

JUL 17 2007

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Albany Medical College

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Vincent P. Verdile, M.D., F.A.C.E.P.
Dean, Albany Medical College
Executive Vice President for Health Affairs
Albany Medical Center

June 20, 2007

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

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

Dear Administrator Norwalk:

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

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

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, these medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating



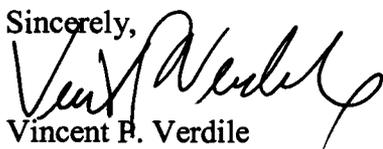
future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

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

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

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

Sincerely,



Vincent P. Verdile

Dean, Albany Medical College

Executive Vice President, Albany Medical Center



Children's Mercy
HOSPITALS & CLINICS
www.childrens-mercy.org

2401 Gillham Road
Kansas City, Missouri 64108
(816) 234-3000

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Randall L. O'Donnell, PhD
President and CEO

Phone: (816) 234-3650
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June 18, 2007

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

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

Dear Sir/Madam:

On behalf of Children's Mercy Hospitals and Clinics I would like to submit comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid proposed rule on Graduate Medicaid Education (GME) published in the May 23rd *Federal Register*. Without federal Medicaid funding dedicated to GME, the ability of teaching hospitals, including my hospital, to train providers would be seriously threatened. Therefore, we believe CMS should rescind the proposed rule.

The proposed rule would disproportionately affect children's hospitals. Because of children's hospitals' critical role in both the delivery of care to children and training the pediatric workforce of tomorrow, the proposed rule would negatively affect health care for all children, not just Medicaid patients seen by children's hospitals.

Training the next generation of pediatric providers is a critical mission of children's hospitals, including Children's Mercy. Our hospital and children's hospitals across the country play a key role in training the nation's pediatricians and pediatric specialists. In fact, children's hospitals, both freestanding and those that operate within a larger medical center, devote, on average more than 50 percent of their patient care to children assisted by Medicaid, and most provide GME. Together, these children's hospitals represent less than five percent of all hospitals in the country but train most of the nation's pediatric workforce, provide hospital care for more than 40 percent of all hospitalized children and deliver virtually all of the subspecialty hospital care for children with serious conditions such as cancer or heart conditions.

We recommend rescission of the proposed rule for several reasons:

- **CMS plans to end Medicaid GME funding without adequate justification, despite permitting the practice for decades.** For decades, states, with the approval of CMS or its predecessor the Health Care Financing Administration, have used Medicaid dollars to support graduate medical education. Despite this long history, the proposed regulation asserts that Medicaid does not have the authority to provide funding for graduate medical education. The regulation does not adequately explain this abrupt change in longstanding policy that has provided critical support for teaching hospitals.

- **The loss of Medicaid GME funding would threaten our hospital's ability to train the next generation of pediatric providers.** Children's Mercy receives approximately \$7 million annually in Medicaid GME funding. It provides critical support to our training program. Without this dedicated funding, the costs of our training program would not be fully covered. If federal Medicaid GME funding ends, we would have to make serious decisions about the sustainability of our training program.

Our hospital is very dependent on Medicaid funding. Children covered by Medicaid account for nearly 50% of all inpatient days. Therefore, any decrease in Medicaid reimbursement, including the loss of Medicaid GME dollars, would have a profound impact not only on our training program but also on our services overall.

- **The proposed rule would shift costs to the states and providers.** Under the proposed rule, our state Medicaid program could continue to pay for GME with state-only funds. This means that the state could shoulder all of the cost, reduce funding or end GME funding completely. Any reduction in GME funding by our state would shift costs of training to Children's Mercy. Children's hospitals are critical trainers of pediatric providers and any attempts to cut back or end support for GME programs could have dire effects on the country's pediatric health care workforce. It is not fair for the federal government to simply shift the costs for GME to states and providers.
- **The proposed rule contradicts the significant flexibility states are currently allowed under the Medicaid program.** Since the repeal of the Boren amendment in 1997, the federal government has given states significant flexibility to set provider reimbursement rates. This proposed regulation contradicts earlier policies allowing substantial flexibility in Medicaid payment to providers by prohibiting states from supporting graduate medical education through their Medicaid programs.

Due to the concerns expressed above, we believe CMS should rescind the proposed rule. We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Genny Nicholas, Vice President of Government Relations, 816-234-3661 or gnicholas@cmh.edu. Thank you for your consideration.

Sincerely,



Randall L. O'Donnell, Ph.D.
President and Chief Executive Officer



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June 21, 2007

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

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

Dear Administrator Norwalk:

As the Designated Institutional Official for Graduate Medical Education at Iowa Methodist Medical Center in Des Moines, Iowa, I am writing to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments. At a time when we are struggling with financing for graduate medical education, finalizing this rule would further challenge the financial condition of this teaching hospital significantly.

It is difficult for me to understand this substantial reversal of a long-standing Medicaid policy. Iowa Medicaid has supported the higher costs of the teaching hospitals in this state, and in the past, these payments have been approved and matched by the Health Care Financing Administration (HCFA) or CMS. Our budget office has suggested that for this institution alone the loss of these funds would amount to over \$700,000 annually. It goes without saying that as a teaching hospital we are heavily reliant upon these Medicaid funds to support our teaching programs.

Iowa is a state where physician manpower is a significant concern. Residents who train in our program in Des Moines are more likely to stay within the state than those trained elsewhere, and our community based residency programs are an important supplier of physicians to our state.

Our health system plays an important role in our community, and our residents support and provide care in many settings beyond our walls such as the Hispanic clinic and the county hospital.

I think that it is imperative that this proposed rule be rescinded, and I urge you to do so. The Iowa Medicaid Program needs to continue to receive federal matching assistance for GME particularly in light of all of the other uncertainty in financing for teaching hospitals.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Douglas B. Dorner, M.D., FACS". The signature is written in a cursive style with a large initial "D".

Douglas B. Dorner, M.D., FACS
Senior Vice President, Medical Education & Research
Designated Institutional Official

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



California
Department of
Health Services

JUL - 9 2007

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:

1. 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

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
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770 L Street, Suite 1000
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Deputy Secretary
Office of Program and Fiscal Affairs
California Health and
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Sacramento, CA 95814

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Assistant Secretary
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Sacramento, CA 95899-7413

JUN 28 2007

June 19, 2007

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

Re: GME Financing

Dear Administrator Norwalk:

On behalf of the nine family medicine residencies in Colorado, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services proposed rule entitled *Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates*.

The actions that CMS proposes in these changes, and from recent implementation of other recent misguided policies, are a grave threat to the survival of our residency programs. The funds from CMS's support of GME are the largest source of revenue supporting our residency programs. These new rules and proposed changes seem to indicate that CMS is now attacking Graduate Medical Education Funding and such actions will gravely harm our programs. We ask that you not adopt these changes and further clarify the current rules of the GME funding. The August 18, 2006 Medicare Final Rule on changes on FY 2007 Inpatient Prospective Payment, combined with these proposed new rules, indicates that CMS and the Administration are assaulting Graduate Medical Education. Taken together these actions on behalf of the Administration will unravel Graduate Medical Education infrastructure in our residency programs in Colorado and perhaps lead to their end. We believe your actions are extremely harmful to the well-being of the citizens of Colorado and the United States.

Our combined residency programs train the vast majority of rural physicians in the state of Colorado. Our residents also provide extensive primary care services, under the direction of paid and volunteer faculty, for many of the neediest persons in the state of Colorado. Our residency practices provide both inpatient and outpatient care for a markedly disproportionate share of the Medicare, Medicaid, and uninsured patients in the state of Colorado. We are dismayed that CMS seems determined to eliminate funding for the training of family physicians. Our graduates provide the highest quality, most cost effective health care in the United States.

The following actions will be extremely harmful to our family medicine residency programs and should not be enacted.

- May 23, 2007, CMS proposed rule would eliminate Medicaid payments for Graduate Medical Education.
 - There has been Medicaid support for GME for more than 40 years. Our residency programs care for many Medicaid patients. The current CMS and Administration's decision that the statute does not allow such payment, after 40 years of making such payments, is an insane attack on Graduate Medical Education in America. This proposed rule should not be enacted.
- May 11, 2007, Final Rule Medicare Program: Prospective Payment System for Long-Term Care Hospitals FY 2008: Annual Payment Rate Updates, and Policy Changes; and Hospital Direct and Indirect Graduate Medical Education Policy Changes.
 - This rule enacts a regulatory and paperwork nightmare with which hospitals could never fully comply with. A formula is created which must apply to every preceptor (every private doctor working with the resident would have to have specific salary information for each occurrence of seeing a resident) which would result in programs needing to pay all preceptors. Many if not all of our preceptors would refuse such payments and feel it is their ethical duty to answer a resident's question or instruct a resident in normal day-to-day operational interactions. This rule would essentially eliminate most hospitals from ever obtaining enough data or information to even apply for GME financing.
 - This rule is an irrational, bureaucratic, regulatory nightmare created by some unthinking person at CMS as a means to indirectly eliminate GME payments in the United States. We advise the administration and CMS not to use these bureaucratic policies to eliminate GME financing and end many residency programs throughout the United States, thereby shifting costs for Graduate Medical Education to hospitals.
- The August 18, 2006 Medicare Final Rule on changes to FY 2007 Inpatient Prospective Payment.
 - CMS is essentially enacting new legislation, never intended by Congress, to decrease funding for Graduate Medical Education through this regulatory nightmare. Somehow residency programs are to track every resident activity everyday, so that a resident's time seeing and treating a patient might be counted but a resident's time eating a snack, discussing a medical topic with another physician, or attending Grand Rounds would not be counted. Tracking such data accurately is impossible and once again seems to be a direct assault on Graduate Medical Education Funding.

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Page 2

Once again these ridiculous rules created by CMS will be extremely harmful to the American public, and in particular the citizens of Colorado who need primary care.

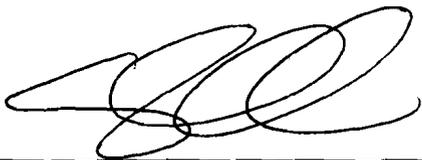
- The elimination of vacation and sick time from the formula used to determine IME and DME reimbursement.
 - Once again CMS is legislating changes never intended by Congress. It is illogical and unreasonable to eliminate these real cost drivers of Graduate Medical Education Programs for hospitals. For 40 years this has been part of GME costs and now CMS has decided to eliminate this. It is simply another instance of an assault by CMS on Graduate Medical Education.

We urge CMS to work with the residency programs throughout the United States and not to develop policies with which residency training programs can not comply. We urge CMS to amend its definition of patient care activities, vacation time, and sick time, and to allow programs such as ours to continue to receive Graduate Medical Education funding.

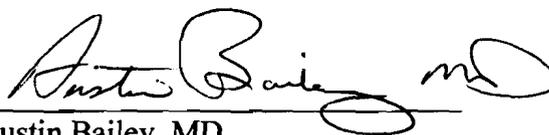
For the past 40 years Graduate Medical Education programs have been sustained by payments to hospitals for Graduate Medical Education made through the Centers for Medicare and Medicaid Services. We find the cumulative impact upon changes proposed and changes made for Graduate Medical Education to be extremely harmful to our programs, and may eventually result in the elimination of our programs. These actions are detrimental to the citizens of Colorado and the United States.

Sincerely,

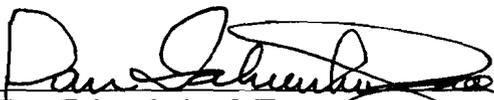
Family Medicine Residency Directors of Colorado
(See attached page for individual signatures.)



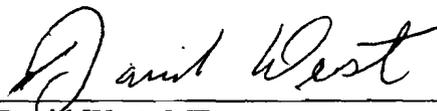
Steve Cobb, MD
Exempla Saint Joseph Family Medicine
Residency



Austin Bailey, MD
Ft. Collins Family Medicine Residency



Dan Fahrenholtz, MD
North Colorado Family Medicine Residency



David West, MD
Saint Mary's Family Medicine Residency



Charles Raye, MD
Southern Colorado Family Medicine Residency



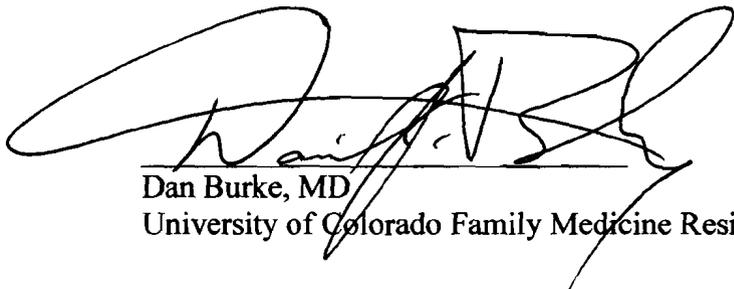
Patrick Sankovitz, MD
St. Anthony Family Medicine Residency



Brian Bacak, MD
Rose Family Medicine Residency



Brad Winslow, MD
Swedish Family Medicine Residency



Dan Burke, MD
University of Colorado Family Medicine Residency

6



State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4688 FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

JUL - 9 2007

JOHN A. STEPHEN
COMMISSIONER

June 21, 2007

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

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

Dear Sir/Madam:

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

We do not take exception to the notion that general medical education payments are not necessary to support the State's medical education systems, nor do we believe that, without appropriate benchmarks and accountability, the payments directly benefit Medicaid recipients as perhaps originally intended. We offer the following:

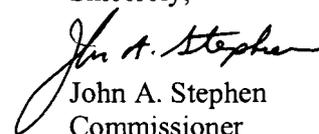
- 1) Of the 26 general hospitals that operate in New Hampshire, this proposal affects only four hospitals, with one hospital being the primary beneficiary of GME payments. These four hospitals are in good financial condition, with all four showing profitability and positive financial health.
- 2) As implemented in New Hampshire, GME is an entitlement program. Currently, hospitals receiving GME payments do not have clear accountabilities and benchmarks to follow for any education, workforce, or other objectives deemed in the State's interests.
- 3) Although it is argued that DME payments have some indirect benefit there is no direct benefit to Medicaid patients since reimbursement is not dependent on direct services to Medicaid recipients.
- 4) IME payments may compensate hospitals in excess of their actual medical education costs.
- 5) Medicare supports NH teaching hospitals through DME and IME payments.

Without clear accountability and well-defined objective benchmarks that ensure direct benefit to the Medicaid program, the Department does not object to the discontinuation of the current Medicaid GME program.

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

Your consideration on this matter is appreciated.

Sincerely,


John A. Stephen
Commissioner



JOSÉ R. RODRÍGUEZ
COUNTY ATTORNEY
EL PASO COUNTY, TEXAS

EL PASO COUNTY HOSPITAL DISTRICT LEGAL UNIT

4815 ALAMEDA
8TH FLOOR, SUITE B
EL PASO, TEXAS 79905

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FAX: (915) 521-7209

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 electronic mail <http://www.cms.hhr.gov/eRulemaking>

Dear Administrator Norwalk:

R. E. Thomason General Hospital, the teaching hospital operated by the El Paso County (Texas) Hospital District urges the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that would eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Should the rule be finalized, the financial condition of teaching hospitals and their ability to continue to fulfill important teaching, patient care and other missions would be jeopardized.

Thomason relies on these and other Medicaid payments to support our critical functions, which include providing the clinical education of future physicians. This is critical in a geographical area such as western Texas with a significant shortage of healthcare professionals. 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.

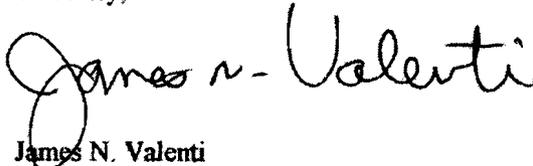
Because the mission of this institution is to provide health care to indigent residents, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing our total financial resources. Thomason provided approximately \$104.7 million of charity care

during FY 2006. Our Trauma Center is the only Level 1 trauma facility within a 250-mile radius, our Emergency Department treats more than 62,000 patients annually and more than 5,000 babies are born here each year.

Less than 15% of our patients have commercial or HMO/PPO coverage. Nearly 25% are self-pay (no coverage of any kind), while 18% receive Medicaid, 13% are Medicare enrollees and 28% are eligible for charity care. Jeopardizing GME funding would, in effect, jeopardize the health of the entire El Paso community – a city with the dubious distinction of having one of the highest percentage of uninsured residents in the United States.

We urge CMS to rescind the proposed rule and allow Thomason to fulfill its crucial role in training physicians in this medically underserved area of our country.

Sincerely,

A handwritten signature in cursive script that reads "James N. Valenti". The signature is written in dark ink and is positioned above the typed name and title.

James N. Valenti
President and Chief Executive Officer

JUN 22 2007

**VIA HAND DELIVERY**

June 22, 2007

**Association of
American Medical Colleges**2450 N Street, N.W., Washington, D.C. 20037-1127
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Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

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

Dear Administrator Norwalk:

On behalf of the Association of American Medical Colleges (AAMC or the Association), I write to urge the Centers for Medicare & Medicaid Services (CMS or the Agency) to rescind the proposed rule entitled "*Medicaid Program; Graduate Medical Education.*" 72 Fed. Reg. 28930 (May 23, 2007). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the IPPS. The AAMC also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

In brief, the proposed rule seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments. We are surprised and greatly disappointed by CMS' decision to pursue this action given the important role of teaching hospitals in caring for Medicaid patients and training the physicians that serve them.

As you are aware, section 7002(a) of the Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Pub. Law 110-28) prohibits, for one year, the promulgation or implementation of "any rule or provisions" restricting Medicaid payments for graduate medical education (GME). We believe this moratorium precludes CMS from collecting comments on the proposed rule. Therefore, we believe the Agency's best course of action is to withdraw the proposed rule, at least until the moratorium expires in May, 2008. Yet, it is our understanding that CMS believes it has authority to accept public comments, even while recognizing that the Agency cannot prepare or publish a final rule until next year.

The AAMC believes that CMS' acceptance of comments may be in violation of the moratorium legislation. Nonetheless, we have chosen to submit comments because of the devastating consequences that would result if this rule is finalized, regardless of when such an action might occur.

SUMMARY OF COMMENTS

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major and abrupt reversal of long-standing Medicaid policy. For decades, state Medicaid programs have supported the GME costs of teaching hospitals. According to a study commissioned by the AAMC in 2005, 45 states and the District of Columbia provided direct GME payments under their Medicaid programs.¹

CMS and its predecessor, the Health Care Financing Administration, have recognized GME as a covered medical assistance cost and consistently approved and matched Medicaid GME payments. Now, CMS attempts to reverse its position through a new interpretation of the Medicaid statute that is so narrow it simply cannot pass legal muster (see attached legal memorandum).

Because the proposed rule cannot be legally justified, it must be withdrawn. To pursue finalization of the rule would reinforce the view that the Agency's motivation for the proposed rule is solely to reduce Federal outlays by cutting nearly two billion dollars in Medicaid payments to teaching hospitals. Cuts of this magnitude would jeopardize the financial condition of many teaching safety net hospitals. The cuts would not only erode critical financial resources that support GME programs, but they would likely also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. Such a result is not in the best interests of the Medicaid program, its beneficiaries, other patients and the nation's health care system.

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

PROPOSED RULE

As set forth in its preamble, the stated purpose of the proposed rule is to "clarify that costs and payments associated with Graduate Medical Education programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid

¹ This count reflects those states who reported providing "direct GME payments" to teaching hospitals as well as those states that reported they did not distinguish between direct GME payments and indirect medical education (IME) payments. Two other states reported that they only made IME payments to teaching hospitals. "Medicaid Direct and Indirect Graduate Medicaid Education Payments: A 50-State Survey." Prepared by Tim M. Henderson, MSPH, for the Association of American Medical Colleges (November, 2006).

Program.” (72 Fed. Reg. at 28930). Specifically, the proposed rule would modify 42 C.F.R. §447.201 by adding a new section (c) that states that state Medicaid plans:

Must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system. . . .

Additionally, the proposed rule would modify the Medicaid upper payment limit (UPL) regulations at 42 C.F.R. §447.272(b) to exclude Medicare direct GME payments from the UPL calculations.

THERE IS NO LEGAL JUSTIFICATION FOR THE PROPOSED RULE

CMS attempts to rationalize the proposed rule by asserting that GME payments are not authorized under the Medicaid statute. The rule states that under section 1905(a), GME is not included in the list of services considered “medical assistance” for purposes of Medicaid coverage.

The AAMC engaged Mark Gallant, Esquire, a partner in the law firm of Cozen and O’Connor, to provide an independent legal review of the proposed rule. His memorandum, which is attached to this comment letter, enumerates the flaws in CMS’ legal arguments and concludes the proposed rule is an “invalid disavowal of federal coverage” for Medicaid GME payments. Mr. Gallant also states unequivocally that “coverage of DGME . . . is clearly authorized under Title XIX [the Medicaid statute], and that CMS does not have discretion under the Act to refuse to federally match State expenditures for medical education as part of their medical assistance programs.”

Several points raised in Mr. Gallant’s memorandum are:

- State Medicaid programs have broad latitude to define “medical assistance” and the fact that GME, as well as other services that are reimbursed under Medicaid, is not specifically enumerated under section 1905(a) of the Medicaid statute is legally inconsequential.
- CMS suggests that GME is not a Medicaid covered expenditure for hospitals because it is not an “operating” cost. Yet, GME is a well recognized cost of “patient care” and there is no basis in law for limiting FFP to only “operating costs.”
- GME falls within the “catch-all” provision under section 1905(a)(28) of the Medicaid statute.
- Congress has recognized that GME is a Medicaid-covered cost. This includes expressly (and without limitation) identifying GME as an allowable expense in the Deficit Reduction Act of 2005 and emphasizing the importance of Medicaid covering costs unique to teaching hospitals in the Boren Amendment of 1981.

- CMS' distinction of Medicare direct GME payments is misplaced. From its inception, Medicare has always covered GME as an allowable cost of patient care under "reasonable cost" reimbursement principles. Congress used the same reimbursement standard for Medicaid at its inception, and the changes in the hospital reimbursement language have only been intended to add to, not to decrease, States' flexibility in formulating their Medicaid reimbursement methods and standards.
- Medicaid case law supports the conclusion that coverage of DGME is authorized, if not required, under the Medicaid statute.
- There is no reasonable basis for the exclusion of Medicare direct GME costs from the UPL calculations.

In summary, Medicaid GME payments are permitted under the Medicaid statute, and it is CMS' effort to eliminate them that lacks legal authorization.

THE PROPOSED RULE WOULD HAVE A MAJOR NEGATIVE IMPACT ON THE NATION'S HEALTH CARE SYSTEM

Teaching hospitals play a unique role in our nation's health care system. In addition to providing basic health services to their communities (including a disproportionately high number of Medicaid and uninsured patients), teaching hospitals also maintain high-quality education programs for all types of health care professionals; provide an environment in which clinical research flourishes; and assure that highly specialized tertiary care services are available around the clock. Given these responsibilities, it is not surprising that teaching hospitals have significantly higher costs than their nonteaching counterparts.

As noted above, many major teaching hospitals share a special mission in treating large numbers of Medicaid and uninsured patients. Representing only six percent of all hospitals, major teaching hospitals are the sites for approximately a quarter of all Medicaid discharges. Indeed, our nation's teaching hospitals provide large amounts of ambulatory care in poor communities, often acting as the "family doctor" in areas where few individual practitioners exist, accept Medicaid as a form of payment, or provide charity care. Major teaching hospitals also provide nearly one-half (45 percent) of all hospital charity care.

Eliminating Medicaid GME payments would significantly threaten the ability of teaching hospitals to continue these activities. The result would be to severely undermine the infrastructure of the American health care system.

Reducing GME Payments Could Cripple Physician Training Programs

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing clinical education for future physicians. Within a supervised patient care team of health care professionals, physician residents provide needed care to Medicaid and other patients as part of their training programs. These clinical experiences prepare them for their future independent practice of medicine. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting current and future physician shortages.

The Health Resources and Services Administration's (HRSA) Bureau of Health Professions projects that the nation will have a shortage of at least 55,000 physicians by the year 2020. This has enormous implications for health care in this country. Indeed, considering the amount of time it takes to educate and train a physician—four years of medical school, plus multiple years of residency training—2020 is now, and teaching hospitals and medical schools must act rapidly to avert this future shortage. The Federal Council on Graduate Medical Education (COGME) issued a 2005 report, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, recommending an increase in medical school enrollment and the cap on Medicare-supported resident positions be increased. In 2006, the AAMC adopted a similar position.

Numerous other reports and news articles have highlighted both current and impending physician shortages across the country.^{2, 3, 4, 5} Moreover, current shortages already are being reported in several specialties—including a recent Department of Health and Human Services (DHHS) report to Congress documenting the shortage of physicians available to care for patients in intensive care units.⁶

Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when they are attempting to expand to assure an adequate supply of physicians, both now and in the future.

² Glabman M. Specialist shortage shakes emergency rooms; more hospitals forced to pay for specialist care. *Physician Exec.* 2005;31:6-11.

³ Rosenblatt RA, Andrilla CHA, Curtin T, Hart LG. Shortages of medical personnel at community health centers: Implications for planned expansion. *JAMA.* 2006;295:1042-1049.

⁴ Mitka M. Looming shortage of physicians raises concerns about access to care. *JAMA.* 2007;297:1045-1046.

⁵ NPR : Doctor shortage in burgeoning U.S. southwest. Available at: <http://www.npr.org/templates/story/story.php?storyId=4754124>. Accessed 6/20/2007, 2007.

⁶ U.S. Department of Health and Human Services. Report to congress: The critical care workforce: A study of the supply and demand for critical care physicians. Available at: <http://bhpr.hrsa.gov/healthworkforce/reports/criticalcare/default.htm>. Accessed 6/20/2007, 2007.

Medicaid GME Payment Reductions Could Impact Other Important Services Provided by Teaching Hospitals

Major teaching hospitals are a critical and fundamental component of the nation's health care system, particularly in most metropolitan areas. Given the disproportionately high volume of low-income and uninsured beneficiaries receiving care at major teaching hospitals, Medicaid payments represent a significant segment of their total revenue. Any Medicaid cuts, and particularly those of the magnitude proposed, will directly affect the fiscal condition of major teaching hospitals and could affect other services offered to Medicaid and other patients.

Reductions in Medicaid funding could limit major teaching hospitals' abilities to maintain critical healthcare services that few other hospitals provide. These include Level I trauma units and burn units, as well as clinical trials that many cancer and other patients seek. 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. Moreover, recent studies demonstrate that, while non-teaching hospitals with high Medicaid percentages have lower adherence to quality measures than others, among teaching hospitals "there are minimal differences in quality regardless of the percentage of patients served."⁷

Major teaching hospitals also provide other services of critical importance to the communities in which they are located. These include large and comprehensive emergency room services, substance abuse outpatient services, geriatric services and crisis prevention activities. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role. The proposed rule cuts could jeopardize the continuation of these programs, or result in teaching hospitals scaling back on these activities.

THE PROPOSED RULE DOES NOT IMPLICATE IME PAYMENTS

In the proposed rule, the Agency requests "comments on the propriety of including Medicare IME adjustments as part of the UPL calculation." (72 Fed. Reg. at 28933) There is no doubt that CMS must continue to include Medicare IME payments in the UPL calculation. As the proposed rule points out IME payments help compensate teaching hospitals for their higher costs in treating Medicare patients. Thus, including them in the UPL is appropriate and nonrefutable.

As an aside, state Medicaid IME payments serve the same purpose as Medicare IME payments (i.e., they address the unique higher patient care costs at teaching hospitals). CMS does not propose to eliminate FFP for IME payments, which we agree is the

⁷ Goldman LE, Vittinghoff E, Dudley RA. Quality of care in hospitals with a high percent of Medicaid patients. *Med Care.* 2007;45:579-583.

Acting Administrator Leslie Norwalk

June 22, 2007

Page 7

appropriate stance. However, out of an abundance of caution, we would point out that if CMS intends otherwise, the Agency would be required by the Administrative Procedures Act to formally issue such a proposal, justify the reasoning behind such a major change in policy, and allow all affected parties the opportunity to comment.

CONCLUSION

The proposed rule is invalid on a legal basis and is contrary to the interests of the Medicaid program, its beneficiaries, other patients, and the nation's health care system. We urge CMS to withdraw or rescind the rule.

If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We may be reached at (202) 828-0490, or rdickler@aamc.org and kfisher@aamc.org.

Sincerely,



Robert M. Dickler
Senior Vice President
Division of Health Care Affairs

cc: Karen Fisher, AAMC
Ivy Baer, AAMC



A PROFESSIONAL CORPORATION

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MEMORANDUM

TO: Ivy Baer, Esquire
Karen Fisher, Esquire
Association of American Medical Colleges

FROM: Mark H. Gallant

DATE: June 20, 2007

RE: Proposed Rule: CMS-2279-P

Background and Executive Summary

We have reviewed the May 2007 Proposed Rule concerning Medicaid expenditures for graduate medical education (“GME”), 72 Fed. Reg. 28930 (May 23, 2007), from a legal standpoint at the request of the Association of American Medical Colleges (“AAMC”), the National Association of Children’s Hospitals, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, the American Academy of Family Physicians, and the Academic Family Medicine Advocacy Alliance.

In the summary of the Proposed Rule, the Centers for Medicare & Medicaid Services (“CMS”) states that the “proposed rule would clarify that costs and payments associated with Graduate Medical Education programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program.” 72 Fed. Reg. at 28930. See also 72 Fed. Reg. at 28933 (“This rule would clarify that GME is outside the scope of medical assistance, and that GME is not an allowable component of payment methodologies [under Medicaid]”). The Proposed Rule not only “clarifies” CMS’ view that GME is not an authorized federal expenditure under Title XIX of the Social Security Act (the “Act”), but also would amend the regulations at

42 C.F.R. §§ 447.272 and 447.321 to preclude counting any costs incurred for GME for purposes of calculating the aggregate Medicare upper payment limits (“UPL”) for inpatient hospitals.

In short, CMS’ so-called “clarification” of the law is nothing of the sort. Rather, the Proposed Rule represents an abrupt reversal of CMS’ own decades old recognition of GME as a covered cost of providing hospital services and patient care under Title XIX, and amounts to an invalid disavowal of federal coverage that could be legitimized only if Congress itself were to amend Title XIX to eliminate coverage of GME.

Analysis

(i) The States Have Broad Latitude to Define Medical Assistance, and the Fact That GME is not Separately Enumerated as a “Health Care Service” under Section 1905(a)(1)-(27) is Legally Inconsequential

As it repeatedly concedes in the preamble to the Proposed Rule, CMS has long “allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient services” through an extensive history of approving State Plan Amendments that include payment for GME. 72 Fed. Reg. at 28931, 28932. CMS proposes reversing its consistent, decades long view that GME is reimbursable under Title XIX based largely on the rationale that GME is not broken out separately as a “health service” under the “benefit package” defined by Section 1905(a)(1) through (27). 72 Fed. Reg. 28931, 28933. That rationale is easily dispatched.

