DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JAN - 6 2020

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter to Secretary Azar regarding graduate medical education (GME). I am responding on his behalf and we appreciate hearing your insights and views on this important issue.

The Administration recognizes that funding for GME comes from multiple, fragmented funding streams. The GME financing system also does not target training to the types of physicians needed in the U.S. In addition, the Medicare statute on GME is prescriptive and limits the program's authority to make payments to hospitals for the costs of approved GME programs, and does not provide the authority to take into consideration workforce needs. To address these concerns, the Administration proposed to consolidate and better target federal spending for GME in the President's FY 2020 Budget.

The GME reform proposal in the President's FY 2020 Budget, if enacted, would consolidate federal GME spending from Medicare, Medicaid, and the Children's Hospital GME (CHGME) Program into a single grant program for teaching hospitals. Total funds available for distribution in FY 2020 would equal the sum of Medicare and Medicaid's 2017 GME payments, plus 2017 spending on CHGME, adjusted for inflation. This amount would then grow at the CPI-U minus one percentage point each year. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The new grant program would be jointly operated by the Administrators of the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration.

This grant program would be funded out of the general fund of the Treasury. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs (e.g., primary care, geriatrics) and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. These changes modernize GME funding, making it better targeted, transparent, accountable, and more sustainable.

With regard to tools and practices to ensure consistency and minimize duplication of payments, the Administration takes seriously its role of administering and overseeing federal GME programs to make appropriate payments to teaching hospitals. For example, President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, announced on October 3, 2019, directs CMS to propose annual changes to combat waste, fraud, and abuse in the Medicare program. We recognize that every dollar spent on Medicare comes from American taxpayers and must not be misused. Program integrity must focus on paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste and abuse.

When hospitals submit claims to Medicare for care provided to beneficiaries, these services must meet the coverage and payment requirements. By law, CMS is only permitted to pay claims for covered services. CMS uses regional contractors, the Medicare Administrative Contractors (MACs), to process and audit payments for health care items and services submitted by enrolled Medicare providers on their annual cost report, including Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. MACs audit the number of Full Time Equivalent (FTE) residents that hospitals report on their annual cost report by reviewing relevant rotation schedules.

As for tracking whether the number of medical residents participating in the program correspond to available residency spots, CMS also requires teaching hospitals seeking to claim payment for GME training to submit Intern and Resident Information System (IRIS) files as part of their cost report. These files contain a list of interns and residents being trained at that provider, as well as their assignment periods, and are used as supporting documentation for the FTE counts claimed in the cost report, which form the basis for DGME and IME payment. CMS maintains an internal IRIS system that validates IRIS files sent in by providers and is used to identify overlaps where multiple hospitals end up claiming payment for the same resident. We also maintain documentation for providers filling out their IRIS submissions. CMS recently implemented a new, national IRIS system, which more easily allows identification of full-time equivalent residents counted in excess of one full-time equivalent because this information is accessible across all MAC jurisdictions.

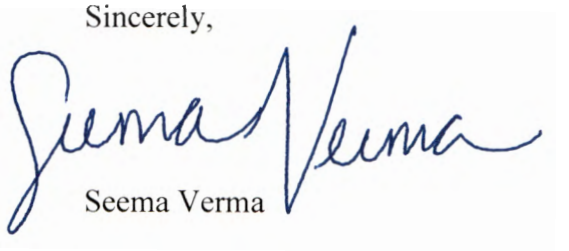
While many teaching hospitals receive payments from multiple sources, which could create a potential for providers to receive duplicate payments, the risk of duplication is reduced by the programs' designs. The CHGME program, which in FY 201-9 funded 58 hospitals, was established for children's hospitals because they did not traditionally receive significant Medicare GME payments. In FY 2017, CHGME funded 58 hospitals for a total of $299 million and trained over 7,360 resident FTEs. Another safeguard against potential duplicate payments, is the Medicare statutory requirement that CMS adjust all DGME payments by the ratio of a hospital's patients covered by Medicare.

We have enclosed information on Medicare program spending for GME, the number of FTE residents at teaching hospitals, and percentage of hospitals participating in Medicare received GME payments in response to your questions. We note that we do not collect all of the

information you have requested because CMS is charged with making payments for Medicare GME according to statute, which, as noted above, is prescriptive. We would be pleased to discuss the GME issue with you further and can provide technical assistance that you may require.

Thank you again for writing to us about this important issue. We appreciate your insights and welcome an opportunity to further discuss GME funding. If you or your staff have questions, please contact the CMS Office of Legislation at 202-690-8220.

Sincerely,



Seema Verma

Enclosure

Medicare GME spending and FTE counts for FY 2017

Source: FY 2017 Healthcare Cost Report Information System (HCRIS)	**DGME**	**IME**
Total Medicare Spending	$4,032,466,718	$10,120,286,476
Capped FTEs, Maximum Potential Supported by Medicare	94,739	89,154
Total Allopathic & Osteopathic FTEs without regard to Cap	115,092	103,856
Weighted FTEs (includes allopathic, osteopathic, dental, podiatry)	104,172	N/A
Paid FTEs	92,271	92,653
Unpaid FTEs	11,901	11,203

Children' GME Program		
Number of Hospitals	**Funding**	**Number of Residents**
58	$299,289,000	7,360

Data Notes:

- CMS pulled FY 2017 hospital cost report data to ensure a reasonable level of completeness. FY 2017 represents the best available data. However, FY 2017 cost report data has not yet been audited, and may contain data entry errors.
- DGME spending includes FFS Part A, Part B, and Medicare Advantage (MA) payments offset by the Nursing & Allied Health MA reduction.
- IME spending includes FFS Part A and MA payments and Capital IME payments.
- Capped FTEs includes all 1996 caps and post-1996 adjustments such as section 422 Medicare Modernization Act, and sections 5503, 5506 Patient Protection and Affordable Care Act.
- Paid FTEs includes uncapped residents in new program growth periods, and residents displaced by program or hospital closure; these FTEs are not included in the total allopathic & osteopathic counts without regard to the cap.
- DGME unpaid FTEs is the difference between the Weighted FTEs and the Paid FTEs
- IME unpaid FTEs is the difference between the total allopathic & osteopathic counts without regard to the cap and the Paid FTEs.

In FY 2017, of 6,150 facilities (including acute care Inpatient Prospective Payment System hospitals, psychiatric, inpatient rehabilitation facilities, critical access hospitals), 1,373 hospitals answered "yes" to being a teaching hospital, representing 22 percent of hospitals. Since the mid-1990s, when the number of teaching hospitals was approximately 1,100, there has been about a 25 percent net increase in the number of teaching hospitals (this accounts for both new teaching hospitals as well as teaching hospital closures).