient hospital services and as such are expressly

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<sup>17</sup> 42 U.S.C. §1396d(a)(1) and (2)(A).

<sup>18</sup> By contrast, certain costs incurred by hospitals are considered unrelated to patient care and are non-reimbursable. Examples include the costs of flower shops, parking garages, cafeterias and other unrelated businesses, and marketing costs. But unlike GME costs, these costs are not incurred in the course of delivering patient care services.

contained within the definition of "medical assistance" eligible for FFP.<sup>19</sup> In fact, were it not for the GME program, hospitals would be forced to increase their physician workforces in order to continue providing the same amount of patient care. Such replacement physician services would clearly be reimbursable.

2. *The Medicare statute defines inpatient hospital services to include GME activities and considers GME payments to be payments for inpatient hospital services.*

In the absence of a statutory definition of "inpatient hospital services" for Medicaid, it is logical to look to the Medicare statute, which was adopted by Congress at the same time as Medicaid, for guidance as to what Congress intended by the term. The Medicare statute defines inpatient hospital services to include GME activities. In particular, Section 1861(b) explicitly defines inpatient hospital services to include services provided by "an intern or a resident-in-training under [an approved] teaching program."<sup>20</sup> Under Medicare, the services provided by residents and teaching physicians expressly are considered inpatient hospital services.

The inclusion of GME costs under the rubric of reimbursement for the provision of inpatient hospital services under Medicare (and derivatively, under Medicaid) is further buttressed by an examination of the inpatient hospital payment provisions of Title XVIII. The Medicare statute specifically includes GME costs under its reimbursement methodology for inpatient hospital services.<sup>21</sup> Section 1886 separates inpatient hospital services into several components, including the "operating costs of inpatient hospital services,"<sup>22</sup> the "capital-related costs,"<sup>23</sup> and "payments for direct graduate medical education costs."<sup>24</sup> The Medicare program reimburses hospitals for each of these components under a distinct payment methodology. CMS looks solely to the operating cost component of inpatient hospital services<sup>25</sup> and, finding that GME costs are excluded from operating costs, appears to leap to the erroneous conclusion that all GME activities are therefore excluded from the definition of inpatient hospital services and that GME payments are not reimbursement for inpatient hospital services.<sup>26</sup>

Section 1886(a)(4)'s exclusion of GME activities from the operating costs of inpatient hospital services stands for the simple proposition that GME activities are not eligible for reimbursement under the payment methodology used for operating costs. It does not

<sup>19</sup> Although beyond the scope of the Proposed Rule, NAPH would like to point out that GME costs also must be considered costs incurred for furnishing hospital services under Section 1923(g) and included in the calculation of a hospital's costs of providing services to Medicaid enrollees and the uninsured.

<sup>20</sup> 42 U.S.C. §1395x(b)(6).

<sup>21</sup> See Section 1886(h); 42 U.S.C. §1395ww(h).

<sup>22</sup> Section 1886(a)-(b) and (d); 42 U.S.C. §1395ww(a)-(b) and (d).

<sup>23</sup> Section 1886(g); 42 U.S.C. §1395ww(g).

<sup>24</sup> Section 1886(h); 42 U.S.C. §1395ww(h).

<sup>25</sup> CMS points to language in Section 1886(a)(4) stating that "the term 'operating costs of inpatient hospital services' . . . does not include costs of approved educational activities . . . ."

<sup>26</sup> 72 Fed. Reg. at 28932 ("Medicare expressly excludes costs associated with educational activities from the operating costs that can be included in the cost base used to develop the basic payment amounts under Medicare's prospective payment system for inpatient hospital services.")

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stand for the broader principle that all GME activities are excluded from the definition of inpatient hospital services or that GME payments are not reimbursement for inpatient hospital services. In fact, the opposite is true. Section 1886 is entitled "Payments to hospitals for inpatient hospital services," clearly indicating that all the payment methodologies outlined in the section – including GME reimbursement under Section 1886(h) – are reimbursement for inpatient hospital services. Each of operating costs, capital costs, and GME costs are components of payments for the provision of inpatient hospital services, and each is eligible for FFP. Additionally, Section 1886 does not offer a new definition for inpatient hospital services, but incorporates the one found in Section 1861.

Finally, Section 1861(v)(8) of the Medicare statute explicitly enumerates certain costs that are unrelated to patient care and therefore not considered to be "reasonable costs" of providing services to Medicare beneficiaries.<sup>27</sup> GME activities are not included on this list (although education expenses for spouses or other dependents of providers *are* on the list). If CMS were right that GME costs were not related to the provision of hospital services they would likely be a part of this list of explicit exclusions. They are not.

The Medicare statute is explicitly clear. For Medicare purposes, most GME activities are included within the definition of inpatient hospital services and all GME payments are characterized as reimbursement for the provision of inpatient hospital services. CMS fails to provide either a legal or policy justification for considering the scope of inpatient hospital services under Medicaid to be narrower than under Medicare.

3. *The Medicaid program historically has had explicit statutory authority to reimburse GME costs.*

A historical analysis of the Medicaid and Medicare statutes demonstrates that Congress intended for the term "inpatient hospital services" to be defined under the Medicaid program as it was under Medicare, a definition that includes GME activities. Prior to 1981, the Medicaid statute required states to pay for inpatient hospital services on a reasonable cost basis.<sup>28</sup> The maximum allowable reimbursement amount was the reasonable cost amount determined according to Medicare's reimbursement methodology. Specifically, each state Medicaid plan was required to provide for "payment of the reasonable cost of inpatient hospital services," but the payment amount was not to "exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services."<sup>29</sup> In other words, the pre-1981 Medicaid statute states that the Medicare reimbursement amount for inpatient hospital services is the maximum amount that a state Medicaid plan may reimburse a hospital for these same services. The reasonable cost of hospital services under Medicare prior to 1981 as

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<sup>27</sup> 42 U.S.C. § 1395x(v)(8).

<sup>28</sup> 42 U.S.C. § 1396a(13)(D) (1976).

<sup>29</sup> *Id.* (emphasis added). "Section 1395x(v) of this title" describes Medicare reasonable cost payment methodology, which was the basis for Medicare's payments for inpatient hospital services. 42 U.S.C. §§ 1395x(v); 1395f(b) (1976).

interpreted by the courts and CMS included DGME costs.<sup>30</sup> The statute was clear; states were permitted to reimburse hospitals for their DGME costs as part of inpatient hospital services.

The two program's payment methodologies have evolved since 1981, and neither still mandates the payment of reasonable costs for acute care hospital services. The Medicare program pays separately for each component of inpatient hospital services, primarily on a prospective payment basis, and the Medicaid program offers states wide flexibility in creating payment methodologies. Yet there is simply no evidence that as Congress broke the link between the Medicaid and Medicare payment systems and granted states flexibility to experiment with different payment methodologies it eliminated the previous authority for states to reimburse the reasonable costs of GME. In fact, quite the contrary, the legislative history indicates that Congress was concerned that states might adopt payment methodologies that did *not* adequately compensate teaching hospitals for their medical education programs.<sup>31</sup> The Medicaid program has historically had express statutory authority to provide FFP for GME activities, and no change to the Medicaid or Medicare statutes has stripped CMS of this authority.

4. *Each component of a medical item or service does not need to be "expressly authorized" under Section 1905(a) to be eligible for FFP.*

Section 1905(a) lists 28 different categories of items and services that are considered to be part of "medical assistance" for which states can claim FFP when provided to Medicaid recipients. Of necessity, the categories are drafted broadly, and do not list every single component of the costs that may go into providing the services which are reimbursable. CMS has provided some additional detail in regulatory definitions,<sup>32</sup> but even the regulations cannot and do not itemize each element of reimbursable costs. It is disingenuous, therefore, for CMS to make the argument that because GME is not specifically listed in Section 1905(a) as an element of medical assistance, Congress did not authorize CMS to provide FFP for GME expenditures.

Moreover, CMS' proposed prohibition on FFP for GME costs directly conflicts with its own longstanding interpretation of the Medicaid statute. In this instance, CMS has concluded that because GME activities are not enumerated in Section 1905(a), FFP is not authorized for GME costs. Yet CMS repeatedly has permitted FFP for other items and services that, similar to GME, are not included as an enumerated item or service under Section 1905(a). To provide just a few examples:

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<sup>30</sup> See, e.g., *Loyola Univ. of Chicago v. Bowen*, 905 F.2d 1061, 1073 (7th Cir. 1990) (holding that for Medicare "to disallow [resident and intern stipend] costs would cause the cost of providing services to Medicare beneficiaries to be shifted to other patients . . . [w]e will not be a party to allowing the Secretary to violate the specific and clear congressional intent expressed in [the definition of reasonable costs]."); 42 C.F.R. § 405.421 (1977).

