

CMS-2279-P-50 Medicaid Graduate Medical Education

Submitter : Ms. Elizabeth Ward

Date & Time: 06/20/2007

Organization : Moses Cone Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

CMS-2279-P-51 Medicaid Graduate Medical Education

Submitter : Dr. Rex Bentley

Date & Time: 06/20/2007

Organization : Duke University Medical Center

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Medicaid funding for GME is extremely important for low-income patients. Physicians need to be trained in the special problems seen in low income populations, and physicians who have received such training are a) better at providing care to these groups, and b) more likely to provide service to these groups. I strongly oppose the elimination of medicaid funding for GME because it will adversely affect the quality and quantity of care available to the low income patients being served by the medicaid program.

CMS-2279-P-52 Medicaid Graduate Medical Education

Submitter : Dr. Garland Anderson

Date & Time: 06/20/2007

Organization : University of Texas Medical Branch-School of Med.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2279-P-52-Attach-1.DOC

June 19th, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of University of Texas Medical Branch at Galveston 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). As I am sure you are aware, our state has the highest percentage of uninsured population in the United States. 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. This is particularly important since the nation faces a future shortage of 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. 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. Since the Galveston National Lab is located on our campus, we are acutely aware of this 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,

Garland D. Anderson, MD
Dean, School of Medicine
University of Texas Medical Branch
301 University Blvd.
Galveston, TX 77555-0133
Phone: 409-772-4793
Email: ganderso@utmb.edu

CMS-2279-P-53 Medicaid Graduate Medical Education**Submitter :** Dr. Richard Auten**Date & Time:** 06/20/2007**Organization :** Duke University**Category :** Physician**Issue Areas/Comments****Background**

Background

The docket identifies the central issue: there is no coherent rational national policy to fund GME that includes government payments via Medicaid.

Provisions of the Proposed**Rule**

Provisions of the Proposed Rule

As usual, the provision of the proposed rule takes the narrow view that training future physicians is "not my problem" because there is no explicitly identified structure to fund GME.

Instead, a more statesmanlike, rational approach would be to propose a comprehensive solution by unifying the rules and provisions between Medicare and Medicaid. This would obviously require new legislation. However, simply ignoring the necessity for funding GME and hoping someone else will just pick up the tab is not prudent fiscal management, it is just grandstanding to 'save' money. Opening a comprehensive discussion about physician manpower needs, distribution, incentives, and the national governments role in GME is the right approach. Simply chopping the funding from medical centers that train tomorrows physicians is not prudent. It is like eating your seed corn, rather than planting for next year's harvest. It is also has the effect of punishing hospitals that care for the neediest patients, namely those receiving Medicaid benefits. Those well-represented, vocal patient constituencies, i.e., Medicare recipients, will continue to funnel federal dollars towards institutions that disproportionately care for seniors. Those facilities that disproportionately care for the poor and for children will be affected disproportionately as well.

CMS-2279-P-54 Medicaid Graduate Medical Education

Submitter : Dr. Satwant Singh

Date & Time: 06/20/2007

Organization : University of Cincinnati

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-54-Attach-1.PDF



June 20, 2007

#51/

College of Medicine
Department of Internal Medicine
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Email cinneph@uc.edu

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

Attention: CMS-2279-P

Dear Administrator Norwalk:

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Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery.

Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

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

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

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

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

Sincerely,



Satwant Singh, M.D.
Professor
Director, Nephrology Fellowship Program

CMS-2279-P-55 Medicaid Graduate Medical Education

Submitter : Dr. Lisa Haglund

Date & Time: 06/20/2007

Organization : University Hospital/University of Cincinnati

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-55-Attach-1.PDF



June 20, 2007

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Acting Administrator
Centers for Medicare & Medicaid Services
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200 Independence Ave, SW
Washington, DC 20201

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Fax (513) 558-2089

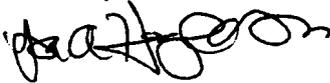
Leslie Norwalk, Esq.
June 20, 2007
Page 2

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

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

Sincerely,



Lisa Haglund, MD FACP
Associate Professor of Clinical Medicine
Program Director
Infectious diseases Fellowship Program
University of Cincinnati College of Medicine

CMS-2279-P-56 Medicaid Graduate Medical Education

Submitter : Dr. Stephen Zucker

Date & Time: 06/20/2007

Organization : University of Cincinnati

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-56-Attach-1.DOC

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:

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

professionals has never been more important given the numerous studies predicting a physician shortage in the near future. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in our medical specialty, Gastroenterology. Moreover, we are one of only 9 centers in the entire United States that is accredited for the training of specialists in the care of liver transplant patients. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education program at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In 2006, University Hospital admitted 10,000 Medicaid patients for inpatient services and provided care for an additional 77,000 Medicaid patients in outpatient settings. This is in addition to the 4,000 indigent care patients admitted for inpatient services and the 111,000 treated in outpatient settings. In 2006, as defined by the Catholic Healthcare Initiative, University Hospital provided over \$71 million in community benefit. This figure is by far the largest in our region and one of the top three among providers in the State of Ohio. Trainees in our gastroenterology program provided indigent care for over 2000 outpatient visits over this past fiscal year.

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.

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

Sincerely,

Stephen D. Zucker, M.D.
Associate Professor of Medicine
Director, Gastroenterology and Transplant Hepatology Training Programs
University of Cincinnati
231 Albert Sabin Way, M.L. 0595
Cincinnati, OH 45267-0595

CMS-2279-P-57 Medicaid Graduate Medical Education

Submitter : Mr. R Reske

Date & Time: 06/20/2007

Organization : University of Michigan Hospitals and Health Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please refer to the attachment.

