April 19, 2024

Illinois Department of Healthcare and Family Services ("HFS")
Bureau of Program and Policy Coordination
Division of Medical Programs
201 South Grand Avenue East
Springfield, IL 62763-0001

Thank you for the opportunity to comment and ask questions regarding the public notice on proposed changes to the Graduate Medical Education (GME) program published March 22, 2024 and effective April 1, 2024. I work with various provider groups. This proposed change did not appear in any of the public documents supporting the Governor's proposed FY 2025 budget. My concern is that the cost of this proposed change will reduce any possible additional funding for other Medicaid funding proposals being considered by the General Assembly which were not part of the Governor's introduced budget.

Teaching hospitals incur costs for training medical residents, interns and fellows in addition to the costs of providing care. These additional costs are referred to as GME costs. Most teaching hospitals receive some support from the federal Medicare program for GME, but this has been capped by Congress since 1996. Because of that cap many teaching hospitals support and train significant numbers of interns and residents that are unfunded by Medicare. While free-standing children's hospitals receive little or no funding from Medicare, they do receive federal funding towards the costs of GME via the Children's Hospitals Graduate Medical Education (CHGME) program, "which provides direct financial support to children's hospitals to train medical residents and fellows"[1]

On the state level, reimbursement for the Medicaid portion of GME costs comes via the hospital assessment program ("HAP"), which was collaboratively designed with input from all hospitals, HFS, and the General Assembly. The GME program does not pay 100% of Medicaid's share of GME costs, but rather limits its support to 30% of those costs (35% for safety-net hospitals and those teaching hospitals with 100 or more full-time equivalent residents and interns). The State's Medicaid GME payments are financed via the tax part of the HAP program, which all hospitals pay.

In 2018 when the HAP GME payment was carefully created, it recognized the different level of commitments hospitals make to training the future physician workforce. As a result, the current GME methodology sets the higher GME cap at 35% for safety-net hospitals and those hospitals with 100 or more full time equivalent ("FTE") residents and interns (all other teaching hospitals are capped at 30%). HFS is proposing a change to this part of the HAP program, which will increase GME payments for only two hospitals that already qualify and receive Medicaid GME payments at the 35% cap level. As a result of HFS' proposal, two hospitals will have 100% of their Medicaid GME costs paid for under the HAP. My questions:

1. Will this be part of a possible Medicaid Omnibus bill and thus its costs will reduce the available funding for other provider groups requests?

2. What is the rationale to alter the GME methodology to pay certain hospitals 100% of their Medicaid GME costs while only paying other teaching hospitals 35% (or 30%) of their Medicaid GME costs?

[1] Congressional Research Service, "Children's Hospitals Graduate Medical Education (CHGME) R45067", June 13, 2023 The CHGME program is administered by the Health Resources and Services Administration (HRSA) which is within the federal Department of Health and Human Services ("HHS").

3. This proposed change was not in the public documents for the Governor's FY 2025 introduced budget or HFS' Illinois State Legislative ("ISL") forms supporting the FY 2025 budget request. How will this proposed change be financed? Will HFS be asking for an increase in General Revenue Funds in their FY 2025 proposed budget to fund these payments or will this change be financed by an increase in the hospital tax?

I understand that HFS may from time-to-time need to address specific hospital issues. However, HAP reimbursement methodologies established to address specific costs like GME, and are tied to utilization, acuity and patient care, should not be altered to create specially targeted hospital payments. Additionally, new targeted hospital payments should not be funded by the hospital tax.

Thank you again for the opportunity to submit comments and questions on this proposed change. I look forward to your response.

Sincerely,

Matthew W. Werner

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