<sup>31</sup> See discussion accompanying notes 44-47.

<sup>32</sup> See 42 C.F.R. § 440.1 - 185.

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- CMS provides FFP for expenditures for durable medical equipment as part of the cost of providing home health services,<sup>33</sup> yet such equipment is not expressly authorized under Section 1905(a).
- The State Medicaid Manual defines “personal care services” to include assistance with laundry, meal preparation, grocery shopping, using the telephone, and money management,<sup>34</sup> yet none of these services – which appear to be much further afield from the delivery of medical services than the services provided by interns and residents -- are expressly authorized under Section 1905(a).
- CMS provides FFP for oral and written translation services,<sup>35</sup> yet these activities are not expressly authorized under Section 1905(a). In many states, such services are provided as a component of delivering hospital services.<sup>36</sup>
- CMS provides FFP for disease management programs as part of the services provided by “other licensed practitioners” or as “preventive services,”<sup>37</sup> yet disease management services are not expressly authorized under Section 1905(a).
- CMS defines “home health care services” to include home health aide services,<sup>38</sup> yet home health aide services are not expressly authorized under Section 1905(a).
- CMS continues to provide FFP for payments for capital costs incurred by hospitals, despite the fact that capital payments, similarly to GME, are excluded from the definition of the operating costs of inpatient hospital services under Medicare and are not listed as a separate item or service under Section 1905(a).
- CMS allows states to reimburse the costs of necessary transportation for Medicaid recipients to and from providers pursuant to its authority to identify other medical care as part of medical assistance,<sup>39</sup> yet transportation is not expressly authorized under Section 1905(a).
- Similarly, CMS provides FFP for the cost of “emergency hospital services” that are either provided by a non-participating provider or are outside the scope of “inpatient” or “outpatient hospital services” as part of the same catchall authority to identify other medical care, yet such emergency services are not expressly authorized under Section 1905(a).

Congress itself clarified that it did not intend for the items listed under Section 1905(a) to be interpreted narrowly. The concluding paragraph of Section 1905(a) prohibits a state from excluding any service, including counseling, from the definition of medical assistance solely because the service is provided as a treatment for alcoholism or drug dependency. Clearly then, although counseling services are not an enumerated item, they are included within the definition of medical assistance. The only coherent reading of Section 1905(a) is that counseling services falls within one of the 28 general categories.

<sup>33</sup> 42 C.F.R. § 440.70(b)(3).

<sup>34</sup> State Medicaid Manual, Publication No. 45, Part 4, Section 4480.

<sup>35</sup> Letter to State Medicaid Directors, issued August 31, 2000.

<sup>36</sup> See National Association of Public Hospitals and Health Systems, *Medicaid and SCHIP Funding for Language Services*, Research Brief, April 2007, available at <http://www.naph.org/Template.cfm?Section=Publications&template=/ContentManagement/ContentDisplay.cfm&ContentID=8403>.

<sup>37</sup> Letter to State Medicaid Directors, issued February 25, 2004.

<sup>38</sup> 42 C.F.R. § 440.70(b)(2).

<sup>39</sup> 42 C.F.R. § 440.170(a).

Similarly, Section 1903(i) specifies the conditions under which FFP is available to states for organ transplant procedures.<sup>40</sup> Organ transplants are not specifically listed under Section 1905(a) and also must fall within one of the 28 listed categories.

Through these and countless other examples, it is quite clear that the items and services listed under subsections (1) through (28) were not intended to be and are not interpreted narrowly by CMS. CMS' sudden alarm at not finding express authority in Section 1905(a) for GME reimbursement is at odds with its own reasonable interpretation of the statute over the last 40 years. There simply is no basis to assume that the failure to list a component of a cost of providing a service listed in one of the 28 broad categories of items and services means that no FFP is available for that service. GME is part of the cost of providing inpatient and outpatient hospital services and as such FFP is available for states providing reimbursement for such costs.

5. *Congress has repeatedly indicated its intent for the Medicaid program to reimburse states for GME costs.*

As explained above, prior to 1981, the Medicaid program was required to reimburse hospitals on a reasonable cost basis for inpatient hospital services.<sup>41</sup> The maximum amount of these reasonable costs was Medicare's reasonable costs for the same services.<sup>42</sup> In the Omnibus Budget Reconciliation Act of 1981 (1981 OBRA), Congress revised the Medicaid statute to permit states to adopt Medicaid payment methodologies that were not on a reasonable cost basis.<sup>43</sup> During this revision of the Medicaid statute, Congress did not, and since has not, indicated that GME activities are no longer considered inpatient hospital services for Medicaid payment purposes. In fact, the opposite is true. Congress has repeatedly recognized the importance of federal support, through FFP, of GME activities.

Congressional intent to support medical education through Medicaid financing is most explicitly set forth in the legislative history of the 1981 OBRA. The House report accompanying the initial version of the legislation states that the committee "intends States to recognize that facilities that provide teaching services . . . may have operating costs which exceed those of a community hospital."<sup>44</sup> The Committee urged states to "take into account the differences in operating costs of the various types of facilities."<sup>45</sup> The House Conference Report contains similar support for the direction of Medicaid funds towards medical education, and notes that, "[t]he conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and [the conferees] are concerned that a State take into account the special situation that exists in these institutions in

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<sup>40</sup> 42 U.S.C. § 1396b(i).

<sup>41</sup> 42 U.S.C. § 1396a(13)(D) (1976).

<sup>42</sup> *Id.*

<sup>43</sup> Section 2173 of the Omnibus Budget Reconciliation Act of 1981, Pub. Law 97-35.

<sup>44</sup> H.R. Rep. No. 158, 97th Cong., 1st Sess. 294.

<sup>45</sup> *Id.*

developing their rates.”<sup>46</sup> Federal courts have similarly found this language persuasive, and the Third Circuit concluded that the “legislative history suggests that Congress intended teaching hospitals . . . to be adequately supported by medicaid plans.”<sup>47</sup>

During the intervening 26 years, Congress has unambiguously acted under the assumption that the federal government provides FFP for state GME costs. In 1993, the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce published an updated version of the “Medicaid Source Book: Background Data and Analysis” (the Yellow Book). The Yellow Book provides an overview of state Medicaid plan payment methodologies, and notes that many states adjust their Medicaid rates based on the “presence of teaching programs.”<sup>48</sup> The Yellow Book gave no indication that these increased payments for teaching programs were not eligible for FFP under the Medicaid program.

Congress again recognized Medicaid’s authority to provide FFP for GME activities in section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).<sup>49</sup> In section 705(a) of BIPA, Congress explicitly instructed CMS to adopt an aggregate Medicare-related UPL. Enacted shortly after CMS proposed a regulation establishing aggregate UPLs within three categories of providers – state owned or operated, non-state owned or operated and private -- BIPA required that HHS “issue . . . a final regulation based on the proposed rule announced on October 5, 2000 that . . . modifies the upper payment limit test applied to State medicaid spending for inpatient hospital services . . . by applying an aggregate upper payment limit to payments made to governmental facilities that are not State-owned or operated facilities.” In requiring that the final regulations be based on the proposed rule issued on October 5, 2000, Congress explicitly endorsed the establishment of a UPL based on Medicare payment principles, which included payments for GME.

Congress most recently expressed its understanding that the Medicaid program is authorized to provide FFP for GME activities during the passage of the Deficit Reduction Act of 2005 (DRA).<sup>50</sup> Section 6085 of the DRA limited Medicaid payments to certain emergency service providers for emergency services provided to enrollees of a Medicaid managed care plan. Congress set the maximum payment amount as the maximum Medicaid payment amount, minus any payments that would otherwise be made for “indirect costs of medical education and direct costs of graduate medical education.” This GME carve-out illustrates both congressional understanding that FFP generally is available for GME costs and CMS’ explicit authority to continue providing FFP for GME costs under all other circumstances.

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<sup>46</sup> H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in U.S. Code Cong. & Admin. News 1010, 1324.

<sup>47</sup> *WVUH*, 885 F.2d at 27.

<sup>48</sup> Yellow Book, at 316.

<sup>49</sup> H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) (BIPA).

<sup>50</sup> S. 1932, 109th Cong., enacted into law in Pub. L. No. 109-171 (DRA).