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

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

CMS-2279-P-58 Medicaid Graduate Medical Education

Submitter : Dr. Anne Barbara Mongey

Date & Time: 06/20/2007

Organization : University Hospital/University of Cincinnati

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-58-Attach-1.PDF



College of Medicine
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Division of Immunology

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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:

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Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Leslie Norwalk, Esq., Attention: **CMS-2279--P**

Page 2

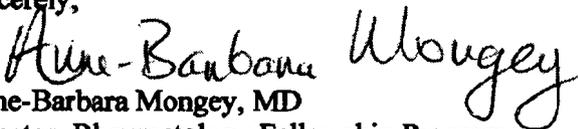
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Sincerely,


Anne-Barbara Mongey, MD
Director, Rheumatology Fellowship Program

ABM/sg

CMS-2279-P-59 Medicaid Graduate Medical Education

Submitter : Dr. Malek Safa

Date & Time: 06/20/2007

Organization : University of Cincinnati

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-59-Attach-1.PDF

CMS-2279-P-59-Attach-2.PDF



#59.

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Division of Hematology-Oncology
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Fax (513) 558-2203

June 20, 2007

Leslie Norwalk, Esq.
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Hubert H. Humphrey Building
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200 Independence Ave, SW
Washington, DC 20201

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

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

Sincerely,



Malek Safa, M.D.
Assistant Professor of Medicine
Director, Division of Hematology-Oncology
Fellowship Program

MS/wfh

CMS-2279-P-60 Medicaid Graduate Medical Education

Submitter : Dr. Ernest Yoder

Date & Time: 06/20/2007

Organization : St. John Health

Category : Physician

Issue Areas/Comments

Background

Background

Please see General Comments above.

GENERAL

GENERAL

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 St. John Health 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 strongly urge the Agency to rescind the proposed rule.

Sincerely,

Ernest L. Yoder, MD, PhD, FACP
Vice President, Academic Affairs
St. John Health
Warren, MI

**Provisions of the Proposed
Rule**

Provisions of the Proposed Rule

Please see general comments above.

CMS-2279-P-61 Medicaid Graduate Medical Education

Submitter : Dr. Robert Wissman

Date & Time: 06/20/2007

Organization : Department of Radiology/UC Medical Center

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

#61

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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

CMS-2279-P-62 Medicaid Graduate Medical Education

Submitter : Dr. Lisa Haglund

Date & Time: 06/20/2007

Organization : University Hospital/University of Cincinnati COM

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-62-Attach-1.PDF



College of Medicine
Department of Internal Medicine
Division of Infectious Diseases
University of Cincinnati Medical Center
PO Box 670560
Cincinnati OH 45267-0560
Phone (513) 558-4704
Fax (513) 558-2089

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:

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Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

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

Leslie Norwalk, Esq.
June 20, 2007
Page 2

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

Sincerely,



Lisa Haglund, MD FACP
Associate Professor of Clinical Medicine
Program Director
Infectious diseases Fellowship Program
University of Cincinnati College of Medicine

CMS-2279-P-63 Medicaid Graduate Medical Education

Submitter : Mr. Rick Pollack

Date & Time: 06/20/2007

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-63-Attach-1.DOC



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 20, 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

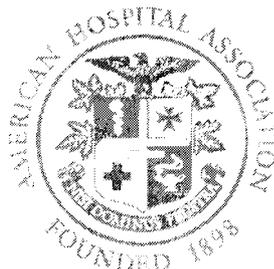
Re: (CMS-2279-P) Medicaid Program; Graduate Medical Education (Vol. 72, No. 99), May 23, 2007

Dear Ms. Norwalk:

On behalf of our 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.**



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,

Rick Pollack
Executive Vice President

CMS-2279-P-64 Medicaid Graduate Medical Education

Submitter : Mr. Michael Chirieleison

Date & Time: 06/20/2007

Organization : Safety-Net Association of Pennsylvania

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-64-Attach-1.DOC

Safety-Net Association of Pennsylvania

112 Walnut Street • Harrisburg, PA 17101 • 717-234-6970 • 717-234-6971 fax • www.pasafetynet.org

June 20, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Attention: File Code CMS-2279-P

To Whom it May Concern:

I am writing on behalf of the Safety-Net Association of Pennsylvania (SNAP) to express our concern about the proposed regulation governing federal matching of state Medicaid payments for graduate medical education (*Federal Register*, Vol. 72, No. 99, May 23, 2007, p. 28930). SNAP opposes this regulation for several reasons, addressed individually below, and urges the Centers for Medicare & Medicaid Services (CMS) to withdraw this proposal and continue the federal government's current policy of matching state Medicaid payments for graduate medical education.

Policy Change

In the commentary explaining the proposed regulation, CMS notes that "This 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." SNAP disagrees with the assertion that this regulation constitutes a "clarification."

Medicaid has matched state expenditures for graduate medical education for many years. During this period, states have routinely included payments for graduate medical education in the state Medicaid plans they submit to the federal government for review and approval – and those state plans, including their provisions for payments for graduate medical education, have just as routinely been approved. That approval has continued, moreover, throughout the current administration. We do not understand how, in the absence of new legislation or other regulations that effectively change federal policy, something that was routinely considered acceptable and appropriate for so many years can now be considered contrary to federal law. Thus, we believe CMS's announced intention to discontinue this practice constitutes a change in policy – from our perspective, a major change in policy – rather than clarification of existing policy.

SNAP questions this policy change. Traditionally, Medicaid has given states considerable latitude regarding the services they provide and the payments for which they can receive federal financial participation; this has long been a hallmark of the state-federal partnership that is Medicaid's cornerstone. Now, however, CMS appears interested in reducing that latitude – but in just this one area while continuing to match other state-covered Medicaid expenditures. SNAP wonders why graduate medical education has been chosen for this literal interpretation of the federal statute – especially after so many years of an unmistakably different interpretation – while so many other aspects of state Medicaid programs remain unchallenged.