In Section 1903(a)(1) of the Act, Congress authorized federal financial participation for funds “expended for medical assistance under a state plan.” When a service is covered under Title XIX, CMS has an affirmative obligation, not merely an option, to federally match State medical assistance expenditures under the mathematical standards prescribed pursuant to Section 1901 of the Act. Section 1901 of the Act thus states that the “sums made available under this section shall be used for making payments to States ... [under approved] State plans for medical assistance.” Section 1902(a)(3) says that the Secretary “shall pay” the prescribed matching amounts out of monies appropriated therefore.” As the Supreme Court has observed, “the purpose of Congress in enacting Title XIX was to provide federal financial assistance for all

legitimate state expenditures under an approved Medicaid plan.” Harris v. McRae, 448 U.S. 297, 308 (1980), *reh’g denied*, 448 U.S. 917 (1980). Accord Department of Social Servs. v. Bowen, 804 F.2d 1035, 1040 (8th Cir. 1986) (HHS may not abdicate its responsibility to pay States for legitimate costs under Title XIX).

The notion that Congress prohibited FFP for GME because it did not list GME as a separate line item within Section 1905(a) of Title XIX is misguided. Under Title XIX the States have wide latitude to decide what specific items and services to cover under their MA programs, subject to broad parameters set by federal law. Section 1905 of the Act sets forth an array of medical assistance services that states may choose to provide, or must provide under their medical assistance programs pursuant to Sections 1902(a)(10)(A) and 1902(a)(13)(B). Inpatient and outpatient hospital services are among the services States are obligated to cover under their federally approved State Plans. Sections 1905(a)(1), (2). CMS’ position that GME may not be funded under the Act because it is not “listed” within the array of medical services catalogued under Section 1905 incorrectly presumes that GME is a “medical service.”

GME is not like the other types of “services” listed, which are categories of care (e.g., hospital; hospice; home health; lab), but more aptly is characterized as a *cost* of delivering “hospital services.” The costs that may be included in rates for hospital services are the subject of a separate provision of the Act – i.e. Section 1902(a)(13)(A), 42 U.S.C. § 1396a(13)(A). As CMS recognizes, States are afforded broad “flexibility” under the Act, subject to a reasonable estimate of what Medicare could have paid for the service, to designate specific items and services covered under their medical assistance plans and “to develop their own methods and standards” of reimbursement. 72 Fed. Reg. 28932.¹

Even if graduate medical education were viewed as a “service,” one would not logically expect it to be separately enumerated as a line item under Section 1905(a) because it is a

¹ Accord H.R. Rep. No. 158, 97th Cong. 1st Sess. 292, 293 (1981 amendments to the institutional reimbursement provisions of Title XIX were intended to give state “greater flexibility” and “greater latitude” in designing their reimbursement methods).

subsidiary component of a broader class of services, namely, hospital services. See, e.g., Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004) (incontinence supplies are covered within the broader category of “home health services”). In fact, CMS has spelled out what services comprise inpatient hospital services under Title XIX by regulation, along with specific exclusions. See 42 C.F.R. § 440.10(a) & (b). That regulation makes clear that such services include *any* services “ordinarily furnished by a hospital” that are “under the direction of a physician.” This broad description clearly encompasses GME, which, conversely, is not excluded from the definition of inpatient hospital services by § 440.10(b).

That a particular component (like GME) of a broader service (like hospital services) need not be specifically listed under Section 1905(a) is apparent from the terms of Section 1905(a) itself. The last sentence of Section 1905(a) (following subparagraph (28)) that states: “No service (including counseling) shall be excluded from the definition of medical assistance solely because it is provided as a treatment service for alcoholism or drug dependency.” “Counseling” is not separately enumerated in subsections (a)(1) through (a)(27), but (like GME) was plainly regarded by Congress as a covered service because it falls within the ambit of hospital services.

Additionally, in Section 1905(a)(28) Congress included a “catch-all” provision that states that the cost of “*any other medical care ... recognized under State law*” may be reimbursed as medical assistance. Coverage of services under Section 1905(a) is viewed expansively, not restrictively. See generally Coe v. Hooker, 406 F. Supp. 1072 (D.N.H. 1976); Skubel v. Sullivan, 925 F. Supp. 930 (D. Conn. 1996), *aff’d as modified*, 113 F. 3d 330 (2d Cir. 1997) (rejecting Secretary attempts under Section 1905(a) to deny coverage of home health care services, noting Medicaid coverage is broader than Medicare coverage). These cases moreover predated the addition of the “catch-all” provision (which provision CMS ignores). Consistent with both the catch-all provision and the broad compass of covered services under the Act, CMS has identified both transportation services and durable medical equipment as a covered service (within the broader class of home health services), even though neither service is listed under Section 1905(a)(1) through (27). See 42 C.F.R. §§ 440.70(b)(2), 440.170(e).

CMS' position also is demonstrably incorrect in that GME costs plainly fall within the costs of hospital services under Medicare, and the Title XVIII reimbursement concepts were imported by Title XIX. From the enactment of Title XIX until 1981, Section 1902(a)(13)(A), like Title XVIII, provided for reimbursement of hospital services based on the "reasonable costs" of those services. This standard was congruent with the reimbursement standard used under Medicare – Title XVIII of the same statute – prior to the advent of the Prospective Payment System. The same words used in the same statute generally are given the same meaning and effect. Rowan Cos. v. United States, 452 U.S. 247, 250 (1981). Since GME unquestionably is a covered cost for hospitals under the Medicare "reasonable cost" reimbursement standard, it is deemed covered under the parallel terms of Title XIX of the same statute. Congress was clearly cognizant of the widespread use of Medicare cost reimbursement principles under Title XIX. For example, in a comprehensive survey of State Medicaid programs, the House Subcommittee on Health and the Environment noted that, with a few special exceptions, "[a]ll States use title XVIII standards for determining payments."²

From 1981 (when the Boren Amendment was enacted) until the Balanced Act of 1997 ("BBA") amendments,³ Section 1902(a)(13)(A) required the States to "assure" CMS that their rates are "reasonable and adequate" to cover the costs of "efficiently and economically operated hospitals" (taking into account "quality," "safety" and "access"). The Boren Amendment also granted the States broad discretion to determine the costs they deemed to be "reasonable and adequate" by authorizing rates "determined in accordance with methods and standards developed by the State[s]." It is universally understood that the Boren Amendment was intended to further enhance the States' flexibility to craft hospital reimbursement schemes, not to restrict or limit the items or services the States might cover under the preexisting version of Section 1902(a)(13)(A).⁴ The 1997 BBA amendments, which substituted the "public process"

² Data on the Medicaid Program: Eligibility, Services and Expenditures, Fiscal Years 1966-77, 95th Cong., 1st Sess., Comm. Print 95-10 at 19 (1977).

³ Pub. L. No. 105-33 (July 29, 1997).

⁴ As CMS observed in declining to adopt highly formulaic regulations to implement the Boren Amendment, States that paid hospitals based on Medicare allowable costs – which include

requirements for the requirement imposed under the Boren Amendment, were designed to give the States even greater latitude to determine which hospital costs to reimburse. This delegation of specific ratesetting authority nowhere excludes GME costs from the costs of facility services. CMS' current theory is incompatible with congressional intent to expand – not limit – the States' flexibility to define cost coverage for hospitals through the various amendments to Section 1902(a)(13)(A).

(ii) Congress Clearly Has Indicated Its View That GME is a Covered Cost Associated With the Services Provided by Teaching Hospitals

Perhaps most importantly, the central premise of the Proposed Rule that GME was not intended to be funded under Title XIX is contrary to the plain language of the Act and its legislative history. It is therefore unsustainable under the seminal decision in Chevron U.S.A. Inc. v. NRDC, Inc., 467 U.S. 837 (1984). In Chevron, the Supreme Court formulated the standards for judicial review of agency regulations that purport to interpret provisions of law. Under the first prong of Chevron, the courts must determine if “Congress has directly spoken to the precise questions at issue” in the regulation. 467 U.S. at 842. If Congress has so spoken, either in statute or the legislative history, “the agency must give effect to the unambiguously expressed intent of Congress.” Id. at 842-843. If Congress has not addressed the issue, a court must defer to the agency's regulatory interpretation, but only if it is “based on a permissible construction of the statute,” and represents a “reasonable” interpretation of the law, taken in context. 467 U.S. at 844, 845.

Congress has repeatedly made explicit its intention to cover under Title XIX the costs incurred by teaching hospitals, including GME. In the recently enacted Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006) (the “DRA”), Congress amended § 1932(b)(2) of the Act to provide for a “default rate” based on the “rates paid to hospitals under this title, when emergency services are furnished to Medicaid managed care patients by a provider that does not

GME – were already deemed to satisfy Section 1902(a)(13)(A), and the purpose of Boren Amendment “was to increase the States' administrative and fiscal discretion to set payment rates.” 48 Fed. Reg. 56046, 56047, 56048 (Dec. 19, 1983).

have in effect a contract with the patient's Medicaid managed care organization. Id. at § 6085. The rate Congress prescribed in 2006, effective January 1, 2007, is as follows:

The amounts (less any payments for indirect costs of medical education and graduation medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such [MCO] entity.

§ 1932(b)(2)(D) of the Act, 42 U.S.C § 1396u-2(b)(2)(A) (emphasis added). Were reimbursement by the States for GME (and IME) not authorized under Title XIX, there would have been no reason to exclude such payments from the amounts Medicaid managed care organizations must pay non-contracted hospitals under Section 1932(b)(2)(1). "It is an elementary rule of construction that effect must be given, if possible, to every word, clause and sentence in a statute," and that no clause or word should be "construed as superfluous, void or insignificant." Singer, Sutherland Statutory Construction, 6th Ed. (2000), § 46:06 at pages 181, 191 (and cases cited therein).

Congress, has thus "spoken directly" to the coverage of GME (and IME) under Medicaid in its most recent amendment of Title XIX, and left no doubt that it considers GME (and IME) to be payable by the states subject to federal matching under Title XIX. CMS' fundamental premise for the Proposed Rule, that GME is not meant to be covered under Title XIX, conflicts squarely with the plain terms of the Act, and thus fails under the first prong of Chevron. This provision in and of itself precludes CMS from going forward with the Proposed Rule as a matter of law, since it is founded on a premise that conflicts squarely with the plain terms of the Act.

Although the DRA amendment is dispositive, other legislative pronouncements strongly buttress the conclusion that the Proposed Rule conflicts with the statute and Congressional intent. As noted, in 1981, through the enactment of the Boren Amendment, Congress amended Section 1902(a)(13)(A) of the Act, 42 U.S.C. § 1396a(a)(13)(A) to afford the States even greater flexibility in formulating payment methods and standards for facility services, including the adoption of prospective payment systems that might be "reasonable and adequate to meet the costs" only of "efficiently and economically operated" hospitals. In liberalizing this standard

from one based on the retrospective payment of all reasonable costs, the Conference Committee went out of its way to underscore the importance of covering the costs of hospitals that provide medical education to ensure that Medicaid beneficiaries would not be denied access to the sophisticated, “tertiary” level of care that is the province of teaching hospitals. The Conference Committee relevantly stated:

The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rules.

H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, *reprinted in* 1981 U.S. Code Cong. & Admin. News 1010, 1324 (emphasis added).

Given the pains the conferees took to emphasize their concerns that Medicaid payments take into account the “special situation” that exists in “teaching hospitals,” it is inconceivable that Congress construed Title XIX as precluding coverage of GME (let alone IME). The “special situation” quite obviously, entails the added costs that “teaching hospital(s)” incur in the performance of “teaching.” That Congress assumed these costs would be covered is supported not only by the direct reference to GME and IME in § 6085 of the DRA of 2005, but by the fact that although numerous opportunities existed for Congress to state otherwise, no steps were ever taken over the past 40 years to indicate that Title XIX did not cover GME or to limit payment of such costs.

(iii) CMS’ Reinterpretation of Title XIX Would not Constitute a “Reasonable” One Under the Second Prong of Chevron Given the Legislative History and the Inconsistencies in CMS’ Position

Even putting aside Congress’ express description of GME as an expense that is reimbursable under Title XIX, the Proposed Rule could not pass muster as a “reasonable” interpretation of the statute under the second prong of Chevron. As noted above, Congress also has underscored its concerns about the importance of “teaching hospitals,” ensuring that the tertiary levels of care they deliver are available to Medicaid recipients, and the dependence of

teaching hospitals on Medicaid reimbursements. Page 5-6, *supra*. An intentional “cost shifting” of GME “teaching” expenses from Medicaid to other payers, which would flow from the Proposed Rule, is not reasonably reconciled with those stated concerns.

Moreover, the “reasonableness” of an agency’s interpretation of the law takes heavily into account whether that interpretation is one the agency has embraced on a consistent basis. See Thomas Jefferson Univ. v. Shalala (“TJU”), 512 U.S. 504, 516 (1994) quoting INS v. Cardoza-Fonseca, 480 U.S. 421, 446 n. 30 (1987) (stating that, while it need not be set in stone, “an agency’s interpretation of a statute or regulation that conflicts with a prior interpretation is ‘entitled to considerably less deference’ than a consistently held agency view”). There is a heightened allegation for agencies to justify a clear departure from longstanding agency norms. Verizon Commc’ns, Inc. v. FCC, 535 U.S. 467, 503 (2002). In contrast with the facts in TJU, there is no question here that “[CMS] has interpreted [the controlling law and regulations] in an inconsistent manner.” 512 U.S. at 515.

CMS’ own routine approvals of State Plans that cover GME, over a forty (40) year span, directly contradict the position espoused in the Proposed Rule. CMS approval of a State plan constitutes an official interpretation of the Act.⁵ CMS acknowledges in the Proposed Rule that “47 States and the District of Columbia reported using Medicaid funds to make GME payments under the Medicaid State Plan.” 72 Fed. Reg. 28932. Stated otherwise, CMS has approved at least 47 State Plans or State Plan Amendments that include GME among the allowable costs of hospital services – decades of agency action which it would now portray as *ultra vires* through a supposed regulatory “clarification” of the law.

⁵ See, e.g., Commun. Health Ctr. v. Wilson-Coker, 311 F.3d 132, 134 (2d Cir. 2002); S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 595-96 (5th Cir. 2004); Rite Aid of Pennsylvania v. Houstoun, 171 F.3d 842, 847 (3d Cir. 1999) (all holding that CMS approval of State Plan Amendment constitutes a determination that the SPA conforms to governing statutory and regulatory requirements); 42 C.F.R. §430.15(a)(1) (“Determinations as to whether state plans, including plan amendments, and administrative practices under the plans... meet the requirements for approval are based on relevant Federal statutes and regulations”).

CMS' inconsistency does not stop there. In comprehensively recodifying and amending the Medicaid managed care rules under Part 438 in 2002, CMS included a provision in the proposed rule (42 C.F.R. § 438.60) that would have precluded States from making payments directly to a provider for services provided under a contract with an MCO, PIHP or PAHP, except as otherwise provided for in statute or regulation. 66 Fed. Reg. 43614, 43666 (Aug. 20, 2001). Several commenters voiced concerns that this provision might preclude the States from directly paying providers GME on account of managed care patients. 67 Fed. Reg. 40989, 41004 (June 14, 2002). In response to the comments, CMS added a "new section 438.6(c)(5)(iv)," which requires States making payments for providers for GME costs under an approved State plan, "to adjust the actuarially sound capitation rates to account for the aggregate amount of GME payments to be made directly to hospitals on account of enrollees covered under the contract." 67 Fed. Reg. 41004-05 (emphasis added); accord 67 Fed. Reg. 41022-23. 42 C.F.R. § 438.60, as finalized specifically takes into account direct reimbursement for direct "payments for graduate medical education."

Thus, in sharp contrast with its 2007 "clarification" that payment for GME is "not authorized" under Title XIX, CMS in 2002 expressly and unqualifiedly referenced those GME payments in regulation, and further acknowledged that "GME payments have become a common payment practice in State Medicaid Programs." Ibid. In addition, CMS' reference to "GME payments on account of [Managed Care] enrollees" implicitly recognizes that GME is a cost related to the delivery of patient care.

In sum, CMS has a forty (40) year history of recognizing in multiple ways and contexts that GME is a valid and authorized expenditure under Title XIX. No change has occurred in the underlying law to remotely support the agency's complete reversal of field.

(iv) Case Law Further Supports the Conclusion that Coverage of GME is Authorized, if not Required, Under Title XIX

That GME is an allowable cost of hospital services under Title XIX also is consistent with judicial interpretations of the Act. Coverage of GME (and IME) under Title XIX was addressed directly by the U.S. Court of Appeals for the Third Circuit in West Virginia Univ.

Hosp. v. Casey, 885 F.2d 11 (3d Cir. 1989) (WVUH). In that case, a teaching hospital situated just across the border from Pennsylvania challenged Pennsylvania's use of differing payment methodologies for in-state and out-of-state hospitals. As an element of its claim, WVUH contended that Pennsylvania had violated the Act's requirement to pay "reasonable and adequate" rates to out-of-state hospitals by limiting GME payments to only those participating hospitals that are located in Pennsylvania. The Third Circuit agreed that Pennsylvania's bifurcated payment system, including its denial of reimbursement of GME expenses for non-Pennsylvania hospitals, "violates federal law." WVUH, 885 F.2d at 35. In arriving at this conclusion, the Court took cognizance of the Conference Report language that is quoted above, as well as the House Report which together "reflect great sensitivity to the special needs of teaching and tertiary care hospitals." 885 F.2d at 26.⁶

Recognizing that IME is an inherent part of the "operating costs" of teaching hospitals, the Court of Appeals concluded that GME costs – like capital expenses – also fall within the "reasonable and adequate" costs of rendering "patient care." The opinion pertinently states:

Teaching Hospitals, the District Court found and defendants do not contest, incur even greater costs than non-teaching hospitals in delivering the same service. 701 F. Supp. at 515. The court found that the bulk of a teaching hospital's direct medical education

⁶ House Rep. No. 158, 97th Cong., 1st Sess. 294, similarly states: "The Committee intends to recognize that facilities that provide teaching services . . . may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by States recognize the need to provide a full range of . . . tertiary care services to Medicaid beneficiaries . . ." These remarks reflect congressional concern about underpaying teaching hospitals, not the concern – espoused now by CMS – about a supposed overabundance of trained physicians. CMS construes the law as though Congress has expressed a desire to reduce physician training, but supports that supposition solely by reference to unattributed congressional sentiments gleaned from a 1994 OIG Report. 72 Fed Reg. 28932. Ironically, the very *OIG Report to which CMS points recognizes* that, "[s]ince the inception of the Medicare program, Medicare has shared in the allowable portion of reasonable costs hospitals incurred for GME" and that "*submitting legislation*" would be necessary to fundamentally change the statutorily protected status of GME payments. June Gibbs Brown, A Study of Graduate Medical Education Costs (A-09-93-00096) (July 28, 1994), at cover memo to Bruce Vladeck and pages 9, 18.

(GME) costs is made up of residents salaries. And ... residents spend about seventy-five percent of their time administering patient care. Thus, the court concluded, reimbursement of GME costs is in large part a reimbursement for patient care.

* * *

Pennsylvania recognizes that a teaching hospital will not be adequately reimbursed for its teaching function if it is reimbursed at a rate deriving from the average indirect costs of teaching and non-teaching hospitals. Moreover, Pennsylvania acknowledges that the GME costs will necessarily shift those costs to another payer, and the failure of all payers to compensate for GME costs will eventually cause serious financial problems for teaching hospitals."

WVUH, 885 F.2d at 27 (emphasis added); see also id. at 16 ("GME" is a type of "cost reimbursement" for "costs associated with Medicaid").⁷ While the Third Circuit did not expressly conclude that a state must always cover Medicaid's fair share of GME, it left no doubt whatsoever that GME is an authorized expenditure under Section 1902(a)(13)(A) of the Act which states may choose to cover and for which they may receive FFP.

Congress is deemed aware of judicial interpretation of federal law, and is deemed to ratify or acquiesce in such interpretations when it has the opportunity to amend the law to overcome a faulty interpretation but instead leaves the law intact.⁸ Here, Congress not only took no action to override the Third Circuit's understanding of GME coverage, it echoed and expressly ratified the understanding that reimbursement of GME (and IME) was covered in § 6085 of the DRA of 2005, *supra*.

⁷ See also Thomas Jefferson Univ. v. Shalala, 512 U.S. 504 (1984) at 507-508 (approved GME program participants "learn by both treating patients and observing other physicians do so" and "GME programs take place in a patient care unit"); at 513 ("the Secretary interprets the regulation [42 C.F.R. 413.85] to allow for costs of educational programs traditionally engaged in by hospitals"); and at 528-529 (Thomas, dissenting) (the "salaries" and costs of "teaching physicians" and support staff "would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care").

⁸ See Kay v. FCC, 443 F.2d 634, 646-47 (D.C. Cir. 1970); In re NBW Commercial Paper Litig., 826 F.Supp 1448, 1459 (D.C. Cir. 1992).

(v) The Provisions of Medicare Law Discussed by CMS Conflict With, Rather Than Support, the Proposed Rule

As an alternative basis for its drastic reinterpretation of what is reimbursable under Title XIX, CMS claims in the Proposed Rule that GME is not properly recognized as a “patient care cost” because GME is reimbursed separately under Medicare, rather than as part of hospital “operating costs” embodied in the Medicare DRG rates. 72 Fed. Reg. 28931-32. To support this thesis, CMS relies heavily on the fact that Section 1886(h) of Title XVIII excludes GME from the base DRG rates (which encompass a hospital’s operating costs). Even if it is assumed that GME is not an “operating cost,” this rationale would be flawed.

First, as the Third Circuit recognized in WVUH, *supra*, nothing in Title XIX limits FFP for hospital services to “operating costs,” and nothing in the Proposed Rule suggests that “capital” costs – which, like GME, historically were reimbursed separately from operating costs – are somehow not allowable elements of providing hospital services under Title XIX. Under an “operating cost” limitation, Title XIX would equally exclude authority to cover capital costs, which would be absurd. The crux of the issue is not whether GME is an “operating cost,” but whether is a reasonable cost related to the provision of patient care by a “teaching hospital.” In fact, the very provision of the Act on which CMS relies *confirms* that GME is a reasonable and allowable cost of providing inpatient services.

Since the very inception of the Medicare program,⁹ Congress provided for coverage of the allowable portion of direct costs of approved medical education programs based on the premise that “these activities enhance the quality of care in an institution.”¹⁰ Until the adoption of the prospective payment system (“PPS”) in 1983, GME was included in Medicare cost reports in precisely the same manner as all other allowable costs of patient care. As the OIG has recognized, “[d]irect GME costs include salaries and fringe benefits for I&Rs, [and] teaching

⁹ See OIG Report No. A-09-93-00096 at 9

¹⁰ H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965); see also Report to Congress, Rethinking Medicare’s Payment Policies for Graduate Medical Education and Teaching Hospitals at 4 (Aug. 1999).

physicians time spent supervising I&Rs in patient care services not billed [under Part B].”¹¹ The “allowable” portion of reasonable costs [of] hospitals for GME “do not include the portion of [D]GME costs allocated to research, nursery and other nonreimbursable costs centers.”¹²

With the advent of PPS in 1983, Congress initially retained GME as a pass-through paid on the retrospective, reasonable cost basis. Beginning with FY 1986, Section 1886(h) of the Act established the prospectively determined, average per resident amount (“APRA”) as the basis for reimbursing GME, in lieu of the prevailing retrospective, cost based pass through payments. Although CMS suggests that GME was separately authorized by Sections 1886(h) and (k) of Title XVIII of the Act – which have no counterpart in Title XIX – the coverage of GME as an allowable cost of patient care long preceded the enactment of these provisions, which merely provided for a prospective payment system for GME under Medicare. The creation of a prospective payment system for GME closely paralleled the use of a prospective DRG system for operating costs. The fact that GME was broken out from the base DRG rates under Section 1886(h) of Title XVIII was unrelated to the nature or character of GME as a patient care (or hospital) service, as the Proposed Rule suggests. Rather, a separate prospectively determined APRA was utilized in addition to the prospective base DRG rates because Congress decided to pay for GME on a prospective basis and established a prospective payment formula for GME that is different from that used to reimburse those costs included with the DRG rates.

Significantly, Section 1886(h)(l) begins by stating: “Notwithstanding section 1861(v), instead of any amounts that are other payable under this Title [XVIII] with respect to the reasonable costs of hospitals for direct graduate medical education costs [GME shall be reimbursed based on a fixed APRA].” (Emphasis added.) In other words, in limiting GME payments going forward under the APRA system to amounts that might not fully cover the Medicare’s fair share (allocation) of those costs, Congress created an express *exception* for GME from the rule of Section 1861(v) to pay Medicare’s full share of hospital patient care costs, and

¹¹ OIG Report A-09-93-00096, *supra* at 2

¹² Id. at 9

against cost shifting.¹³ Obviously, Congress viewed, and continues to view GME, as among the allowable costs of patient care encompassed by Section 1861 and to which the Medicare anti cost-shifting rules apply in the first place. Otherwise, it would have had no reason to except GME from the operation of Section 1861 in Section 1886(h)(1). Thus, a proper reading of Section 1886(h), in conjunction with Section 1861, refutes the very proposition CMS seeks to support by its reference to that provision by making clear that GME *is* a cost of patient care.

Congress also underscored its support for paying GME to providers under the Act through its enactment of § 4624 of the BBA. In amending Title XVIII by adding Section 1886(h)(3), Congress provided in the BBA for the removal of GME from the capitation payments made to Medicare Advantage Plans and provided, instead, for the direct payment of GME to hospitals on account of managed care patients by the hospitals' regular Medicare fiscal intermediaries. See also 62 Fed. Reg. 29901, 29938 (June 2, 1997) (CMS recognition of the need to remove IME and GME funding from the capitation pool in order to ensure these funding streams were paid directly to teaching hospitals).

CMS has also made clear its own understanding that GME represents a reasonable cost of providing care to hospital patients in adopting its regulations governing teaching physician reimbursement under Part B of Medicare, 42 C.F.R. § 415, *et. seq.* Those rules were formulated to limit the circumstances under which teaching physicians might separately bill Part B for rendering professional services to Medicare beneficiaries. They were designed to avoid "double dipping" owing to the fact that hospitals receive GME payments under Part A which in large part already compensates them for medical services provided to patients by interns and residents under the supervision of teaching physicians, both of whose salaries (for these patient care

¹³ See also Mercy Catholic Medical Center v. Thompson, 380 F.3d 142, 145 (3d Cir. 2004) (noting that "Medicare has paid its full pro rata share of all allowable graduate medical education costs and operating costs actually incurred [by teaching hospitals], consistent with the statutory requirement preventing shifting the costs of services incurred on behalf of Medicare beneficiaries to other patients and third party payers. 42 U.S.C. § 1395x(v)(1)(A) (emphasis added)"). As the Mercy case also discusses, CMS required intermediaries to reaudit the FY 1985 APRA "base year" costs owing to the fact that hospitals often classified operating costs, and costs that were properly reportable under the intern and resident cost centers interchangeably.

services) are funded by GME payments. In the preamble to the Final Teaching Physician Regulations, CMS observed as follows:

It is important to distinguish between the services of interns and residents and the services of teaching physicians. Medicare fiscal intermediaries pay teaching hospitals for the services of interns and residents. Those services are described in sections 1861(b) and 1832(a) of the Act and are paid under the methodology established by section 1886(h) of the Act. Thus, the fiscal intermediaries are already paying teaching hospitals for services furnished to beneficiaries by residents . . . (emphasis added).

60 Fed. Reg. 63124, 63144 (col. 2) (Dec. 8, 1995). Accord id. at col. 1 (noting that, “contrary to the commenter’s suggestion, teaching activities related to patient care were, or could have been included in the Part A base year costs”). The assumption in the Proposed Rule that GME expenses are not a cost of medical services is, therefore, also completely contrary to the basic premise of this entire chapter of Medicare regulations.

(vi) The Proposed Exclusion of GME Costs From the UPL Calculations Lacks a Reasonable Basis

The Proposed Rule also would correspondingly modify the upper payment limit (“UPL”) regulations at 42 C.F.R. § 447.272 and § 447.321 to exclude consideration of GME. CMS directly ties this proposed limitation to its assertion that payment of GME conflicts with Section 1902(a)(30)(A) of the Act, which provides that Medicaid service rates must be “consistent with economy, efficiency, and quality of care.” This proposal, however, focuses on the “economy” requirement to the exclusion of the “quality” requirement of Section 1902(a)(30)(A).

Heretofore, CMS always has construed the UPL rules – for which CMS has expressly relied on Section 1902(a)(30)(A) as its underlying authority¹⁴ – to require payments that are consistent with efficiency, economy, and quality, and therefore encompassing all “amounts that would be paid . . . under Medicare judgment principles in subchapter B of this chapter.” 42

¹⁴ 42 C.F.R. §§ 447.200 and 447.300 (both identifying Section 1902(a)(30)(A) as the basis for Subparts B and F).

C.F.R. §§ 447.272(b) and 447.321(b). Costs “paid under Medicare, and under subchapter B plainly include all costs recognized under Section 1861(v) of the Act, not just “operating” costs.

This longstanding interpretation is consistent with Section 1861(v) of the Act and the “reasonable cost” regulations published in Part 413 of the Code of Federal Regulations. 42 C.F.R. 413.9 includes “general principles” for ascertaining what Medicare regards as the “cost of service . . . related to the care of beneficiaries.” Subsection (b) states that this includes “both direct and indirect costs of providers of services” and prohibits cost coverage methodologies under which “the [provider’s] costs with respect to individuals covered by the program will not be borne by individuals not so covered,” and vice versa. Under the same Part of the regulations, CMS lists specific categories of properly covered costs which *specifically include* GME. 42 C.F.R. § 413.75 *et seq.*

Thus, CMS has always rightly treated GME as an appropriate, patient-care related cost of hospitals under Medicare, and – through the use of UPLs to set aggregate payment limits – under Medicaid. If anything, the UPL concept incorporates an expansive liberal view of what costs would be payable under Medicare, not the highly restrictive and subtractive view that would be taken – based on an erroneous and novel assumption of limits inherent in Section 1902(a)(30)(A) – under the Proposed Rule.¹⁵

Moreover, GME has been included in approved State Plans from the inception of the program, and the UPL regulations which include Medicaid coverage of GME costs under the authority of Section 1902(a)(30)(A), have been in effect for twenty (20) years. Congress is presumed to be aware of agency interpretations of federal law, and the failure to amend a law to overturn a stated agency interpretation amounts to a congressional ratification of the same. See Zemel v. Rusk, 381 U.S. 1 (1965); Bob Jones Univ. v. United States, 461 U.S. 574, 599-600 (1983); Haig v. Agee, 453 U.S. 280, 300-301 (1981); United States v. Board of Comm’rs of

¹⁵ See, e.g., HHS Departmental Appeals Board Dec. No. 1578 (May 29, 1996), *reprinted in Medicare & Medicaid Guide (CCH)* ¶ 44, 484 (recognizing that, for purposes of UPLs, Medicare cost reimbursement principles are to be liberally construed, and may be applied without TEFRA limits on allowable costs).

Sheffield Alabama, 435 U.S. 110, 134 (1978). Congress was well aware of the UPL regulations.¹⁶ Because Congress has repeatedly amended Title XIX – including amendments (such as the amendments to Section 1923) expressly limiting allowable costs – without taking steps to preclude Medicaid reimbursement for under well worn reasonable cost principle, or to exclude GME from UPLs, it is deemed to have ratified the coverage of GME and CMS’ prior and less restrictive version of the UPL regulations.