6. *CMS is required to provide FFP for costs related to IME activities.*

CMS asked for comments on the propriety of including Medicare IME adjustments as part of the UPL calculation. NAPH does not believe that comments are necessary on this issue, as CMS does not have the authority to exclude IME adjustments from the UPL calculation. The inclusion of IME payments in the UPL is an acknowledgement that IME costs are part of the costs of providing inpatient hospital services. We agree with CMS that under Medicare statutory payment principles, IME expenses are not only inpatient hospital services, but are part of the operating costs of inpatient hospital services. Section 1886(d) applies an IME adjustment to Medicare reimbursement of a hospital's operating costs for inpatient hospital services. Even under CMS' narrow interpretation of Section 1886, IME adjustments must be considered reimbursement for operating costs of inpatient hospital services and eligible for reimbursement under the Medicaid program. CMS is required to provide FFP for IME costs, and will exceed its statutory authority if it should make any attempt to restrict these matching payments.

**IV. Clarifications:**

1. *CMS should clarify that it will provide FFP for IME activities.*

CMS recognizes that the Medicare statute includes IME costs as a component of the operating costs of inpatient hospital services and expressly authorized under Section 1905(a). Therefore, CMS has not excluded IME costs in the calculation of the UPL under proposed 42 C.F.R. § 447.272 and proposed 42 C.F.R. § 447.321. However, proposed 42 C.F.R. § 447.201 provides that a state plan may not include "payments for graduate medical education" or "include costs of graduate medical education as an allowable cost." Additionally, proposed 42 C.F.R. § 447.257 prohibits FFP for any "expenditures for graduate medical education." We urge CMS to clarify these latter two provisions and indicate that a state plan may include payments for IME expenses.

**V. Conclusion:**

The payment cuts set forth in this Proposed Rule are in contravention to federal law and will cause serious harm to Medicaid beneficiaries, teaching hospitals, and our nation as a whole. We urge CMS to withdraw the Proposed Rule.

**Submitter :** Mr. Paul Westrick  
**Organization :** Columbia St. Mary's  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attached Document

CMS-2279-P-235-Attach-1.DOC

June 22, 2007

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

Attention: CMS-2279—P      Via Email

Dear Administrator Norwalk:

I am writing on behalf of Columbia St. Mary's health system to urge the Centers for Medicare & Medicaid Services 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 community teaching hospitals and jeopardize our abilities to continue to fulfill important teaching, patient care and community service missions.

If these cuts to state Medicaid programs are finalized, safety-net hospitals like Columbia St. Mary's will face financial jeopardy, ultimately harming some of our most vulnerable citizens, who are covered by the Medicaid program.

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.

We 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.

Columbia St. Mary's has over 40 residents in training each year in the specialties of Family Medicine, Obstetrics/Gynecology, Surgery and Psychiatry. Eliminating FFP for

state Medicaid agency payments for GME could harm 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.

As a teaching hospital, we provide an environment where highly specialized tertiary patient care such as burn care, neonatal intensive care, trauma and cardiac care services take place. We are able to offer the most advanced, state-of-the-art services and equipment to everyone in need; and with residents and supervising physicians available around-the-clock.

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,

**Submitter :** Mr. Stephen Harwell  
**Organization :** Healthcare Association of New York State  
**Category :** Health Care Provider/Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2279-P-236-Attach-1.DOC



Healthcare Association  
of New York State

June 22, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2279-P  
7500 Security Boulevard  
Baltimore, Maryland 21244-8050

**Re: CMS-2279-P; Medicaid Program, Graduate Medical Education; Proposed Rule**

Dear Ms. Norwalk:

The Healthcare Association of New York State (HANY), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, including 60 major teaching hospitals, submits the following comments on the proposed rule related to Medicaid Graduate Medical Education (GME) payments.

As you know, this proposed rule is subject to a one-year moratorium secured by P.L. 110-28. HANY believes that the moratorium should preclude the Centers for Medicare and Medicaid Services (CMS) from soliciting comments and recommends that the agency withdraw this proposed rule. However, CMS has chosen to continue collecting comments, noting that it cannot finalize any of the proposed changes until May 2008. Because CMS has not withdrawn the rule, HANY is submitting these comments with strong opposition to the policy changes proposed in this rule.

CMS proposes to modify regulations to specify that, for purposes of Medicaid reimbursement eligible for Federal Financial Participation (FFP), GME is not an allowable cost or payment for medical assistance under an approved Medicaid State Plan. The provision would apply to all Medicaid providers and would be implemented for each state in the first full state fiscal year following the effective date of the final rule.

Implementation of this proposed rule would reverse decades of federal and New York State Medicaid policy. Most states use Medicaid funds to pay the program's share of hospital costs related to GME. The methodologies employed by states to pay hospitals have been reviewed and approved by CMS and its predecessor, the Health Care Financing Administration. Hospital payments that have included GME costs have never been called into question by federal regulators for not being eligible for FFP under federal statutory provisions.

Education of the next generation of physicians is in the public's interest and New York State makes \$1.2 billion in Medicaid GME payments to teaching hospitals each year to help offset

some of the costs of physician training, with half of those funds coming from the federal government as Medicaid matching funds. Importantly, in New York, all payers contribute to GME. The elimination of these federal funds would remove one payer from paying its fair share and undermine New York's ability to train physicians, diminish the value of this public good, and jeopardize the finances of some of the nation's finest teaching hospitals and academic medical centers.

### **Teaching Hospitals' Leadership in Patient Care**

Because of their education and research missions, academic medical centers and teaching hospitals employ the latest and most advanced medical services and equipment, enabling the provision of highly-specialized patient care. Teaching hospitals, by the nature of the services they provide, treat the most medically-complex patients and Medicaid beneficiaries, and other patients often seek out or are referred to teaching hospitals for specialized levels of treatment. These levels of care are the most costly and Medicaid GME payments ensure that Medicaid beneficiaries have access to these specialized and lifesaving services. The intensive practice of training physicians leads to higher patient care costs and Medicaid must continue to pay its fair share.

The mission of teaching hospitals, like all New York hospitals, includes a responsibility to care for the uninsured and underinsured. A recent HANYS analysis found that \$1.35 billion of the \$1.65 billion in uncompensated care delivered in New York State annually is provided by the 29% of New York hospitals that are considered major teaching hospitals. Hospitals are only partially reimbursed for providing that care and part of the reimbursement is subsidized by New York State's indigent care pool, which is funded in part by a tax on providers.

### **Teaching Hospitals Vital to Health Care Services for Medicaid Enrollees**

Access to teaching hospitals is vital to health care services for Medicaid (fee-for-service and health maintenance organization) beneficiaries. In 2004, 74% of Medicaid inpatient admissions in New York State were to major teaching hospitals. In addition, 68% of emergency room visits and 83% of clinic visits in New York State were provided by these hospitals. Other vital services such as trauma, neonatal, and burn care are provided almost exclusively by teaching hospitals.

The continuation of FFP for GME is vital to teaching hospital finances. Major teaching hospitals in New York as a group had overall operating margins of negative 0.6% in 2005; 59% of major teaching hospitals were operating in the red that year. Without Medicaid participation in GME, access to teaching hospitals will be impeded for Medicaid beneficiaries and all other populations.

GME funding has already endured significant federal reductions over the years. As a result of the Balanced Budget Act of 1997, New York's major teaching hospitals and academic medical centers experienced a drastic 9.5% or \$5 billion reduction in total Medicare payments between 1998 and 2005. These reductions in Medicare funding have left the state-federal Medicaid partnership a critical source of funding for GME.

## **Medical Education and the Physician Workforce Shortage**

Many parts of New York State face a growing shortage of physicians, and patients are feeling the brunt of these shortages. Patients are being forced to travel as certain physician specialties are either no longer available in their communities or have limited available hours with growing waiting periods for appointments. Primary care physician shortages are requiring patients to rely on expensive emergency rooms for primary care. Hospitals are often forced to transfer patients away from their home communities for treatments that would have been available in the past. Undermining physician training programs would exacerbate the shortages at a time when policymakers should be investing in the physician workforce.

Severe physician shortages are widespread in some regions of New York State. For example, the total number of physicians declined by 6% in the nine-county Finger Lakes region and 9% in the five-county Western New York region, according to a study of physician supply between 2001-2005 by the State University of New York (SUNY) at Albany Center for Health Workforce Studies. At the county level, the total number of physicians declined by 8% in the Bronx, and by 49% in Washington County.

In other areas of the state, the worst shortages are specific to primary care or certain specialties. For example, the declining number of primary care physicians is a growing problem in the seven-county North Country, which saw an 8% decline, in addition to declines in both the Finger Lakes and Western New York regions. The number of general surgeons declined by 16% in New York City and a similar decline was found in the six-county Mohawk Valley region, and the North Country, Southern Tier, and Western New York regions. The total number of general surgeons declined by 10% statewide.