Regulatory Impact

In the proposed regulation, CMS projects federal savings of \$140 million in FY 2008, \$290 million in FY 2009, \$440 million in FY 2010, \$450 million in FY 2011, and \$460 million in FY 2012. On the surface, these appear to be relatively modest savings, but we believe they may be understated. In Pennsylvania alone, the federal share of medical education payments made to teaching hospitals was more than \$42 million in the state's 2006 fiscal year. Similarly, a recent commentary in the publication *Modern Healthcare* (June 11, 2007, p. 20) stated that New York's teaching hospitals receive \$1.2 billion a year in Medicaid graduate medical education payments. A 2002 survey by the National Conference of State Legislatures found that state Medicaid programs were spending \$2.5-\$2.7 billion a year on Medicaid medical education payments. Even recognizing that some of this money is for indirect medical education and some is for direct medical education, it appears likely that the actual numbers are much greater than the estimate offered in the draft regulation. Consequently, the impact of this change in policy would most likely be much greater than CMS formally anticipates.

The Impact of the Proposed Policy Change

More important than the question of whether this is a clarification or a policy change or the precise cost to associate with this change is the broader concern that eliminating federal matching funds for state graduate medical education payments to teaching hospitals will have a significant impact on individual teaching hospitals, on the health care safety net in the U.S. today, and on access to care in this country tomorrow and into the future because state Medicaid programs are unlikely to be able to afford to compensate for this significant, sudden, and unexpected loss of federal funds.

Safety-net hospitals such as those represented by SNAP are far more dependent on public payers than most hospitals. Medicare and Medicaid are among our most important payers, and these hospitals also care for significant numbers and proportions of uninsured patients. Reducing Medicaid payments to these hospitals by depriving our state of matching funds for graduate medical education payments – payments the federal government has long made – would weaken the financial health of teaching hospitals that already operate on extremely slim margins. Ours are the hospitals to which many low-income Americans – and in our case, low-income and Medicaid-insured Pennsylvanians – turn for care. Often, the medical residents whose training is underwritten in part by these funds are directly involved in the care of our low-income patients. Thus, eliminating medical education payments would increase the financial burden on our teaching hospitals and possibly jeopardize access to care for many of our low-income patients.

On a wider scale, teaching hospitals constitute an important part of the health care safety net in the U.S. today, and Pennsylvania's teaching hospitals are a vital part of that safety net. Today, one-half of all Medicaid discharges in this country are from teaching hospitals and more than one-half of all charity care is provided by these same hospitals. Eliminating the federal government's long-time practice of matching state payments for graduate medical education would weaken the financial foundation upon which these teaching hospitals operate and, in so doing, weaken the American health care safety net.

Finally, eliminating federal matching funds for state Medicaid graduate medical education payments may result in a tragic and avoidable loss of access to care in the future. As described in the proposed regulation itself, the origins of federal support for graduate medical education can be traced to Medicare and the national physician shortage of the 1950s and 1960s. While the proposed regulation notes that by the 1980s the nation had a surplus of physicians, it does not mention a report by the Association of American Medical Colleges that maintains that by 2020, the U.S. will have a shortage of at least 55,000 physicians. This finding was essentially confirmed by the Council on Graduate Medical Education, a non-partisan group created to advise

the administration and Congress, in its 2005 report *Physician Workforce Policy Guidelines for the United States, 2000-2020*. To respond to that shortage, we as a society must act today, not wait until 2020, and eliminating Medicaid's support for graduate medical education would directly and dramatically detract from our ability to meet this latest challenge.

If hospitals are required to absorb more of the cost of educating their medical residents – states are unlikely to make up for this loss of federal funds – one natural response will be for them to make the inevitable, unfortunate, but financially responsible choice to train fewer physicians. With fewer training opportunities available, medical schools will be compelled to reduce their enrollment – again, an approach that would directly contradict the American Association of Medical Colleges' call for a 30 percent increase in medical school enrollment over the next eight years. Even today, our nation has thousands of federally designated medically underserved areas. Federal policy should seek to reduce the number of such areas, not pose a threat to the training of physicians that could lead to an increase in their numbers. As the proposed regulation describes in detail, Medicare has a long-standing policy of helping hospitals with the cost of graduate medical education, and that support remains firm today. SNAP believes CMS should demonstrate a similar level of support for what has long been an integral part of state Medicaid programs.

Acknowledging the Challenges Posed by Graduate Medical Education

While SNAP strongly encourages the federal government to continue matching state Medicaid payments to teaching hospitals for graduate medical education, we are not unaware of the challenges this poses for federal regulators. The proposed regulation notes, for example, that it is difficult for regulators to track these payments in many states. We would like to note, though, that this is not the case in all states and is not the case in our state of Pennsylvania, where medical education payments are not folded into other Medicaid payments and instead are paid directly, and discretely, to eligible teaching hospitals. We believe that if this approach can be taken in some states – 15 states today, according to the American Association of Medical Colleges – it can be introduced in others as well. Consequently, we encourage CMS to ask Congress for the authority to develop regulatory guidelines that compel such payments to be made directly and discretely, thereby enhancing regulators' ability to monitor the appropriateness and efficacy of medical education payments and to ensure that they reach their intended beneficiaries. With Congress's clear understanding and support, Medicaid has found graduate medical education payments to be worth making for many, many years, and they did not suddenly lose their value or their purpose. If monitoring their use poses a challenge, SNAP encourages CMS to work to meet that challenge rather than to choose simply to do away with the payments entirely.

Medicare IME Payments and UPL Calculations

In NAUH's view, Congress clearly believes that Medicaid should shoulder its share of responsibility for funding medical education. Consistent with this view, we believe that medical education costs should be included in upper payment limit (UPL) calculations.