CMS’ central assumption that Title XIX covers only hospitals’ “operating costs” also conflicts directly with positions taken by CMS on closely related issues. While the Proposed Rule would disavow GME as an allowable cost under Medicare on this basis, CMS recently has taken the opposite position in its implementation of hospital-specific Medicaid disproportionate share hospital (“DSH”) limits under Section 1923 of Title XIX. Added to the Act by the Omnibus Budget Reconciliation Act of 1993, Section 1923(g)(1) limited hospital-specific DSH payments under a State Plan to “uncompensated costs,” including costs of treating Medicaid patients that are unmet by medical assistance reimbursement. Under the more recently enacted Section 1923(j)(2) of the Act, States were required to audit the uncompensated care costs used to set the hospital-specific DSH limits including the unpaid allowable costs of Medicaid patient.

In implementing these provisions, HHS has issued a series of guidance to the states to underscore CMS understanding that at least those costs that were allowable under Medicare are considered allowable costs under Title XIX. In her widely disseminated August 17, 1994 “Dear Medicaid Director” communication, Sally K. Richardson, Director, Center for Medicaid and State Operations, advised that “the legislative-history of this provision makes it clear that States may include both inpatient and outpatient cost in the calculation of the limit [of the Cost of services to Medicaid Patients]” and that Medicaid costs are properly determined “under the Medicare principles of cost reimbursement.” Id. at page 3. CMS (then HCFA) stated it:

¹⁶ See, e.g., Hearing Before the Sen. Comm. on Finance, 106th Cong., 2d Sess. (Sept. 6, 2000) at 6, 8, 20, 29, 40 (expressly reviewing UPL rules and acknowledging their incorporation of Medicare cost reimbursement principles).

Believes this interpretation of the term “costs incurred” is reasonable because it provides states with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.

Id. The understanding that any costs that may be claimed on a Medicare cost report are regarded as allowable costs under Title XIX is also memorialized in Office of Inspector General audits under Section 1923. See, e.g., A-05-01 00099 (Audit of Payments to Univ. of Ill. at Chicago Hospital; Oct. 13, 2004); A-09-00054 (Audit of California; May 29, 2003).

The Proposed Rule offers no viable, reasoned explanation of why the same costs recently proclaimed to be allowable costs of medical assistance for purposes of calculating hospital-specific DSH limits under Section 1923 of the Act by both CMS and the OIG are, suddenly, not allowable costs under Title XIX. Accordingly, and for the above reasons, the Proposed Rule, including the proposed amendment of the UPL provisions, would not pass judicial muster even under the second prong of Chevron.¹⁷

(vii) It Would Be Even More Inappropriate for CMS to Modify its Treatment of IME

Finally, the Proposed Rule also solicits comments about the propriety of potentially excluding IME costs from the Medicare-based UPLs used to limit aggregate hospital payments under Title XIX. We comment briefly on this point, which goes beyond CMS’ current rulemaking proposal, out of an abundance of caution.

In short, excluding IME costs from the UPL calculations would be even more untenable than the proposed change in treatment of GME. First, Section 6085 of the DRA of 2005 also explicitly reflects Congress’ view that IME is an allowable expense under Title XIX. Further, the case law and relevant legislative history discussed above is particularly emphatic about the obligations of the States to consider the indirect impact of operating teaching programs on

¹⁷ See also Motor Vehicles Manuf. Ass’n. of the United States v. State Farm Mutual Ins. Co., 463 U.S. 29, (1983) (overturning Department of Transportation’s regulatory about face on airbag and passive safety belt standards).

hospital operating costs. The House Report that accompanied the initial 1981 amendments to Title XIX mentioned expressly Congress' intention that Medicaid payments account for the fact that teaching hospitals "have operating costs which exceed these of a community hospital."¹⁸ IME adjustments have long been the traditional means for quantifying the impact of teaching activities on "operating costs," and CMS has conceded as much in "distinguish[ing] direct GME payments from indirect medical education (IME) payments because IME payments (as defined under Medicare payment principles) represent an additional Medicare payment for health care services provided to Medicare beneficiaries in teaching hospitals." 72 Fed. Reg. at 28932 (col. 2).¹⁹ Finally, CMS' own rationales offer no discernable basis to conclude that IME expenses are not authorized expenditures under Title XIX. On the contrary, CMS largely justifies excluding coverage of GME because it is excluded from the Medicare DRG rate which contains "operating costs." This rationale leads inexorably to the conclusion that IME is allowable as a cost of hospital care because it *is* a factor contributing to the operating costs of teaching hospitals.

Aside from these substantive bars, CMS could not in any case properly amend the IME coverage standards under the current rule as a procedural matter. A final rule must be a "logical outgrowth" of a proposed rule.²⁰ The actual scope of the Proposed Rule, and CMS' stated basis for excluding coverage, to which the commenters are responding, extends only to GME costs. If CMS were to issue a final rule that also restricted FFP relating to IME without first publishing a rule that actually proposed taking such action, it would violate the notice and comment rulemaking requirements of 5 U.S.C. § 553(b). A final rule that were to modify Medicaid's treatment of IME costs would not comprise a logical outgrowth of the Proposed Rule both because CMS has only actually proposed altering coverage of GME, and because, as noted, it

¹⁸ See H.R. Rep. No. 158, quoted at page 11 above.

¹⁹ As Congress observed in creating the DRG system, the IME adjustment is used as a proxy to account for a number of factors which legitimately increase operating costs in teaching hospitals. House Ways and Means Comm. Rep. No. 98-25 (March 4, 1983); Sen. Finance Comm. Rep., No. 98-23 (March 11, 1983). See also R. Schweiker, Report to Congress: Hospital Prospective Payment for Medicare (Dec. 1982) at 48-49.

²⁰ See, e.g., Environmental Integrity Project v. EPA, 425 F.3d 992, 998 (D.C. Cir. 2005); Small Refiner Lead Phase-Down Task Force v. EPA, 705 F.2d 506, 546-47 (D.C. Cir. 1983)

would be contrary to the central premise of the Proposed Rule that Medicaid plainly *should* cover a hospital's "operating costs."

CMS, moreover, cannot avoid its notice and comment obligations under the APA on the basis that a change to the standards pertaining to IME are merely interpretative rules that may be published in final form under Section 553(b). Full notice and comment procedures and an amendment of the underlying regulation *is required* before an agency may reverse a clearly articulated prior interpretations.²¹ CMS has apparently recognized as much in publishing a Proposed Rule to re-interpret whether allowable costs under Title XIX encompasses GME.

Conclusion

For the reasons stated above, we believe that coverage of GME (not to mention IME) costs incurred by hospitals is clearly authorized under XIX as a cost of patient care, as Congress has clearly recognized on numerous occasions. CMS does not have discretion under the Act to refuse to federally match State expenditures for medical education as part of their medical assistance programs. Rather, the elimination of FFP for GME expenses at this juncture would require an amendment of the Act itself. Because its proposal to amend the UPL regulations is founded on the same misperceptions about Title XIX, and is a radical but inexplicable departure from established agency norms, that proposal would fail for lack of a sustainable, reasonable basis.

²¹ See, e.g., Sweet v. Sheehan, 235 F.3d 80, 90 (2d Cir. 2000); Paralyzed Veterans of America v. D.C. Arena, 117 F.3d 579 (D.C. Cir. 1997); Mt. Diablo Hosp. v. Bowen, 860 F.2d 951 (9th Cir. 1988); Nat'l Med. Centers v. Shalala, 826 F. Supp. 558 (D.D.C. 1993).

**AMERICAN OSTEOPATHIC ASSOCIATION
AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE**

June 22, 2007

The Honorable Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: Medicaid Program: Graduate Medical Education
72 Fed. Reg. 28930 *et seq.* (May 23, 2007) (CMS-2279-P)

Dear Administrator Norwalk:

On behalf of the nation's 59,000 osteopathic physicians and more than 12,000 osteopathic medical students, the AOA appreciates this opportunity to comment on the agency's proposed "clarification" of long-standing Medicaid policy on graduate medical education (GME). If finalized, this proposal would prohibit certain costs and payments associated with GME programs from being considered expenditures for medical assistance that are federally reimbursable under the Medicaid program. The proposal also seeks to amend current regulations to preclude counting direct graduate medical education (DGME) costs when calculating the upper payment limit (UPL) for Medicaid for inpatient hospitals.

Title XIX of the Social Security Act (Act) authorizes federal grants to states for the Medicaid program, which provides medical assistance to low income families, the elderly and persons with disabilities. In accordance with the statute, federal financial participation (FFP) is available to the states for a percentage of the amounts "expended . . . for medical assistance under the State plan." Although GME is not explicitly included in the list of "care and services" that may, or must, be provided under a state Medicaid plan, the vast majority of states use Medicaid funds to make GME payments, either by including these payments in per diem inpatient hospital rates, through supplemental payments, or both supplemental and per diem payments.

Teaching hospitals provide care and expand access for Medicaid beneficiaries in hospital emergency departments, outpatient facilities, continuity clinics, and other inpatient and ambulatory settings. Since Medicaid's inception, the states have recognized the nexus between medical education and high level care for beneficiaries by including GME as a component of Medicaid payment for inpatient and outpatient services. The proposed rule would reverse this long-standing policy, adversely affecting beneficiaries, GME, teaching hospitals and the valuable medical care and services they provide.

Medicaid has recognized DGME as a covered cost of providing hospital services and patient care for decades. There is nothing in the Act that compels the radical change in agency policy this proposal represents. Indeed, based on the Act, Congressional intent and interpretative case law, only Congress has the power to deny federal matching funds for medical assistance and services included in approved state plans. Without Congressional action, the Centers for Medicare and Medicaid Services (CMS) has an affirmative obligation to provide a federal match for the amounts the states expend for the costs of medical assistance under their approved Medicaid plans.

Expenditures for DGME clearly fall within the costs of hospital services under Medicare. As the history of the program demonstrates, Medicaid adopted payment concepts from Title XVIII. The states are accorded great flexibility in designing their state plans, which are submitted to CMS for review. CMS has approved state Medicaid plans that cover DGME expenditures routinely for more than 40 years. These approvals constitute official interpretations of the Act. The agency cannot now "clarify" its regulations in a way that negates these actions in order to reduce the UPL and deny the states federal matching funds for a recognized cost of providing hospital services.

CMS attempts to distinguish between DGME and indirect medical education (IME) costs on the grounds that the former are not hospital operating costs nor are they separately enumerated as services in the Medicaid statute. It is inconsequential whether DGME is separately enumerated as a "health care service." Federal financial participation is authorized for funds "expended for medical assistance under a state plan." CMS has an affirmative obligation to provide a federal match for state expenditures for services covered under Title XIX.

Whether or not DGME is an "operating cost" also is irrelevant for Medicaid purposes. Nothing in Title XIX limits FFP for health care services to "operating costs." The issue is not whether DGME is an "operating cost" but whether it is a reasonable cost of providing hospital services. Similarly, there is no reasonable basis for excluding DGME from UPL calculations, which are governed by regulations that have been in effect for 20 years. Under these regulations, UPL calculations include all costs recognized in the statute, not just "operating costs."

At a time of increasing concern about whether the number of physicians will be adequate to address the health care needs of the nation, this proposal is ill-conceived and short-sighted. If implemented, it threatens to hurt Medicaid beneficiaries, reduce access to care, impair educational quality and exacerbate physician supply and distribution problems that could haunt the nation for decades to come.

Congress recognized the importance the states place on supporting GME by enacting a one-year moratorium on the implementation of this proposal one day after the proposed rule was published in the Federal Register. In accordance with the moratorium, the agency is prohibited from taking any action to promulgate or implement "any rule or provisions" that would restrict Medicaid payments for GME for one year.

For the reasons set forth in this letter and the attached Memorandum, the AOA respectfully recommends that CMS rethink this misguided proposal, following Congress' lead by foregoing implementation on a permanent basis.

The Hon. Leslie V. Norwalk
June 22, 2007
Page 3 of 3

Thank you for your consideration of our concerns.

Sincerely,

John A. Strosnider, DO

John A. Strosnider, DO
President, AOA

Stephen C. Shannon

Stephen C. Shannon, DO, MPH
President and CEO, AACOM

Cc: Peter B. Ajluni, DO, President-Elect
Silvia M. Ferretti, DO, Chair, AACOM Board of Deans
Marcelino Oliva, DO, Chair, Bureau on Federal Health Programs
John B. Crosby, JD, AOA Executive Director
Sydney Olson, AOA Associate Executive Director
Shawn Martin, AOA Director, Department of Government Relations
Michael J. Dyer, JD, AACOM Vice President for Government Relations
Margaret J. Hardy, JD, AOA Director, Hospital and Medical Educator Affairs

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June 22, 2007

Centers for Medicare & Medicaid Services
Room 445-G, Hubert H Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-2279-P

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule, "Medicaid Program; Graduate Medical Education" (72 FR 28930, May 23, 2007). AHIP is the national association representing nearly 1,300 member companies providing health coverage to more than 200 million Americans. This proposed rule could have a significant effect on AHIP's member organizations, many of which contract with State Medicaid agencies to provide coverage to beneficiaries under State Medicaid managed care programs. We note that Section 7002(a)(1)(C) of the supplemental appropriations bill signed by the President on May 25, 2007 prohibits implementation of the provisions of this proposed rule for one year but that such rules could be implemented after that time.

Comments

AHIP's member organizations have demonstrated their commitment to meeting the health care needs of Medicaid beneficiaries through their longstanding participation in State Medicaid programs. We believe strongly in ensuring sufficient funding for State Medicaid programs to promote the availability and accessibility of services for Medicaid beneficiaries whether they are enrolled in Medicaid health plans or receiving services through Medicaid fee-for-service programs. We are concerned that the proposed rule has the potential to disrupt funding to State Medicaid programs, particularly funding for safety net providers.

We are further concerned that the proposed rule could have the potential to hinder beneficiary access to Medicaid health plans. Many states have incorporated payments for GME into Medicaid health plan rates. By reducing the availability of federal matching funds, the proposed rule therefore could reduce funding for state Medicaid managed care programs and as a consequence, beneficiary access to these health plans. Medicaid health plans have a demonstrated record of improving health care access and quality for Medicaid beneficiaries

June 22, 2007

Page 2 of 2

while ensuring that the federal government and state Medicaid programs receive the highest possible value for the dollars they spend on health care.

The concerns discussed above grow out of our assessment that the implementation of revisions to the regulations as proposed by CMS could result in a significant reduction in overall funding available for State Medicaid programs. In the regulatory impact statement (72 FR at 28934), CMS projects that the proposed rule would reduce Federal Medicaid funding by \$140 million in the first year and \$1.78 billion in federal expenditures over five years. However, we believe this estimate may be understated because it does not reflect changes to the calculation of upper payment limits to hospitals under the recently published final rule revising the upper payment limit rule (72 FR 29748, May 29, 2007). Moreover, when combined with the estimated \$3.78 billion reduction in federal funding that is estimated to result from this final rule, the proposed GME rule could significantly affect state Medicaid programs and their ability to maintain coverage of health care services critical to Medicaid beneficiaries.

AHIP strongly urges CMS to reconsider the impact of these changes on States, beneficiaries, and affected providers and to reevaluate the approach reflected in the proposed rule. If CMS nonetheless determines that matching funds for GME will be eliminated, we strongly recommend that the agency provide a period of transition to enable States and providers to prepare for the changes so as to minimize any disruptions to the program and to beneficiaries.

We appreciate the opportunity to provide comments. If you would like to discuss any of the issues we have raised or would like additional information, please contact me at (202) 778-3209 or at cschaller@ahip.org.

Sincerely,



Candace Schaller
Senior Vice President, Federal Programs



4802 Tenth Avenue
Brooklyn, NY 11219

Tel: 718 283-6009
Fax: 718 283-8814

www.maimonidesmed.org

Pamela S. Brier
President
& Chief Executive Officer

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 Maimonides 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).

Maimonides Medical Center is the most tertiary medical center in Brooklyn, New York and one of the nation's largest independent teaching hospitals. Finalizing this rule would seriously erode the financial condition of the Medical Center and thereby jeopardize our ability to offer high quality graduate medical education *and* fulfill our patient care responsibilities as a major community-based specialty care hospital.

The proposed rule reverses long-standing Medicaid policy. Since the program's inception, New York and most other state Medicaid programs have supported the higher costs of teaching hospitals with enhanced reimbursement rates. At the federal level, CMS (and before that HCFA) have routinely approved these reimbursement methodologies and authorized federal financial participation for GME. In 2006, Maimonides Medical Center received \$31 million in Medicaid GME reimbursement.

With 23 residency programs, Maimonides trains more than 400 medical students and residents every year. These medical students and newly graduated doctors work under the supervision of more than 300 full-time faculty physicians with academic appointments.

We offer 20 fellowships and graduate-level physician-training opportunities in such growing fields as interventional cardiology, geriatric medicine and interventional neuroradiology. While maintaining a broad spectrum of specialty training, Maimonides has also made a major commitment to primary care programs. We are dedicated to preparing residents for a lifetime of medical practice that meets the highest professional standards.

Today, Maimonides Medical Center has the largest physician-training program in Brooklyn. Many of our graduates continue to practice in the borough. Thus, our education efforts “grow our own” and help maintain access to the highest quality medical care for 2.5 million Brooklyn residents.

Payments for graduate medical education through Medicaid are essential to sustaining these academic medical programs. Eliminating GME payments would, quite simply, cripple our residency training programs at a time when there still are many underserved neighborhoods in Brooklyn, throughout New York City and elsewhere in the nation.

Not only would this proposal seriously compromise our ability to train physicians, the elimination of this funding would undermine our ability to provide critical medical services to the Medicaid population living in the communities we serve. We now treat 12 percent of Brooklyn’s Medicaid population. One quarter of our inpatients are over age 75 and half of these elderly patients are dually eligible for Medicare and Medicaid. In 2006, there were 98,000 Medicaid-funded outpatient clinic visits and 46,000 Medicaid-funded emergency room visits.

Moreover, since our service delivery integrates the treatment of Medicaid patients with all other patients, the ripple effects of a \$31 million reduction in Medicaid funding would go well beyond services to the Medicaid population.

With sound fiscal management, Maimonides has managed to operate with a slight surplus each year (less than a one percent of our total budget). Our fiscal stability and commitment to clinical excellence and community service allow us to continue to support a broad range of critically important medical services for all our patients. For example:

We deliver more babies than any other hospital in New York State.

Our Infants and Children’s Hospital is fully accredited as a “children’s hospital within a hospital,” one of only three such facilities in New York City. Maimonides is the sub-specialty care hub for a regional pediatric care system, delivered in partnership with Lutheran Medical Center and Coney Island Hospital. Primary and community hospital services are available at each facility, and highly specialized services, such as neonatology, pediatric surgery, genetics and orthopedics, are concentrated at Maimonides.

The emergency department logs in more than 90,000 patient visits each year and is the entry point for medical crises in southern Brooklyn. We provide critically ill patients with the most advanced critical care through our Stroke Center, Cardiac and Vascular Institutes.

Our ambulatory care, community mental health, rehabilitation and other outpatient clinics provide more than 210,000 visits, procedures and therapies annually.

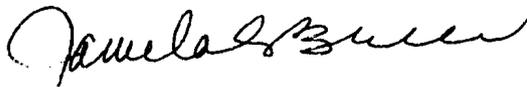
More than 50,000 people are diagnosed with some form of cancer each year and the number of cancer cases is projected to increase over the next twenty years. To meet the growing need, Maimonides has just opened the only dedicated, comprehensive cancer center in Brooklyn. We built a state-of-the-art facility, recruited stellar physicians and now offer the most advanced care to Brooklyn patients.

The CMS proposal, if finalized and implemented, jeopardizes these and many other critically important services. It would create a fiscal crisis for Maimonides Medical Center at the very time when the population and disease burden in the communities we serve is growing. This would ill serve our Medicaid patients and their access to essential medical care.

For all these reasons, I join with my other colleagues in teaching hospitals across the nation to oppose this proposed rule. Given our vitally important teaching and service roles and the financial uncertainty for America's teaching hospitals, it is imperative that state Medicaid programs continue to receive federal matching assistance for Graduate Medical Education.

I urge CMS in the strongest terms to rescind the proposed rule.

Sincerely,

A handwritten signature in cursive script, appearing to read "Pamela S. Brier".

Pamela S. Brier



June 20, 2007

Ms. Leslie V. Norwalk, Esq., Acting Administrator
 Centers for Medicare and Medicaid Services
 Department of Health and Human Services
 Attention: CMS-2279-P
 P.O. Box 8016
 Baltimore, MD 21244-8016

Dear Dr. Norwalk:

Thank you for the opportunity to provide commentary on CMS-2279-P. I am writing as Chair of the Graduate Medical Education, Inc. (GMEI) Board of Directors to share our concerns and to request reconsideration of your reinterpretation of Medicaid's role with regards to graduate medical education (GME) funding. First, the proposed rule will cut funding and resources for teaching hospitals and residents who provide a large portion of healthcare services to the Medicaid population. Second, the Federal cuts will shift financial responsibility to States, local governments and health systems. Finally, our nation's healthcare system faces a physician shortage that will require an increase in resident training and thus additional GME funding. The cuts proposed by CMS-2279-P will counteract efforts aimed at resolving the expected physician shortage. This is especially true for the state of Michigan, which trains a substantial number of residents that provide healthcare services across the nation.

GME is a fundamental component of providing quality health services, especially to Medicaid and underserved populations. According to the Association of American Medical Colleges (AAMC), 6% of the nation's hospitals are teaching hospitals, yet they provide 40% of the nation's hospital charity care. The Council of Teaching Hospitals and Health Systems (COTH) institutional members contribute significantly to the care of Medicaid beneficiaries. An AAMC survey found that approximately 26 percent of the nation's Medicaid discharges are from COTH hospitals. Additionally, the Department of Justice considers residents to be employees who provide patient care for about 74 hours of the resident's allowable 80 hour work week. This further illustrates that residents spend a substantial part of their time caring for Medicaid and underserved populations through their residency programs. MHA data shows that Residents provide the care for 75% of the State's Medicaid and indigent patients.

CMS-2279-P estimates the proposed cut at \$140 million in funding for GME programs for fiscal year 2008. We submit that this is a gross underestimate of the true impact of CMS-2279-P, if this policy is implemented and state dollars directed toward GME go unmatched by Medicaid. In Michigan alone, teaching hospitals stand to lose \$95.8 million. How could the estimate of \$140 million nationally be accurate if one state accounts for 68% of the expected savings in the first year of implementation?

The loss of \$95.8 million represents 57% of all Medicaid money being directed to GME that enables the residencies to operate and care for the State's indigent. This will have a dramatic impact on

teaching hospitals' abilities to provide care to Medicaid and underserved populations. While CMS suggests that the lost Federal dollars could be replaced by funding with State-only dollars (21), this is highly improbable in Michigan. Michigan's economy is in a state of crisis and is unlikely to have the means to finance additional GME program needs with State dollars at this time. The loss in federally matched dollars reduces funding for Michigan GME programs by about \$96 million. In a state with an estimated 1.5 Billion dollar revenue shortfall projected in the next fiscal year, there is no mechanism for the State to make up this shortfall.

Furthermore, CMS-2279-P states: "For purposes of Executive Order 13132, we find that this rule will not have a substantial effect on State and local government" (23). On the contrary, any reduction of funding to GME programs is a substantial burden to States, local governments, and health systems that will ultimately deal with the repercussions of poorly funded GME programs. Health systems, in particular, will be forced to realign their resources to lower cost training programs and reduce or even eliminate more expensive programs such as Family Practice and OB/GYN.

CMS-2279-P clarifies that States are not required to fund GME programs (22). Passing the responsibility of funding GME programs to local healthcare systems increases the burden to our communities. For example, one teaching hospital in the Lansing area indicates that the cost of current GME programs exceeds the direct medical education (DME) payments. This hospital has chosen to redirect part of the indirect medical education (IME) funding to subsidize DME expenses. Implementation of the new rule would result in expending 100% of the IME on DME expenses. Thus, this teaching hospital will no longer be subsidized for indirect expenses, which include the availability of specialized services and treatments and providing care for sicker patients. As mentioned previously, we are concerned that a reduction in funding of this magnitude will result in a reduction of residency and fellowship slots, particularly in the more expensive programs such as Family Practice and OB/GYN.

Compounding this problem is the projected national physician shortage, which will be especially burdensome to the State of Michigan. The Blue Ribbon Physician Workforce Committee found that although Michigan is the 7th largest 'teaching hospital' state, we are losing physicians to warmer climates and stronger economies in other areas of the country. The benefits of GME programs to Medicaid and underserved populations reach beyond state borders; therefore, the responsibility of funding GME programs should not be passed from the Federal government to State and local governments or healthcare systems.

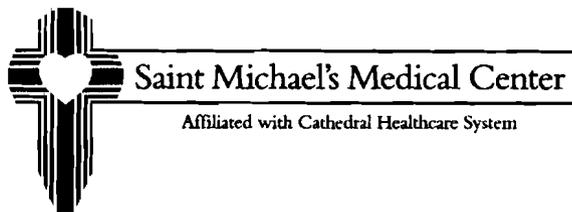
It is recommended that CMS reassess the true financial burden imposed upon GME programs by the CMS-2279-P proposal and the effects that the reduction in funding will have on the quality of health services provided to our communities, especially for our nation's disadvantaged population.

Thank you for your attention.

Sincerely,


William P. Gifford, MD
President, Board of Directors
GMEI, Inc.

Rec'd
6/26/07
A



June 22, 2007

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

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

Dear Ms. Norwalk:

On behalf of our employees, physicians, and patients, Cathedral Healthcare System appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rulemaking changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs. As you know, the proposed rule is subject to a year- long moratorium secured by P.L. 110-28.

Cathedral Healthcare System believes that the moratorium should preclude 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, Cathedral Healthcare System is submitting these comments with strong opposition to the policy changes proposed in this rule.

The proposed rule substantially departs from long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs. Although CMS claims this rule clarifies existing GME policy, it completely reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The agency's recent decision will result in a cut of nearly \$2 billion in federal funds out of the program. **If these cuts to state Medicaid programs are finalized, many safety-net hospitals, such as Saint Michael's Medical Center, will face financial jeopardy. This will ultimately harm some of our most vulnerable citizens, who are covered by the Medicaid program and served by these hospitals.**

Leslie Norwalk, Esq.
June 20, 2007
Page 2 of 5

The agency's belated conclusion that FFP is unavailable for hospitals' GME costs is primarily based on the fact that GME is not specifically listed as a service in the Medicaid statute. In addition, CMS maintains that GME cannot be considered part of "hospital services" because it is not included in the rates paid to hospitals for services under the Medicare inpatient prospective payment system (PPS). The agency's analysis is flawed on both counts.

Agency Rationale

Medical Assistance:

CMS in the preamble to the proposed rule states:

"The care and services that may (or in some cases, must) be included within the scope of medical assistance under a Medicaid state plan are generally set forth in section 1905(a)... Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance.... we do not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately. GME is not a health service that is included in the authorized coverage package...."

The Medicaid statute, in Section 1905(a), defines the term "medical assistance" and lists the types of populations and services for which Medicaid will pay all or part of the costs. CMS' implementing regulations at 42 C.F.R. Part 440 expand upon this list of services.

If CMS rigorously applies its rationale for not recognizing GME costs to other costs defined in Part 440, but not listed in Section 1905(a), some very significant costs would now be defined as "illegal" for purposes of FFP. For example, durable medical equipment (DME), such as walkers, wheelchairs, or hospital beds, is not listed in Section 1905(a). Nevertheless, DME is appropriately considered medical assistance eligible for FFP under the regulations (42 C.F.R. 440.70(a)(3)). Similarly, transportation or other travel expenses, including meal and lodging costs en route to and from medical care and expenses for an attendant to accompany a Medicaid beneficiary to ensure that he or she is able to receive medical examinations and treatment, are not included in Section 1905(a). Nevertheless, they also are appropriately included as medical assistance eligible for FFP in CMS' regulations (42 C.F.R. 440.170(a)).

The statutory basis that allows things like transportation expenses to be eligible for FFP is unclear. Perhaps these expenses are included under Section 1905(a)(28) or another provision of the Medicaid statute such as Section 1902(a)(4). If this is the case, then GME should be eligible for FFP by falling within a provision such as the "catch-all"

Leslie Norwalk, Esq.
June 20, 2007
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Section 1905(a)(28). The fact that FFP is available for these expenses, even though they are not referenced in the Medicaid statute, contradicts CMS' position that FFP is unavailable for GME because it is not listed in the statute. It seems that CMS has singled out GME because it is a convenient budget-saving strategy.

Covered Hospital Services:

Even if CMS were correct in reasoning that FFP should be available only for the items and services listed in the Medicaid statute, FFP would still be available for GME because it is part of inpatient and outpatient hospital services.

In the proposed rule, CMS notes that the Medicaid statute permits states flexibility to develop their own methods and standards for determining payment requirements for covered hospital services within reasonable estimates of what Medicare would have paid for the services. Since Medicare pays for GME as a hospital service, state Medicaid payments for inpatient and outpatient hospital services that include GME costs are eligible for FFP.

CMS is inaccurate in stating that 42 C.F.R. 412.2(2)(e) excludes GME from the inpatient PPS payment rate. In fact, GME is not on the list of "excluded costs;" rather, it is found in C.F.R. 412.2(f) on the list of "additional payments to hospitals" along with other patient care-related costs such as outlier cases, capital and indirect medical education

costs. Hospitals receive an additional Medicare payment for GME precisely because it is a patient-related cost. The fact that the GME payment is separate from the PPS payment is irrelevant to whether GME is a reimbursable hospital cost under Medicare. For example, capital costs are paid outside the inpatient operating PPS, yet no one would argue that they are not reimbursable by Medicare as a hospital cost.

Similarly, Medicare GME payments compensate teaching hospitals for the direct costs of their educational activities by measuring the number of medical residents trained. These medical residents, who work within a supervised patient care team of health care professionals, provide needed care to Medicare and Medicaid patients as part of their training programs. Research looking at interns' and residents' in-hospital time confirms this. In one study, residents, on average, spent 57% of their time on clinical or service-oriented activities (Magnusson A.R., *et al.*: "Resident Educational Time Study: A Tale of Three Specialties." *Academic Emergency Medicine*, July 1998; 5(7): pp 718-725). In another study, house staff (interns and residence) spent a majority of their time engaged in direct patient care activities – 81% of the interns' workdays, and 64.5% of the residents' workdays (Guarisco S., *et al.*: "Time Analysis of a General Medicine Service:

Leslie Norwalk, Esq.
June 20, 2007
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Results from a Random Work Sampling Study.” *Journal of General Internal Medicine*, May 1994; 9(5): pp 272-277).

Reversal of Long-Standing Policy

The proposed rule acknowledges that CMS must first approve hospital payment methodologies as a condition of receiving federal funds (FR Vol. 72, No. 99 p 28932). It also acknowledges a 2005 study commissioned by the Association of American Medical Colleges, which reported that 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. CMS’ approval of the state plan amendments providing for GME constitutes an official interpretation that these plan amendments met governing statutory and regulatory requirements. Thus, the agency’s proposed rule attempts to sweep aside its prior actions and interpretations.

CMS’ public acknowledgement and approval of GME payments do not rest with state plan amendment review, but also extend to its own rulemaking for Medicaid managed care plans. In August 2001, CMS issued a Medicaid managed care proposed rule that declared a state Medicaid program could not make payments directly to a provider for services available by an approved managed care entity (FR vol. 66, No. 161 pp 43628, 43666). When the final rule was published in June 2002, the agency explained that, in response to public comment, it had “...modified that section to permit such payments to the extent the capitation rate has been adjusted to reflect the GME payment made directly to the hospital” (FR Vol. 67, No. 115 pp 41004, 41005, 41103). In fact, current rules (42 C.F.R. 438.60) specifically acknowledge that GME payments can be made directly to the provider as long as the GME payment amount is carved out of the managed care capitation payment.