Compounding these shortages, over the next two decades the "baby boom" generation will be reaching retirement age and many of New York's active physicians are expected to retire. More than one-third of New York's active patient care physicians are age 55 and older; 14% are age 65 or older. In several counties, such as Washington, Montgomery, and Sullivan, more than 50% of physicians are age 55 and older.

Addressing the physician workforce shortage will require a multi-faceted approach that includes the active participation of teaching hospitals, which will need to develop programs for the recruitment and retention of physicians in New York's under-served communities. Development of these programs will require an investment in medical education and an increase in the number of medical residents, something that can not be accomplished with the reductions included in this proposed rule.

## **Medical Research**

Many of the advances started in the research laboratories of medical schools are incorporated into patient care through clinical research programs at teaching hospitals. The participation of all payers in medical education has allowed New York State to be a leader in medical research and has produced many of the nation's finest research physicians. This investment has been the foundation for the development of many new cures and vaccines. The ability to make these

advances in state-of-the-art medicine is significantly influenced by the GME programs that keep high quality faculty and the most current and advanced technologies available. Reduction in GME funding would lead to a reduction in medical research.

### **Teaching Hospitals' Leadership in Their Communities**

In addition to providing high level patient care, training physicians, and conducting medical research, teaching hospitals are an integral part of their communities. At one inner city teaching hospital, for example, medical residents teach fifth-grade students at five elementary schools a curriculum on air and water quality, asthma, the digestive system, diet, nutrition, childhood obesity, the respiratory system and the effects of smoking, and other topics that integrate science and health care. Many of these children are enrolled in Medicaid.

The dissolution of the link between Medicaid and GME would make it difficult for teaching hospitals to continue programs in their communities. Other New York teaching hospital community outreach examples include primary care and specialty clinics to provide for the needs of children in medically under-served communities; organized flu vaccine outreach programs; and regular health screenings, health fairs, and educational presentations and discussions. These programs, which are not directly reimbursed, not only provide care for high-Medicaid populations, they also instill in medical residents a spirit of community service to those in need.

### **Conclusion**

Without federal participation in Medicaid GME funding, New York's teaching hospitals would be forced to consider the closure of many intensive and high-cost specialty services, thereby reducing access to care for Medicaid beneficiaries and others. In addition, losing any portion of current Medicaid investment in GME will diminish New York's ability to attract and retain the physician workforce of the future, continue with groundbreaking research opportunities, and provide the current high levels of uncompensated care and community service.

HANYS again reiterates that CMS should withdraw this proposed rule while the regulatory moratorium is in place, but in the absence of such action submits these comments opposing the withdrawal of Medicaid FFP for medical education payments. If you have any questions regarding our comments, please contact me at (518) 431-7777 or at [sharwell@hanys.org](mailto:sharwell@hanys.org).

Sincerely,

Stephen Harwell  
Vice President, Economics, Finance, and Information

**Submitter :** James H. Ross  
**Organization :** University of Missouri Health Care  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

GENERAL

GENERAL

See Attachment

CMS-2279-P-237-Attach-1.DOC



#237

James H. Ross  
Chief Executive Officer

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Columbia, Missouri 65212

PHONE (573) 884-8738  
FAX (573) 884-4174

June 22, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of University of Missouri Health Care (UMHC) 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. The University of Missouri Health Care receives approximately \$14 million annually from the Missouri Medicaid Program. This Program has been in place for many years. 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. In Missouri, changes brought about by managed care, Medicare, revisions to Medicaid, and historical under-funding have made it increasingly difficult to provide access to the number of students needed in Missouri to meet the state's growing health care needs. MU's School of Medicine provides training each year to over 300 physicians completing residencies and fellowships. Physicians coming out of MU's program encompass many specialties and are essential for underserved areas and specialties, such as neurosurgery and anesthesia, where more doctors

are needed. As demand increases for medical care, this source of new physicians is invaluable. 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 our own case, University of Missouri Health Care treats more than 24,000 Medicaid patients per year, resulting in over 130,000 adult and pediatric visits, and provides over \$40 million in uncompensated care.

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 of Missouri Health Care serves a unique role in the central Missouri area. We are one of only two Tier 1 Safety Net Hospitals in Missouri and are the only level 1 trauma center in mid-Missouri. UM Health Care serves a disproportionate share of Medicaid and uninsured or underinsured individuals. For example, last year, we treated more than 39,000 patients in our Emergency Room.

UMHC treats patients from every county in the state of Missouri. Care may be delivered in one of our hospitals; in one of numerous clinics; during an outreach clinic in one of our affiliate hospitals; or via our Missouri Telehealth Network. In fiscal year 2006 we recorded approximately 560,000 clinic visits, cared for 20,000 inpatients and delivered nearly 1,600 babies. UMHC has mid-Missouri's only burn center, houses the region's most comprehensive center for wound care and hyperbaric medicine, provides the area's only nationally accredited air ambulance service, is one of only 15 centers nationally to provide comprehensive eye care treatment and surgery, and provides the most comprehensive neonatal intensive care unit in mid-Missouri and the region's only pediatric transport service, just to name a few of the specialty services offered. In 2006, over 26% of our patients were Medicaid recipients, a portion of these being children who benefit from pediatric specialties not available elsewhere in central Missouri.



**James H. Ross**  
**Chief Executive Officer**

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Columbia, Missouri 65212

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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 H. Ross  
Chief Executive Officer, University of Missouri Health Care

cc: Missouri Hospital Association

**Submitter :** Mr. Edward C. Burke  
**Organization :** The University Hospital  
**Category :** Hospital  
**Issue Areas/Comments**

**Date:** 06/22/2007

**GENERAL**

GENERAL

See Attachment

CMS-2279-P-238-Attach-1.PDF

CMS-2279-P-238-Attach-2.PDF

CMS-2279-P-238-Attach-3.PDF

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 *The University 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.

University Hospital (UH) is a full-service acute care hospital, owned and operated by the University of Medicine and Dentistry of New Jersey (UMDNJ). As New Jersey's only state-owned acute care hospital, UH is the Safety Net Hospital and Family Physician for its local communities as well as for the region and state. It is the primary teaching hospital for the New Jersey Medical School (NJMS) and supports the largest medical and health sciences teaching program in the state. Given its dual role as the state's leading safety net hospital and training ground for future physicians, the proposed regulation would have a devastating impact on UH.

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. UH receives approximately \$7 M in Medicaid GME payments 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 New Jersey's largest medical and health sciences teaching program, UH has residency programs in virtually every clinical specialty and provides exposure to high-risk patients. In addition to serving as the primary teaching hospital for NJMS, UH also serves as the locus for UMDNJ's New Jersey Dental School, School of Nursing and School of Health Related Professions and Allied Health. The elimination of Medicaid GME payments would affect University Hospital disproportionately compared to other NJ hospitals because of the size of its teaching program, resulting in a loss of \$34M over a five-year period. 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. As New Jersey's leading safety net hospital, UH provides by far the largest level of charity care in the state, providing 70% (\$63M) more than the 2<sup>nd</sup> largest charity care hospital in the state. Medicaid and uninsured patients make up almost 60% of our payer mix. Many live in poverty in a city faced with high rates of substance abuse, HIV, TB, accidents and injuries, and infant mortality. Their care is complex due to multiple medical co-morbidities and complications. UH provides over 235,000 outpatient visits annually, including hard-to-access specialty care services. Our emergency department is the busiest in the state, approaching 100,000 visits annually, including psychiatric and pediatric emergency services.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care (e.g., burn care, trauma and cardiac care, and transplant services) takes 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.

UH is a regional referral center for highly specialized services, serving both the local and larger New Jersey community. UH thus provides the medically indigent population access to specialized care that would not otherwise be available to them. University Hospital is a State designated Level I Trauma Center for Northern New Jersey, a Regional Perinatal Center serving high risk women and newborns, and the state's only Medicare-certified Liver Transplant Center. UH operates highly specialized programs in neurology, neurosurgery, ophthalmology and orthopedics. UH has also played a major role in the development of New Jersey's emergency preparedness initiatives.

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,

Edward C. Burke,  
Chief Financial Officer

Cc: Darlene L. Cox, MS, RN  
President & CEO

**Submitter :** Ms. Malisa Brown  
**Organization :** Tufts-New England Medical Center  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please See Attachment

CMS-2279-P-239-Attach-1.DOC



**Tufts-New England Medical Center  
Floating Hospital for Children**

June 22, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of Tufts-New England 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. For Fy2008 Tufts-New England Medical Center will rely on approximately \$2.7 million dollars in reimbursement from the state in order to provide the training and experiences necessary for the next generation of medical personnel. 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.