Conclusion

Medicaid's contribution to the training of this country's next generation of physicians is a vital part of the American health care system – so important that today, 47 states and the District of Columbia make such payments. The need for this support has not diminished in any way; in fact, in light of the impending shortage of physicians that we face as a nation over the next 20 years, that need has actually grown. Other

health care payers – most notably Medicare, which CMS cites extensively in the proposed regulation – continue to pay their fair share of medical education costs, and we urge Medicaid to continue doing so as well. Teaching hospitals are a vital part of the health care safety net in Pennsylvania today, and in the U.S. today, and eliminating Medicaid's contribution to their good work threatens to undermine their efforts to care for their many low-income and medically vulnerable patients. SNAP urges CMS to withdraw this proposed regulation, reaffirm Medicaid's commitment to the graduate training of our nation's next generation of physicians, and support the broader mission of service of the teaching hospitals that provide this essential training.

About the Safety-Net Association of Pennsylvania

The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of the commonwealth. Safety-net hospitals are the 25 percent of hospitals in Pennsylvania that care for the highest combined proportion of uninsured patients, Medical Assistance recipients, and Medicare SSI recipients and that therefore constitute the state's health care safety net. Located in 20 of the state's 67 counties, these hospitals can be found in the eastern, central, and western regions of Pennsylvania and in urban, suburban, and rural areas. They are large and small and include community hospitals, teaching hospitals, and some of the largest and most important academic health centers in the country today.

* * *

We welcome any questions you may have about the views expressed in this letter and appreciate your attention to our concerns.

Sincerely,

Michael Chirieleison
Executive Director

CMS-2279-P-65 Medicaid Graduate Medical Education

Submitter : Ms. Ellen Kugler

Date & Time: 06/20/2007

Organization : National Association of Urban Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attached

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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

CMS-2279-P-66 Medicaid Graduate Medical Education

Submitter : Ms. Ellen Kugler

Date & Time: 06/20/2007

Organization : National Association of Urban Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-66-Attach-1.DOC

#66

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

June 20, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Attention: File Code CMS-2279-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our concern about the proposed regulation governing federal matching of state Medicaid payments for graduate medical education (*Federal Register*, Vol. 72, No. 99, May 23, 2007, p. 28930). NAUH opposes this regulation for several reasons, addressed individually below, and urges the Centers for Medicare & Medicaid Services (CMS) to withdraw this proposal and continue the federal government's current policy of matching state Medicaid payments for graduate medical education.

Policy Change

In the commentary explaining the proposed regulation, CMS notes that "This 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." NAUH disagrees with the assertion that this regulation constitutes a "clarification."

Medicaid has matched state expenditures for graduate medical education for many years. During this period, states have routinely included payments for graduate medical education in the state Medicaid plans they submit to the federal government for review and approval – and those state plans, including their provisions for payments for graduate medical education, have just as routinely been approved. That approval has continued, moreover, throughout the current administration. We do not understand how, in the absence of new legislation or other regulations that effectively change federal policy, something that was routinely considered acceptable and appropriate for so many years can now be considered contrary to federal law. Thus, we believe CMS's announced intention to discontinue this practice constitutes a change in policy – from our perspective, a major change in policy – rather than clarification of existing policy.

NAUH questions this policy change. Traditionally, Medicaid has given states considerable latitude regarding the services they provide and the payments for which they can receive federal financial participation; this has long been a hallmark of the state-federal partnership that is Medicaid's cornerstone. Now, however, CMS appears interested in reducing that latitude – but in just this one area while continuing to match other state-covered Medicaid expenditures. NAUH wonders why graduate medical education has been chosen for this literal interpretation of the federal statute – especially after so many years of an unmistakably different interpretation – while so many other aspects of state Medicaid programs remain unchallenged.

Regulatory Impact

In the proposed regulation, CMS projects federal savings of \$140 million in FY 2008, \$290 million in FY 2009, \$440 million in FY 2010, \$450 million in FY 2011, and \$460 million in FY 2012. On the surface, these appear to be relatively modest savings, but we believe they may be understated. In Pennsylvania, the federal share of medical education payments made to teaching hospitals was more than \$43 million in the state's 2006 fiscal year; New York's teaching hospitals receive \$1.2 billion a year in Medicaid graduate medical education payments; and a 2002 survey by the National Conference of State Legislatures found that state Medicaid programs were spending \$2.5-\$2.7 billion a year on Medicaid medical education payments. Even recognizing that some of this money is for indirect medical education and some is for direct medical education, it appears likely that the actual numbers are much greater than the estimate offered in the draft regulation. Consequently, the impact of this change in policy would most likely be much greater than CMS formally anticipates.

The Impact of the Proposed Policy Change

More important than the question of whether this is a clarification or a policy change or the precise cost to associate with this change is the broader concern that eliminating federal matching funds for state graduate medical education payments to teaching hospitals will have a significant impact on individual teaching hospitals, on the health care safety net in the U.S. today, and on access to care in this country tomorrow and into the future because state Medicaid programs are unlikely to be able to afford to compensate for this significant, sudden, and unexpected loss of federal funds.

Private, non-profit urban safety-net hospitals such as those represented by NAUH are far more dependent on public payers than most hospitals. Medicare and Medicaid are among our most important payers, and these hospitals also care for significant numbers and proportions of uninsured patients. Reducing Medicaid payments to these hospitals by depriving states of matching funds for graduate medical education payments – payments the federal government has long made – would weaken the financial health of teaching hospitals that already operate on extremely slim margins. Ours are the hospitals to which many low-income Americans turn for care. Often, the medical residents whose training is underwritten in part by these funds are directly involved in the care of our low-income patients. Thus, eliminating medical education payments would increase the financial burden on our teaching hospitals and possibly jeopardize access to care for many of our low-income patients.