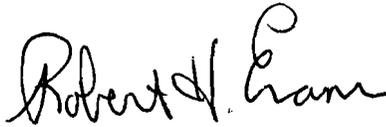
There is no doubt that CMS’ reversal of long-standing policy acknowledging GME as an allowable cost is based on flawed reasoning. **By failing to justify termination of the federal funds supporting Medicaid GME programs, CMS should permanently withdraw this proposed rule.** The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs, which, through their teaching function, provide care to some of our most vulnerable populations.

Leslie Norwalk, Esq.
June 20, 2007
Page 5 of 5

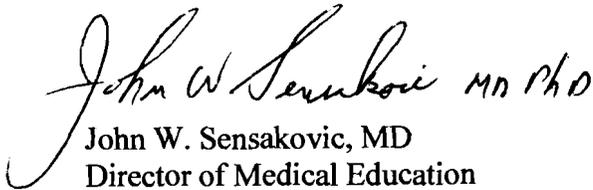
Sincerely,



William L. Vazquez, FACHE
Chief Administrative Officer
Cathedral Healthcare System



Robert Evans
President
Cathedral Healthcare System



John W. Sensakovic, MD
Director of Medical Education
Saint Michael's Medical Center

Rec'd 15
6/22/07

Beaumont®

William Beaumont Hospital
Royal Oak

John R. Musich, M.D.
Vice President and Director, Medical Education

June 22, 2007

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

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

Dear Administrator Norwalk:

On behalf of Beaumont Hospitals, I am writing to express our opposition to the recent May 23, 2007 proposed rule issued by the Centers for Medicare and Medicaid Services that would eliminate all federal funds for graduate medical education (GME) programs. We do not agree with CMS's position that GME payments are unrelated to patient care. In fact, we believe supporting GME is critical to patient care, especially of Medicaid patients, and that cutting funding for GME could end up costing the federal government more money in the long run.

By way of background, Beaumont Hospitals is comprised of two hospitals: a 1,061-bed tertiary care hospital and a 296-bed community hospital, both of which rank among the busiest hospitals in the country for hospitals their size. Both hospitals are among *U.S. News and World Report's* "America's Best Hospitals." Our teaching program consists of 350 residents and fellows in 35 medical specialty areas. In 2006, funding to support our graduate medical education program from the government and private insurers was \$18 million less than our cost to train our residents. If this CMS rule were adopted, Beaumont would have to divert \$3 million from patient care expenses or eliminate resident positions to make up for the loss of federal Medicaid funding.

Given the low Medicaid reimbursement rates paid to physicians in Michigan, there are very few physicians in private practice willing to see Medicaid patients for primary care services. Therefore, Medicaid patients in our area have two options for receiving primary care: the hospital emergency room, which is very expensive, and our outpatient clinics, which are staffed primarily by our residents as part of their GME training program. Last year, the Beaumont Hospitals had nearly 45,000 outpatient visits paid for by the state's Medicaid program, and the majority of these were office visits provided in our Outpatient Clinic, primarily for obstetrics, pediatrics, and internal medicine. Graduate Medical

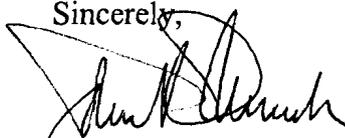
Education is directly related to patient care, especially for Medicaid patients who have few options when seeking health care services.

Given the predicted shortage at the national level of as many as 96,000 physicians by 2020, and efforts to get medical schools to increase the number of medical students to address this shortage, it seems counter intuitive that the federal government would eliminate the funding these medical students need to complete their education in residency programs. Michigan ranks in the top tier of states in the country for physician education, due to our four medical schools and 49 teaching hospitals. Beaumont Hospitals recently announced an affiliation with Oakland University to begin a new, privately funded medical school, which we anticipate opening in 2010 with 50 students in its inaugural class. We do not expect the federal government to pay the full cost of our larger residency program as a result of the medical school, but it would be extremely difficult to continue at our current levels if federal funding is eliminated.

While Beaumont is pleased that Congress adopted language to prevent implementation of this proposed rule for one year, we hope that CMS will reconsider the likely unintended consequences of eliminating GME funding. This would likely exacerbate the physician and divert Medicaid patients to a more high-cost setting for their primary care services.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "John Musich", written over a circular stamp or mark.

John Musich, M.D.
Vice President and Director
Medical Education

JM/sk



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North Carolina Hospital Association

June 21, 2007

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

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

Dear Ms. Norwalk:

The North Carolina Hospital Association (NCHA) represents more than 100 acute care hospitals in the State of North Carolina. NCHA welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding changes to Medicaid policy as it relates to federal reimbursement for graduate medical education (GME) costs. As you know, the proposed rule is subject to a year-long moratorium secured by P. L. 110-28.

The proposed rule departs from the long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation, for hospitals' graduate medical education. Although CMS states this rule clarifies existing GME policy, it completely reverses years of agency policy recognizing GME as a covered medical cost. If these cuts are finalized, the impact to North Carolina hospitals is over \$50 million. Hospitals which service the most vulnerable citizens, who are covered by Medicaid, will lose access to care. The loss of the funding not only impacts those hospitals with graduate medical education programs but the entire medical community, as these institutions educate the physicians who will ultimately work within the state. The lack of funding for medical education programs jeopardizes all communities, but rural areas in particular.

CMS's conclusion that FFP is unavailable for hospitals' GME costs is primarily based on the fact that GME is not specifically listed as a service in the Medicaid statute. In addition, the agency maintains that GME cannot be considered part of "hospital services" because it is not included in the rates paid to hospitals for services under the Medicare inpatient prospective payment system. NCHA believes the analysis by the agency is flawed on both counts.

The agency, in their proposal, has taken the suggestive language in certain sections of the regulations that medical education is not part of cost which should be paid by the Medicaid program. However, if CMS wants to rigorously apply this rationale, other major clinical services not on this list would need to be removed for allowable cost. The fact that CMS has continued to allow FFP for other expenses, even

though they are not referenced in the Medicaid statute, contradicts CMS' position that FFP is unavailable for GME because it is not listed in the statute.

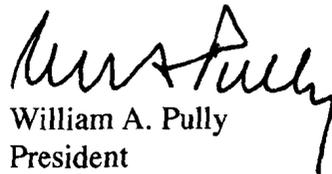
CMS has commented on a portion of the cost allowed for the inpatient prospective payment system, and forgotten the section of the regulation which lists additional payment to hospitals along with other patient related care cost. If CMS had reviewed the entire regulation governing payments to hospitals under the Medicare rules, they would find other costs in addition to GME listed as "additional payments to hospitals."

NCHA believes that CMS' reversal of long-standing policy acknowledging GME as an allowable cost is based on a limited view of the existing regulations. CMS needs to permanently withdraw this proposed rule. The Medicaid program has a responsibility to pay for its share of the cost associated with GME programs which provide care to some of the most vulnerable citizens in every State.

Thank you for considering NCHA's comments to the proposed rule for Medicaid Graduate Medical Education. If you have questions regarding NCHA's comments, you may contact Amelia Bryant at (919) 677-4225.

Sincerely,

NORTH CAROLINA HOSPITAL ASSOCIATION



William A. Pully
President

Cc: Amelia Bryant, FHFMA
Director of Financial Services

NCHA Member Hospitals

Vinson & Elkins

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June 21, 2007

By Federal Express

Tracking No. 7925 0892 7040

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
Mailstop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code: CMS-2279-P

To Whom It May Concern:

We appreciate the opportunity to comment on the May 23, 2007 proposed rule of the Centers for Medicare and Medicaid Services (CMS) to abolish federal financial participation (FFP) for Medicaid payments for services furnished by physicians who are hospital residents-in-training in a graduate medical education (GME) program. We submit these comments on behalf of the Wayne County Hospital Coalition, which includes Detroit Medical Center, Henry Ford Health System, Oakwood Healthcare, Inc., and St. John Health System. The Hospital members of the Coalition are major providers of services to Medicaid recipients in Michigan, and the Hospitals currently receive Medicaid GME payments based on the services furnished by the full-time equivalent of over 2000 physician residents-in-training in approved GME programs.

In the notice of its proposed rule, CMS asserts incorrectly that it lacks statutory authority to provide federal Medicaid matching funds for costs of services the notice describes as "graduate medical education" or GME. *See, e.g.*, 72 Fed. Reg. 28930, 28935 (May 23, 2007) (Preamble). This is wrong. As discussed below:

- CMS clearly has statutory authority to pay FFP for GME costs. CMS has provided federal Medicaid matching funds for such costs to as many as 47 States and the District of Columbia since the inception of the Medicaid program.

- CMS is not only permitted, but is required, to pay FFP for costs of these services. States are required to cover, and CMS is required to pay FFP for State expenditures for, physicians' services. There is no exception to these requirements in the law for services furnished by physicians who are hospital residents-in-training in a GME program.
- A State may elect to reimburse hospitals for the costs of resident physicians' training as direct or indirect costs of inpatient or outpatient services furnished to hospitals' Medicaid patients by resident physicians in training. A State is entitled to FFP for these Medicaid patient care costs regardless of the payment methodology chosen by the State.
- Even if CMS had discretion not to pay FFP for GME costs (and it does not), the moratorium enacted by Congress two days after publication of the proposed rule would prohibit CMS from adopting or implementing such a rule before May 2008.

For these reasons, we respectfully request that the proposal be abandoned.

I. CMS HAS STATUTORY AUTHORITY TO PAY FFP FOR GME COSTS.

CMS's present assertion that it lacks authority to pay FFP for services of physicians who are hospital residents-in-training is enigmatic to say the least. According to the report cited in the Preamble, *Medicaid Direct and Indirect Graduate Medical Education Payment: A 50 State Survey*, 47 States received federal Medicaid matching funds for Medicaid GME costs estimated to exceed \$2.5 billion in 2002. According to the author of that same report, States have made Medicaid GME payments and received matching funds for those payments since the inception of the Medicaid program. See Tim M. Henderson, *Medicaid's Role in Financing Graduate Medical Education*, Health Affairs, 2000. After providing billions of dollars for Medicaid GME to nearly every State in the union, it is hard to understand CMS's present assertion that it cannot pay FFP for GME costs.

To the extent that the Preamble insinuates that CMS has unwittingly paid FFP for GME costs paid by States "under the guise of payments made for covered Medicaid services," 72 Fed. Reg. 28932, that implication is demonstrably false. CMS's approval of Michigan's State plan provides one example. The HHS Office of Inspector General (OIG) explained in a recent report that Michigan "filed a State plan amendment and obtained CMS approval to pay Medicaid graduate medical education funds to teaching hospitals." OIG, HHS, *Review of Medicaid Support for Graduate Medical Education in the State of Michigan* (2006) <http://oig.hhs.gov/oas/reports/region5/50500018.pdf>. These payments were not

surreptitiously added to the State plan unbeknownst to CMS. As evidenced by the OIG's report, the State plan amendment that CMS approved was clear. The State explicitly applied for, and received, approval of payments for GME costs.

CMS also specifically recognized its authority to pay FFP for GME costs in a 2002 Medicaid managed care rulemaking. *See* 67 Fed. Reg. 40988, 41004-05 (June 14, 2002). CMS had proposed to eliminate direct Medicaid GME payments to hospitals that receive capitation payments through a Medicaid managed care plan. CMS received responses from "many commenters" arguing that such a provision would "disturb longstanding arrangements in many States." 67 Fed. Reg. 41005. CMS specifically modified the proposed regulation "to permit such payments to the extent the capitation rate has been adjusted to reflect the amount of the GME payment made directly to the hospital." *Id.* The 2002 rule certainly does not suggest that CMS lacks authority to pay FFP for Medicaid GME costs.

II. STATES MUST COVER, AND CMS MUST PAY FFP FOR STATE EXPENDITURES ON, SERVICES FURNISHED BY PHYSICIANS WHO ARE HOSPITAL RESIDENTS-IN-TRAINING.

A. Residents Are "Physicians" and Their Services Are Medicaid Covered "Physicians' Services."

Not only does CMS have the authority to pay for resident physician services under Medicaid, it *must* pay for those services. Section 1903(a) of the Social Security Act (the "Act") states: "the Secretary . . . shall pay to each State which has a plan approved under this title . . . an amount equal to the Federal medical assistance percentage . . . of the total amount expended . . . as medical assistance under the State plan." (Emphasis added.) One form of medical assistance that States *must* provide is "physician services." Section 1902(a)(10)(A) of the Act requires a State to make "medical assistance" available for "the care and services listed in paragraphs (1) through (5) . . . of section 1905(a)." Section 1905(a)(5) of the Act, in turn, lists "physician services" in its definition of the "medical assistance" that States must provide. CMS, therefore, must provide FFP for physician services under an approved state plan. Further, as more fully explained below, resident physician services are physician services under Medicaid; therefore, CMS must provide FFP for State payments for resident physician services under the approved State plan.

Section 1905(a) of the Act defines "medical assistance" to include, in addition to inpatient and outpatient hospital services (discussed below), "physicians' services, furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere. . . ." Social Security Act

§ 1905(a)(5). Section 1861(r) of the Act is the Medicare statute's definition of "physician." Section 1861(r) states: "The term 'physician', when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. . . ." Physicians in hospital residency training programs satisfy this definition: they are "doctor[s] of medicine or osteopathy legally authorized to practice medicine and surgery by the State. . . ." There is nothing in the Medicaid definition that bars a resident physician from being considered a physician.¹

In contrast to the carve-out of resident physician services from the definition of physician services in the Medicare statute, *see* Social Security Act § 1861(q), the Medicaid statute contains no such exception. The Medicaid regulation provides the following definition of "physician services":

"Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician – (1) Within the scope of practice of medicine or osteopathy as defined by State law; and (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

42 C.F.R. § 440.50(a). Under the Medicaid definition, services of physicians who are hospital residents-in-training under the supervision of teaching physicians in approved GME programs clearly qualify as covered physician services.

B. States May Also Cover and Receive FFP for the Costs of Physicians' Services as Inpatient or Outpatient Hospital Services.

Given that resident physicians are "physicians," as defined for Medicaid purposes, and their services are "physicians' services" under Medicaid, a State may cover or pay for their services separately, as described above, or as inpatient or outpatient hospital services. *See* Social Security Act § 1902(a)(10)(A) (*requiring* state plans to "provide for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) . . . of section 1905(a)"), Social Security Act §§ 1905(a)(1) and (a)(2) (defining

¹ In fact, in the Medicare context, Congress implicitly recognized that a hospital resident-in-training is a "physician" as defined in section 1861(r) of the Act. In the Medicare definition of "physician services," which is not incorporated in the Medicaid statute, Congress carved out the services of hospital residents-in-training from the definition of physician's services in section 1861(q) of the Medicare Act.

the required medical assistance of “inpatient hospital services” and “outpatient hospital services,” respectively).

The Medicaid regulations define inpatient and outpatient hospital services. 42 C.F.R. § 440.10 defines “inpatient hospital services” as “services that – (1) Are ordinarily furnished in a hospital for the care and treatment of inpatients; (2) Are furnished under the direction of a *physician* or dentist. . . .” Section 440.20 defines “outpatient hospital services” for Medicaid purposes as: “preventive, diagnostic, therapeutic, rehabilitative, or palliative services that – (1) Are furnished to outpatients; (2) Are furnished by *or* under the direction of a *physician* or dentist” (emphasis added).

A State may elect to pay for resident physicians’ services as physicians’ services and/or as hospital services. These categories are not mutually exclusive. *See, e.g., Alaska Dep’t of Health and Soc. Services*, DAB No. 1919 at *20 (2004), 2004 WL 1038088 (“Numerous services which may meet the definitions of inpatient or outpatient hospital services are also themselves defined separately, such as laboratory and x-ray services, *physicians’ services*, pharmacy services, and diagnostic services.” (Citing 42 C.F.R. §§ 440.30, 440.50, 440.120, and 440.130) (emphasis added).

III. GME PAYMENTS ARE PAYMENTS FOR PATIENT CARE SERVICES FOR WHICH STATES ARE ENTITLED TO FFP.

CMS may not deny FFP based on a label. Although CMS does not define what precisely it means by the “GME” label it uses in its proposed rule, the term “GME” comes from Medicare. In Medicare, GME is simply the label assigned to the cost of patient care related services furnished by physicians who are hospital residents-in-training. Likewise, in Medicaid, GME costs are among the many costs of care to Medicaid recipients, costs for which States are entitled to FFP.

Consistent with a State’s flexibility in determining how to pay for covered services,² when a State pays for resident physicians’ services through Medicaid payments to a hospital, the State may properly consider the costs of the residents’ training as direct or indirect costs to the hospital of the services furnished to patients by the resident physician. In economic

² *See* Section 1902(a)(13)(A) of the Social Security Act (requiring that a State plan establish public process for determination of payment rates but otherwise setting forth only general guidelines as to how the rates should be determined); 42 C.F.R. § 447.201 (“[T]he plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State’s Medicaid program”).

terms, the training cost is a form of in-kind consideration provided to the resident physician for services furnished to the hospital and its patients. The Medicare Payment Advisory Commission (“MedPAC”) has previously articulated this concept in its report on Medicare GME payments. *Rethinking Medicare’s Payment Policies for Graduate Medical Education and Teaching Hospitals* (Aug. 1999).

In that report, MedPAC stated: “In the analytic framework of economics, the direct and indirect costs associated with training programs are indistinguishable; both represent costs of providing patient care.” *Id.* at 6. MedPAC explains that the cost of training is borne by the resident physician him or herself because the resident physician provides “patient care and other services in conjunction with their training that are of value to the institution where they train, while accepting compensation for the services they provide that is lower than they might otherwise be able to earn given their skill level.” *Id.* at 7. It follows then that “[s]ince residents bear the cost of their training, Medicare is paying not for training costs but rather for patient care.” *Id.* at 8. Based on these principles of economics, MedPAC stated unequivocally, “direct GME costs that hospitals report on their Medicare cost reports represent the net value of the patient care services residents provide.” *Id.* at 7. Likewise, in the Medicaid payment system, the costs of resident training are components of the total allowable cost incurred by a hospital for resident physicians’ services furnished to Medicaid patients.

This concept is grounded in Medicare’s historical payment for the costs of resident training. Before the implementation of the Medicare prospective payment system in 1983, the costs of resident physician services furnished to Medicare beneficiaries, which are now paid under “GME,” were paid on a reasonable cost basis under Medicare Part A. *See* Social Security Act §§ 1814(b)(1), 1861(v)(1)(A). Since the inception of the Medicare program, and before the advent of PPS or GME, Medicare recognized the costs of “formally organized or planned programs of study” as Medicare-allowable costs of patient care related services furnished by hospital residents-in-training. The implementing regulation was first promulgated in 1966 at 20 C.F.R. § 405.421, and later redesignated as 42 C.F.R. § 405.421 in 1977, and as 42 C.F.R. § 413.85 in 1986. But, it has also always been the case under Medicare, that *all* reimbursable costs must be “related to patient care.” *See, e.g.,* 42 C.F.R. § 413.9 (“All payments to providers of services must be . . . related to the care of beneficiaries”); *see also* Provider Reimbursement Manual § 2100 (“All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act *and related to the care of beneficiaries. . .*”) (emphasis added).

Medicare has always defined the allowable costs of approved residency training programs as including both the direct costs (residents’ stipends and the teaching physician

compensation paid to teacher) and indirect costs (overhead) costs of the program as determined under Medicare cost-finding principles. *See* 42 C.F.R. § 413.85(d)(2)(ii); *see also* 42 C.F.R. § 413.9(b)(1). Both of these types of costs were, therefore, necessarily recognized as “related to beneficiary care.”

Although the label applied to these payments has changed (they have been called GME payments since the enactment of the Medicare prospective payment system for the operating costs of inpatient hospital services), the requirement that the services relate to patient care remained the same. In the 1989 preamble to the rule in which the current GME program was implemented, CMS stated: “We are guided by the general principle that, to be allowable at all, the costs must be related to patient care furnished in the hospital, and, to be allowable as a direct GME cost, the costs must be related to the GME program in the hospital.” 54 Fed. Reg. 40286, 40302 (Sept. 29, 1989). Again, CMS stated: “To reiterate, services that are *both* related to the care and treatment of the hospital’s patients and furnished in support of the training of interns and residents meet the requirements for payment.” *Id.* (emphasis added).

Medicare GME payments are not, and indeed cannot be considered, some form of payment that is unrelated to patient care. Nowhere does the Medicare statute allow for payments that are not related to patient care. Clearly, GME payments have been both implicitly and explicitly recognized by CMS as reimbursements for patient care services furnished to Medicare beneficiaries. Regardless of the label affixed to them, costs related to residents’ patient care services are likewise allowable in the Medicaid context. Under the Medicaid statute, States that participate in Medicaid are not only allowed but required to pay for these services and are entitled to FFP for such payments.

IV. MORATORIUM

On May 25, 2007, two days after publication in the Federal Register of CMS’s notice of its proposed rule, Congress responded by enacting legislation that prohibits CMS from adopting or implementing the proposed rule before May 2008, if ever.

Section 7002(a) of Pub. L. No. 110-28 states: “prior to the date that is 1 year after the date of enactment of this Act,” the Secretary is prohibited from taking “any action . . . to . . . promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program.” U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007, Pub. L. No. 110-28, 2007. Clearly, finalizing a regulation to eliminate Medicaid GME payments before May 2008 would violate Congress’ moratorium.

Besides its immediate effect of limiting the authority of the Secretary to enact this regulation until May 25, 2008, the passage of this provision, in direct response to, and just two days after, CMS's proposal to eliminate Medicaid GME, suggests that federal assistance for state Medicaid GME programs enjoys widespread support from Congress and is not beyond CMS's statutory authority.

V. CONCLUSION

Based on the foregoing, the Wayne County Hospital Coalition requests that CMS not adopt the proposal to eliminate FFP for GME costs.

Sincerely,



Dennis M. Barry

cc (via fax and U.S. Mail):

Michael Pelc, Detroit Medical Center
Mary Whitbread, Henry Ford Health System
Bob Plaskey, Oakwood Healthcare, Inc.
David Buckley, St. John Health System

DC 684765v1



CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

June 21, 2007

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

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

Dear Ms. Norwalk:

On behalf of the California Association of Public Hospitals and Health Systems ("CAPH"), I am writing to express our strong opposition to the proposed Medicaid rule (CMS-2279-P) regarding Graduate Medical Education ("GME").¹ We appreciate the opportunity to advise the agency of the far-reaching, damaging effects that the rule would have on California's public health care safety net. The proposal would eliminate Medicaid payments for essential services provided by interns and residents to Medi-Cal patients, with devastating results for CAPH member hospitals and the communities they serve. CAPH urges you to withdraw this proposed rule.

CAPH represents 21 public hospitals, health care systems and academic medical centers, located in 16 counties in California. Our hospitals are a cornerstone of the State's health care system. With the exception of one member, all CAPH members operate GME programs in their hospitals, and many of the GME programs extend to non-hospital settings as well. CAPH member hospitals train nearly half of California's physicians, and operate nearly 60% of California's top-level trauma centers, which are state-of-the-art emergency medical units that treat the most catastrophic, life-threatening injuries. They also operate almost 45% of the State's burn centers and provide more than 60% of California's emergency psychiatric care.

¹ 72 Fed. Reg. 28930 (May 23, 2007).

In addition to providing the learning venue for the nation's future physicians, these safety net providers rely heavily on GME programs as a means of providing care to the vulnerable populations they serve. The GME costs at issue in this proposed regulation represent the reasonable and necessary cost of providing services to Medicaid beneficiaries. Failure to recognize these costs as an element of Medicaid expenditures is directly contrary to the Medicaid statute.

CAPH members estimate that the proposed rule would result in a loss of at least \$86 million annually in federal Medicaid funding for their facilities. If the rule extends to costs incurred in providing care to the uninsured under California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act ("Hospital Waiver"), the losses could be substantially greater. This loss of federal funding will likely result in a reduction in those critical health care services that public hospitals are uniquely qualified to provide, thereby limiting services and health care access for Medicaid beneficiaries and for the community as a whole.

I. Key Comments

A. The proposed rule and its preamble language suggest that the Centers for Medicare and Medicaid Services ("CMS") fails to recognize the damaging impact that the loss of federal Medicaid funding will have on the quality and accessibility of care for Medicaid recipients. To a significant extent, safety net providers rely on teaching programs to provide the workforce necessary to render services to their patients. The loss of federal Medicaid funding will severely undermine that system of care.

B. CMS' assertion that GME is not covered under the Medicaid program is incorrect. The GME costs that would be eliminated as a component of payments to Medicaid providers represent direct costs of providing direct health care services to Medicaid recipients in a teaching setting. Providers are entitled to payment for the essential and cost-effective services provided to Medicaid patients by interns and residents. The continued recognition of GME as a component of provider payments is necessary to ensure compliance with the Medicaid statute.

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

II. Specific Comments on the Proposed Rule

A. Medicaid services are provided in conjunction with GME programs.

The proposed rule would eliminate federal Medicaid matching funds for GME costs. However, neither the proposed rule nor the preamble define what these costs include. In failing to provide affected parties with clear notice of the particular costs that it seeks to exclude

from allowable Medicaid payments, the proposed rule does not meet basic notice and comment rulemaking requirements under the Administrative Procedure Act.²

Neither the Medicaid statute nor the Medicaid regulations contain a definition of the term “GME.” In light of the many references in the regulatory preamble to the Medicare program’s treatment of this issue, CAPH must assume that CMS intends to apply the Medicare definition of “GME.” In a 1989 rulemaking notice, CMS stated that allowable Medicare GME costs include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, certain other teachers’ salaries, and related indirect costs (for example, employee health and welfare benefits) that are appropriately allocated to the medical education cost center.³

It is critical that CMS focus on the actual direct health care services that are the subject of the proposed rule, rather than on the term “GME.” Once the vague term “GME” is defined, it becomes abundantly clear that the costs that CMS is attempting to avoid under Medicaid are not general educational costs, but in fact represent the cost of rendering services to patients. The services at issue primarily consist of direct health care services provided by interns and residents to specific patients, including hospital inpatients and outpatients. The statement in the proposed rule that “GME is not a health service” indicates a lack of understanding of the vital role that interns and residents play in the provision of health care, and particularly in the provision of inpatient hospital services in teaching hospitals.

In the CAPH member hospitals, as in many large teaching hospitals across the country, interns and residents provide an enormous amount of direct patient care. They work directly in the hospital patient care areas, including the emergency rooms and wards, and spend the vast majority of their time caring directly for patients. The use of a large number of interns and residents is the only way that many teaching hospitals can maintain the workforce necessary to adequately care for their patients.

Generally, GME programs operate on a principle of progressive responsibility. Depending on their medical training, interns and residents can provide a range of services. As an intern or resident becomes more skilled, he or she takes on greater responsibility for patient care. While interns and residents are carefully supervised by teaching physicians, there is no doubt that the volume of care provided through GME programs could not be replicated by simply requiring those teaching physicians to provide the services directly. Because many health care professionals are paid more than interns and residents and generally have a shorter work week, replacing this volume of care may be so costly as to be impossible in many locations.

The fundamental flaw in CMS’ proposal is that it fails to recognize that the GME costs at issue represent services rendered to Medicaid recipients by interns and residents and supervised by teaching physicians. As discussed below, it would be inconsistent with the Medicaid statute to exclude these costs from consideration in the Medicaid payment process.

² 5 U.S.C. § 553.

³ 54 Fed. Reg. 40286 (Sept. 29, 1989). See also Provider Reimbursement Manual, Part I, Section 402.2.

B. The Medicaid statute authorizes federal financial participation (“FFP”) for GME costs.

In the preamble, CMS notes that GME is not specifically included in the list of care and services covered within the scope of medical assistance in Section 1905(a).⁴ CMS relies on this fact to conclude that GME is not a service covered by the Medicaid program. While CMS is correct that GME is not listed as a service, its absence is not surprising because medical education is not itself a service. Instead, GME costs represent the direct health care provided by interns and residents that constitute a necessary component of listed services, such as inpatient hospital services.

For example, inpatient hospital services are listed as covered Medicaid services in Section 1905(a). There is no statutory language or legislative history to support the conclusion that Congress intended to exclude the costs of services provided by interns and residents from the definition of inpatient hospital services. The Medicaid statute does not contain a definition of the term “inpatient hospital services.” However, Section 1861(b)⁵ of the Medicare statute defines “inpatient hospital services,” and specifically includes medical or surgical services provided by interns or residents in an approved training program in that definition. In the preamble, CMS provides no basis to support its inference that Congress, at the time that it enacted the Medicare and Medicaid programs, intended the term “inpatient hospital services” to have different meanings in the Medicaid and Medicare statutes. Accordingly, the correct interpretation of Section 1905(a) is that Congress intended that medical or surgical services provided by interns and residents in an approved program are included in the scope of inpatient hospital services, and therefore are covered Medicaid services.

The Medicaid regulations do not list the specific types of services that are included in the term “inpatient hospital services.” Instead, the Medicaid regulations at 42 C.F.R. § 440.10(a) state that “inpatient hospital services” means services that are ordinarily furnished in a hospital for the care and treatment of inpatients. As intern and resident services are ordinarily furnished in teaching hospitals for the care and treatment of inpatients, they clearly meet the definition of inpatient hospital services in the Medicaid regulations. Furthermore, the Medicare definition of “inpatient hospital services” at 42 C.F.R. § 409.10(a) includes medical or surgical services provided by interns and residents. Congress has been aware that state Medicaid programs have been reimbursing GME costs as part of the services provided to Medicaid beneficiaries and has never amended the statute to eliminate Medicaid funding for GME activities. Accordingly, GME costs are appropriately recognized as a component of a covered service whenever those costs are incurred as part of rendering services to Medicaid recipients.

C. CMS’ reliance on the Medicare statute is misplaced.

CMS’ selective use of Medicare provisions to support its assertion that GME is not a “health service” is misguided. In the preamble, CMS mischaracterizes Medicare reimbursement to hospitals by stating that payments made to hospitals are segregated into

⁴ 42 U.S.C. § 1396d(a).

⁵ 42 U.S.C. § 1395x(b).

“basic” payments for operating costs and capital costs of inpatient hospital services, which are then “supplemented” by payments for GME and indirect medical education (“IME”). CMS points to Section 1886(a)(4)⁶ of the Medicare statute, which identifies the “operating costs of inpatient hospital services” that are reimbursed by Medicare under IPPS, and notes that the costs of approved educational activities are excluded from this definition of “operating costs of inpatient hospital services.”

In stating that GME and IME are “supplemental” payments, CMS apparently intends to create the impression that such payments are unrelated to actual costs of providing care to hospital patients. In fact, GME and IME represent payment for the actual costs of furnishing patient care. A review of the Medicare statute and regulations clearly establishes that Medicare has always considered the costs of intern and resident services (*i.e.*, GME costs) to be allowable costs for teaching hospitals.

The Medicare statute at Section 1861(b) lists the services that are included in the definition of “inpatient hospital services.” These services expressly include services provided by interns and residents under an approved teaching program. Thus, CMS’ contention that Medicare law somehow supports its assertion that intern and resident services are not health care services or are not inpatient hospital services is without basis.⁷

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

Furthermore, since its inception, the Medicare program has expressly recognized that intern and resident services are an important component of inpatient hospital services, and has compensated providers for the cost of such services.