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.

Tufts-New England Medical Center is home to two full service hospitals providing care to the neediest citizens in the Commonwealth of Massachusetts. Tufts-New England Medical Center provides all aspects of adult and pediatric care, serving a diverse population base, 33 percent of which is a racial or ethnic minority. We have developed specialized services, such as our Asian Access Program and interpreter services in over 50 different languages, to help serve the needs of the 15 percent of our patient population who are non-English speaking.

Tufts-New England Medical Center provides level 1 pediatric trauma services and provides one of the few pediatric emergency departments in the state. In FY2006 we had over 307,000 clinical visits, 37,328 visits to our emergency department and more than 17,000 patient discharges. Also in FY2006 we were able to provide neonatal intensive care to 544 patients.

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,  
Malisa Brown  
Director, Government Relations  
Tufts-New England Medical Center



**Submitter :**

**Date: 06/22/2007**

**Organization :** The University of Texas System

**Category :** Academic

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

See Attachment

CMS-2279-P-240-Attach-1.TXT

February 28, 2008

Leslie Norwalk  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2279-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

File Code: CMS-2279-P

Dear Ms. Norwalk:

On behalf of the University of Texas (UT) Health System, we are writing to express serious objections to the proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) on May 23, 2007 that would end federal Medicaid support for graduate medical education (GME) programs. The UT Health System is the second largest academic health system in the country and the largest in the State of Texas. Our six health institutions—UT Southwestern Medical Center at Dallas, UT Medical Branch at Galveston, UT Health Science Center at Houston, UT Health Science Center at San Antonio, UT M.D. Anderson Cancer Center, and UT Health Center at Tyler—and more than 50 affiliated teaching hospitals and clinics together annually train more than 3,300 physicians in over 250 residency programs. In addition to the vital work we undertake in educating future physicians, the UT Health System and its teaching hospital partners also are responsible for delivering medical care to millions of Texans, providing more than 1.4 million days of hospital care and over 5.5 million outpatient visits last year. Because of Medicaid's importance for training the next generation of physicians in Texas and elsewhere, and because of our explicit mission to ensure access to quality health care for poor and vulnerable Texans, we strongly oppose implementation of the May 23<sup>rd</sup> Medicaid GME proposed rule and any other efforts on the part of CMS to prohibit federal financial participation under Medicaid for GME programs. We trust you will consider the points we have raised below and re-examine the rationale used to come to the conclusion you have reached about Medicaid GME.

The UT Health System and our affiliated teaching hospitals are the cornerstones of the health care systems in most of the major metropolitan areas in Texas. UT-affiliated hospitals and clinics frequently are the first "responders" for Texans in need of primary, acute, or emergency care services. This is particularly true for those Texans who are uninsured or those who are enrolled in Medicaid. Compared to other institutions, our teaching hospitals and clinics serve a disproportionately high volume of Medicaid and low-income patients. In 2006 alone, UT-affiliated hospitals and physicians provided over \$1.4 billion in unsponsored charity care. We play a critical role in sustaining the health of the communities in which we serve as well as in maintaining access to basic health care services for Texas Medicaid beneficiaries.

For these reasons alone, the CMS proposed policy would further fragment the delivery of services. But, in addition to being the primary resource for basic health care services, the UT Health System and its teaching hospitals often are the sole resource in their communities for advanced specialty care, care that is highly complex and specialized. As an academic health system, one of our main goals is to pursue the development and delivery of leading edge therapies and technologies. Severely ill patients, and those with rare or complex conditions, often turn to us because we can provide them with specialty care that no one else can provide. This includes care ranging from organ transplants to open heart surgery to neonatal intensive care services. We also shoulder the responsibility for being on "standby" for major emergencies and disasters. As a result, we continually operate Level I trauma centers and burn units. Nearly every Texan in the regions we serve, especially Medicaid beneficiaries, rely on us to deliver these specialized, innovative, and technologically-complex services.

Our ability to provide Texas Medicaid beneficiaries with basic and specialty medical services is wholly contingent on the availability of a sufficient physician workforce, beginning with physician residents. Physician residents in Texas annually provide at least 25 million hours of patient care that teaching hospitals otherwise would have been unable to provide, especially to Medicaid and indigent patients. However, despite an increasing demand for health care services, the number of physician residents in GME programs in the State remains little changed from 25 years ago, roughly 6,400. Texas trains only 28 physician residents per 100,000 population compared to the national average of 35 per 100,000. This has been an insurmountable barrier to Texas' prospects for developing a physician workforce for the State that can satisfy its Medicaid and other community health needs. Research consistently has shown that the location of the training program is a major determinant of where residents will establish their practices. The shortage of GME means the UT Health System loses physician residents who otherwise would have trained with us and would have been more likely to remain in Texas to practice. Texas ends up losing the invaluable care services physicians could have rendered both during the periods of their residency training and in the future as part of their permanent practices.

In fact, due to current law, our teaching hospitals and others throughout Texas have been confronting difficult challenges in maintaining adequate physician staffing for some time now. For at least the last two decades, Texas' average has fallen well short of the national average in the ratio of physicians per 100,000 population. Texas currently has an estimated 155 physicians per 100,000 population compared to the national average of approximately 240 physicians per 100,000. More than two-thirds of Texas' 254 counties, or 177 counties, are designated in part or in whole as a federal Health Professional Shortage Area. In 2005, 154 counties had not a single obstetrician-gynecologist while 141 counties had no pediatricians. The severity of the physician shortage, however, is not limited to primary care providers alone. The State suffers from a dearth of physicians in numerous medical specialties. This inability to train and retain physicians in Texas thus perniciously sets arbitrary limits on Texas Medicaid beneficiaries' ability to receive care. As institutions anchoring the health care system and serving a

disproportionately high volume of Medicaid patients, the UT Health System's affiliated hospitals and clinics struggle more than most to maintain access to the essential basic and specialty health care services those enrolled in Medicaid have a right to expect. Arbitrarily ending federal support for Medicaid GME funding would further diminish access to health care for Texas Medicaid beneficiaries in the future in that the proposed rule would adversely impact the UT Health System's capacity to supply the Texas Medicaid program with physicians. If the State's Medicaid obligations are to be satisfied, there must be sufficient availability of GME to produce the physician residents necessary to grow into a fully-trained physician workforce.

There are other dimensions to Medicaid GME funding that warrant your consideration. It is vitally important for Texas, in fact for all States, to retain the flexibility to receive Medicaid federal financial participation for GME. Consistent with its stated policy over the past few years to grant States greater flexibility in meeting their specific State Medicaid needs, CMS should allow, even encourage, Texas and other States to seek federal Medicaid support for GME to expand Medicaid beneficiaries' access to care.

At a time when soaring costs and rising demand for services make it especially difficult for academic health institutions like ours to maintain care for the Texas Medicaid population, limiting Texas' options for financing its physician needs would further undermine our education and training programs for the next generation of physicians, therefore worsening the already severe physician shortage. This in turn would fray the delicate Medicaid health care infrastructure in the State. Texas, like most other States, is examining reforms to strengthen its health care safety net. Federal policy that reduces Medicaid dollars and re-directs them toward other objectives creates only further dysfunction in an already complex and challenging Medicaid delivery system.

Such flexibility is extremely important for introducing innovation into the delivery of services under the Texas Medicaid program. We and other academic health systems in the State have long been the centers for the development of new technologies and clinical processes. Our three-pronged mission to undertake patient care, research, and medical education means that we are uniquely positioned to educate new physicians in the latest technologies and patient care practices. GME programs at Texas academic health institutions are a crucial means through which these clinical advances can be disseminated into the Texas physician workforce and subsequently into the Texas Medicaid program. Medicaid beneficiaries directly benefit from the technologically-sophisticated, innovative care pioneered in an academic health setting such as the UT Health System and diffused through GME and physician residents. In order for the Texas Medicaid program in the future to have the greatest opportunity to absorb advances in technology and clinical care, the State's current option of accessing and creatively utilizing federal funding for Medicaid GME must remain open.