On a wider scale, teaching hospitals constitute an important part of the health care safety net in the U.S. today. Today, one-half of all Medicaid discharges in this country are from teaching hospitals and more than one-half of all charity care is provided by these same hospitals. Eliminating the federal government's long-time practice of matching state payments for graduate medical education would weaken the financial foundation upon which these teaching hospitals operate and, in so doing, weaken the American health care safety net.

Finally, eliminating federal matching funds for state Medicaid graduate medical education payments may result in a tragic and avoidable loss of access to care in the future. As described in the proposed regulation itself, the origins of federal support for graduate medical education can be traced to Medicare and the national physician shortage of the 1950s and 1960s. While the proposed regulation notes that by the 1980s the nation had a surplus of physicians, it does not mention a report by the Association of American Medical Colleges that maintains that by 2020, the U.S. will have a shortage of at least 55,000 physicians. This finding was essentially confirmed by the Council on Graduate Medical Education, a non-partisan group created to advise the administration and Congress, in its 2005 report *Physician Workforce Policy Guidelines for the United States, 2000-2020*. To respond to that shortage, we as a society must act today, not wait until 2020, and

eliminating Medicaid's support for graduate medical education would directly and dramatically detract from our ability to meet this latest challenge.

If hospitals are required to absorb more of the cost of educating their medical residents – states are unlikely to make up for this loss of federal funds – one natural response will be for them to make the inevitable, unfortunate, but financially responsible choice to train fewer physicians. With fewer training opportunities available, medical schools will be compelled to reduce their enrollment – again, an approach that would directly contradict the American Association of Medical Colleges' call for a 30 percent increase in medical school enrollment over the next eight years. Even today, our nation has thousands of federally designated medically underserved areas. Federal policy should seek to reduce the number of such areas, not pose a threat to the training of physicians that could lead to an increase in their numbers. As the proposed regulation describes in detail, Medicare has a long-standing policy of helping hospitals with the cost of graduate medical education, and that support remains firm today. NAUH believes CMS should demonstrate a similar level of support for what has long been an integral part of state Medicaid programs.

Acknowledging the Challenges Posed by Graduate Medical Education

While NAUH strongly encourages the federal government to continue matching state Medicaid payments to teaching hospitals for graduate medical education, we are not unaware of the challenges this poses for federal regulators. The proposed regulation notes, for example, that it is difficult for regulators to track these payments in many states. We would like to note, though, that this is not the case in all states. In some states, medical education payments are not folded into other Medicaid payments and instead are paid directly, and discretely, to eligible teaching hospitals. We believe that if this approach can be taken in some states – 15 states today, according to the American Association of Medical Colleges – it can be introduced in others as well. Consequently, we encourage CMS to ask Congress for the authority to develop regulatory guidelines that compel such payments to be made directly and discretely, thereby enhancing regulators' ability to monitor the appropriateness and efficacy of medical education payments and to ensure that they reach their intended beneficiaries. With Congress's clear understanding and support, Medicaid has found graduate medical education payments to be worth making for many, many years, and they did not suddenly lose their value or their purpose. If monitoring their use poses a challenge, NAUH encourages CMS to work to meet that challenge rather than to choose simply to do away with the payments entirely.

Medicare IME Payments and UPL Calculations

In NAUH's view, Congress clearly believes that Medicaid should shoulder its share of responsibility for funding medical education. Consistent with this view, we believe that medical education costs should be included in upper payment limit (UPL) calculations.

Conclusion

Medicaid's contribution to the training of this country's next generation of physicians is a vital part of the American health care system – so important that today, 47 states and the District of Columbia make such payments. The need for this support has not diminished in any way; in fact, in light of the impending shortage of physicians that we face as a nation over the next 20 years, that need has actually grown. Other health care payers – most notably Medicare, which CMS cites extensively in the proposed regulation – continue to pay their fair share of medical education costs, and we urge Medicaid to continue doing so as well. Private, non-profit, urban teaching hospitals are a vital part of the health care safety net in the U.S. today, and eliminating Medicaid's contribution to their good work threatens to undermine their efforts to care for their many low-income and medically vulnerable patients. NAUH urges CMS to withdraw this proposed regulation, reaffirm Medicaid's commitment to the graduate training of our nation's next generation of physicians, and support the broader mission of service of the teaching hospitals that provide this essential training.

We welcome any questions you may have about the views expressed in this letter and appreciate your attention to our concerns.

Sincerely,

Ellen Kugler, Esq.
Executive Director

CMS-2279-P-67 Medicaid Graduate Medical Education**Submitter :** Mrs. Suzanne Barnette**Date & Time:** 06/20/2007**Organization :** Montgomery Regional Hospital**Category :** Other Health Care Professional**Issue Areas/Comments****GENERAL**

GENERAL

Eliminating federal Medicaid matching payments for the costs of graduate medical education will cripple the ability of teaching hospitals to continue to provide training institutions for physicians. We are facing an extreme shortage of physicians at a time when we need highly trained physicians the most. I live in a rural area, and we are in desperate need of new physicians to provide high quality care to our community. My hospital, Montgomery Regional Hospital in Southwest Virginia, is beginning an important GME program in an effort to provide a high quality training institution for graduates from VCOM and other medical schools. It is our hope that these physicians will train here and stay here to establish and build a practice to serve our community. If funding is cut, physicians will only be able to go to university hospital training institutions and will not have the option to go to more rural and suburban areas where well-trained professionals are desperately needed. GME funding must be protected so that we will have adequate and appropriately located teaching institutions. Please do not further damage our healthcare system by taking away the ability for hospitals to train physicians and turn out the highest quality caregivers for everyone, in all locations of our country. Cutting funds is very a short-sighted action that would impede the progress that is being made in physician training and the overall advancement of medicine by our young medical school graduates. Please see 'Modern Healthcare' attachment for specific details.