From 1966 to the 1980s, the Medicare program reimbursed hospitals for health care services provided to their inpatients and outpatients based on the reasonable cost of providing such services. Section 1861(v)(1)(A) states that the “reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services.” As intern and resident services

⁶ 42 U.S.C. § 1395ww(a)(4).

⁷ See 42 C.F.R. §§ 409.10(a)(7) and 409.15 (“medical or surgical services provided by an intern or a resident-in-training are included as ‘inpatient hospital or inpatient CAH services’ if they are provided by an intern or resident . . . under a teaching program” that has been approved by the appropriate body).

are included in the list of inpatient hospital services in Section 1861(b), hospitals were entitled to receive reasonable cost reimbursement for such services.⁸

In the Social Security Amendments of 1983, Congress provided that Medicare reimbursement for the “operating costs” of hospital inpatient services would be made through the IPPS, rather than on a reasonable cost basis. Under the IPPS, the Medicare payment amount for the operating costs of inpatient hospital services is based on the Diagnosis Related Group (“DRG”) to which the patient is assigned. Medical education costs were excluded from the IPPS, but continued to be reimbursed under a cost-based system until 1985.

In 1985, Congress added a new Section 1886(h)⁹ to revise the method for calculating Medicare payment for the direct costs of approved GME activities, effective for cost reporting periods beginning on or after July 1, 1985. Unlike the current CMS proposal, that change in payment methodology was properly adopted via legislation, rather than through administrative action. However, the purpose of Section 1886(h) was not to change Medicare’s coverage of intern and resident services, but to change the payment methodology for such services. Regions Hospital v. Shalala, 522 U.S. 448, 460 (1998).

In sum, contrary to CMS’ suggestions in the preamble, the Medicare program has always recognized GME costs as reasonable costs of providing services to patients, and it continues to compensate providers for the patient care services rendered through GME programs.

D. The proposed regulation is inconsistent with the Medicaid statute and Congressional intent, and would result in inadequate payment, thereby restricting access to services for Medicaid beneficiaries.

The preamble to the proposed GME rule notes that Section 1902(a)(30)(A)¹⁰ requires that Medicaid payment rates be consistent with economy, efficiency and quality of care. In its recently published regulation limiting payments to governmentally operated providers to costs, CMS asserts that cost-based payments to these providers are adequate to meet this statutory requirement.¹¹ Now, CMS is proposing to limit federal funding to these providers further by eliminating a significant portion of those very costs – the cost of services rendered by interns and residents.

Under Section 1902(a)(30)(A), Medicaid inpatient hospital payment rates must bear a reasonable relationship to an efficient and economical hospital’s costs of providing quality services. See Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998); see also Alaska Department of Health and Social Services v. CMS, 424

⁸ See 20 C.F.R. § 405.421 (1966) (allowable costs include the net cost of approved educational activities, including the stipends of trainees, compensation of teachers, and other costs).

⁹ 42 U.S.C. § 1395ww(h).

¹⁰ 42 U.S.C. § 1396a(a)(30)(A).

¹¹ 72 Fed. Reg. 29748, 29773, 29782 (May 29, 2007).

F.3d 931 (9th Cir. 2005). CMS has performed no analysis in support of its apparent conclusion that GME programs are an inefficient and uneconomical means of providing Medicaid services, and the proposed rule provides no explanation as to how the exclusion of intern and resident costs will bear a reasonable relationship to costs.

Furthermore, the preamble provides no assurance that the resulting Medicaid rates would be adequate to ensure access to care by Medicaid beneficiaries as required by the same statutory provision. The complete statutory principle in Section 1902(a)(30)(A) sets forth the requirement that:

payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

CAPH members and teaching hospitals across the country rely upon GME programs to ensure the adequate access to quality care required under this provision. Teaching hospitals are able to bring together the multi-disciplinary teams of physicians and other health care professionals needed to provide quality care. Often the learning opportunities available at teaching hospitals will attract interns, residents and teaching physicians who might otherwise choose more desirable work places. GME programs act as a magnet to ensure access in otherwise under-served areas. There is no indication whatsoever in the proposed regulation that CMS has considered the impact of eliminating GME-related payments on the quality and access requirements of Section 1902(a)(30)(A).

Moreover, the proposed rule would improperly restrict the ability of states to determine the most efficient and effective way for hospitals to provide services to Medicaid patients. For many years, states have been permitted to make Medicaid payments to hospitals for intern and resident services, and most states have determined that this is a proper method of providing services to Medicaid patients. The states, rather than CMS, are better able to determine the most efficient and effective way to provide services to Medicaid patients. The proposed elimination of FFP for intern and resident services would place an improper restriction on the states in their ability to determine the most cost-effective way of providing inpatient hospital services to Medicaid beneficiaries.

E. The proposed rule is not a “clarification” of existing law, but a fundamental change in the law. CMS has not provided a rational basis for such change.

The proposed rule would result in a complete reversal in CMS’ long-standing interpretation of the Medicaid statute that GME costs are an allowable component of Medicaid payments. As CMS acknowledges, it has been aware for years that many states have included intern and resident services as a component of their Medicaid expenditures for inpatient and outpatient hospital services, and it has approved numerous state Medicaid plans that included intern and resident costs as allowable costs of providing services to Medicaid patients. Thus, the proposed rule would constitute a fundamental change in law, and not a “clarification” of existing law.

The preamble does not establish a rational basis for adoption of the proposed rule, and it therefore does not meet the applicable rulemaking requirements under the Administrative Procedure Act. As discussed above, CMS' legal arguments regarding the Medicaid and Medicare statutes are not well founded. CMS is unable to cite any changes to the Medicaid statute – or any other rational basis – that support its newly revised interpretation of the statute.

The preamble fails to demonstrate that the proposed rule would promote efficiency and economy in the provision of quality Medicaid services. Furthermore, CMS has failed entirely to address the impact that the proposed rule would have on access to care. As discussed above, if hospitals are to provide the same patient care services, they would have to provide these services through other health care professionals in order to receive Medicaid reimbursement for the services. The preamble sets forth no estimate of the projected costs of providing services through persons other than interns and residents, or the possible savings to the Medicaid program if such a change in the delivery of services were made.

Furthermore, the 1994 OIG report entitled *A Study of Graduate Medical Education Costs* notes that when the Medicare program was established, Congress believed that educational programs contributed to the quality of care and, as such, provided for Medicare funding of educational programs. OIG recommended that CMS consider submitting legislation to reduce or possibly eliminate Medicare GME payments, but only with respect to those particular specialties for which there was a surplus of physicians. OIG did not recommend that Medicare eliminate GME payments, and OIG did not address GME payments under the Medicaid program. Thus, the report provides no support for elimination of Medicaid reimbursement for GME costs.

F. Other Specific Comments on the Proposed Rule

1. Upper payment limit

The proposed rule would revise the Medicaid upper payment limit (“UPL”) calculation by providing that states may not include Medicare GME payments as part of the reasonable estimate of Medicare payments to hospitals.¹² This proposal is a complete reversal of the position set forth by the agency when the UPL regulation was implemented. At the time of the adoption of the UPL regulation, CMS indicated that states have the flexibility to use the Medicare prospective payment system, which includes IME and GME payments, as the basis for the UPL calculation.¹³

The adoption of the UPL regulations was the result of an extensive rulemaking process during which the proposed limits were scrutinized by Congress, the public and the agency. At that time, CMS addressed the issue of GME costs and concluded that the UPL must include amounts that Medicare would pay for the services rendered by interns and residents. While an administrative agency can change its policy through the rulemaking process, it must have a rational basis for doing so and the rulemaking record must support the change. Motor

¹² Proposed Sections 447.257, 447.272, 447.321.

¹³ 66 Fed. Reg. 3148, 3153 (Jan. 12, 2001).

Vehicles Manufacturers Association v. State Farm, 463 U.S. 29, 57 (1983). In the matter of the proposed rule, CMS has failed to provide adequate support for the proposed reversal of a Medicaid policy so recently affirmed by the agency. There has been no change in the Medicaid statute that supports the elimination of GME costs or payments from the UPL. On the contrary, the Medicaid statute at Sections 1902(a)(13)(A)¹⁴ and 1902(a)(30) continues to provide for state flexibility in establishing payment methodologies. More importantly, CMS has set forth no data whatsoever in support of its contention that the recognition of costs associated with services provided by interns and residents in a teaching setting will result in excessive payments to providers. As a result, the proposed amendments to Sections 447.257, 447.272 and 447.321 should be withdrawn.

Similarly, the proposed change to Section 438.60, eliminating direct GME payments to providers serving managed care enrollees, should be withdrawn. Moreover, CAPH would oppose any attempt to exclude these costs in determining the actuarial soundness of payments to managed care organizations. As discussed in detail above, the recognition of GME costs as reasonable costs of providing services to Medicaid recipients in teaching settings is critical to ensuring adequate payment for direct health care services provided by residents and interns. Capitation payments must be adequate to ensure that the managed care organizations can properly pay for this component of the services rendered to their Medicaid enrollees. Medicaid providers that utilize interns and residents to provide direct patient care in conjunction with graduate medical education programs are entitled to adequate payment for the services rendered to Medicaid enrollees, whether those payment are made by the state agency on a fee-for-service basis, or by a Medicaid contracting managed care organization.

2. Medicaid payments for IME are appropriate.

CMS' proposal to allow states to include Medicare payments for IME in the UPL calculation is proper. As CMS correctly notes, these payments represent reimbursement for additional costs associated with providing services in teaching hospitals. The fact that the Medicare program reimburses these costs through an adjustment to the hospital's prospective payment rate rather than directly on the basis of reasonable costs does not change the fact that they are payments for patient care services.

G. Regulatory Impact

1. The estimated impact is unreliable.

In the preamble, CMS estimated that federal Medicaid payments would be reduced by \$140 million in FY 2008 if the proposed rule is adopted, increasing to \$460 million in FY 2012. However, this estimate appears to be both unreliable and substantially understated.

CMS based its estimate on a survey conducted by the National Conference of State Legislatures ("NCSL") and published in the *Journal of Health Affairs* in 2000.¹⁵ The use

¹⁴ 42 U.S.C. § 1396a(a)(13)(A).

¹⁵ "Medicaid's Role in Financing Graduate Medical Education," by Tim M. Henderson, *Health Affairs*, vol. 19, no. 1, pg. 221 (January/February 2000).

of this survey to estimate the impact of the proposed rule is questionable for the following reasons:

- The NCSL survey was conducted in late 1998 and early 1999. Thus, the survey data is now at least eight years old, and it is unclear whether it reflects the current level of Medicaid expenditures. Although CMS used the Consumer Price Index to trend the estimates forward, it did not provide any basis for its assumption that this is an accurate trend factor.
- In its report, NCSL estimated the total annual Medicaid payment amount in 1998 for GME to be \$2.3 to \$2.4 billion. This amount includes both direct GME and IME. It is unclear how CMS separated this amount into the direct GME and IME components. The estimated impact amounts in the proposed rule appear low.
- In the preamble, CMS stated that it is unable to track Medicaid GME payments due to the way in which these payments are made, and therefore, it is difficult to quantify Medicaid GME payments. It is unclear why CMS relies on NCSL's estimate when CMS claims that it is unable to accurately quantify the Medicaid GME payments.
- CMS stated that it was applying an offset to account for behavioral changes, but it provided no information supporting this offset.
- CMS did not take into account that the services that are currently provided by interns and residents will still have to be provided even if the proposed rule is adopted. In order to obtain Medicaid payment for such services, hospitals will have to make changes in the way they deliver services. A reliable estimate of the impact of the proposed rule must include an estimate of the cost of providing such services by other healthcare professionals, and a comparison of that amount to the cost of interns and residents providing the services. In the absence of such a comparison, CMS' estimate of the impact of the regulation is unreliable.

2. The proposed rule constitutes an unfunded mandate on states.

The discussion of unfunded mandates misses the point that the services currently provided by interns and residents will have to be provided by other healthcare professionals in order for hospitals to obtain Medicaid payment for the services. Although the Medicaid statute does not mandate that state Medicaid programs provide GME payments, it requires participating states to provide inpatient and outpatient hospital services. If federal Medicaid payments for the patient care services provided by interns and residents are eliminated, states will be forced to pay these costs. Accordingly, the proposed rule constitutes an unfunded mandate.

III. It is unclear whether the proposed rule has an impact on Section 1115 Demonstration Projects.

Nothing in the preamble indicates whether or how this proposed rule will impact states, like California, which operate under Section 1115 Demonstration Projects. In the recently published Medicaid regulation imposing a cost limit on payments to governmentally operated

providers, CMS explained that there would be no impact on California providers because the cost of services to the uninsured, which are matched with federal funds under the California Demonstration Project, are considered Medicaid eligible costs.¹⁶ Similarly, CMS indicated that an adjustment to the State's budget neutrality limit would not be required because that regulation did not change "benefits, coverage or eligibility."¹⁷ CAPH urges CMS to adopt the same approach with respect to this regulation. The GME costs at issue in this proposed regulation have been expressly recognized as allowable under the Demonstration Project in California. As discussed above, the rule does not represent a change to benefits, coverage or eligibility categories, therefore, based on the CMS policy as set forth in the recently published final regulation, a budget neutrality adjustment would not be required in this instance.

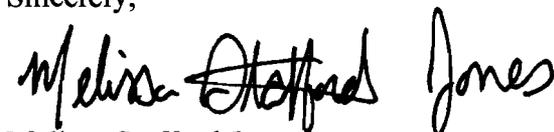
IV. Moratorium

In Section 7002(a)(1)(C) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, signed by the President on May 25, 2007, Congress enacted a one-year moratorium on the promulgation or implementation of any rule or provisions restricting payments for graduate medical education under the Medicaid program. In light of the fact that CMS is barred from issuing a final regulation restricting Medicaid payments for GME at least until May 25, 2008, we believe that CMS should withdraw the proposed rule. If CMS is still interested in pursuing the policy change reflected in the proposed rule after the moratorium period is over, it should reissue the rule as a proposed rule and provide another comment period in order to obtain current input from affected parties.

V. Conclusion

Finally, CMS must acknowledge that the proposed regulation will adversely affect the ability of CAPH members to continue to provide critically needed direct health care services to the most needy in California. The purpose behind the proposed rule appears to be purely a financial one, to reduce Medicaid expenditures. In doing so, the rule would limit the state flexibility guaranteed by the Medicaid statute to determine how services can best be provided to Medicaid patients and to set appropriate Medicaid payment rates. The elimination of FFP for the health care safety net in California under this rule will be devastating to our member providers, the people they serve, and to the well-being of the State as a whole. Therefore, CAPH urges you to withdraw this proposed rule.

Sincerely,



Melissa Stafford Jones
President and CEO

¹⁶ 72 Fed. Reg. at 29814.

¹⁷ 72 Fed. Reg. at 29814, 29815



Mary Hitchcock Memorial Hospital

Fiscal Services
One Medical Center Drive
Lebanon, New Hampshire 03756
603-653-1155

June 19, 2007

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

RE: Graduate Medical Education

I am writing on behalf of the Dartmouth-Hitchcock Medical Center (DHMC) to request the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate funding associated with the Medicaid Graduate Medical Education payments.

By way of background, DHMC is comprised of Mary Hitchcock Memorial Hospital, a 337 bed teaching hospital, the Dartmouth-Hitchcock Clinic, a large academic group practice, Dartmouth Medical School, and the Veterans Administration Hospital. Mary Hitchcock is the only academic tertiary care hospital in the state of New Hampshire, and is one of only a few major rural teaching hospitals in the country.

In regards to the proposed rule, we find it interesting that CMS is now using the term "clarification", on a long-standing Medicaid policy, as the reason for further budget cuts. At a time when there are numerous studies predicting that there will be significant physician shortages, in the near future, CMS is considering to eliminate a key funding source, funding that is critical for the continued clinical education and training of our future physicians.

By being the only academic tertiary care hospital in the state, we treat the sickest of the sick while offering the most advanced state of the art services and equipment to our patients. We continue to do this at a time when the operating margins for hospitals continue to decline. MedPAC's testimony to Congress on May 15, 2007 indicated that overall hospital margins have become even more negative in recent years. MedPAC is projecting a -5.4% (negative) Medicare margin for FY07, compared to a -3.3% (negative) Medicare margin in FY05. The operating margins for Medicaid programs are significantly weaker, especially in the State of New Hampshire.

We strongly urge CMS to rescind the proposed rule. We also ask that CMS assign a task force to study the reasons for the continued downward spiral of hospital Medicare margins.

Thank you for consideration of these comments.

Sincerely,

Robin F. Mackey
Director of Corporate Accounting & Reimbursement

June 20, 2007

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

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

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule concerning Medicaid Graduate Medical Education. Memorial Health University Medical Center (MHUMC) is a 530-bed teaching hospital with one of only four Level I trauma centers in Georgia.

MHUMC urges CMS to rescind the above referenced proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments. Finalizing this rule would further erode the financial condition of teaching hospitals and jeopardize their ability to continue to fulfill important teaching, patient care and other missions.

Medicaid Graduate Medical Education Background

Title XIX of the Social Security Act (the Act) authorizes federal grants to states for Medicaid programs that provide medical assistance to low-income families, the elderly, and persons with disabilities. Under section 1903(a)(1) of the Act, FFP is available to States for a percentage of amounts "expended for medical assistance under the state plan." Section 1905(a) spells out the care and services that are included in the scope of medical assistance. Inpatient and outpatient hospital services are included in this scope but GME is not specifically included. Even though CMS has allowed states to include GME as a component of Medicaid inpatient and outpatient hospital services in the past, it now believes that GME is not a health service that is included in the authorized coverage package under the Medicaid statute and is proposing to preclude FFP from state payments for GME.

Medicaid Graduate Medical Education Comment

States are responsible for and have a great deal of flexibility in determining inpatient hospital rates as long as the rates are consistent with economy, efficiency, and quality of care. The upper payment limit (UPL) is used to measure a state's adherence to rates that are consistent with economy, efficiency, and quality of care and is defined as "a reasonable estimate of what Medicare would have paid for the same services using Medicare payment principles" which currently includes GME payments. Given the flexibility states have in setting rates, they should be able to choose if they are going to support GME or not and be able to count on FFP for services that they believe are consistent with economy, efficiency, and quality of care as allowed by the UPL and Medicare payment principles.

In the Medicare prospective payment system (PPS), Medicare separates GME into two payments, one for direct graduate medical education (DGME) and one for indirect medical education (IME). DGME is the direct costs of educational activities which Medicare does not recognize as part of operating costs for patient services but does recognize that teaching hospitals need this funding to ensure that a physician shortage does not occur. IME costs are the costs to a teaching hospital that are due to "learning by doing" teaching methods and are recognized by Medicare and CMS as being part of "operating costs of inpatient hospital services." In addition to precluding FFP for state GME payments, CMS is also proposing to eliminate Medicare DGME payments from the UPL but include IME payments because they "represent additional costs of providing services in teaching hospitals." Since CMS recognizes IME as a hospital operating cost and the Medicaid statute does not preclude FFP for inpatient and outpatient hospital services, at the very least, states should have the option to help pay for IME costs.

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 MHUMC, these payments amount to \$7.7 million and represent 40% of the current funding that we receive for our medical education programs. Even if the state decided to continue the state portion of GME payments, there would still be a \$4.8 million reduction in funding which is still 25% of the current level. 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

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health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. As the region's only teaching hospital, we provide the medical education experience for more than 100 residents in six different programs: Internal Medicine, Family Practice, Pediatrics, Surgery, OB/GYN, and Radiology. AAMC has called for existing medical schools to increase their residency enrollment by 30% in order to avoid the physician shortages predicted for the near future. Funding for graduate medical education will be necessary in order to train these additional graduates. MHUMC has already reached its allowable resident FTE cap. This means that no additional funding is available for any future increases to our number of graduate medical education slots. If this proposal is adopted, MHUMC will have no choice but to make significant changes in our resident positions to balance the loss in funding. As the only academic medical center within a 200-mile radius, I believe we have a responsibility to the citizens of our city, region, and state to graduate competent physicians to meet their future healthcare needs. However, our greater responsibility is to meet our region's immediate healthcare needs. If this proposed rule is adopted, MHUMC will be forced to make some very difficult choices. Eliminating FFP for state Medicaid agency payments for GME at a time when more physicians are needed throughout the country is not in our nation's best interest.

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 2006, Medicaid represented 26% of MHUMC's volume and uncompensated care (defined as indigent, charity & bad debt write-offs and allowances) amounted to \$110 million.

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.

Service to the Community

Memorial Health is a two-state healthcare organization serving a 35-county area in southeast Georgia and southern South Carolina. The system is headquartered in Savannah, Georgia and includes:

Memorial Health University Medical Center (MHUMC), a 530-bed tertiary care hospital
CareOne Home Health Services, a two-state home care service

The Curtis and Elizabeth Anderson Cancer Institute which includes a basic research component

Memorial Health University Physicians, the area's largest physician group practice, consisting of 30 practices and more than 110 primary and specialty care physicians
A major medical education program that includes six physician residency programs and training for third- and fourth-year medical students from Mercer University School of Medicine in Macon, Georgia
Memorial Health Partners, a medical insurance option for local businesses
NurseOne, a 24-hour call center

Memorial Health is the only teaching and research hospital in the region and has plans to open a Savannah campus of Mercer University School of Medicine with the first class to begin in 2008. Memorial Health is also the home of the region's only trauma center, high-level intensive care nursery, and children's hospital.

Within Chatham County live 238,000 people, 127,000 of which live within the city limits of Savannah. Almost 23% percent of Savannah residents live below the poverty level; the national average is 12.5%. Additionally, the per capita income of Savannahians is only \$17,193, while nationally the per capita income is \$25,036. However, Savannah is also in one of the fastest growing population centers of the state, expected to see 11% growth for the decade 2005-2015. These statistics mean that a large number of the population is uninsured — in fact, more than the average across the nation or even within Georgia.

Memorial Health is the community's partner in addressing public health. Throughout the 52 years of its existence, MHUMC has provided a large amount of charity care to the Savannah-Chatham County area. In 2006, Memorial provided more than \$85 million in charity care. Memorial's emergency department, designed for 48,000 visits per year, received 85,000 in 2006. Many of these visits were for primary care.

In 1997, MHUMC began partnering with the Savannah-Chatham area community by strategically investing in and facilitating the creation of new points of access for primary care for uninsured and underinsured Chatham County residents. Together, these access points form a community-based primary healthcare network that serves the uninsured and underinsured in an integrated and efficient manner.

In the last decade, MHUMC has invested over \$14 million, as support and as seed money, in these community partnerships. Memorial's partners include:

Union Mission's J. C. Lewis Health Care Complex and Phoenix Project
Community Health Mission
Chatham County Health Department
Curtis V. Cooper Primary HealthCare
MedBank Foundation, Inc.
Chatham County Safety Net Planning Council
Savannah Area Behavioral Health Collaborative (SABHC)

Memorial has partnered longest with Union Mission. Funds from Memorial Health have helped to start a respite care program, visiting nurse program for HIV-positive individuals, primary care access, and most recently a full cadre of behavioral health services.

The respite care program provides appropriate care for homeless patients once they have been released from hospitals or other acute care facilities. An additional benefit is that these patients are immediately connected with other social services for their needs.

With Memorial Health's partnership and support, Union Mission also opened a federal qualified health care facility to provide primary care for the homeless, the J. C. Lewis Health Care Complex. This clinic provided a medical home for 3,415 homeless people in 2006 representing 12,106 visits.

For years, Memorial Health has partnered with Savannah Health Mission (SHM) a not-for-profit, volunteer-doctor organization providing free care to uninsured people. Savannah Health Mission reports \$58 per patient as its cost for primary care to uninsured patients and provided over 9,800 patient visits in 2006, more than 12% above the prior year, with an estimated \$2.5 million saved in patient visit costs. By providing needed primary care and prevention to uninsured diagnosed diabetics, \$26 million in medical costs were saved (based on data from the American Diabetes Association). Memorial Health provides the stability needed to ensure the success of this type of clinic by pledging annual support; in 2006, support equaled \$275,000.

For some patients, being compliant to their doctor's orders is not an option. Purchasing medications would break the family budget. For those patients that meet the income requirements, their medications can be provided free-of-charge by MedBank. Memorial Health has supported MedBank (a liaison to the pharmaceutical company programs that assist low-income individuals in accessing prescription drugs) since its inception, providing seed money for development and some stability for this essential service organization. In 2006, Memorial Health supported MedBank with \$60,000. This funding, with other community support, allowed MedBank to supply \$3.2 million worth of free medications to over 5,800 people who would otherwise be unable to continue their medications. These patients are those who take medications on a regular basis for chronic conditions. By helping patients remain compliant, MedBank and Memorial Health are able to improve the medical outcome for the patient and reduce that patient's need for emergency services.

Memorial Health also provided an additional \$20,000 in challenge grant dollars specifically to allow MedBank to partner with other community providers for uninsured patients. This was done to facilitate increased partnerships and thus the efficiency of each provider. MedBank has now begun partnering with Community Health Mission (CHM) and Savannah Area Behavior Health Collaborative (SABHC) to provide access to free medications in their clinics. In the first three months of the SABHC partnership, MedBank provided almost \$380,000 of free prescription medication. A new partnership

Ms. Leslie Norwalk

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with the Curtis V. Cooper Primary HealthCare Center is in progress and has been estimated to have a savings potential of over \$2.5 million for patients in need.

Memorial Health was a founding member of the Chatham County Safety Net Planning Council. Created in March 2004, the Council is an all-volunteer organization authorized by the Chatham County Commissioners and brings together various partners with a shared interest in improving access to health care for Chatham County residents. Council partners include government, private and not-for-profit organizations with a shared goal to improve health care and achieve efficiencies through collaboration.

The Council helps its members and the County Commissioners understand the depth of the problem of uninsured and underinsured in Chatham County through studies. It also advises of valuable partnerships and opportunities for increased efficiencies. Additionally, the Council collects data from each of its members regarding its patient population and is able to alert and advise the County Commissioners of new trends and needs.

These community partnerships and investments in the Savannah-Chatham County community have improved access to healthcare for its citizens. MHUMC is an integral part of the partnerships. MHUMC also serves as the support system for this community network as the region's only Level 1 trauma center, high-level neonatal intensive care unit, and children's hospital. This dependence on MHUMC spreads across 35 counties in two states.

Given their vital 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 CMS to rescind the proposed rule.

Thank you for considering our remarks, and if you have any questions, please contact me.

Sincerely,

MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER



Ramon V. Meguer, M.D.

Senior Vice President and Chief Medical Officer

cc: Robert A. Colvin, President and CEO
Margaret Gill, Chief Operating Officer and Interim Chief Financial Officer
Darcy Davis, Vice President of Finance
Amy Hughes, Vice President of Government Affairs
Julie Windom, Safety Net Coalition



VANDERBILT UNIVERSITY

School of Medicine

THE UNIVERSITY of TENNESSEE
HEALTH SCIENCE CENTER
Memphis, Tennessee

June 20, 2007

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

Attention: **CMS-2279-P**

Dear Administrator Norwalk:

This letter is on behalf of the Deans of each of Tennessee's four medical schools 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).

Removing Medicaid GME funding would have serious consequences for the physician supply for the country and cause potentially irreparable harm to the nation's underserved Medicaid population by limiting its access to medical care.

We fully believe that it was the intent of Congress to have CMS support GME funding through the Medicare *and* Medicaid programs when it passed enabling legislation in 1986. Recognizing and responding to such implied intent would appear to explain CMS support for GME through the Medicaid program to date, recognizing the public good that such funding provides, just as it does through Medicare. Tennessee's experience with Medicaid (TennCare) GME support demonstrates that an accountable system can be developed that can match the flow of funds with expected outcomes. In Tennessee's case, Medicaid's match to the state's contribution to GME has been linked to training collectively fifty percent (50%) of the four medical schools' residents in primary care, with financial penalties if that ratio is not achieved. Likewise, annual audits of each medical school's Medicaid GME allocation ensures that the GME monies are spent on only allowed graduate teaching expenditures. This accountability model could be applied to all states receiving Medicaid GME funds.

With Medicaid GME funds going to academic medical centers around the country, Medicaid patients are assured of gaining specialty as well as primary care services provided by residents and their supervising attending physicians. Access to specialty services for Medicaid patients is increasingly difficult in

today's market place. Our teaching hospitals and clinics staffed with residents and their attending physicians supported by Medicaid GME funds guarantee access for Medicaid patients to specialty care coupled with access to the latest advances in health care found at academic medical centers and affiliated teaching hospitals.

Most concerning about the potential elimination of Medicaid GME dollars is the likely reduction in residency slots around the country at a time when we are facing an acute physician shortage. All predictions suggest a major shortfall in needed specialists and primary care physicians over the next twenty years, as the demand for medical care increases with our growing population (especially the elderly) while the supply of residents graduating each year remains constant. The Association of American Medical Colleges has called for a thirty percent (30%) increase in the number of MDs graduating each year to help address this shortfall. Tennessee's experience again may serve as a bellwether for the nation. When the TennCare program began more than ten years ago, no GME money was budgeted. Within months, emergency meetings were held as The University of Tennessee and East Tennessee State University were faced with the decision to cut residency slots by up to thirty percent (30%) because of the lack of GME support. State dollars with a match through Medicaid ensured the continuation of these residency programs with stipulations as described above.

The Tennessee medical schools receive a total of forty-eight million dollars (\$48,000,000.00) in Medicaid GME toward the residency and retention programs.

	ETSU	Meharry	Vanderbilt	UT	Total
# of residents	238	90	640	830	1798
Amt of GME \$	7,939,612	2,930,825	14,369,876	22,759,687	48,000,000

Were it not for the Medicaid GME dollars, cuts would have been made, which would likely be the case across the nation in many if not most teaching programs if we lost Medicaid GME dollars. Such action would further exacerbate the impending shortage of physicians. Even more concerning is that access to medical care for Medicaid patients would significantly worsen as the number of residents and their supervising physicians declined.

Eliminating Medicaid GME funding at such a crucial time for the nation is not good public policy. Access to needed primary and specialty care will worsen for all Americans, especially our most vulnerable populations, those who depend on Medicaid for their health care. We appreciate your understanding on this vitally important issue.

Sincerely,

Philip Bagnell /s/gg

Dean Philip Bagnell, M.D.
East Tennessee State University
James S. Quillen College of Medicine

Valerie Montgomery-Rice, M.D.

Dean Valerie Montgomery-Rice, M.D.
Meharry Medical College

Steve J. Schwab /maw

Dr. Steve J. Schwab, M.D., Executive Dean
The University of Tennessee Health Science Center

Steven G. Gabbe

Dean Steven G. Gabbe, M.D.
Vanderbilt University School of Medicine



American Public Human Services Association



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

June 20, 2007

Leslie Norwalk, Esq.
Acting Administrator
(by hand/courier)
Hubert H. Humphrey Building
Room 445-G
220 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2279-P: Comments on Proposed Rule *Medicaid Program; Graduate Medical Education*, 72 Federal Register 28930

Dear Administrator Norwalk:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on Graduate Medical Education published in the May 23, 2007 Federal Register (72 *FR* 28930) for the Centers for Medicare & Medicaid Services (CMS).