We have additional objections to the proposed rule. The CMS rationale for issuing the proposed rule is premised on the argument that the Medicaid statute does not give explicit authority to Medicaid to pay for GME since GME is neither a health service included in the statutory list of

Medicaid-covered services nor is it a component of Medicaid hospital services. We disagree with this narrow interpretation of the Medicaid statute. Although physician resident training is not strictly a health service by itself, it is inextricably a component of all Medicaid health services since physicians ultimately deliver care under the Medicaid program and they must be properly trained to deliver such care. The Medicaid program, therefore, shares in the responsibility with Medicare for the education and training of tomorrow's physicians as part of its broader mandate to provide care to Medicaid beneficiaries. We note, furthermore, that nothing in the Medicaid statute expressly prohibits the Medicaid program from paying for GME. The statute is in fact entirely silent on the matter. The absence of any explicit prohibition against federal payments for Medicaid GME clearly gives CMS wide discretion to partner with States on structuring Medicaid and Medicaid GME programs that would enhance access to care for Medicaid beneficiaries. Consequently, the UT Health System believes it is fully consistent with both the spirit behind the Medicaid program and the letter of the Medicaid statute for federal financial participation to continue to be available to States for Medicaid GME.

For similar reasons, we also believe the calculation of upper payment limits (UPLs) for Medicaid inpatient and outpatient hospital services should continue to include both Medicare direct graduate medical education (DGME) payments and Medicare indirect medical education (IME) payments. The proposed rule would exclude DGME payments from hospital UPL calculations while continuing to permit the inclusion of IME payments. We understand CMS is proposing this change because the agency believes IME costs represent additional costs associated with providing patient care services in teaching hospitals while, using this reasoning, DGME costs are unrelated to patient care costs.

The UT Health System strongly disagrees. The entire residency training experience revolves around providing patient care. In fact, physician residents are paid salaries for the patient care services they furnish during their residency programs and faculty are paid salaries for supervising this care furnished by physician residents. Medicare DGME payments compensate teaching hospitals for these wages paid to physician residents and faculty to provide and oversee patient care. As a result, DGME costs, just like

IME costs, are an intrinsic part of the costs of patient care delivery in teaching hospitals and should be treated as such in all Medicaid reimbursement methodologies. Removing Medicare DGME costs from the calculation of Medicaid hospital UPLs would mean disregarding substantial patient care costs uniquely incurred by teaching hospitals. The net effect would be a lowering of the Medicaid hospital UPL payment ceilings, and, subsequently, a reduction in the allowable amounts the State could pay UT-affiliated hospitals and others. This would unfairly deprive Texas teaching hospitals of reasonable reimbursement for legitimate patient care costs. Inclusion of both Medicare DGME and IME costs in the Medicaid hospital UPLs is necessary to ensure that we receive appropriate payment for our patient care costs. Appropriate Medicaid payment for care costs attributable to Medicaid patients is crucial if we are to continue serving the Medicaid population, consistent, we argue, with the original intent of the Medicaid statute.

Finally, CMS' desire to end federal financial participation for Medicaid GME appears to be due in part to serious concerns about perceived shortcomings in the current oversight of Medicaid GME funding. However, CMS has refrained from considering any approaches to enhance such oversight because it believes it lacks the statutory authority to make Medicaid GME payments and, consequently, lacks the authority to regulate them. This logic escapes us. CMS readily exercises broad discretionary authority in many areas of Medicaid. Here, we support strengthened efforts by CMS to hold States accountable for GME payments. Scarce federal dollars for GME should be used for physician training purposes and should not be diverted elsewhere. As long as they do not impose an excessive administrative burden on either State Medicaid agencies or on teaching hospitals, we agree in principle with the CMS ideas for improving Medicaid GME oversight and accountability: better State reporting of Medicaid GME costs to CMS, a stronger review by CMS of State reimbursement methodologies for Medicaid GME, and implementation of standard Medicaid GME payment parameters consistently applicable to all States. Thus, we encourage the agency to continue federal funding for Medicaid GME in conjunction with undertaking reasonable oversight activities. CMS, States, teaching hospitals, and GME programs all would benefit from improved Medicaid GME oversight and accountability.

Thank you for the opportunity to express our views of the proposals contained in the proposed rule. We greatly appreciate your consideration of our comments. We urge CMS not to proceed with finalizing the May 23<sup>rd</sup> proposed rule and instead continue to extend to Texas and other States the flexibility to support GME through federal Medicaid funding. We also urge CMS to continue to allow both Medicare DGME and Medicare IME costs to be included as part of Medicaid hospital UPL calculations.

Federal Medicaid GME funding has an essential role for ensuring that well-trained physicians will be available in the future to provide access to health care services for Texas Medicaid beneficiaries and to bring much needed reform and innovation into the Medicaid program. The UT Health System and our affiliated hospitals and clinics strive to meet a vital mission: to serve all Medicaid patients in the best ways possible. Federal Medicaid GME funding is critical for fulfilling this fundamental mission, now and in the future.

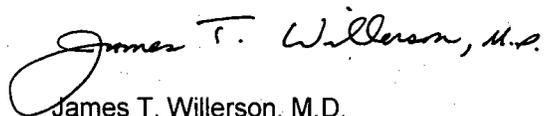
Sincerely,



Kenneth I. Shine, M.D.  
Executive Vice Chancellor for  
Health Affairs, The University of  
Texas System



Kirk A. Calhoun, M.D.  
President, The University of Texas  
Health Center at Tyler



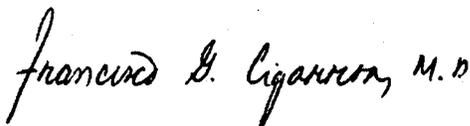
James T. Willerson, M.D.  
President, The University of Texas  
Health Science Center at Houston



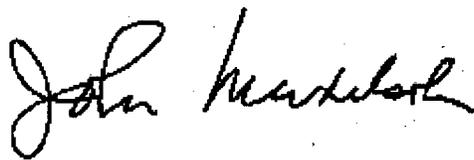
Kern Wildenthal, M.D.  
President, The University of Texas  
Southwestern Medical Center



John D. Stobo, M.D.  
President, The University of  
Texas Medical Branch



Francisco G. Cigarroa, M.D.  
President, The University of Texas  
Health Science at San Antonio



John Mendelsohn, M.D.  
President, The University of Texas  
MD Anderson Cancer Center

**Submitter :** Mr. Blair Childs  
**Organization :** Premier  
**Category :** Health Care Provider/Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2279-P-241-Attach-1.DOC



June 22, 2007

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

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San Diego, CA 92130  
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(28208)  
P.O. Box 668800  
Charlotte, NC 28266-8800  
T 704 357 0022  
F 704 357 6611

Reference: CMS-2279--P

Dear Administrator Norwalk:

444 N Capital Street NW  
Suite 625  
Washington, DC 20001-1511  
T 202 393 0860  
F 202 393 6499

On behalf of the 1,700 leading not-for-profit hospitals and health systems allied in Premier, I 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.

premierinc.com



The Premier healthcare alliance, owned by approximately 200 independent, not-for-profit health systems, serves more than 1,700 hospitals and 46,500 other healthcare sites nationwide. Premier is a leader in initiatives to improve the quality of hospital care, including the CMS/Premier Hospital Quality Incentive Demonstration project.

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.

Leslie Norwalk, Esq.  
June 22, 2007  
Page 2 of 2

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,



Blair Childs  
Senior Vice President, Public Affairs

**Submitter :** Mr. Marvin O'Quinn  
**Organization :** Jackson Health System  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

#242

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

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

**Submitter :** Mr. Mark Chastang  
**Organization :** University of Toledo Medical Center  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

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

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

**Submitter :** Dr. Dixie Tooke-Rawlins  
**Organization :** Virginia College of Osteopathic Medicine  
**Category :** Academic

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

Background  
see attachment

**GENERAL**

GENERAL  
See attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule  
see attachment

CMS-2279-P-244-Attach-1.WPD

CMS-2279-P-244-Attach-2.DOC

Comments Regarding File Code CMS-2279-P

CMS is proposing to eliminate federal funding of Graduate Medical Education (GME) through the Medicaid program. With existing physician shortages in many areas of the country and a pending overall national shortage of physicians, now is not the time to reduce funding for GME. The following must be considered:

1. Hospitals are largely dependent on Federal and State funding to provide GME.
2. Hospitals have over the past decade already realized significant reductions in GME funding through the Medicare program by reductions in the IME Adjustment Formula where the Adjustment Factor has been reduced from 1.72 in Fiscal Year 1998 to 1.32 in Fiscal Year 2007.
3. Well respected organizations are predicting physician shortages in the future:
  - 65,000 – 150,000 by 2020 - Council on Graduate Medical Education, Sixteenth Report, January, 2005.
  - At least 55,000 by 2020 - Association of American Medical Colleges.
4. CMS has, by historically making Federal payments to states for GME, recognized the public good of insuring adequate funding for GME programs.
5. CMS does not truly know the overall impact of the proposed change as evidenced by the agencies' request for information regarding the impact on small entities.
6. CMS in proposing this change really does not know the financial impact. The proposed rule states: "the amount actually expended on Medicaid GME is not readily determinable"
7. CMS, based on the information provided in the Federal Register, has apparently not considered anything other than financial considerations. The impact on the ability to train an adequate supply of physicians and the overall impact on the healthcare system is not mentioned.