CMS-2279-P-67-Attach-1.PDF

Don't play games with GME

CMS' bid to cut off funds for teaching docs would be a disaster for healthcare

On May 18, the CMS issued a proposed regulation that would eliminate federal Medicaid matching payments for the costs of graduate medical education. If enacted, this regulation would severely and perhaps irrevocably compromise the ability of teaching hospitals to continue their critically important mission of training physicians. As healthcare policy, this decision represents a stunning disregard for the long-term well-being of our nation's healthcare system.

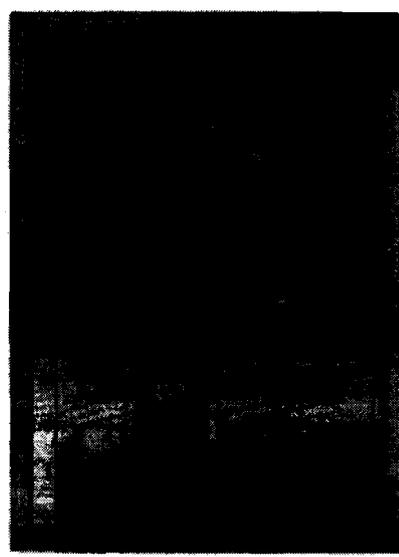
The timing of this proposal could not be worse. The U.S. is on the brink of an alarming physician shortage that will coincide with the medical demands of the retiring baby boomers. A 2005 report by the federal Council on Graduate Medical Education, the nonpartisan advisory body created to provide recommendations to the Bush administration and Congress, found that while the supply of physicians is expected to increase over the next two decades, demand for services is likely to grow even more rapidly.

According to the Association of American Medical Colleges, the nation will have a shortage of at least 55,000 physicians by the year 2020. The AAMC has called for a 30% increase in U.S. medical school enrollment by 2015, which would result in an additional 5,000 new physicians annually. Pursuing that goal would require an increase in graduate medical education, or GME, programs. Given 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 right now.

GME funding reimburses teaching hospitals for the additional costs incurred in training physicians. Teaching hospitals typically provide this intensive clinical training to individuals for three to seven years (depending on the specialty chosen by the physician resident) after medical school graduation so physicians can develop the necessary skills to practice autonomously.

In New York state alone—with 121 teaching hospitals, 56 of which are considered major teaching hospitals, and where one out of every six practicing physicians in the U.S. is trained—total annual Medicaid GME payments to hospitals are \$1.2 billion. Clearly, the White House Office of Management and Budget's estimate of the regulation's impact on teaching hospitals nationwide—a loss of \$1.8 billion over five years—is grossly understated.

Indeed, the CMS concedes that it has no accurate way of identifying precisely how much



After a reprieve, come May 29, 2008, Medicaid GME will once again be on the chopping block.

states pay in Medicaid GME each year. It follows, then, that the CMS does not fathom how much its proposal would damage the nation's ability to produce needed physicians. But New York, 46 other states, and the District of Columbia—all of which make GME payments through Medicaid to support physician training—do know the implications, and they are devastating.

Consider the breadth and depth of contributions made by teaching hospitals—24 hours a day, seven days a week—as they train the next generation of doctors in a unique environment that combines cutting-edge patient care with energetic young doctors, seasoned and intellectually engaged teaching physicians, research and education. Without exception, the end results are innovation, medical breakthroughs and the advancement of patient care. In hospitals serving Medicaid patients, it also allows for the provision of world-class medical care to our most vulnerable residents.

So, at a time when the mission of our teaching hospitals to train the next generation of doctors has never been more important, they face the prospect of severe funding cuts. Eliminating Medicaid GME funding would be an astonishingly shortsighted policy.

Fortunately, there is short-term good news. A provision in the revised Iraq war funding bill that President Bush signed into law on May 25

blocks for one year the implementation of the Medicaid GME rule. But come May 25, 2008, Medicaid GME funding will once again be on the chopping block. Hopefully, the CMS will change its course and not seek to eliminate it.

Operating a teaching hospital is a very costly proposition. Hospitals that get GME payments are subject to accreditation oversight that sets standards for the field and ensures quality. Accreditation by the main national organization, the Accreditation Council for Graduate Medical Education, is all but required because so much of teaching hospital funding hinges on appropriate accreditation. Teaching hospitals must constantly adapt and adopt the latest medical technologies and practices to maintain accreditation. They also serve disproportionate numbers of poor and uninsured patients and provide undercompensated but critical services, such as trauma centers and burn units, as well as helping with emergency preparedness.

In short, teaching hospitals are indispensable.

Given what's at stake, it is imperative that Medicaid GME funding be protected. You do not address an imminent physician shortage by drastically weakening the very institutions that do the training. It would be the equivalent of a city addressing a violent crime wave by stripping its police officers of firearms, handcuffs and radios.

In the U.S., the physician-training process follows a rigorous system so that the end product—the fully trained, independent physician—can provide the highest quality, state-of-the-art care that patients expect and deserve. This pathway is built on a foundation of educators, senior physicians and administrators who work together to ensure that the training of these "physicians of tomorrow" continues to serve as a model for the rest of the world. It is vital, therefore, that all of the funding mechanisms that make this treasured system work so well are fiercely protected. Our future health depends on it. <<

*Kenneth Raske is
president of
the Greater
New York Hospital
Association,
New York*



CMS-2279-P-68 Medicaid Graduate Medical Education**Submitter :** Mr. Abe Feld**Date & Time:** 06/20/2007**Organization :** Cooper University Hospital**Category :** Health Care Professional or Association**Issue Areas/Comments****Background**

Background

CMS proposed rule for elimination of Medicaid Graduate Medical Education funding

GENERAL

GENERAL

I am writing on behalf of Cooper University Hospital #31-0014 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. Cooper receives between \$1.2 to \$1.6 million annually from the State of New Jersey in order to help support the excellent training provided to residents in our Graduate Medical Education teaching program. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Cooper trains around 220 residents annually in a multitude of specialties, but the hospital is particularly renown for its Trauma and Emergency Medicine programs. Cooper is located in the inter city of Camden, NJ where demand for well trained physicians to care for the large indigent population has never been greater.

Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In our case, Cooper had about 35,302 Medicaid and an additional 14,380 Charity Care patient days representing about 40% of our total volume in FY2006.

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.

Abe Feld, MHA
Sr. Reimbursement Analyst
Cooper University Hospital

**Provisions of the Proposed
Rule**

Provisions of the Proposed Rule

CMS proposed rule for elimination of Medicaid Graduate Medical Education funding

CMS-2279-P-69 Medicaid Graduate Medical Education

Submitter : Dr. Larry Goodwin

Date & Time: 06/20/2007

Organization : The College of St. Scholastica

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2279-P-69-Attach-1.PDF

#19,

June 20, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of The College of St. Scholastica, Department of Graduate Nursing 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 clinics jeopardizing 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 and clinics. 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 including the education of advance practice nurses who are significant providers of care in our health care systems across the country. These funds provide agencies and preceptors an added incentive as they add the work and cost of educating advanced practice nurses or other medical students to their already heavy workloads. The loss of funding may jeopardize this very critical role in preparing health care providers for the future.

Leslie Norwalk, Esq.
June 20, 2007
Page 2

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future advanced practice nurses such as nurse practitioners, clinical nurse specialists, nurse midwives, and nurse anesthetists as well as other providers of health care such as physicians and dentists. Within a supervised patient care team of health care professionals, these developing young professionals provide needed care to Medicaid and other patients as part of their educational programs. Educating future advanced practice nurses and other health care professionals has never been more important given the numerous studies predicting a shortage of advanced practice nurses and other providers in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate education programs at a time when more providers of health care 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 care, cardiac care, high risk care of mothers and infants, treatment of cancer and other immunological disorders, 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 care for the nation's most ill and elderly patients. Most recently, teaching hospitals are also 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. It is essential to maintain the current high quality of nursing and medical education in order to address the predicted shortages of health care providers particularly in rural areas. **We urge the Agency to rescind the proposed rule.**

Sincerely,



Larry Goodwin, PhD
President
The College of St. Scholastica

LG:jh

CMS-2279-P-70 Medicaid Graduate Medical Education

Submitter : Dr. Dewayne Andrews

Date & Time: 06/20/2007

Organization : University of Oklahoma College of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-70-Attach-1.PDF



The University of Oklahoma
College of Medicine

OFFICE OF THE EXECUTIVE DEAN

June 20, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of the University of Oklahoma College of Medicine to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). Finalizing this rule will erode the financial condition of teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions. It will also adversely affect public medical schools in those states such as Oklahoma where the Medicaid system, with federal approval, also provides GME payments to medical schools.

Although characterized by CMS as a "clarification," 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. As noted above, some medical schools also rely on these payments as critical to their operations and mission.

Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. These payments are critical in Oklahoma for this purpose. Within a supervised patient care team of health

CMS-2279-P-71 Medicaid Graduate Medical Education

Submitter : Mr. David Burd

Date & Time: 06/20/2007

Organization : Nebraska Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2279-P-71-Attach-1.DOC



June 20, 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; Proposed Rule (Vol. 72, No. 99), May 23, 2007

Dear Ms. Norwalk:

On behalf of our 85 member hospitals and the 39,000 persons they employ, the Nebraska Hospital Association (NHA) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule that would exclude costs and payments associated with Graduate Medical Education (GME) programs from being considered federally reimbursable under the Medicaid program.

The NHA is very concerned about this proposed rule and would urge CMS not to issue a final rule. Finalizing this rule would erode the financial condition of many safety-net hospitals and jeopardize their ability to continue to serve some of our most vulnerable citizens that are covered by the Medicaid program.

Although characterized by CMS as a “clarification,” the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. Hospitals’ GME costs in Nebraska have been supported by the Medicaid program for several years. It is estimated that annual direct GME payments in Nebraska total \$5.7 million. This amount includes the federal match and has been approved by CMS. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs.

Medicaid GME payments help hospitals sustain efforts to provide clinical education to future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. In 2005, over half of Nebraska’s counties (49 of 93) were federally designated, either in full or in part, as primary care Health Professional Shortage Areas (HPSAs). According to the report “The United States Health Workforce Profile,” which was released by The New York Center for Health Workforce Studies,

the number of physicians in Nebraska for every 100,000 people (185.09) is significantly below the national average (214.09).

Eliminating federal financial participation (FFP) for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout Nebraska and the nation. 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 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.

CMS has not been directed by Congress to eliminate payments for GME. In fact, Congress recently passed a one year moratorium preventing CMS from implementing any changes that would eliminate GME payments under Medicaid. It is critical that state Medicaid programs continue to receive federal matching assistance for GME to ensure that we continue to develop our future physicians to be able to meet the health care needs of some of our most vulnerable people. **We strongly urge CMS to rescind the proposed rule.**

The NHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact David Burd, Senior Director of Finance, at (402) 742-8144 or dburd@nhanet.org.

Sincerely,



Laura J. Redoutey, FACHE
President

CMS-2279-P-72 Medicaid Graduate Medical Education

Submitter : Dr. Neal Weintraub

Date & Time: 06/20/2007

Organization : University of Cincinnati

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2279-P-72-Attach-1.DOC

#72



College of Medicine
Department of Internal Medicine

Division of Cardiovascular Diseases
University of Cincinnati Medical Center
PO Box 670542
Cincinnati OH 45267-0542

231 Albert Sabin Way
Phone (513) 558-4721
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June 20, 2007

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

Attention: CMS-2279--P

Dear Administrator Norwalk:

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

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. In 2006, University Hospital received \$17 million in support of its care of the Medicaid population. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. University Hospital and the University of Cincinnati College of Medicine sponsor more than 45 ACGME accredited residency and fellowship training programs and train more than 525 physicians each year. As noted by the Association of American Colleges, we are anticipating a looming physician shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. In 2006, University Hospital admitted 10,000 Medicaid patients for inpatient services and provided care for an additional 77,000 Medicaid patients in



outpatient settings. This is in addition to the 4,000 indigent care patients admitted for inpatient services and the 111,000 treated in outpatient settings. In 2006, as defined by the Catholic Healthcare Initiative, University Hospital provided over \$71 million in community benefit. This figure is by far the largest in our region and one of the top three among providers in the State of Ohio.