As you are aware, Graduate Medical Education (GME) payments are an option that state Medicaid programs may choose to provide, subject to approval by CMS. States have the flexibility to determine how to best use available GME funds. GME payments are one tool that has allowed states to become more prudent, farsighted purchasers of care. Many states recognize that support for GME is a valuable tool for meeting the future health care provider workforce needs of Medicaid beneficiaries and the public in general and for providing vital access to care for Medicaid beneficiaries. For example, states increasingly are requiring that some or all Medicaid GME payments be directly linked to state policy goals intended to vary the distribution of, or limit, the health care workforce. Therefore, the elimination of Medicaid funding for GME would not be appropriate.

There is no reason why States should be prevented from using their congressionally mandated flexibility to include all, a portion, or none of a hospital's GME costs as part of a reimbursement methodology especially where doing so would be consistent with accessible care to vulnerable populations and quality of care.

APHSA/NASMD are concerned about the manner in which CMS can "clarify" that payments associated with GME are no longer federally reimbursable under the Medicaid program. States have expressed a great deal of concern because they have participated in state Medicaid GME payments since the beginning of the Medicare and Medicaid

programs. If Medicare payments are allowable it makes sense that the Medicaid program should also pay its share of these expenses. Almost all states reimburse for GME under their Medicaid programs and thus CMS has reviewed and approved Medicaid reimbursement of GME numerous times over a significant period of time. States are grappling with the reasoning behind CMS' decision to issue this proposed rule as there is no record of reports questioning Medicaid payments for GME. States believe that the fact Medicare pays for GME should strengthen the rationale for why Medicaid also pays and should continue to pay for GME. Reducing the payments to hospitals could potentially turn hospitals away from taking Medicaid patients. States will have considerable difficulties if payments to state teaching facilities are reduced and it will put tremendous pressure on state budgets. All of the expenditures are tracked and can be reported separately if necessary. There is no evidence of cases that payments are directed to facilities that do not render services to Medicaid clients.

Looking at this from a different angle, federal financial participation (FFP) is available for care and services that are provided in hospitals under a Medicaid State plan. Some care is rendered at a cost incurred generally by the hospital, but more specifically, by medical residents who are working in an approved GME program. GME is therefore a component of the cost of care incurred by teaching hospitals. Ultimately, residency programs' direct and indirect costs are not separately identifiable units of services. CMS does not appropriately capture the nature of GME costs by indicating that GME is a separate type of care or service rather than a cost of care by indicating that "GME is not included in the list of care and services within the scope of medical assistance." CMS' perspective that GME is not a cost of delivering Medicaid services to beneficiaries overlooks the fact that a sufficient supply of qualified physicians must be maintained to ensure access to both mandatory and optional Medicaid funded services and that residents provide a vital source of access to care for Medicaid beneficiaries. According to the Association of American Medical Colleges (AAMC) the retention rate is nearly three quarters, if the physician was from the state, went to medical school in the state, and did GME in the state. There are many items that are not specifically listed and are considered a cost of doing business (e.g., meals at hospitals) and are therefore included in the rates of payment. It is imperative that states have trained professionals available to serve their Medicaid clients.

CMS asserts that "there is generally no assurance that supplemental Medicaid payments for GME are actually effective in supporting these programs, or in furnishing any benefit to Medicaid program beneficiaries." It is the states' position that the provision of funding to medical educational programs is critical to their continuation and thus the withdrawal of this funding will hurt these programs. States believe that the GME reimbursement by Medicaid is a useful and beneficial part of the program and that eliminating this funding would cause significant harm to the physician workforce.

Medicaid claims including direct and indirect GME cost, as supported by Medicare cost reports, are used for the calculation of payments to training hospitals under the Medicaid GME program. As a result, hospitals in many states which receive GME federal match funds are receiving reimbursement for training costs incurred while providing services to

current Medicaid beneficiaries in conjunction with preparing future providers to the underserved in the states.

States believe that this proposed rule asserts that there is no longer a physician shortage but this is not the case as evidenced in S.896 *Physician Shortage Elimination Act of 2007* which indicates “one third of active physicians are over the age of 55 and are likely to retire in the next ten years, while the population will have increased by 24 percent.” “These demographic changes will cause the population-to-physician ration to peak by the year 2020. Further, in 2005 the Council on Graduate Medical Education stated in a report to Congress that there will be a shortage of not fewer than 90,000 full time physicians by 2020.” Further this does not recognize physician shortages in certain geographic areas, including rural areas or certain physician specialty groups. While CMS may indicate that there is no legal obligation for states to fund GME, the reality is that this regulation will require states to commit significant additional state dollars if they are to maintain training capacity for medical providers. Without doing so, States will have no way to ensure future access to physician services if there is a lack of physicians and thus state Medicaid agencies will be forced to reimburse at higher rates to gain physician access in a more competitive market.

This proposed rule would take effect in the first full State fiscal year following the publication of the final rule. Depending on state fiscal years, this could mean as little as a month or two and that is not sufficient time to make the changes. The states adamantly oppose this rule becoming final but if it does CMS should give states at least 12 months to adjust payment mechanisms or find local funds to offset the loss of these federal funds.

We urge CMS to put GME into statute as an allowable Medicaid expense and/or to work with Congress to make the GME moratorium permanent. Funds made available by the Medicaid GME program are essential to the continued support of access to primary care providers in underserved areas throughout the country. The proposal to eliminate the federal share of funding for this important program reflects a transfer of responsibility for training and access to primary care from the federal government to the states.

We would be happy to provide you with additional information on our comments as you go forward. Please contact Martha Roherty, Director of NASMD, at 202-682-0100 if we can be of further assistance.

Sincerely,



Jerry W. Friedman
Executive Director
American Public Human Services Association



David Parrella
Chair
NASMD Executive Committee



23
Finance Administration
3000 New Bern Avenue
Raleigh, NC 27610

919 350-8344
Fax 919 350-5363

June 19, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore MD 21244-1850

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

Dear CMS Administrator Norwalk:

The purpose of this letter is to comment on the Centers for Medicare and Medicaid Services' proposed rule on the Medicaid Program; Graduate Medical Education (GME) displayed May 23, 2007. I work for WakeMed Health & Hospitals in Raleigh, North Carolina. WakeMed is an 870-bed private, non-profit health system. WakeMed consists of two acute care hospitals, one inpatient rehabilitation facility, two skilled nursing facilities, one home health agency, two outpatient facilities, and six outpatient rehabilitation facilities. WakeMed is the largest off-site teaching program for the University of North Carolina at Chapel Hill School of Medicine.

The proposed rule states that CMS will no longer provide federal Medicaid matching funds for graduate medical education purposes. According to the rule, the Federal Medicaid statute does not explicitly provide for the payment of GME. The proposed rule would clarify that for the purpose of Medicaid reimbursement eligible for Federal Financing Participation (FFP), GME is not an allowable cost or payment for medical assistance under a state's approved Medicaid Plan.

The federal government has always provided funds to teaching hospitals through the Medicare and Medicaid programs to help cover the cost of educating and training doctors. These funds have helped defray some of the costs to a hospital for medical interns and residents to treat elderly and indigent patients. In 2006 WakeMed had 51 interns and residents that provided care for almost 200,000 Medicare and Medicaid patients. I am concerned that if the proposed rule is implemented it could have a significant impact on WakeMed and other teaching hospitals in the state of North Carolina. If the federal government eliminates matching funds the state has two options: provide its own funding or shift funding away from GME. If the state shifts its Medicaid spending away from graduate medical education, because of the loss of federal matching funds, WakeMed stands to lose approximately \$10 million dollars per year in funding under the state's Medicaid Reimbursement Initiative. For this reason, I urge CMS to withdraw CMS-2279-P.

Please contact Christine Sibley at 919-350-7974 or Christine Craig at 919-350-2951 if you have any questions.

Sincerely,

Rebecca Andrews
Vice President, Finance

cc: Christine Sibley
Christine Craig



June 18, 2007

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

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

St. John's Mercy Medical Center (SJMMC) is a 979-bed, acute care hospital in St. Louis, Missouri. This includes subprovider units for Psych, Rehab, and SNF. SJMMC currently operates a Graduate Medical Education (GME) Program with 90 interns and residents. We are writing to provide comments concerning the proposed rule clarifying that costs and payments associated with GME programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program. Thank you in advance for considering our comments.

The care and services that may be included within the scope of medical assistance under a Medicaid State plan are generally set forth in section 1905(a) of Title XIX of the Social Security Act (the Act). Per CMS, GME is not included in this list of care and services within the scope of medical assistance. Section 1905(a)(5) includes services furnished by a physician whether furnished in the office, patient's home, a hospital, or a nursing home, or elsewhere. We fully understand that "physician", per Section 1861(r) of the Act, means a doctor of medicine legally authorized to practice medicine and surgery by the State in which he/she performs such function or action. Interns and Residents (residents) may not be licensed by the State however they are an integral part of the continuum of care provided to all patients. We believe CMS did not consider the significant cost of replacing residents with licensed physicians. Physicians provide patient care through the supervision of residents. Without this arrangement, additional licensed physicians would be required at a significant cost. Previous analysis on our own GME program supported an additional \$6 million of net cost when residents were replaced by licensed physicians. This additional cost would be borne by all payers, including Medicaid.

In this proposed rule, CMS distinguishes between direct GME payments and indirect medical education (IME) payments. CMS states that IME payments represent an additional Medicare payment for health care services provided to Medicare beneficiaries in teaching hospitals. This implies that IME costs fall within the definition of medical assistance and therefore federally reimbursable under the Medicaid program. As noted above, GME services and costs are **not**

within the scope of medical assistance. CMS is acutely aware that the premise for IME payments are based on resident's historically ordering additional patient care services such as lab tests and diagnostic imaging. SJMMC fails to find the logic how IME costs are considered medical assistance when these same costs are the result of residents ordering additional tests.

CMS refers to a state survey conducted by the Association of American Medical Colleges. This report mentions that States generally do not track Medicaid GME payments because payments are made through increases in per diem rates for covered Medicaid services. It is difficult to break out GME funding within the per diem. For this reason, CMS believes it is difficult to quantify Medicaid GME payments or monitor and measure the effect of Medicaid payments on GME programs. We believe CMS should make it mandatory for States to account for and monitor funding for GME programs. States are permitted flexibility to develop their own methods and standards to determine the price they will pay for Medicaid covered services. SJMMC applauds CMS for allowing States this flexibility. We believe the ability to quantify Medicaid GME payments should start with the Medicare Cost Report. Worksheet E-3, Part IV, Title XIX should be the basis to develop Medicaid GME payment methodologies to be included, and ultimately reviewed, by CMS for approval. SJMMC presumes CMS already utilizes this cost report workpaper to quantify, monitor, and measure Medicare payments on GME programs.

While GME costs are not specifically identified or considered "medical assistance" under the Act, they have a significant influence in the determination of medical assistance costs. CMS misses the point that GME costs are an integral part of the continuum of care for patients regardless of the provider. We believe CMS should consider GME costs and payments as expenditures for medical assistance that are federally reimbursable under the Medicaid program.

Thank you again for considering our comments. Should you have additional questions, please contact Ron Trulove at 314-364-3504.

Sincerely,



Randall J. Combs
Executive Vice President, CEO & COO

MICHIGAN STATE
U N I V E R S I T Y

June 20, 2007

Ms Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Ms. Norwalk:

The Deans of Michigan State University's Colleges of Human Medicine and Osteopathic Medicine are writing in response to the proposed rules eliminating federal financial participation (FFP) in Medicaid payments in support of graduate medical education (GME). We understand that Congress has placed a moratorium on the implementation of this rule for at least a year. However, we are concerned about possible implementation following the expiration of the moratorium. We strongly oppose the adoption of CMS-2279-P. Our opposition to the proposed rules is based on the following:

COLLEGE OF
HUMAN MEDICINE

Michigan State University
East Fee Hall
East Lansing, MI
48824-1316

COLLEGE OF
OSTEOPATHIC
MEDICINE

Michigan State University
East Fee Hall
East Lansing, MI
48824-1316

1. Implementation of the proposed rules would reverse more than 40 years of federal and state Medicaid policy. As noted in the preamble to the proposed rules, 47 states and the District of Columbia use Medicaid funds to pay the program's fair share of hospital costs related to GME. Michigan has included GME costs in its hospital payments or have specifically identified and paid GME costs since 1970. Most states have adopted Medicare principles to calculate Medicaid's fair share of GME costs. 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 auditors for not meeting federal statutory provisions and to our knowledge CMS has never received a federal audit exception for allowing such payments.
2. CMS has no express authority to limit FFP for hospital payments beyond that given in statute which is to limit them to a reasonable estimate of what Medicare would have paid for the service. Within this broad limit, states are given the flexibility to develop hospital payment methodologies that ensure access to quality hospital services and which further the goals of the Medicaid program with regard to hospital services. CMS has acknowledged this flexibility and limitation on page 28932 of the Federal Register under the heading "Medicaid State Plan Payments".

Michigan, as well as every other Medicaid program, has submitted its hospital payment methodology to CMS and received approval for the same. Hospital services are a mandatory State Plan Service. Neither the statute nor rules promulgated by CMS or its predecessor the Health Care Financing Administration have specified every component of the rate methodology for hospital payments or any other service covered by Medicaid.

3. The proposed rule is inconsistent with Medicare and other major third party payer policies regarding the payment of GME costs. As stated in the preamble to the proposed rule Medicare is required by Title XVIII to pay its share of GME costs. Other major payers like Blue Cross and Blue Shield of Michigan also cover GME costs in their payments to teaching hospitals. If FFP for GME payments made by state Medicaid agencies is disallowed, Medicaid beneficiaries will be denied access to the high quality specialty services offered by teaching hospitals because the payments offered by the Medicaid program will be even lower and will not cover the hospital's legitimate costs of providing services. Medicaid payments are already among the lowest of all third party payers and this forced reduction would make them even further out-of-step with other payers.
4. Eliminating FFP for state Medicaid agency payments for GME would cripple graduate medical education at a time when Michigan and the nation as a whole are facing significant physician shortages. The January 2005 report of the federal Council on Graduate Medical Education (COGME) forecasts a national shortage ranging from 85,000 to 96,000 physicians in 2020. Application of the COGME methodology to Michigan's physician needs yields a shortage of approximately 4,400 physicians by 2020. To inflict such a devastating blow to GME funding at a time when more physicians are needed throughout the country is unwise.
5. The CMS position that GME funding is not allowed as a Medicaid expenditure is also inconsistent with the Department of Justice's position that residents are employees who spend as much as 74% of their time in activities directly related to patient care. Without residents many of the nation's safety net hospitals would be unable to provide care to Medicaid beneficiaries at current Medicaid payment rates.
6. If Medicaid stops funding its share of GME costs it will result in additional cost shifting to other third party payers and employers who fund the costs of their employees' health care directly. Cost shifting is already a major issue for these groups and an additional burden may further erode employer-sponsored health care coverage. This is at a time when employers, particularly small employers, are dropping employee health coverage at an unprecedented rate.

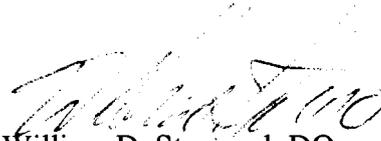
Given the above, we believe that the proposed rules should be withdrawn and that FFP should remain available for GME expenditures made by states. The federal government has already protected itself from profligate spending by states through the application of the statutory upper payment limit on hospital costs. In addition, the recently imposed CMS requirements that ensure that providers keep the payments made to them under the

Medicaid program protect against state funding schemes that are intended to reduce the state's share of Medicaid costs.

Sincerely,



Marsha D. Rappley, MD
Dean
College of Human Medicine



William D. Strampel, DO
Dean
College of Osteopathic Medicine

Cc: Michigan Congressional Delegation
Michigan Hospitals Involved in GME
American Association of Medical Colleges

26
Rec'd
6/21/07

Alan D. Aviles
President

June 21, 2007

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

Dear Administrator Norwalk:

SUBJECT: CMS-2279-P

On behalf of the New York City Health and Hospitals Corporation (NYCHHC), the public hospital system of New York City, I urge the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2279-P (the Proposed Rule). The Proposed Rule would eliminate federal financial participation (FFP) matching funds for Medicaid Graduate Medical Education (GME) payments. Implementation of this rule would seriously undermine the finances of public hospital systems such as NYCHHC, which plays an important role in training the nation's physicians. Currently 2,294 physician residents are receiving their training at NYC HHC hospitals. Finalization of the rule would result in a \$200 million reduction in federal Medicaid funds for our system in the first year of implementation; and a total of \$1 billion over five years. More than one third of projected GME reductions in New York State would come from NYCHHC facilities as a result of the implementation of the proposed rule.

Nearly half of the full time physicians working at NYCHHC are medical residents. Currently, NYCHHC, like many public systems, relies heavily on resident physicians to help provide quality care to our patients. It is only right that Medicaid should help pay for graduate medical education when these medical residents are providing health care services to Medicaid eligible patients.

Additionally, due to the unique patient mix at our facilities, which is approximately 45% Hispanic, 40% African American and 10% Asian, with immigrants from every corner of the earth, doctors with NYCHHC training are highly coveted. New York City is a gateway to the United States and many diseases from abroad make their first major American splash at our facilities. This provides essential training and experience for medical residents who, ultimately, practice medicine across the country. Eliminating federal support for GME would have a devastating affect on our medical training programs, with major ramifications for the quality of medical care in New York and nationwide.

Leslie Norwalk, Esq.
June 21, 2007
Page 2

The proposed rule is a major reversal of long standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs associated with training physicians. There is no rational reason why Medicaid should end its historic contribution to training the nation's doctors. Teaching hospitals receive medical education payments from multiple payers because each payer is expected to contribute its "fair share" of medical education costs. Medicaid should make its fair contribution – even if not explicitly required by statute. Policymakers, over decades, have recognized the responsibility of both Medicaid and Medicare to help support GME.

At a time when the supply of doctors in the United States is also grossly inadequate for an expanding and aging population, it is ill advised for the federal Government to drastically reduce support for physician training programs. In fact, the Council on Graduate Medical Education (COGME), an independent body charged with providing advice and recommendations regarding the supply of physicians and financing policies, issued a report in 2005 recommending an increase in U.S. medical school enrollment of 15%. The fact that our nation is already heavily dependent on doctors from abroad to fill about a fifth of residency slots in U.S. hospitals illustrates the acute shortage that currently exists. More than 25% of current U.S. physician residents have attended foreign medical schools. Lessening support for training physicians could only worsen the situation.

The NYCHHC system encompasses eleven public hospitals, six trauma centers, four long-term care facilities and an extensive primary care network. Health care is provided to more than 1.3 million New Yorkers, of whom 400,000 are uninsured. In 2006, NYCHHC facilities accounted for one fifth of the acute hospital discharges in New York City, more than 21,000 births and almost 1 million emergency department visits. Additionally, NYCHHC is an essential provider of highly specialized tertiary services such as trauma care, neonatal intensive care, burn units and psychiatric emergency care for all New York City residents.

Policy decisions that reduce physician training funding will undoubtedly have a profound negative effect on the health and welfare of millions of New Yorkers and individuals across the country. On behalf of NYCHHC and the 1.3 million patients we serve every year, I urge you to withdraw this ill-conceived rule. Now is the time to increase, not decrease, Medicaid's historic rule in helping train the nation's physicians.

Sincerely,

A handwritten signature in black ink that reads "Alan D. Aviles". The signature is written in a cursive style with a large, stylized initial "A".

Alan D. Aviles



Charles N. Kahn III
President

June 22, 2007

VIA HAND-DELIVERY

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

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

Dear Ms. Norwalk:

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

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

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

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

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

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

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

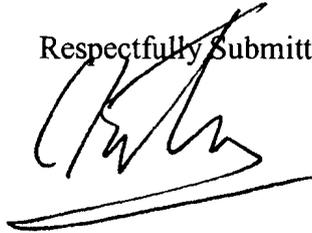
Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced,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

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

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

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

Respectfully Submitted,

A handwritten signature in black ink, appearing to be 'C. Speil', written over a horizontal line.

28

June 20, 2007



2007 JUN 22 AM 11: 11

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

Re: CMS-2279—P, Medicaid Program; proposed changes to the Medicaid program that concern costs and payments for Graduate Medical Education programs as federally reimbursable expenditures for medical assistance.

Dear Administrator Norwalk:

I am writing on behalf of the Yale New Haven System. YNHHS is the leading health care system in the state of Connecticut, with approximately 12,000 employees. YNHHS – through Yale-New Haven, Bridgeport and Greenwich hospitals and their affiliated organizations – provides comprehensive, cost effective, advanced patient care characterized by safety, quality and service. Although we work in multiple locations, we have a common set of goals: to deliver out-standing patient care; create the best working environment for our employees and physicians; and use our resources effectively and efficiently. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule for proposed changes to the Medicaid program. These changes concern costs and payments for Graduate Medical Education programs as federally reimbursable expenditures for medical assistance.

Yale New Haven Health System is pleased to note the Medicaid provision contained in the Fiscal Year 2007 Emergency Spending Supplemental Appropriations bill. This bill imposes a 1 year moratorium on the Medicaid Final Rule regarding cost limits as well as any proposal to prohibit support for Medicaid GME funding.

While we are pleased that the moratorium is in place, we feel strongly that we must 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). We also respectfully request that CMS abandon any future attempts to impose this proposed rule. Implementation of this rule would severely damage the financial condition of our teaching hospital and negatively impact our opportunity to fulfill our mission of not only teaching but also patient care and outreach.

The proposed rule represents a reversal of a Medicaid policy that Yale New Haven Health System and CMS have followed in excess of 50 years. Yale New Haven Health System has advancing the education of health professionals at the core of its mission. We annually train over 500 resident physicians in over 100 medical specialties. And, at Yale-New Haven Hospital alone, one out of every four patients is a Medicaid recipient.

789 Howard Avenue
New Haven, CT 06519-1300

At a time when hospitals are providing unreimbursed care to the uninsured and under insured at growing rates and in a state with one of the lowest Medicaid hospital reimbursement rates in the country, eliminating the FFP payments for GME would be devastating. In 2004, our most recent filed Medicaid cost report, YNHHS was paid \$3.8 million by Medicaid for inpatient GME.

It is vitally important to our hospital and our community that state Medicaid programs receive federal matching assistance for GME. Yale New Haven Health System urges the Agency to rescind the proposed rule.

Sincerely,

A handwritten signature in cursive script that reads "Kyle L. Ballou".

Kyle L. Ballou Esq.
Administrative Director
Community and Government Relations
Yale New Haven Health System

June 19, 2007

200 First Street SW
Rochester, Minnesota 55905
507-284-2511

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

Re: CMS-2279-P
Comments Regarding the CMS Proposal to Exclude Medicaid Graduate Medical Education Reimbursement

Dear Ms. Norwalk:

Mayo Clinic is pleased to have the opportunity to respond to the proposed rule published in the *Federal Register* on May 23, 2007. This proposed rule would exclude costs and payments associated with Medicaid Graduate Medical Education (GME) programs as qualified expenditures for medical assistance when used in determining Federal grant funding. Mayo Clinic has teaching hospitals located in Minnesota, Arizona, Florida and Wisconsin that provide care to both Medicare and Medicaid beneficiaries. GME funding, both at the State and Federal level, is a key component for these hospitals in providing patient care to low-income families, the elderly, and persons with disabilities.

CMS's conclusion for this proposed rule appears to be based upon two statements: 1) GME is not a specifically listed covered health service under the Medicaid Statute and 2) GME is not recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services. We disagree with both of these statements and present our arguments below.

Covered Health Service under the Medicaid Statute

Federal grant funding or federal financial participation (FFP) is available to States for a percentage of the amounts expended for medical assistance under the State plan. As CMS states in the proposed rule, medical assistance is generally set forth in section 1905(a) of the Social Security Act. CMS states that GME is not specifically included in this list of care and thus concludes GME services are not within the scope of medical assistance. We disagree with this conclusion and believe that GME services are defined in section 1905(a)(5) as services furnished by a physician. These physician residents within GME programs provide medical services to Medicaid patients. The costs for these residents are borne by the teaching hospitals.

The Accreditation Council for Graduate Medical Education (ACGME) defines GME as "the period of didactic and clinical education in a medical specialty which follows the completion of a recognized undergraduate medical education and which prepares 'physicians' for the independent practice of medicine, also referred to as residency education."^[1] ACGME also defines a resident as a "physician" in an accredited graduate medical education program. As stated by CMS, most states use Medicaid funds to make GME payments to hospitals under the Medicaid State Plan and

^[1] Accreditation Council for Graduate Medical Education, Glossary of Terms (June 27, 2006), http://www.acgme.org/acWebsite/about/ab_ACGMEglossary06_06.pdf

are either included in hospital rates or some other supplemental payment. Based upon these arguments, we believe that GME services are considered a covered service under the Medicaid statute.

Cost Component of Hospital Services

CMS also tries to rationalize excluding GME costs from Medicaid funding because it is not specifically defined as an inpatient hospital operating cost under section 1886(a)(4) of the Act. We note that section 1886 defines all Medicare payments to hospitals for inpatient services and not just the operating portion. We agree that GME is not a normal operating cost because not all acute care hospitals have an approved GME program. However, GME is still considered an eligible component of inpatient hospital payments under section 1886(h) of the Act even if apart from the prospective payment amount. Therefore, we are confused with CMS's rationale for excluding GME costs from Medicaid funding on the basis that it does not meet the definition as an "operating" cost for Medicare.

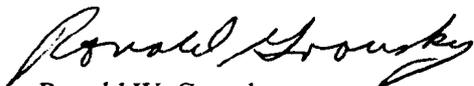
The rules for FFP are covered under 42 CFR Subpart 447. The limitations are governed in 42 CFR §447.257, whereby funding for hospital inpatient services is not allowable for amounts in excess of the upper payment limit (UPL). The UPL is further defined in 42 CFR §447.272(b)(1) as the reasonable estimate of the amount that would be paid for services furnished under Medicare payment principles. There are no references in this subpart to exclude GME activities nor that it be based only on "operating" costs. Therefore, since FFP is governed by Medicare payment principles and Medicare principles allow for reimbursement of GME for those qualified inpatient hospital services, we believe that costs and payments associated with GME programs are considered qualified expenditures for medical assistance under the Medicaid program.

Conclusion

We strongly urge CMS to rescind the provisions of this proposed rule. We believe CMS has not provided any justification in the Statutes and Regulations to exclude the costs and payments for GME activities for qualification for medical assistance. In addition, the estimated \$1.8 billion impact to teaching hospitals over the next five years could have significant ramifications throughout the country.

If you should have any additional questions or comments, please feel free to contact either Robert Howey at (904) 953-2698 or me at (507) 284-4627.

Very truly yours,



Ronald W. Grousky
Director, Medicare Strategy Unit
Mayo Clinic



Wake Forest University Baptist

JUN 25 2007

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Gina B. Ramsey
Vice President, Financial Services
Chief Financial Officer
North Carolina Baptist Hospital
Telephone: (336) 716-3005
Fax: (336) 716-2067

June 22, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: (CMS-2279-P)
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201

Dear Ms. Norwalk:

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled, "Medicare Program; Graduate Medical Education," (Vo.72, No.99), May 23, 2007." NCBH is part of Wake Forest University Baptist Medical Center, an academic health system comprised of 1,157 acute care, psychiatric, rehabilitation and long-term care beds located in the northwestern section of North Carolina, the region's main tertiary referral center.

We are writing to express our serious concerns about CMS' plan to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education payments (GME).

Background:

On May 23, 2007, CMS released CMS-2279-P, which seeks to clarify for purposes of Medicaid reimbursement eligible for FFP, that GME is not an allowable cost or payment for medical assistance under the approved Medicaid State Plan. The provision would apply to all Medicaid providers and must be implemented in the first full State fiscal year following the effective date of the subsequent final rule.

Problems with the Proposed Rule:

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid

North Carolina Baptist Hospital

Medical Center Boulevard • Winston-Salem, North Carolina 27157

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. As a teaching hospital, we rely on these and other Medicaid payments.

Medicaid GME payments help NCBH sustain one of its 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 future. In fact, The North Carolina Institute of Medicine, which studies the healthcare workforce, released projections on December 21, 2006 that suggest North Carolina could face as much as a 21% drop in the number of doctors per 10,000 residents by 2030. Many North Carolina physicians will be retiring over the next few years, at the same time many new residents are making North Carolina their home. The report stated the North Carolina academic medical centers must train more doctors to meet this demand. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed not only in North Carolina, but throughout the country as well.

Impact:

According to CMS, the regulation as proposed would cut Medicaid funding by at least \$1.8 billion over five years. It is said that these cuts are necessary in order to ensure the fiscal integrity of the Medicaid program. NCBH believes in having a healthy Medicaid program, but thinks the proposed regulation goes far beyond what is needed to attain financial stability. We firmly believe that CMS-2279-P would undermine the already fragile viability of the nation's health care safety net and reduce or eliminate access to health care services for millions of low-income patients.

The proposed cuts would significantly limit the funding available for state Medicaid programs. With insufficient financing for its share of Medicaid, North Carolina would be forced to find new funding sources or make cuts to the program, which would directly affect participant eligibility and a reduction in benefits and services provided. These types of cuts would threaten our ability to continue to provide health care to our Medicaid and uninsured population.

At NCBH we fulfill a unique and critical role in the health care system by providing high intensity services, such as trauma and neonatal intensive care to the entire community and the western region of our state while also ensuring that Medicaid recipients and the uninsured have

access to all medical services. In fact, the number of Medicaid inpatient admissions for NCBH has grown from 5,028 admissions in 2001 to 7,198 in 2006; an increase of 43.2%. In 2001, Medicaid admissions represented 16.3% of our total admissions. In 2006, it represented 20.8% of our total admissions. The number of our uninsured patient admissions from 2001 to 2006 has grown by 75.5% from 1,225 admissions in 2001 to 2,150 in 2006. To help put this in perspective, our total admission grew only 12% from 2001 to 2006, from 30,828 in 2001 to 34,525 admissions in 2006. The Medicaid and uninsured patient population admissions have significantly outpaced our overall growth rate.

It is estimated if the FFP matching funds associated with Medicaid GME payments are eliminated, NCBH would lose approximately \$13 million annually in Medicaid GME funding, which is crucial to our ability to fulfill our mission as an academic medical center. We will be forced to eliminate needed services and eliminate jobs.

Recommendations:

NCBH opposes the proposed rule and respectfully requests that CMS rescind it.

NCBH remains committed to working with CMS, other health care organizations, such as the American Hospital Association (AHA), Association of American Medical Colleges (AAMC), National Association of Children's Hospitals (NACH), the National Association of Public Hospitals (NAPH) and the National Governors Association (NGA) to ensure that Medicaid beneficiaries have continued access to high quality, efficient and effective health care. We look forward to a continuing dialog as it relates to this proposed rule.

If you have any questions concerning these comments, please contact Joanne C. Ruhland, Vice President, Government Relations at jruhland@wfubmc.edu or 336-716-4772.

Sincerely,


Gina B. Ramsey

C: Senator Elizabeth Dole
Senator Richard Burr
Representative Virginia Foxx
Representative Mel Watt



"People
helping people
help
themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

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Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

June 21, 2007

Ms. 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

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

Dear Ms. Norwalk:

On behalf of the State of Indiana, I am writing to express concerns regarding the proposed rule CMS-2279-P (Medicaid Program; Graduate Medical Education) published in the *Federal Register* on May 23, 2007. The Centers for Medicare and Medicaid Services proposes to eliminate federal financial participation for direct graduate medical education costs incurred by teaching hospitals. This change will result in a significant decrease in reimbursement for teaching hospitals overall, and raises serious public health concerns regarding the future of graduate medical education programs with the proposed elimination of Medicaid as a funding source.