At a time when many well respected organizations including the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Osteopathic Association, and the Council on Graduate Medical Education are predicting a physician shortage and at a time when these organizations are calling for an increase in the number of allopathic and osteopathic medical students including the creations of more osteopathic and allopathic medical schools; we cannot afford to make further cuts to the funding of graduate medical education in this country.

At a time when we will be graduating more physicians, we will need to expand our graduate medical education programs in order to train this increasing supply of physicians. Cutting the funding of these programs would most impact rural areas where medical education is most desperately needed.

Studies have shown that when individuals from rural areas train in a larger metropolitan medical center, they are more likely to stay there to practice and conversely physicians who train in rural areas are more likely to go back to those areas to practice. Here in Southwest Virginia, we are a new osteopathic medical school that has just graduated our first class of approximately 150 students. The mission of our school, The Edward Via Virginia College of Osteopathic Medicine, is to train physicians for the greater Appalachian region of the United States. An area that is severely underserved medically. It is our intention over the next five to ten years to have enough training programs in the greater Appalachian region to provide graduate medical education training for our graduates. In order to achieve our mission and our goals, it is imperative that the funding is available to train these physicians. If that funding is not available, hospitals will not be able to afford nor will the economically challenged regions of Appalachia be able to afford to bear the burden of these costs. This will set healthcare back in this region tremendously.

At a time when the baby-boomer generation is approaching retirement age and many physicians from that generation will be retiring, we must focus on training the next generation of physicians to take care of an ever aging and expanding population. Many projections do not take into account the burden of covering care for certain underserved populations, such as the currently over 40 million uninsured Americans. If the healthcare

system is expected to take care of these patients, this will only further compound the healthcare shortage in this country.

Here in Southwest Virginia we have a tremendous shortage of both primary and subspecialty physicians. In our area, there is a real shortage of both primary care physicians as well as sub specialists. By developing new residency programs as well as facilitating the growth of existing graduate medical education programs in this region, we will be able to provide, not only training for primary care physicians but also specialty and sub specialty physicians as well. We are confident that by training medical students and residents in this physician shortage area we will be able to supply the much needed physician workforce to counter the upcoming physician shortage. The development of these vital residency programs can occur only if the funding is available to cover the cost of this training.

We are encouraged by the fact that Congress acted swiftly to put a moratorium on the implementation on these proposed changes. We are hopeful that as our leaders in Congress and the American people learn more about these cuts and the potential harm that cuts in GME funding could mean to our healthcare system, there will be a nationwide outcry to defeat any regulation that would restrict funding for graduate medical education. We feel very strongly that in order to train the next generation of physicians we need to eliminate the "cap" on GME slots and to bolster the funding for new graduate medical education programs. When we identify areas of healthcare disparity, we must enable those areas to provide adequate training in order to supply physicians to those

areas. When we fail to support the future of graduate medical education, we jeopardize the future of the American healthcare system.

**Submitter :** Mr. Fred Salzinger  
**Organization :** Creighton University  
**Category :** Academic

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

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

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

**Submitter :** Ms. Nancy Hutchison  
**Organization :** Safety Net Financing Division, CDHS  
**Category :** State Government

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

Background  
See Attachment

**GENERAL**

GENERAL  
See Attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule  
See Attachment

CMS-2279-P-246-Attach-1.PDF

State of California—Health and Human Services Agency  
Department of Health Services



California  
Department of  
Health Services

SANDRA SHEWRY  
Director

ARNOLD SCHWARZENEGGER  
Governor

June 22, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2279-P, Mail Stop C4-26-05  
Baltimore, MD 21244-1850

Dear Sir or Madam:

The California Department of Health Services (CDHS), on behalf of the State of California, appreciates this opportunity to comment on the proposed regulation changes. Please find California's comments below in response to the Notice of Proposed Rule Making (NPRM) (CMS-2279-P) published at 72 Fed. Reg. 99 (May 23, 2007). The NPRM proposes amendments to 42 C.F.R. Parts 438 and 447.

The Centers for Medicare & Medicaid Services' (CMS') proposed regulations would exclude any Medicare payments associated with direct Graduate Medical Education (GME) when calculating the Medicaid Upper Payment Limit (UPL) and exclude costs and payments associated with GME as an allowable cost or payment for medical assistance under the approved Medicaid State Plan for purposes of Medicaid reimbursement eligible for federal financial participation; it would not prohibit reimbursement for Indirect Medical Education (IME) costs.

The State of California strongly objects to these proposed regulations based upon their potential negative impact on public and private hospitals that provide safety net services for Medicaid beneficiaries and for others, which could place this critical care in jeopardy. CMS's proposed rule would have the effect of creating shortages of medical professionals throughout the nation, reducing access to care for Medicaid patients, and reducing funding for a critical safety net that provides care to Medicaid beneficiaries.

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

shared by the federal government through its federal financial participation (FFP)—to pay rates that are consistent with “quality of care” and that assure “access to care.”

With this proposed rule, CMS seeks to “clarify” that costs associated with GME are not reimbursable expenditures for “medical assistance” under the Medicaid program. It argues that the exclusion of direct GME costs from the Medicare prospective payment system is grounds for the conclusion that “GME is outside the scope of medical assistance, and that GME funding is not an allowable component of payment methodologies included in a State’s approved Medicaid State Plan or in any Medicaid managed care payment.” 72 Fed. Reg. 28933 (May 23, 2007). There is nothing in the statute or the history of either the Medicare or Medicaid program to support these conclusions.

The proposal’s attempt to distinguish Medicare and Medicaid is fundamentally flawed and cannot explain why costs reimbursed for treating the nation’s elderly should not also be reimbursed for care provided to its poorest and most fragile citizens. The proposal is without merit and without basis in the statute and should be withdrawn in its entirety.

#### **COMMENTS:**

##### **The proposed regulation could affect California’s current Medi-Cal section 1115 demonstration project.**

The proposed GME prohibition could affect payments to the designated public hospitals that are covered under the section 1115 *Medi-Cal Hospital/Uninsured Care Demonstration* (Demonstration) because CDHS currently reimburses their costs (including those associated with medical education) through the certified public expenditure (CPE) methodology. It is clear that CMS would likely apply the requirement in the Special Terms and Conditions (STCs) which states that a new law or regulation must be applied to the Demonstration. If this proposed rule is applied to the STCs and direct costs associated with medical education are excluded when the designated public hospitals certify their expenditures, then their payments would be reduced because their costs would not be as high.

##### **2. Excluding GME costs when calculating the Medicaid UPL could cause a reduction in the aggregate payments to private hospitals under the current Medi-Cal section 1115 demonstration project.**

Private hospitals would be impacted by the proposed GME prohibition because, under Item 23 of the STCs, CDHS cannot exceed the UPL. If the UPL were reduced due to the exclusion of Medicare GME payments, then aggregate payments to private hospitals could also be reduced.

**3. To ensure access to care and quality of care, California needs the flexibility to consider GME costs in setting hospital payment rates.**

Title XIX of the Social Security Act at section 1902(a)(30) requires States to develop payment methodologies for services provided under the Medicaid State Plan 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 areas;...." Similarly, state plans must ensure that "care and services will be provided in a manner consistent with simplicity of administration and the best interests of recipients" at section 1902(a)(19) of the Act.

To ensure access to care and quality of care, California needs the flexibility to consider GME costs in setting hospital payment rates. While States are not required to reimburse teaching hospitals for the cost of GME in providing hospital services, virtually every State with a teaching hospital has elected to do so, to some degree. The responsibilities imposed on States by Title XIX require that they continue to have the discretion to recognize these costs in setting hospital payment rates. State Plans must ensure that "care and services will be provided in a manner consistent with simplicity of administration and the best interests of recipients."

California may have increased difficulty meeting these obligations if it is prohibited from considering GME costs in setting payment rates for hospital services, or if it is required to cut payments in order to satisfy the proposed lowering of the Medicare UPL.