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

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

Sincerely,



Neal L. Weintraub, M.D.
Stonehill Professor of Medicine
Director, Division of Cardiovascular Diseases
University of Cincinnati Medical Center
neal.weintraub@uc.edu

CMS-2279-P-73 Medicaid Graduate Medical Education

Submitter : Mr. Douglas Bagley

Date & Time: 06/20/2007

Organization : Riverside County Regional Medical Center

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-2279-P-73-Attach-1.PDF

CMS-2279-P-73-Attach-2.PDF



OFFICE OF THE DIRECTOR

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

RE: CMS-2279--P

Dear Administrator Norwalk:

I am writing on behalf of Riverside County Regional Medical Center (RCRMC) 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). Finalization of this rule would be contrary to the core intent of the Medicaid statute to provide direct patient care to Medicaid recipients, who constitute the majority of the patients at RCRMC and of all of California's public hospitals. The federal contribution to the costs of Medicaid GME allows public hospitals not only to play a vital role in the provision of critical medical services, but also to provide a learning venue for the nation's future physicians. We estimate that this harmful rule would cost RCMRC \$1.8 million and California's public hospitals approximately \$86.5 million per year, which would have an extremely detrimental impact on our hospitals' ability to provide access to quality medical care for our Medicaid patients.

Although the proposed rule characterizes the elimination of GME Medicaid costs as a "clarification," it actually represents a major reversal of the long-standing Medicaid policy to pay for the costs of direct patient services. Interns and residents at RCRMC assume an absolutely necessary role in the provision of direct patient services and, as such, CMS' attempt to change precedent upon which public hospitals have relied for more than 40 years is clearly erroneous. This precedent is grounded in the statute's stated purpose of reimbursing reasonable costs incurred in the efficient delivery of needed health services. Utilization of residents and interns reinforces the workforce that is needed to render quality and cost-effective direct health care services to RCRMC's patients. If Medicaid declines to pay the costs of GME, safety net hospitals like ours will be forced to hire additional physicians, the cost of which would be

prohibitive to fulfilling our missions to care for our most vulnerable patients. We, and the other public hospitals in the state, not only constitute the cornerstone of the health care safety net, but also provide necessary services on which our communities rely, including, including trauma, burn and emergency psychiatric care.

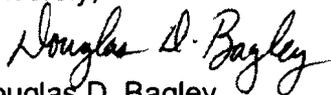
In addition, the decline in teaching new physicians will certainly lead to physician shortages which will also impede access to medical care for our patients. For decades, most state Medicaid programs, including California's, have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. California's public hospitals rely on these payments as a reasonable and necessary cost of providing services to Medicaid beneficiaries. Without the essential services of residents and interns, RCRMC and the state's other public hospitals will suffer greatly. Our hospitals count on GME and other Medicaid payments to support our critical dual role of delivering quality care and of educating our future physicians.

California's public teaching hospitals perform nearly half of all Medi-Cal discharges in the state and approximately half of all hospital care to the uninsured. As such, the proposed GME funding cut could also affect other services offered to Medicaid and other vulnerable patients by reducing teaching hospitals' total financial resources. In RCRMC's case, for example, we provide \$80 million in care to Medicaid patients, and \$60 million in uninsured care.

Public teaching hospitals are environments in which specialty patient care, including burn, trauma, cardiac and transplant services are available and where clinical research can flourish. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment. Residents and supervising physicians provide around-the-clock, direct, complex care for the nation's sickest patients. In addition, communities look to teaching hospitals as front-line responders in the event of a biological, chemical, or nuclear attack.

Given the important role of RCRMC and California's other public teaching hospitals in providing direct health care services to Medicaid recipients, and the current and future uncertainty surrounding their financial security, it is critical that California's Medicaid program continue to receive federal matching assistance for GME. **We therefore urge CMS to rescind the proposed rule.**

Sincerely,



Douglas D. Bagley
Chief Executive Officer

cc: Melissa Stafford Jones
President and CEO, CAPH

26520 Cactus Avenue, Moreno Valley, California 92555
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CMS-2279-P-74 Medicaid Graduate Medical Education**Submitter :** Dr. Judith Ramaley**Date & Time:** 06/20/2007**Organization :** Winiona State University**Category :** Academic**Issue Areas/Comments****GENERAL**

GENERAL

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 Winona State University 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 and clinics. 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 including the education of advance practice nurse who are significant providers of care in our health care systems across the country.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future advanced practice nurses such as nurse practitioners, clinical nurse specialists, nurse midwives, and nurse anesthetists as well as other providers of health care such as physicians and dentists. Within a supervised patient care team of health care professionals, these developing young professionals provide needed care to Medicaid and other patients as part of their educational programs. Educating future advance practice nurses and other health care professionals has never been more important given the numerous studies predicting a shortage of advanced practice nurses and other providers in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate education programs at a time when more providers of health care 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 care, cardiac care, high risk care of mothers and infants, treatment of cancer and other immunological disorders, 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 advance practice nursing students and residents and their respective supervisors around-the-clock, teaching hospitals care for the nation's most ill 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,

Judith A. Ramaley, PhD
President
Winona State Un