The commentary of the proposed rule distinguishes two types of costs unique to teaching hospitals – direct graduate medical education and indirect medical education. Direct graduate medical education is defined in the rule as compensation for “the direct costs of their educational activities, as measured by the number of residents being trained and the historic cost of training residents.” In the context of the Medicare cost report, it is unclear whether the direct GME costs to be disallowed are direct costs of salaries and benefits for interns and residents from Worksheet B Part I or the Medicare allowed direct GME cost calculated on Worksheet E-3 Part IV. It is also not clear whether other hospital overhead costs allocated to the education program cost centers would constitute indirect medical education costs or would be included as direct medical education costs and therefore considered to be non-allowable costs.



The proposed addition at §447.201(c) does not make the distinction between direct and indirect GME and states "the plan must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system". However, within the CMS commentary it is stated that States "are able to recognize, as part of the inpatient hospital rate structure, the additional Medicaid covered service costs that teaching hospitals incur when delivering Medicaid covered services". Clarification is requested as to whether the proposed addition to §447.201(c) refers only to direct graduate medical education costs.

The exclusion of direct graduate medical education costs from direct reimbursement to teaching hospitals and from the estimate of Medicare payments used in the calculation of upper payment limits essentially forces either the State or the hospitals to absorb these higher costs. The reduction in overall reimbursement that teaching hospitals could experience as a result of this rule may have the unintended consequence of creating a disincentive for hospitals to continue to provide graduate medical education programs. This could lead to a future shortage of medical professionals, especially those providing services to low-income or indigent patients, and bring about the same situation which payments for graduate medical education were originally intended to remedy.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeff M Wells", written in a cursive style.

Jeffrey M. Wells, MD
Director of Medicaid



JUN 20 2007

June 18, 2007

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

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

ATTENTION: CMS-2279-P

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

Dear Sir or Madam:

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

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

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

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

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

(government, non-State government, or private), exceed a reasonable estimate of what Medicare would have paid for the same services using Medicare payment principles.)

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

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

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

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

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

1. GME has been historically recognized, accepted and paid by the Federal and State governments as a legitimate component of inpatient & outpatient hospital cost of care for teaching providers, since Title XIX (Medical Assistance) was enacted in 1965

2. GME has been historically recognized as a necessary and proper cost of teaching providers that is related to patient care and has been recognized as a component cost of inpatient and outpatient hospital services
3. The Federal Government's attempt to shift a portion of their financial responsibility for a component of teaching facility cost and treatment to other payers
4. Short and Long-term consequences to the proposed discontinuation of federal financial participation in the training of qualified physicians, through GME programs, that could potentially lead to reduced quality of care and services for our disadvantaged MA patient populations and ultimately, other payers

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

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

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

“Medicare has historically paid a share of the net cost of approved medical education activities. Our regulations at 42 CFR 413.85(b) currently define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. These activities include approved training programs for physicians, nurses, and certain paramedical health professionals (sometimes referred to as allied health professionals), for example, physical therapists. The allowable costs of these activities include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for

example, employee health and welfare benefits) that are appropriately allocated to the particular medical education cost center." ...

"The Medicare program has shared in the costs of approved medical education activities, as defined above, on a reasonable cost basis. Section 1861(v)(1)(A) of the Social Security Act (the Act) defines reasonable cost as the cost actually incurred, excluding any cost unnecessary in the efficient delivery of needed health services to Medicare beneficiaries. Section 413.85 of the regulations further specifies that the allowable cost of approved educational activities is the net cost, which is determined by deducting tuition revenues from total costs."

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

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

As the above payment notations prove, GME costs while not paid under the Medicare Inpatient Prospective Payment System (IPPS) DRG operating and capital payment formulas, are still being recognized and paid under a different Medicare "pass through" payment methodology. As such the implied position taken in the proposed rule, that these GME costs

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

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

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

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

- Costs related to patient care (42 CFR § 413.9):
 - *Principle* - All payments to providers of services must be based on reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and

proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost...”

- “(1) *Reasonable Cost* - Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.”
- “(2) *Necessary and Proper Costs* - Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.”

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

- GME costs are necessary and proper because they are costs incurred that are common and accepted treatment costs in teaching hospitals
- Interns/residents are performing direct patient care (inpatient, outpatient, psychiatric, rehabilitation, ancillary, etc.) activities in accordance with their approved GME training program requirements
- GME costs were limited over the years through various means (by Medicare and State government) to assure the reasonableness of the GME costs
- All hospital specific MA GME base limits applied in Pennsylvania were determined through true step down allocation methodology approaches to assure that net GME costs related to patient care were allocated to appropriate patient service areas and that the MA GME amount was based on the proportion of actual medical assistance patient utilization
- Historically both Medicare and Medical Assistance have recognized GME costs as necessary and proper costs of teaching providers and

have paid for their share of these costs under different payment methodologies over 42 years

- The proposed rule attempts to portray GME expenses as a “specific health service” and not recognize it as a component part of every patient service. Residents and their supervising physicians are critical parts of the treatment teams (in teaching providers) rendering all types of needed services to all patients (Medicare, MA and all other patients).
- GME costs are the “hands on” resident and supervising physician costs associated with actual patient care. The AAMC describes Graduate medical education (GME) as:

“...the second phase of the formal educational process that prepares doctors for medical practice. GME is required of all medical school graduates seeking full medical licensure and board certification in one of the specialties and/or subspecialties of medicine. This phase of medical education is, of necessity, conducted primarily in clinical settings, and requires direct participation by residents in the delivery of patient care services.”

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

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

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

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

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

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

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

We contend that this proposed rule to stop funding of Medical Assistance GME expenditures is contrary to this guiding Medicare principle which has been historically followed by Medicare. The Medical Assistance portion of GME costs for

teaching providers will now have to be borne by other patients or other tax payers. Clearly this proposal is not fair to the other patients, taxpayers or to teaching providers. Again we urge CMS to rescind this proposed rule.

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

If this proposed rule to eliminate all Federal financial participation in Medical Assistance GME expenditures is not withdrawn then it will have an immediate negative impact on all State governments and teaching providers. Long-term consequences will clearly impact all patients through a decline in the caliber of its physicians, an unavoidable decline in the quality of care, possible slow-down in long-term clinical innovations and or a general cut in patient services. While teaching hospitals and State governments will clearly attempt to continue their training programs the challenges of finding other GME funding sources will clearly place significant financial stress on all involved. While some states may decide to increase taxes to fund the lost federal match, others will not and may drop Graduate Medical Education (GME) funding all-together. These GME funding shortfalls will place an immediate financial and administrative burden on teaching providers who have limited short term options in dealing with revenue shortfalls. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country. Short-term remedies would require immediate reduction in hospital staffing, reduced or closed clinic hours, and planned reductions in residency programs or FTEs would also be required. All these options clearly reduce quality, the educational opportunities for residents, and patient care options and services, to the detriment of all patients.

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

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of UPMC's education and research missions, we offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, UPMC is looked to as a front-line responder in the event of a local and/or national disaster and have implemented plans to fulfill that role. If this FFP funding for GME payments is removed it hinders UPMC's ability to continue to fulfill these missions.

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

Conclusion

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

Sincerely,

Edward Karlovich *CK*

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

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



June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201
Attention: CMS-2279-P

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

Dear Administrator Norwalk:

The American Dental Education Association (ADEA) strongly urges the Centers for Medicare and Medicaid Services (CMS) to rescind its proposed rule that would eliminate federal financial participation (FFP) matching funds for state Medicaid payments for graduate medical education (GME), as published in the May 23, 2007 Federal Register. Eliminating these federal matching funds would have a very deleterious impact on resident training programs throughout the country, including dental programs.

ADEA is the national organization that speaks for dental education. It is dedicated to serving the needs of all 57 U.S. dental schools, 714 U.S. dental residency programs, 550 allied dental programs, as well as 11,332 full- and part-time dental school faculty, 5,577 dental residents (both hospital- and school-based) and approximately 34,000 dental and allied dental students.

Some dental programs rely on GME funding to operate. For these programs, any reduction in this funding stream could mean a change in the number of residents being trained or the quality of the training provided. We understand that at least as of 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education (IME) funding under their Medicaid programs. Residency programs operate under very tight budget constraints and any reductions, including simply the FFP matching funds, have a significant impact.

The mission of the American Dental Education Association is to lead individuals and institutions of the dental education community to address contemporary issues influencing education, research, and the delivery of oral health care for the improvement of the health of the public.

2007-08 BOARD OF DIRECTORS

Table listing the 2007-08 Board of Directors with names, titles, and roles such as President, Vice President, and Executive Director.

Leslie Norwalk, Esq.
June 22, 2007
Page 2

While CMS describes this proposal as simply a "clarification," such is just not the case. In fact, for decades, state Medicaid programs have included these GME payments in their state plans, which CMS has reviewed and approved, knowing that FFP matching funds would be provided. This proposed rule represents a clear shift in federal policy. As such, it is certainly deserving of much more thought and planning than what a 30-day comment period provides. Moreover, Congress has enacted legislative language that would impose a one-year moratorium on this rule. We urge CMS to use this moratorium to seriously rethink this proposal.

Post-graduate dental residents staff the dental clinics nationwide that provide much needed dental care to the indigent. In turn, many of these residency programs depend upon GME funding to operate at their current levels. In enacting the Balance Budget Act of 1997, Congress excluded dental residents from the GME/IME cap on residency programs, recognizing the urgent need in our country to train more dental residents. It would undercut that goal to decrease GME/IME funding in any way.

Again, we urge CMS to rescind this proposed rule with respect to eliminating FFP matching funds for state Medicaid GME payments.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard W. Valachovic" with a stylized flourish at the end.

Richard W. Valachovic, D.M.D., M.P.H.
Executive Director



American Academy of Family Physicians

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June 22, 2007

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

CMS-2279-P

Dear Administrator Norwalk:

On behalf of the five family medicine organizations we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) proposed rule entitled *Medicaid Program; Graduate Medical Education* (72 Fed. Reg. 28930, May 23, 2007.)

Our position on this proposed regulation is clear - we oppose any policy that would not allow Medicaid to fund graduate medical education. We urge the Agency to withdraw this proposed rule. In fact, we do not understand CMS's rush to publish this proposal when the Agency was well aware that Congress was in the process of acting to prevent such an administrative action. As the Agency is well aware, the President was just days away from signing into law a bill that included a one-year moratorium (H.R. 2206 - a FY2007 supplemental appropriations bill) prohibiting the Secretary of Health and Human Services from "take [ing] any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to ..."promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program."

In this proposal, CMS contends that "costs and payments associated with Graduate Medical Education programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program," and that "GME cannot be included as part of any payment methodology in the Medicaid State Plan."

We are providing a legal analysis (attached) asserting that the Agency is mistaken in its belief that there is no legal foundation for Medicaid to pay for graduate medical education. The preponderance of evidence is clearly weighted toward our view that it is entirely appropriate for Medicaid to continue to be able to pay for GME, as determined by each state.

In addition to our compelling legal analysis, we have several policy concerns with this proposal. We can not fathom how the Administration can choose to believe that it would be in the best interest of our nation as a whole, let alone the academic medical enterprise, to remove such large sums of money from teaching hospitals.

Financial Implications to Hospitals

We are concerned with the large financial insult to teaching hospitals that would result should this proposal ever be allowed to go forward. These funds can often make the difference between a positive or negative operating margin. We find it unseemly that a federal agency would try to prevent a willing partner in the graduate medical education enterprise from taking on a share of the burden of training the nation's doctors. Taken together with the other graduate medical education positions of CMS, the result is the effective denial of billions of dollars in Medicare and Medicaid funding to help teaching hospitals and residency programs defray the cost of medical education. Meanwhile, the Medicare Payment Advisory Commission has called for reducing IME funding factor by 1 percent and the Bush Administration's fiscal year 2008 budget calls for diverting \$30 billion in capital funds and Medicare and Medicaid disproportionate share, or DSH, funds from hospitals and other health care facilities. We would like CMS to explain how the academic medical infrastructure would be able to support such a tremendous loss of funding?

Even if the Administration were correct in its legal analysis, we find it inconceivable to think that anyone truly believes a positive impact would result from the loss of this funding from the medical education enterprise.

Physician Workforce Implications

It is generally acknowledged that our nation will be seeing a physician shortage in the near future – particularly in the primary care specialties – and as a nation we have still not solved the maldistribution problem. As Medicare physician reimbursement is falling, or uncertain at best, costs are increasing as physicians are re-tooling to meet the health information technology demands and the new model of practice, and attention to new methods of assessing and improving the quality of physicians performance are being incorporated into practice, this is clearly a time when the cost of training physicians is going up. In addition, the aging of the baby-boomer generation is creating unprecedented growth of the Medicare eligible population and a demand for an increased production of physicians. In addition, we point out what CMS seems to have forgotten - that residents themselves provide a tremendous amount of direct patient care to Medicaid recipients. This role is particularly critical in underserved areas. Ignoring this critical patient care role ignores the impact this rule would have on access to care for Medicaid recipients if funding for training of a large number of the providers in teaching hospitals is eliminated. We can not see how a policy that would diminish the stability of the

production of physicians and care for the underserved in this country at this time would be to the benefit of the nation.

Policy Goals of Medicaid GME

States have used the ability of Medicaid to fund graduate medical education to help advance specific policy goals that are needed in their states. Many have been explicit about those goals, ranging from workforce questions to safety-net issues, and include the following:

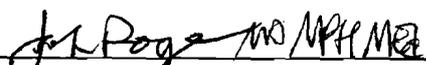
- Encourage training in certain specialties (e.g. primary care)
- Encourage training in certain settings (such as underserved communities)
- Increase supply of health professionals serving Medicaid beneficiaries, and
- Improve geographic distribution of workforce.

From a policy perspective, we cannot understand CMS's lack of support for these laudable goals. While an extremely creative effort, we find it short-sighted at best to use a transparently poor legal argument to attempt cost-shifting or cost-savings. Rather, we would urge CMS's efforts at creativity be spent on finding ways to encourage such goals through graduate medical education policy, both within Medicare and Medicaid.

Conclusion

Should this proposal ever reach fruition, we can expect at best an uncertain future for the country's teaching hospitals and training programs. We can expect a massive disruption in physician training programs caused by the loss of revenue to hospitals and other providers and a breakdown of our already fragile safety net of care for un- and under-insured people. We urge CMS to withdraw this proposal.

Sincerely,


John Rogers, MD, MPH, MEd, President
Society of Teachers of Family Medicine


Rick Kellerman, MD, FAAFP, President
American Academy of Family Physicians


Mark Robinson, MD, President
Association of Family Medicine Residency
Directors


Perry Dickinson, MD, President
North American Primary Care Research
Group


Harold Williamson, MD, MSPH, President
Association of Departments of Family
Medicine



Oregon

Theodore R. Kulongoski, Governor

JUN 28 2007

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June 21, 2007

Transmitted electronically to <http://www.cms.hhs.gov/eRulemaking>.
Hard copy via U.S. Mail.



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

Re: Medicaid Program: Graduate Medical Education

Dear Administrator Norwalk:

The Oregon Department of Human Services (DHS) respectfully submits this comment letter in response to the published rules. DHS *disagrees* with the intent of the rules, which seek to clarify costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program. *If the states make up the shortfall, the costs will be shifted to them. If the states do not make up the shortfall, these costs will be shifted to the teaching hospitals, their residents, or their patients.* The rule would have a *significant* impact on teaching hospitals.

The reasons to maintain Medicaid support for teaching hospitals are compelling. Teaching hospitals are where the nation's doctors, nurses and other health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that absolutely depends on reliable, long-term financial support.

"Assisting People to Become Independent, Healthy and Safe"
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Leslie Norwalk, Esq.

June 21, 2007

Page Two

Each year, more than 100,000 resident physicians are being trained in numerous medical specialties at teaching hospitals around the country. As the nation's proving grounds for medical innovation and discovery, teaching hospitals are inherently more expensive to operate than other hospitals. And precisely because teaching hospitals are where medicine advances, these institutions are also where the most vulnerable patients are admitted for care. Teaching hospitals are an integral part of the traditional care for local communities. This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly and persons with disabilities.

Oregon wholeheartedly agrees to share in the goal of a healthy Medicaid program, but we are opposed to the rule which we feel goes far beyond what is needed to attain federal financial stability. We believe this proposal would undermine the nation's already fragile health care safety net and further limit or eliminate access to health care for millions of low-income and medically fragile patients.

Sincerely,

A handwritten signature in black ink that reads "Bruce Goldberg". The signature is written in a cursive style with a large, sweeping flourish at the end of the name.

Bruce Goldberg, M.D.
Director

BG:FFP:tlemman



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
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JUN 22 2007

Michael Nardone
Acting Deputy Secretary
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

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

Dear Sir or Madam:

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

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

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

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

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

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

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

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

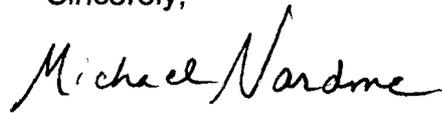
Concerns recently expressed by the medical education community over the potential loss of federal funding for GME, specifically Direct Medical Education (DME) payments, also underscore how critical GME payments are to these hospitals. Darrell G. Kirch, M.D., President of the Association of the American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

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Michael Nardone". The signature is written in a cursive style with a large, prominent initial "M".

Michael Nardone

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



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

June 21, 2007

Leslie V. 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

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

Dear Administrator Norwalk:

The State of New York, which annually supports over 16,000 residents in training at approximately 100 teaching hospitals throughout the state, is writing in order to provide comments on the proposed rule to end federal financial participation (FFP) in Medicaid reimbursement for the costs associated with graduate medical educations (GME) programs.

Justification for Opposition to Proposed Rule

The proposed rule overturns the Federal Government's historic commitment to share in the Medicaid program's support to train physicians that serve America's hospitals and care for all patients including low-income families, the elderly, and persons with disabilities. Since the Medicaid program started in the 1960s, federal funding has been provided for GME. After Medicare, Medicaid has been the largest explicit payor for GME. Eliminating federal support through Medicaid would have a devastating impact on New York's GME system with an estimated loss of over \$600 million annually. This is more than the total fiscal impact being projected by CMS for the entire nation.

In addition, it is incomprehensible that CMS, after 40 years of providing federal financial participation (FFP) for Medicaid GME, has realized that there is no explicit authority in federal law to do so and it will now be ended. This is especially confounding since CMS and its predecessor, HCFA, have repeatedly approved provisions in New York's Medicaid State Plan that detail the State's methodology for reimbursing GME. Fortunately, the Congress has recognized the devastating impact that this proposed rule have on the country's physician training programs by placing a one year moratorium on its implementation, with a special provision included within the "U.S. Troop Readiness,

Veterans Care, Katrina Recovery, and Iraq Accountability Appropriation Act, 2007” signed into law on May 25, 2007.

The State is further concerned with the CMS interpretation that since Medicare expressly excludes costs associated with educational activities from the basic payment amounts under Medicare’s prospective payment system for inpatient hospital services, Medicaid should similarly deny FFP. The federal decision to separate GME, as well as disproportionate share and outlier payments, from the PPS basic payment does not suggest that these are not legitimate components of the reimbursement for hospital inpatient care services. Rather, this change reflects only a different method of reimbursing for these different components.

New York trains 16 percent of the nation’s total residents. As a result, New York provides a large supply of physicians to the nation as 50 percent of New York’s residents leave the State for other States after completing their training. Cuts in federal funding for GME training will limit the supply of newly trained physicians because many programs will not be able to sustain current levels. This will exacerbate an already predicted physician supply shortage. Twelve states have issued reports concerning current and future physician shortages, twelve national specialty societies have raised concern over lack of physicians in their specialty and national Council on Graduate Medical Education (COGME) projects a net shortage of 85,000 physicians by 2020. To address this shortage, the AAMC recommends a 30 percent increase in U.S. medical school enrollment with a concurrent increase in GME positions over the next decade.

New York State has provided continued accountability for GME funding. Data on Medicaid GME funding is collected and updated annually in New York and include: the cost of direct medical education (DME) in annual hospital cost reports; resident counts by hospital, specialty and post-graduate year (PGY) through an annual survey; and identification of annual Medicaid expenditures for GME (both DME and estimated IME).

New York State has its own Council on Graduate Medical Education (COGME), created by Executive Order in 1987, to act as an advisor to the Governor, Commissioner of Health and Legislature on medical education and training issues. The State is actively engaged in GME policy through the COGME. New York State uses federal Medicaid funding along with State Medicaid funding to encourage teaching hospitals to train residents in primary care specialties and other preventive specialties in short supply.

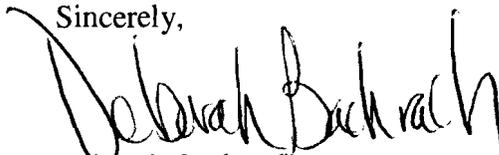
The impact of the CMS proposal will also be substantial nationally. In a 2003 state survey conducted by the Association of American Medical Colleges (AAMC), 47 States and the District of Columbia reported using Medicaid funds to make GME payments under their State programs and States view these payments as critical to State GME policy implementation. By federal fiscal year 2012, the proposed rule would reduce federal Medicaid GME payments by \$460 million annually.

The CMS proposal offers limited options to address medical education funding without federal support, including replace federal funding with State-only funding or private

sector funding and increase taxes. New York already provides a substantial commitment for GME through a \$354 million state-funded Professional Education Pool.

NYS urges CMS to reconsider the issuance of a final rule that eliminates FFP for Medicaid expenditures related to GME. Should CMS wish to discuss the impact of this proposal to NYS in further detail, please contact my office at (518) 474-3018.

Sincerely,

A handwritten signature in black ink that reads "Deborah Bachrach". The signature is written in a cursive style with a large, sweeping initial "D".

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs



**American Hospital
Association**

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June 20, 2007

Rec'd
6-21-07

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

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

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rulemaking changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs. As you know, the proposed rule is subject to a year-long moratorium secured by P.L. 110-28.

The AHA believes that the moratorium should preclude 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, the AHA is submitting these comments with strong opposition to the policy changes proposed in this rule.

The proposed rule substantially departs from long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs. Although CMS claims this rule clarifies existing GME policy, it completely reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The agency's recent decision will result in a cut of nearly \$2 billion in federal funds out of the program. **If these cuts to state Medicaid programs are finalized, many safety-net hospitals will face financial jeopardy, ultimately harming some of our most vulnerable citizens, who are covered by the Medicaid program and served by these hospitals.**

Leslie Norwalk, Esq.
June 20, 2007
Page 2 of 4

The agency's belated conclusion that FFP is unavailable for hospitals' GME costs is primarily based on the fact that GME is not specifically listed as a service in the Medicaid statute. In addition, CMS maintains that GME cannot be considered part of "hospital services" because it is not included in the rates paid to hospitals for services under the Medicare inpatient prospective payment system (PPS). The agency's analysis is flawed on both counts.

Agency Rationale

Medical Assistance:

CMS in the preamble to the proposed rule states:

"The care and services that may (or in some cases, must) be included within the scope of medical assistance under a Medicaid state plan are generally set forth in section 1905(a)... Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance.... we do not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately. GME is not a health service that is included in the authorized coverage package...."

The Medicaid statute, in Section 1905(a), defines the term "medical assistance" and lists the types of populations and services for which Medicaid will pay all or part of the costs. CMS' implementing regulations at 42 C.F.R. Part 440 expand upon this list of services. If CMS rigorously applies its rationale for not recognizing GME costs to other costs defined in Part 440, but not listed in Section 1905(a), some very significant costs would now be defined as "illegal" for purposes of FFP. For example, durable medical equipment (DME), such as walkers, wheelchairs, or hospital beds, is not listed in Section 1905(a). Nevertheless, DME is appropriately considered medical assistance eligible for FFP under the regulations (42 C.F.R. 440.70(a)(3)). Similarly, transportation or other travel expenses, including meal and lodging costs en route to and from medical care and expenses for an attendant to accompany a Medicaid beneficiary to ensure that he or she is able to receive medical examinations and treatment, are not included in Section 1905(a). Nevertheless, they also are appropriately included as medical assistance eligible for FFP in CMS' regulations (42 C.F.R. 440.170(a)).

The statutory basis that allows things like transportation expenses to be eligible for FFP is unclear. Perhaps these expenses are included under Section 1905(a)(28) or another provision of the Medicaid statute such as Section 1902(a)(4). If this is the case, then GME should be eligible for FFP by falling within a provision such as the "catch-all" Section 1905(a)(28). The fact that FFP is available for these expenses, even though they are not referenced in the Medicaid statute, contradicts CMS' position that FFP is unavailable for GME because it is not listed in the statute. It seems that CMS has singled out GME because it is a convenient budget-saving strategy.

Covered Hospital Services:

Even if CMS were correct in reasoning that FFP should be available only for the items and services listed in the Medicaid statute, FFP would still be available for GME because it is part of inpatient and outpatient hospital services.

In the proposed rule, CMS notes that the Medicaid statute permits states flexibility to develop their own methods and standards for determining payment requirements for covered hospital services within reasonable estimates of what Medicare would have paid for the services. Since Medicare pays for GME as a hospital service, state Medicaid payments for inpatient and outpatient hospital services that include GME costs are eligible for FFP.

CMS is inaccurate in stating that 42 C.F.R. 412.2(2)(e) excludes GME from the inpatient PPS payment rate. In fact, GME is not on the list of "excluded costs;" rather, it is found in C.F.R. 412.2(f) on the list of "additional payments to hospitals" along with other patient care-related costs such as outlier cases, capital and indirect medical education costs. Hospitals receive an additional Medicare payment for GME precisely because it is a patient-related cost. The fact that the GME payment is separate from the PPS payment is irrelevant to whether GME is a reimbursable hospital cost under Medicare. For example, capital costs are paid outside the inpatient operating PPS, yet no one would argue that they are not reimbursable by Medicare as a hospital cost.

Similarly, Medicare GME payments compensate teaching hospitals for the direct costs of their educational activities by measuring the number of medical residents trained. These medical residents, who work within a supervised patient care team of health care professionals, provide needed care to Medicare and Medicaid patients as part of their training programs. Research looking at interns' and residents' in-hospital time confirms this. In one study, residents, on average, spent 57% of their time on clinical or service-oriented activities (Magnusson A.R., *et al.*: "Resident Educational Time Study: A Tale of Three Specialties." *Academic Emergency Medicine*, July 1998; 5(7): pp 718-725). In another study, house staff (interns and residence) spent a majority of their time engaged in direct patient care activities – 81% of the interns' workdays, and 64.5% of the residents' workdays (Guarisco S., *et al.*: "Time Analysis of a General Medicine Service: Results from a Random Work Sampling Study." *Journal of General Internal Medicine*, May 1994; 9(5): pp 272-277).

Reversal of Long-Standing Policy

The proposed rule acknowledges that CMS must first approve hospital payment methodologies as a condition of receiving federal funds (FR Vol. 72, No. 99 p 28932). It also acknowledges a 2005 study commissioned by the Association of American Medical Colleges, which reported that 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. CMS' approval of the state plan amendments providing for GME constitutes an official interpretation that these plan amendments met governing statutory and regulatory requirements. Thus, the agency's proposed rule attempts to sweep aside its prior actions and interpretations.

Leslie Norwalk, Esq.
June 20, 2007
Page 4 of 4

CMS' public acknowledgement and approval of GME payments do not rest with state plan amendment review, but also extend to its own rulemaking for Medicaid managed care plans. In August 2001, CMS issued a Medicaid managed care proposed rule that declared a state Medicaid program could not make payments directly to a provider for services available by an approved managed care entity (FR vol. 66, No. 161 pp 43628, 43666). When the final rule was published in June 2002, the agency explained that, in response to public comment, it had "...modified that section to permit such payments to the extent the capitation rate has been adjusted to reflect the GME payment made directly to the hospital" (FR Vol. 67, No. 115 pp 41004, 41005, 41103). In fact, current rules (42 C.F.R. 438.60) specifically acknowledge that GME payments can be made directly to the provider as long as the GME payment amount is carved out of the managed care capitation payment.

There is no doubt that CMS' reversal of long-standing policy acknowledging GME as an allowable cost is based on flawed reasoning. **By failing to justify termination of the federal funds supporting Medicaid GME programs, CMS should permanently withdraw this proposed rule.** The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs, which, through their teaching function, provide care to some of our most vulnerable populations.

Sincerely,

A handwritten signature in black ink that reads "Rick Pollack". The signature is written in a cursive, flowing style with a long horizontal line extending to the right.

Rick Pollack
Executive Vice President

American Psychiatric Association

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E-mail apa@psych.org
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June 25, 2007

RE: Centers for Medicare & Medicaid Services (CMS) Proposed Rule: “Medicaid Program; Graduate Medical Education;” [CMS–2279–P] RIN 0938–A095

Dear Administrator:

The American Psychiatric Association (APA), the national medical specialty society representing more than 38,000 psychiatric physicians, appreciates the opportunity to submit these comments in response to the proposed rule by the Centers for Medicare & Medicaid Services (CMS), entitled “Medicaid Program; Graduate Medical Education,” concerning 42 C.F.R. Parts 438 and 447, published in the Federal Register on May 23, 2007.¹

Two days after this proposed rule was published, H.R. 2206 was enacted into Public Law 110-28 on May 25, 2007, as “U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007.”² Section 7002(a)(1)(C) of P.L. 110-28 prohibits HHS from being able to “promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program” for one year after the date of enactment of P.L. 110-28 on May 25, 2007.³ This provision precludes CMS from finalizing and implementing this proposed rule until after May 25, 2008.

However, Section 7002(a)(1)(C) does not terminate or modify the public comment period or process that runs to June 22, 2007, triggered by the Federal Register

¹ Centers for Medicare & Medicaid Services (CMS) Proposed Rule: “Medicaid Program; Graduate Medical Education;” [CMS–2279–P] RIN 0938–A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)].

² H.R. 2206 / Public Law 110-28 “U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007;” (May 25, 2007; 121 Stat. 112) not yet published in final form.

³ Public Law 110-28, “SEC. 7002. (a) PROHIBITION.—
(1) LIMITATION ON SECRETARIAL AUTHORITY.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to the date that is 1 year after the date of enactment of this Act, take any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to—
... (C) promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program.”

publication date of the proposed rule. Also, CMS has not published a modification of the due date for the comments. This interpretation of the effect of P.L. 110-28 Section 7002(a)(1)(C) on this proposed rule was confirmed with CMS on June 7, 2007.⁴ For that reason, we now submit our comments in conformance with the stated deadline, June 22, 2007.

By this proposed rule, CMS intends to prohibit states from receiving federal funds under the Medicaid program in any manner that could be construed as payment related to a provider's graduate medical education (GME) costs. CMS would apply that payment prohibition, regardless of how accurately or in what detail a state plan would require a provider to calculate and track GME costs for the purpose of payment under Medicaid. The prohibition would apply whether the GME costs were incorporated into services rates or offset through supplemental Medicaid payments.

While CMS maintains that GME-related payments have not been adequately traced and accounted for, deducing that this is a reason for non-payment, CMS also summarily rejects the alternative solution: improved tracking. CMS also asserts that, "because there is no direct statutory authority for GME payments under a Medicaid State Plan, there is little authority to regulate or oversee such payments if allowed."⁵ Either it is legally permissible to do so or it is not. CMS does not claim that it is *not* permissible to do so or why CMS found it completely appropriate to approve such payments for decades.