A University of California Academic Medical Centers study (*Fulfilling Critical Missions in an Increasingly Challenging Environment*, April 2002) states that:

*From the outset of the program in 1965 Medicare has reimbursed hospitals for its share of GME costs because it recognizes the value of graduate medical training for both its beneficiaries and society at large. (p. 8)*

The study further notes that the University of California and other California medical centers provide a disproportionate share of care to the State's indigent population, and that:

*Medicare payment changes have broad implications. Many insurance plans tie reimbursement to the Medicare fee schedule. Therefore, any Medicare reductions will have far-*

*reaching impacts as they ripple through the health care payment system. (p. 16)*

In summary, the study states that:

*...both the UC medical centers and the faculty medical groups confront a health care environment in which the expense of providing services is increasing significantly more than revenues. This situation is greatly exacerbated by threatened decreases in the funding that has provided support for graduate medical education and indigent care. (p. 7)*

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

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

By reducing the UPL, the proposed regulation would affect access of providers to programs thereby limiting services to Medicaid beneficiaries since GME payments provide a portion of teaching hospital costs associated with hospitals that serve eligible Medicaid beneficiaries. It is imperative that California continue to educate medical school residents to assure a continued supply of qualified physicians necessary to serve Medicaid beneficiaries.

**4. The standard for assessing Medicaid payment rates is one of efficiency, economy, access to care and quality of care based on overall payments.**

The proposed rule pays lip service to the States' "flexibility, subject to a reasonable estimate of what Medicare would have paid for the services, to develop their own methods and standards to determine the price they will pay for

Medicaid covered services," but then takes the position that including payment for GME is not within that authority because "it is difficult to quantify Medicaid GME payments or monitor and measure the effect of Medicaid payments on GME programs." There is no requirement in Title XIX to "quantify" one cost item of a payment rate or to "monitor and measure" the effects of including it. Rather, the standard for assessing Medicaid payment rates—established by Congress—is one of efficiency, economy, access to care and quality of care based on overall payments. Nowhere in the proposed rule does CMS explain how its new interpretation can be reconciled with that standard.

**5. The reason for a GME prohibition at this time remains unclear.**

It is unclear as to why the regulation is being proposed at this time because CMS conducted a complete review of the UPL process in 2000 and 2001 and did not make any changes regarding GME. California is not aware of any new problem that would necessitate the proposed regulation.

In conclusion, California believes that the proposed rule is ill-conceived. It is not based on any reasonable construction of the statute, and is in fact contrary to the statutory directives granting States the flexibility to set payment rates to achieve the objectives of quality of care and access to care. The premise that the costs of GME can only be appropriately considered in Medicare and not Medicaid is unfounded, as is the attempted distinction between IME and GME payments. For these reasons, the proposed regulation should be withdrawn.

If you have any questions, or if we can provide further information, please contact me at (916) 440-7800.

Sincerely,



Stan Rosenstein  
Deputy Director  
Medical Care Services

cc: See Next Page

The Centers for Medicare & Medicaid Services

Page 6

June 22, 2007

cc: Mr. Toby Douglas  
Deputy Director  
Medical Care Services  
California Department of Health Services  
1501 Capitol Avenue, MS 4000  
P.O. Box 997413  
Sacramento, CA 95899-7413

Mr. Keith Berger  
Executive Director  
California Medical  
Assistance Commission  
770 L Street, Suite 1000  
Sacramento, CA 95814

Mr. Joe Munso  
Deputy Secretary  
Office of Program and Fiscal Affairs  
California Health and  
Human Services Agency  
1600 Ninth Street, Room 460  
Sacramento, CA 95814

Mr. Bob Sands  
Assistant Secretary  
Office of Program and Fiscal Affairs  
California Health and  
Human Services Agency  
1600 Ninth Street, Room 460  
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Anthony Lewis, Esq.  
Assistant Chief Counsel  
Office of Legal Services  
California Department of Health Services  
1501 Capitol Avenue, MS 0010  
P.O. Box 997413  
Sacramento, CA 95899-7413

Submitter : Dr. Peter Amenta

Date: 06/22/2007

Organization : UMDNJ-Robert Wood Johnson Medical School

Category : Academic

Issue Areas/Comments

**GENERAL**

GENERAL

Please see Attachment

CMS-2279-P-247-Attach-1.PDF



**ROBERT WOOD JOHNSON  
MEDICAL SCHOOL**

University of Medicine & Dentistry of New Jersey

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 UMDNJ-Robert Wood Johnson Medical School 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. Providing future physicians with experiences in caring for the vulnerable population is an important part of their medical education. There is strong evidence that physician learners with this exposure are much more likely to care for such patients after finishing their training. 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 S. Amenta, M.D., Ph.D.  
Interim Dean

**Submitter :** Dr. Peter Stern  
**Organization :** Univ of Cincinnati - Orthopaedic Surgery  
**Category :** Physician

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

"See Attachment"

CMS-2279-P-248-Attach-1.PDF



**College of Medicine  
Department of Orthopaedic Surgery**

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June 22, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of University 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.

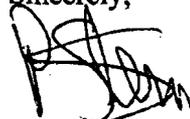
Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals'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

A handwritten signature in black ink, appearing to read "Peter J. Stern", written over a horizontal line.

Peter J. Stern, MD

**Submitter :** Mr. David Hoidal  
**Organization :** UAB Health System  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

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See Attachment

CMS-2279-P-249-Attach-1.PDF



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200 Independence Ave, SW  
Washington, DC 20201

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Dear Administrator Norwalk:

I am writing on behalf of University of Alabama at Birmingham Health System (UABHS) 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.

Although the Alabama Medicaid Agency reimburses most inpatient hospital services on a capitated fee basis, those fees are based on trended historical costs information that includes GME costs. UAB Hospital (the flagship of UABHS) anticipates that those fees would be reduced if GME costs were not covered by Medicaid. Our hospital estimates that the capitation fees that it receives from the Agency contain approximately \$5.2 million related to medical education costs. Our State Medicaid Agency reimbursed GME costs as far back as the 1980s. 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

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near future. UAB Hospital has 80 specialty and subspecialty teaching programs accredited by the Accreditation Council for Graduate Medical Education. A total of 814 residents are enrolled for fiscal year 2006-2007. UAB Hospital has educational affiliation agreements with 12 major participating institutions. In addition, some programs utilize physicians who serve as community preceptors and provide residents with experience in private practice settings.

There is a shortage of emergency medicine physicians in the state of Alabama, and UAB Hospital provides the state's only Emergency Medicine training program. Also, as a state with a large rural constituency, we have shortages of all types of physicians, including primary care and specialty care. All but two counties in Alabama, Autauga County and Baldwin County are designated by the U.S. Department of Health and Human Services as Medically Underserved Areas/Medically Underserved Populations (MUA/MUP). This situation will continue to worsen without proper attention from local, state and national authorities. 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 1,100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In our own case, UAB Hospital provides approximately 43,400 days of care to Medicaid patients annually and 32,800 days of care to charity patients.

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.

Today, UAB Hospital is part of the UAB Health System and is Alabama's major tertiary care center with the only adult Level 1 trauma designation in the state. Located on the University of Alabama at Birmingham campus, among major research centers and clinics, the Hospital provides patients with a complete range of primary and specialty care services and hosts an active medical and dental staff of 1056 members who hold faculty appointments at the University of Alabama School of Medicine and/or University of Alabama School of Dentistry.

The current 908-bed facility encompasses more than 3 million square feet and includes 37 high-tech operating suites, all designated to accommodate robot-assisted surgery, 2 procedure rooms, 3 medical surgical units, 4 intensive care units — trauma and burn intensive care, surgical intensive care, neuroscience intensive care, and cardiovascular intensive care.

UAB Hospital also serves as a key referral source for hard-to-access specialty care services, particularly for the uninsured. Of note, seven UAB programs were recently ranked in *U.S. News*

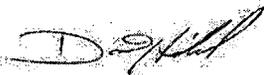
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& *World Report's* annual "America's Best Hospitals" issue. Specialty services include trauma care, burn care, neonatal intensive care, cardiac intensive care, orthopedics, and others. The Trauma/Burn Intensive Care Unit is the only center in Alabama that is designated by the American College of Surgeons as a Level-I trauma center, signifying the existence of resources to provide the highest level of trauma care necessary. In addition, the UAB Comprehensive Cancer Center is recognized as one of the nation's top cancer research and treatment facilities.

UAB Hospital is a Regional Resource Hospital designated by the Regional Medical Control System. The Emergency Department offers comprehensive, 24-hour, acute care services and sees more than 50,000 patients each year, making it one of Alabama's busiest emergency rooms. In addition, the Emergency Medicine program covers bioterrorism and disaster management; residents participate annually in bioterrorism exercises that drill the performance of existing plans. Needless to say, these functions are critical to the community, and they warrant the utmost support from local, state and national authorities.

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

Sincerely,



David Hoidal, MHA  
Chief Executive Officer  
UAB Health System