This proposed rule includes a new paragraph (c) for the regulation 42 C.F.R. Section 447.201 that would specifically prohibit state plans (per Section 1902 of the Act) from including payments for GME or cost of GME as "an allowable costs under any cost-based payment system." The new paragraph (b) under Section 447.257 prohibits FFP in expenditures for GME in hospitals and long-term care facilities. Section 447.272(b)(1) is revised to preclude the potential for states to receive supplemental payments through upper payment limit calculations by prohibiting GME payments as an allowable component of a Medicare payment, that state plans used to use as a reference point.⁶ All of these changes are designed to obliterate methods that states had used in the past with CMS' approval, in order to secure federal payment offsets to GME-related expenditures under the Medicaid program.

The position articulated within this proposed rule represents an unsupported 360-degree turn-around in CMS's longstanding policy of approving payment under Medicaid

⁴ Telephone conversation on July 7, 2007, between APA staff and CMS contact for proposed rule CMS-2279-P, in which CMS contact stated that HHS Office of the General Counsel had determined that the comment period for CMS-2279-P was unchanged by P.L. 110-28, thus remained in effect, with comments due by June 22, 2007, per the Federal Register publication.

⁵ Centers for Medicare & Medicaid Services (CMS) Proposed Rule: "Medicaid Program; Graduate Medical Education;" [CMS-2279-P] RIN 0938-A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)], at 28935.

⁶ *Ibid*, at 28936.

to compensate providers for GME-related costs. While CMS poses a variety of rationales for this complete reversal to Medicaid GME payments, none are legally supported or persuasive. The clear intent of the proposed rule is simply to cut out providers' GME-related payments to gain substantial cost-savings. CMS estimates the cuts at \$290 million for the first full fiscal year 2009 and upward, thereafter.⁷

CMS Reversal of Payment Allowance Policy for GME-related Costs

CMS admits that it has allowed the states to incorporate GME costs as a cost component of Medicaid inpatient and outpatient services to receive federal funds.⁸ Some states were also using supplemental payments along with services payments or alone to offset GME expenses.⁹ CMS obviously followed this policy for several decades because there was legal authority to do so. CMS' legal stance to support the proposed rule is that, "there is no direct statutory authority for GME payments under a Medicaid State Plan."¹⁰ CMS' main rationale is that, "we do not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately." CMS uses two concepts: 1) "GME is not a health service that is included in the authorized coverage package;" and 2) "Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services."¹¹

To support its conclusion, CMS refers to the Sec. 1905 list of state Medicaid services, noting that, "(g)raduate medical education (GME) is not included in this list of care and services within the scope of medical assistance." CMS deduces that GME is precluded from payment because it is not in the list of Sec. 1905 care and services. This concept is inconsistent with the clear purpose of Sec. 1905, which is to define for payment purposes Medicaid care and services that fall under the term "medical

⁷ Centers for Medicare & Medicaid Services (CMS) Proposed Rule: "Medicaid Program; Graduate Medical Education;" [CMS-2279-P] RIN 0938-A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)], at 28934: "ESTIMATED REDUCTION IN FEDERAL MEDICAID OUTLAYS RESULTING FROM THE GRADUATE MEDICAL EDUCATION PROPOSAL BEING IMPLEMENTED BY THIS PROPOSED RULE—ANNUAL EXPECTED SAVINGS

[Amounts in millions]

Reduction in Federal Medicaid outlays in million dollars by fiscal year

	2008	2009	2010	2011	2012
Graduate Medical Education Exclusion	\$140	\$290	\$440	\$450	\$460"

⁸ Ibid, at 28931:

"CMS has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services."

⁹ Ibid, at 28932:

"15 (states) stated using supplemental or a combination of supplemental and per diem payments to make GME payments."

¹⁰ Ibid, at 28935.

¹¹ Ibid, at 28933.

assistance.” Sec. 1905 is not a laundry list of permissible or impermissible components of rate methodologies for Medicaid services.

CMS asserts that states are limited in “designing their Medicaid programs and reimbursement” “to provide funding for GME programs” due to an “absence of any direct authority to reimburse GME under Title XIX” of the Act.¹² States apparently did not experience this limitation in prior years when CMS approved their plans that incorporated GME expenses. To support the argument that “GME is not a health service that is included in the authorized coverage package,” CMS notes that, “(u)nder section 1903(a)(1) of the Act, federal grant funding, or federal financial participation (FFP), is available to States for a percentage of amounts “expended * * * for medical assistance under the State plan.”¹³

Of course, GME is not defined as a health service in the Section 1905 list of definitions but that does not matter. Having it on that list is not the way in which payments to offset GME expenses (a subcategory of overhead and operating expenses) would be authorized. Section 1905 does not define or govern rate or payment methodologies; those are covered by Section 1902. Graduate medical education, or “GME,” is an umbrella label for many categories of expenses related to teaching and training medical students. The label “GME” does not have to be specified by statute as a cost category, as long as federal payments for the related expenses are legally permissible in some fashion under the Medicaid program.

CMS does not cite to the legal authority or explain how the law supported its approval of GME-related payments under Medicaid throughout past decades. CMS also does not provide a detailed statutory interpretation to explain its reversal. Despite the absence of supporting legal authority, CMS now claims that the law precludes the very same actions that it undertook all those years.

State Medicaid Plan Payment Methods under Section 1902

Section 1902, of the Act, “STATE PLANS FOR MEDICAL ASSISTANCE” governs state plans for Medicaid medical assistance and sets forth state requirements for developing payment methodologies.¹⁴ Sec. 1902 allows states substantial discretion to

¹² Centers for Medicare & Medicaid Services (CMS) Proposed Rule: “Medicaid Program; Graduate Medical Education;” [CMS–2279–P] RIN 0938–A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)], at 28933:

“There are limitations on the State’s flexibility in designing their Medicaid programs and reimbursement under current regulations to provide funding for GME programs stemming from the absence of any direct authority to reimburse GME under Title XIX.”

¹³ *Ibid.*, at 28931.

¹⁴ Social Security Act “STATE PLANS FOR MEDICAL ASSISTANCE SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must . . . (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and

determine factors to consider in creating their plan payment methodologies. Sec. 1902 does not list permissible or impermissible economic factors that states can consider, i.e., specific expense categories of overhead costs like salaries, benefits, or other expenditures that all providers take into account when calculating services rates. Naturally, teaching hospitals devote substantial costs to their graduate medical training programs, as part of their overhead and operating costs. They either offset those costs through private or government insurers' payments, pass on the losses through cost-shifting, or consider them to be capital losses.

Section 1902(a) requires that, "(a) State plan for medical assistance must" "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan." GME, as with other overhead and operating expenses, clearly relate to the payment for care and services under the state plan. As CMS notes, GME-related payments were approved by CMS, whether as an integral component of services rates or as supplemental payments; "(u)sually the payments are part of the inpatient hospital Medicaid rate structure."¹⁵

CMS seems to focus unduly on the issue that relevant statutes do not specifically identify "GME" expenses, as is done with Medicare. That statute does not have to label expenses as GME-specific in order to permit their inclusion within the scope of permissible federal payments. The real legal question is whether the pertinent statutes and regulations prohibit or allow federal payments for costs related to medical student education, whether or not they are specifically labeled as GME or itemized at all.

As CMS notes, a 2003 survey showed that "47 States and the District of Columbia reported using Medicaid funds to make GME payments under the Medicaid State Plan." Most states included the payments in their per diem inpatient hospital rates; others used "supplemental or a combination of supplemental and per diem payments to make GME payments."¹⁶

Regardless of the label, it is quite obvious that Section 1902 of the Act provided for the states to incorporate many cost elements into their state plan rate and payment methodologies that are not specified item by item. The cost of training medical students is substantial and there are many categories and types of expenses involved. In the past,

services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;"

¹⁵ Centers for Medicare & Medicaid Services (CMS) Proposed Rule: "Medicaid Program; Graduate Medical Education;" [CMS-2279-P] RIN 0938-A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)], at 28932.

¹⁶ Ibid, at 28932:

"In a 2003 state survey conducted by the Association of American Medical Colleges, 47 States and the District of Columbia reported using Medicaid funds to make GME payments under the Medicaid State Plan. Of these, 35 indicated that the payments were included in their per diem inpatient hospital rates, and 15 stated using supplemental or a combination of supplemental and per diem payments to make GME payments."

state plans obviously used GME-related costs in order to calculate inpatient and outpatient rates that CMS approved.

Section 1903 Authorizes Federal Payments for Compensation and Training of Medical Personnel and their Support Staff, in Addition to Care and Services Payments

Apart from legally authorized Section 1902 discretion to incorporate GME-related costs within services rates, Section 1903 specifically authorizes additional federal payments for the compensation and training of medical personnel and their support staff. CMS does not address this provision in the proposed rule.

CMS omits that Sec. 1903(a)(2)(A) specifically requires federal payments to states for “sums expended” that “are attributable to compensation or training of skilled professional medical personnel.” Federal funds are also to be paid to states for “nursing aide training and competency evaluation programs” [Sec. 1903(a)(2)(B)].¹⁷ CMS does not explain if it intends for the proposed rule to circumvent or disregard this statutory provision. It clearly supports federal payments to offset state expenditures that could easily be interpreted to cover elements of graduate medical education.

Section 1903 authorizes federal payments to states for compensation and training expenses of medical personnel and their support staff, *in addition to* the federal payments to states for the Medicaid care and services they provide to beneficiaries as “medical

¹⁷ Social Security Act “PAYMENT TO STATES” SEC. 1903. [42 U.S.C. 1396b] (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

- (1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan; plus
- (2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus
- (B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus
- (C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus . . .”

assistance,” defined by Section 1905(a). Since federal payment for these cost expenditures is authorized by statute, it follows that states can include these cost elements in some manner for at least some providers, under Sec. 1902 for state plan payment methodologies.¹⁸ Without states setting forth specific amounts attributable to these expense categories, calculation of the federal payment percentile of the amounts would not be possible, per Sec. 1903.

“PAYMENT TO STATES, SEC. 1903. [42 U.S.C. 1396b] (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

- (1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan; plus
- (2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter . . . as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus
- (B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs) . . . as are attributable to such programs; plus . . .”

Contrary to CMS’ assertion that Medicaid’s program “structure does not accommodate the State medical training policy and goals,”¹⁹ Sec. 1903 obviously means to support states in their compensation, education and training of medical personnel. It supports this goal even to the extent of requiring federal payment for expenditures for the support staff of skilled professional medical personnel, as well as nurses’ aides. Payments under Section 1903 for these purposes are in addition to payments made under the state plan for medical assistance services. Apart from this other federal programs that clearly support states’ “medical training policy and goals,” include Medicare, which provides for two types of payments related to graduate medical education.

GME and Medicare

The Medicare program pays teaching hospitals direct (DGME) and indirect (IME) payments for graduate medical education. DGME payments are based on number of residents trained and cost of training; IME payments are adjustments to per-discharge

¹⁸ Social Security Act “STATE PLANS FOR MEDICAL ASSISTANCE SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must . . . (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;”

¹⁹ Centers for Medicare & Medicaid Services (CMS) Proposed Rule: “Medicaid Program; Graduate Medical Education;” [CMS-2279-P] RIN 0938-A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)], at 28933.

payments.²⁰ This federal program supports graduate medical education and accommodates “State medical training policy and goals,” so, it is not logical to conclude that the Medicaid program does not do so.

CMS argues against Medicaid reimbursements for GME by analogy to the Medicare program. For over thirty years since 1965, the Medicare program has reimbursed providers for costs associated with graduate medical education, though the reimbursement method has changed. The Act provides for Medicare direct graduate medical education payments (DGMEs), under Sec. 1886(h) and (k) of the Act, as well as for indirect medical education payments (IMEs) as a per-discharge payment adjustment, under Sec. 1886(d)(5).

As CMS points out, this proposed rule is intended to effectuate substantial cost-savings estimated at \$140 million for FY 2008 and \$290 million for FY2009. Primarily, it is teaching hospitals that will lose this money that has been used to help offset the many expenses associated with teaching medical students.

Teaching hospitals commonly serve inner-city populations with large Medicaid and Medicare case loads, as well as large proportions of non-paying patients. This substantial funding cut would adversely affect the financial welfare of any hospital that has been able to offset its teaching expenses with Medicaid GME payments. Since many inner-city hospitals have for years experienced considerable financial strains that have resulted in closures, an additional cut to their Medicaid payments is against public policy. It would adversely impact the ability of these hospitals to provide services to the uninsured and under-insured, which include Medicaid patients.

In addition, there is a long history of federal support for educating physicians via many federal programs. As noted in a 2003 American Medical Association report, “(s)ince 1965, the federal government has funded graduate medical education (GME), primarily through Medicare but also through other government programs such as Medicaid, the Veterans’ Administration, and the Department of Defense.” AMA found that “the federal government pays nearly two-thirds of the estimated \$18 billion per year it costs to train America’s 100,000 residents.”²¹

²⁰ Centers for Medicare & Medicaid Services (CMS) Proposed Rule: “Medicaid Program; Graduate Medical Education;” [CMS-2279-P] RIN 0938-A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)], at 28932.

²¹ “2003 Report of the American Medical Association – Medical Student Section Task Force on Medical Student Debt,” at 25:

“Currently, Medicare supports teaching hospitals with \$7.8 billion per year for Direct Medical Education funding (resident and faculty salaries) as well as Indirect Medical Education funding (the less tangible costs associated with running an academic hospital). Additionally, certain states provide funding to GME via the federal Medicaid program to the tune of \$2.4 billion dollars a year. The Department of Veterans’ Affairs funds roughly 10% of all resident positions in the US and the Department of Defense covers an additional 3%. Finally, the new Children’s Hospital Teaching Fund provides \$235 million per year in support of GME.⁵³ All told, the federal government pays nearly two-thirds of the estimated \$18 billion per year it costs to train America’s 100,000 residents.”

CMS' Policy Arguments against GME Payments

Apart from CMS' assertion that the Medicaid program "structure does not accommodate the State medical training policy and goals," CMS' other main policy arguments against paying for GME are: 1) "this funding is not necessarily limited to teaching hospitals, linked to educational costs or measures, or coordinated with other sources of GME funding;" and 2) "there is generally no assurance that supplemental Medicaid payments for GME are actually effective in supporting these programs, or in furnishing any benefit to Medicaid program beneficiaries."²²

CMS found statutory authority for the proposed new regulation Section 447.257 to prohibit using GME costs as allowable costs in state plans, although Section 1902 does not prohibit this. CMS does not explain why it cannot, conversely, promulgate a regulation that would require more GME cost tracking and solve a major CMS concern. Since the fact of GME expenses are known, even if exact amounts have not been tracked well, federal reimbursements for GME costs provide an obvious incentive to keep the program, whereas a lack of federal money creates a loss that is an obvious disincentive. Graduate medical personnel treat patients as part of their training, including those who receive Medicaid care and services. For that reason, the nexus between GME expenditures and their benefit to Medicaid patients in a given state is clear.

Then, there are additional payments to those for services. Payments under Sec. 1903(a)(2)(A) to states with approved plans, under Section 1902, are for costs already expended by the state for medical personnel in training. Sec. 1903(a)(2)(A) requires amounts related to compensation and training costs for skilled medical personnel to be specified, in order to calculate the federal percentage based on those amounts to be paid. Whether those amounts drill down to the level of individual hospitals or other providers is a function of the detail the state chooses to document and whether or not CMS requires this detail before it approves the payment plan.

CONCLUSION

CMS has had a longstanding policy of allowing states to include GME expenses within their state plans because doing so is completely permissible under relevant statutes. If CMS intends to reverse a longstanding, substantive policy such as this, a thorough legal interpretation for the public of how and why it is prohibited by statute

²² Centers for Medicare & Medicaid Services (CMS) Proposed Rule: "Medicaid Program; Graduate Medical Education;" [CMS-2279-P] RIN 0938-A095 [Federal Register Vol. 72, No. 99 (May 23, 2007)]. at 28931, referencing the Social Security Act (the Act) Section 1905 (42 U.S.C. 1396d):

"DEFINITIONS

For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services . . . for individuals. . ."

from continuing its path is warranted. The simple assertion in the proposed rule that CMS lacks direct statutory authority to do that which it has done for many years is insufficient to support this policy change or to explain why it found statutory authority for its past actions.

APA urges CMS to use alternatives to this proposed rule, including promulgation of rules that would enhance the accountability of states to track and monitor GME-related expenses. There is no reason why this approach is not viable. Many federal programs support states in their education and training of upcoming physicians because this is an essential activity to preserve national public health and welfare.

APA strongly recommends against changing this policy, which will inflict financial losses upon teaching hospitals, many of which are located in inner cities and serve populations with great need, including Medicaid patients. It is against sound public policy to further strain teaching hospitals by substantially cutting their federal payments under Medicaid to offset the considerable expenses associated with graduate medical education.

Thank you for allowing those of us with APA the opportunity to communicate our concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "James H. Scully Jr.", with a stylized flourish at the end.

James H. Scully Jr., M.D.
Medical Director and C.E.O., American Psychiatric Association

*APA Contact: Angela Foehl, J.D., M.P.H., Deputy Director, Regulatory Affairs
Phone: 703.907.7842 Email: afoehl@psych.org*

**STATE OF IOWA**

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

June 21, 2007

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

Re: May 23, 2007 CMS Proposed Rule (File Code CMS-2279-P)
Medicaid Program Graduate Medical Education Program Expenditures

To Whom It May Concern:

Following are comments by the Iowa Department of Human Services, Iowa Medicaid Enterprise, regarding the proposed rule that the Centers for Medicare and Medicaid Services (CMS) issued on May 23, 2007. The proposed rule provides clarification that costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for medical assistance and are not federally reimbursable under the Medicaid program.

This is a significant change in policy and, considering its magnitude, statute changes would be more appropriate, rather than rule changes. To suddenly argue that GME payments are not in compliance with the statute is highly questionable, considering that the program has been in operation for 40 years.

Our technical-related concerns are described as follows:

Direct Graduate Medical Education (GME) Costs. The CMS commentary of the proposed rule acknowledges two types of cost/payments that are unique to teaching hospitals – direct graduate medical education and indirect medical education. The proposed rule defines direct GME as the direct costs of the educational activities, as measured by the number of residents being trained and the historic cost of training residents. When evaluating this definition in the context of the Medicare cost report (CMS 2552-96), it is unclear if the direct GME costs to be disallowed are all the direct costs of salaries and benefits for interns and residents (the post-step down adjustment found in column 26 of Worksheet B Pt I), or the Medicare allowed direct GME cost as calculated on Worksheet E-3, Pt. IV of the Medicare cost report. It is also not clear if other hospital overhead costs; such as administrative, capital, and maintenance, allocated to the education program cost centers are included as direct medical education costs and therefore deemed as non-allowable costs.

Graduate Medical Education Payments. The proposed rule for § 447.201 (c) states “the plan must not include payments for graduate medical education...” However, CMS commentary for the proposed rule specifically allows states to recognize, as part of the inpatient hospital rate structure, indirect medical education cost. It is not clear if graduate medical education payments in the proposed rule for § 447.201 (c) refers only to direct medical education or if it also refers to

indirect medical education payments. CMS commentary for the proposed rule redefines GME to be only direct medical education since indirect medical education (IME) costs are no longer identified as education costs, but instead are now considered to be an additional cost of providing care at teaching hospitals generally due to the added cost of “learning by doing” treatment methods. However, we request clarification from CMS on the definition of allowable graduate medical education payments, and emphasize that only direct intern and resident costs should be defined as non-health care costs.

Upper Payment Limit (UPL) Calculation. The proposed rule for § 447.272, Inpatient services: Application of upper payment limits, states that “for purposes of the Medicaid upper payment limit calculation, direct medical education payments are not an allowable component of a Medicare payment and must be excluded from the calculation.” As stated above the definition of direct GME costs is unclear. The determination of direct medical education costs to exclude from the UPL calculation could vary based upon whether a cost-based or prospective payment system UPL methodology is utilized. In the past, CMS has allowed states flexibility in their UPL calculations. It is unclear if states will continue to have the flexibility to use the most appropriate definition of direct GME costs based upon the methodology utilized, or whether the proposed rule is intended to limit this long-standing flexibility afforded to states.

Effective Date of Rule. The provisions of the rule must be implemented in the first full state fiscal year following the effective date of the subsequent final rule. Does the language “In the first full state fiscal year” mean any day during the state fiscal year or the first day of the state fiscal year? It is unclear when states must have all reimbursement methodologies in compliance with the new rule, and therefore when any needed state plan amendments must be submitted.

Finally, we have included additional comments on this proposed rule from Iowa’s two largest public teaching hospitals, the University of Iowa Hospitals and Clinics and Broadlawn’s Medical Center, as attachments to this letter. We endorse the views of these hospitals, as well.

Sincerely,

Eugene I. Gessow by PEB

Eugene I. Gessow
Iowa Medicaid Director

EIG/peb

Attachments

ATTACHMENT ONE – UNIVERSITY OF IOWA HOSPITALS AND CLINICS

From: Cyphert, Stacey [stacey-cyphert@uiowa.edu]

Sent: Tuesday, June 05, 2007 4:13 PM

To: Gessow, Eugene

Subject: Comments on GME Regulation

The May 23, 2007 proposed rule regarding Medicaid and Graduate Medical Education [28930-28936] would be detrimental to teaching hospitals. An article that appeared in the May 25, 2007 on-line edition of the *Chronicle of Higher Education* (see below) does a good job of explaining the problems with this proposed rule as well as the financial impact on the University of Iowa Hospitals and Clinics.

In addition to the content of this article, it is worth noting that the University of Iowa Hospitals and Clinics is engaged in the training of a significant number of residents and fellows above our cap. This is done in recognition of the importance of local training for attracting new physicians to the state. Over 36% of Iowa's total physician population has completed a University of Iowa residency or fellowship. A change such as the one being proposed, which would minimally cost the University of Iowa Hospitals and Clinics \$3.9 million annually, could place the University of Iowa Hospitals and Clinics in a position of having to further subsidize residency and fellowship training or reducing our commitment to this practice and possibly negatively impacting Iowa's physician workforce unless replacement funding can be found. This replacement funding is unlikely to come from the private sector.

Teaching Hospitals Could Lose \$1.8-Billion Under Proposed Medicaid Cuts

By KATHERINE MANGAN

Teaching hospitals and other medical-education programs could lose at least \$1.8-billion under regulatory changes proposed this week by the U.S. Department of Health and Human Services.

The department, which for 40 years has provided states with matching grants for graduate medical education through the Medicaid program, has proposed pulling the plug on those grants. That would save the federal government \$1.78-billion between 2008 and 2012, according to a notice published in Wednesday's Federal Register.

The cost to the nation's teaching hospitals could be much higher if states respond to the loss of federal matching money by cutting their own Medicaid contributions for graduate medical education, according to Lynne Davis Boyle, assistant vice president for government relations for the Association of American Medical Colleges.

She said the proposed change, combined with President Bush's proposal to cut indirect medical-education payments for teaching hospitals that treat Medicare patients, could cripple some medical-residency training programs and force some smaller ones to close.

"We feel that this combination is an assault on teaching hospitals," Ms. Davis Boyle said. "Given the impending physician shortage, this is the wrong time for the government to be cutting back on residency training programs."

The medical-colleges' association has called on medical schools to increase their enrollments 30 percent by 2015 to avert a physician shortage as baby boomers age and large numbers of physicians retire (*The Chronicle*, November 7, 2005, and January 12, 2007). Dozens of new medical schools are opening or are in the planning stages, but their graduates will need hospital-based medical-residency programs to complete their training, critics of the cuts point out.

The government's Medicare and Medicaid programs have historically promised a steady supply of money to help teaching hospitals educate medical residents and partially compensate them for the higher costs of treating sicker patients and offering expensive, specialized services like burn units and trauma centers. In addition, hospitals that train physicians are inherently less efficient: "It takes longer to care for patients in a team setting where learning is taking place," Ms. Davis Boyle said.

Although they are not required to, every state except Illinois, North Dakota, and Texas made payments in 2005 toward graduate medical education through their Medicaid programs, according to a 2006 study commissioned by the medical-colleges' association.

The notice in the Federal Register concludes the following: "We do not believe that it is consistent with the Medicaid statute" to pay for graduate-medical-education activities "either as a component of hospital services or separately." Such education "is not a health service that is included in the authorized coverage package." Nor is it "recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services," the notice says.

Ms. Davis Boyle said that argument is unconvincing. "The fact that the government is just now realizing those payments aren't in compliance with the standards is questionable, given the fact that, for 40 years, the Medicaid program has acknowledged those services and costs are reimbursable."

The association is supporting efforts by Sen. Richard J. Durbin, an Illinois Democrat, to require a one-year moratorium before the Centers for Medicare & Medicaid Services could put the cuts in place. He introduced language to that effect in the massive federal spending bill being debated this week.

The University of Iowa Hospitals and Clinics would probably lose \$3.9-million a year in federal money and potentially more if the state cuts its share, said Stacey T. Cyphert, the system's senior assistant director. The system trains about 500 medical residents and 199 fellows. "It would be a challenge for us to figure out how to make up that loss," which represents about 23 percent of its Medicaid support for graduate medical education, Mr. Cyphert said.

ATTACHMENT TWO – BROADLAWN'S MEDICAL CENTER



1801 Hickman Road
Des Moines, Iowa 50314-1597
515.282.2200
www.broadlawns.org

June 1, 2007

Mr. Eugene Gessow
Director of Medicaid
Iowa Department of Human Services
Medicaid Building
100 Army Post Road
Des Moines, IA 50315

Dear Mr. Gessow:

On behalf of Broadlawns Medical Center, I want to take a moment to thank you for requesting Broadlawns Medical Center's input regarding the proposed rule about Graduate Medical Education (GME) funding for the Medicaid program. The following are some of our concerns regarding this proposed rule:

1. Scope of training and value of resident training to the patients: CMS is trying to take a strict limited interpretation on the intent and responsibility for GME payments to include only "medical cost payment." This ignores the value of services provided by the residents to the patients receiving the care. Numerous studies cite the high quality of care in teaching facilities, especially with the current level of training and practices they provide. Based on these reports and our patient care plans we know there is much value added to the patients' care.
2. There are already significant amounts of costs for these programs for which Broadlawns Medical Center does not receive reimbursement. A review of our FY 2006 data shows the total program support by Broadlawns was over \$2,600,000. This includes total costs less all payments including billings to patients for services and existing GME payments.
3. The value of these programs to the State of Iowa and the U.S. healthcare landscape cannot be overlooked. Physicians who received training at Broadlawns Medical Center currently practice in most of the 99 counties in Iowa and across the country. Without these programs, the likelihood of attracting providers especially in rural areas would be significantly impacted.
4. Whose responsibility is it to train tomorrow's healthcare providers? It seems illogical to assume that the full burden for the unrecovered costs should be borne solely by providers such as Broadlawns Medical Center. As noted earlier, there already exists a large unreimbursed cost for these programs which Broadlawns is assuming. As a county hospital, Broadlawns Medical Center receives significant (over 50%) of its funding from

Mr. Gessow
Page 2 of 2
June 1, 2007

county taxes. It is not fair and would be a real issue for the Polk County citizens if they were told they must assume full responsibility for the training of tomorrow's healthcare providers when in fact many will not practice medicine in Polk County.

5. The impact of the proposed payment elimination has been determined by the Iowa Hospital Association to have an impact of approximately \$900,000 to Broadlawns Medical Center. Given our mission to serve all patients without regard to ability to pay and the already significant portion of unreimbursed costs, a reduction such as that proposed here would have a major impact. With annual gross revenues of approximately \$100 million, Broadlawns Medical Center is lucky to have a net income of \$1 million or one percent (1%). Such a reduction would have a repercussion in reduced ability to meet capital and patient needs in the future. We believe such a cost cutting measure is ill-advised.

Finally, this proposed rule would potentially impede Broadlawns Medical Center as we rely on the Residency Program to assist with providing healthcare services to some of our most vulnerable citizens. If our funding was altered and we did not have the Residents, we would need to hire additional physicians to provide the same level of care that we are currently providing. Broadlawns Medical Center would have to evaluate our programs and services to ensure we could continue to provide the same level of services to the community.

The Broadlawns Medical Center Residency Program is key to Iowa's and the United States' economic development in rural communities. Eighty-four or 62.2 percent of these graduates continue to practice medicine in Iowa. One hundred two or 76 percent practice in Iowa or surrounding states.

Two-thirds of all the physicians that are trained at Broadlawns Medical Center stay in Iowa. Broadlawns Medical Center provides healthcare services to individuals whose medical conditions are acute and require intense levels of intervention. The nature of our patients provides a training ground that foster independence so when the physicians leave to practice in a rural community, they are able to manage the care of the community.

Please let me know if I may be of additional assistance.

Sincerely,


Mikki Stier, MSHA, FACHE
Senior Vice President
Government and External Relations

MS/blb

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Via Christi
Wichita Health Network

929 North St. Francis
Wichita, KS 67214-3882

Tel 316-268-5000

Larry P. Schumacher
President and
Chief Executive Officer

CMSO
622689

07 JUN 2007
10:05 am

May 25, 2007

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

**Ref: [CMS-2279-P] Medicaid Program; Graduate Medical Education 42 CFR
Parts 438 and 447; RIN 0938-A095; (71 Federal Register 49506, May 2007.**

Dear Dr. Norwalk:

The proposed rule to eliminate the Graduate Medical Education portion of Medicaid payments threatens to erode the ability of hospitals to sustain their residency programs. Via Christi Health System (VCHS) is the largest healthcare delivery system in Kansas serving the needs of all without regard to their ability to pay.

VCHS operates two major acute care hospitals in Wichita, Kansas, and partners with the University of Kansas School of Medicine and HCA Wesley Health System in a consortium, the Wichita Center for Graduate Medical Education (WCGME) to provide medical training to 260 residents. These residents serve in a variety of roles by providing:

- Care for patients who are uninsured and/or indigent (over 134,000 patient visits to residency clinics in 2001)
- Emergency and trauma care
- In-hospital care of patients who are unassigned and/or indigent
- Code Blue response team
- Care to patients every day and every night

At least 50% of the 75 residents, who annually complete our program, *remain* in Kansas to serve in all areas of the state. Many locate in underserved areas that struggle to attract physicians to care for their residents.

Funding for this program comes from the State of Kansas and the participating hospitals. The Medicaid GME funding WCGME received in 2006 amounted to \$3.7 million yet our annual operating budget exceeds \$38 million. VCHS annually contributes 6.9 million to WCGME to support the program. Eliminating the federal portion of Medicaid GME payments would place the future of our medical education program in Wichita at risk.

Should this proposed rule become effective, we face having to close our residency program, cut back on residency slots, cut faculty positions, limit care to Medicaid and uninsured patients. We urge you to not implement this ill-advised rule at a time when the number of uninsured Americans continues to rise and the cost of healthcare threatens our viability as a safety-net provider in Kansas.

Sincerely,

A handwritten signature in black ink, appearing to read "Larry P. Schumacher". The signature is fluid and cursive, with a long horizontal stroke at the end.

Larry P. Schumacher
President & CEO



929 North St. Francis
Wichita, KS 67214-3882

**TEMP RETURN
SERVICE REQUESTED**

PRESORTED
FIRST CLASS



Leslie L. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 245-G
Washington, DC 20201

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