

CMS-2279-P-1

Medicaid Graduate Medical Education

Submitter : Dr. Mario Pacheco

Date & Time: 05/29/2007

Organization : Northern New Mexico Family Medicine Residency Prog

Category : Physician

Issue Areas/Comments

Background

Background

Medicaid GME payment elimination.

GENERAL

GENERAL

New Mexico has a relatively young population and Medicare GME pays New Mexico a small fraction of what larger states with older populations receive for GME. It is only through supplementation with Medicaid GME funding that I can almost pay a resident's salary from GME funds. Without Medicaid GME, I fear that I will not be able to maintain our small rural family medicine residency program that has placed 80% of it's graduates in rural areas of New Mexico, mostly in Community Health Centers and Indian Health Services. Our community hospital has very marginal financial margins and is unlikely to absorb an even greater loss on a residency training program that provides family physicians to under- served areas that are not affiliated in any formal way. If this rule must be implemented, I would propose an exemption for rural community training programs that retain at least 50% of their graduates in under-served settings.

CMS-2279-P-2 Medicaid Graduate Medical Education

Submitter : Dr. Kimberly D'Eramo

Date & Time: 05/30/2007

Organization : Dr. Kimberly D'Eramo

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I realize that Medicaid funds are extremely tight, however, cutting back funding for support of graduate medical education would significantly alter the ability of programs to provide this inexpensive medical care to patients. Physicians in private practice are already stretched to sustain their businesses while providing for Medicaid patients; it is difficult to provide medical care with such extremely low reimbursement rates. Therefore, the GME programs are the best avenues for Medicaid patients to seek care. Without financial support to continue this system, Medicaid will be unsuccessful in providing for patients.

CMS-2279-P-3 Medicaid Graduate Medical Education

Submitter : Mr. Patrick Finnerty

Date & Time: 06/05/2007

Organization : Virginia Department of Medical Assistance Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-3-Attach-1.DOC



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7833
800/343-0634 (TDD)
www.dmas.virginia.gov

June 5, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-2279-P

Dear Ms. Norwalk:

DMAS is commenting on the proposed rule published May 23, 2007 on the "Medicaid Program; Graduate Medical Education." DMAS is the single state agency responsible for the administration of the Medicaid program in the Commonwealth of Virginia. DMAS opposes the proposed rule and strongly urges CMS to withdraw it.

DMAS questions how CMS can simply "clarify" that payments associated with Graduate Medical Education (GME) are no longer federally reimbursable under the Medicaid program when it has participated in state Medicaid GME payments since the beginning of the Medicare and Medicaid programs, more than forty years ago. Like most states, Virginia reimbursed GME costs because it used Medicare cost reports to determine reimbursable costs. Virginia now reimburses Medicaid GME using a prospective payment methodology previously approved by CMS. Since almost all states reimburse for GME under their Medicaid programs, it is obvious that CMS has reviewed and approved Medicaid reimbursement of GME countless times over a long period. We are also not aware of any reports by the Government Accounting Office or the Office of the Inspector General that question Medicaid payments for GME.

DMAS reviewed the background for the proposed rule and did not see the relevance of this background material to the proposed rule. The extensive discussion of Medicare GME reimbursement being a "supplemental" payment does not seem relevant to the appropriateness of Medicaid reimbursement for GME. Medicare has always paid

Ms. Leslie Norwalk

June 5, 2007

Page 2

for its share of GME despite past efforts, referred to in the background, “by the Congress and this agency to substantially limit or eliminate Medicare GME subsidies.” In the end, the fact that Medicare still pays for GME would seem to strengthen rather than weaken the rationale for Medicaid to also pay for GME.

CMS asserts that Medicaid GME funding does “not necessarily” achieve its goals or that there is “generally no assurance” that it does, but does not provide any evidence that Medicaid GME funding is not effective in “supporting these programs or in furnishing any benefit to Medicaid program beneficiaries.” Indeed it seems self-evident that the provision of significant funding to educational programs could not help but support those programs, and it seems equally clear that the withdrawal of that funding will hurt those programs. It also seems clear that Medicaid recipients benefit from the provision of an adequate supply of physicians, though admittedly GME is not a direct service cost.

Virginia believes that CMS has provided no convincing evidence that GME reimbursement by Medicaid is not a useful and beneficial part of the program, or that the elimination of that funding will not cause significant harm to the preservation of a physician work force.

In conclusion, DMAS appreciates the opportunity to comment on the proposed rule. We do not believe that it is appropriate to eliminate Medicaid funding of GME. We urge CMS to withdraw the proposed rule.

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick W. Finnerty". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Patrick W. Finnerty

PWF/wjl

CMS-2279-P-4 Medicaid Graduate Medical Education**Submitter :** Dr. Leah Wolfe**Date & Time:** 06/08/2007**Organization :** Johns Hopkins University**Category :** Physician**Issue Areas/Comments****Background**

Background

Currently, salaried work hours of medical residents including vacation and sick leave are used to calculate Medicare direct and indirect GME adjustments.

GENERAL

GENERAL

During their graduate medical training, physicians' work hours are long. Even with the recent and very welcome guidelines limiting their duty hours, many trainees are still working just shy of 80-hour work weeks. Although in training, these physicians receive salary and benefits as full-time employees of the institutions that host their training programs. I have crisp memories during my own training of coming home late at night to find my pay stub in the mail - - salaried as a 40-hour per week worker, but often putting in well over 80 hours per week. As employees of the university, they receive benefits including paid vacation and sick leave, but I doubt that the combined hours of vacation and average sick leave taken by residents come even close to offsetting the hours beyond 40 that they put in every week performing their clinical care duties at their host institutions. Sick leave and paid vacation are accepted benefits for any full-time worker, and are especially important benefits for this class of worker. Indirect and direct Medicare payments for GME are intended to subsidize the salaries of this absolutely vital component of the physician work force in these institutions. I can see no rationale for discounting the modest vacation and sick leave benefits from these calculations.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Under this proposed rule, the vacation or sick leave time of physicians in residency training would no longer count in the formula used to calculate direct or indirect GME adjustments for institutions sponsoring graduate medical education training programs.

CMS-2279-P-5 Medicaid Graduate Medical Education

Submitter : Mrs. Sheri Clarke

Date & Time: 06/11/2007

Organization : Ingham Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2279-P-5-Attach-1.DOC

Ingham Regional Medical Center
401 West Greenlawn Avenue
Lansing, MI 48910
June 11, 2007

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

Dear CMS Director:

GME is a fundamental component of providing quality health services, especially to Medicaid and underserved populations. According to the Association of American Medical Colleges (AAMC), 6% of the nation's hospitals are teaching hospitals, yet they provide 40% of the nation's hospital charity care. The Council of Teaching Hospitals and Health Systems (COTH) institutions contribute significantly to the care of Medicaid beneficiaries. An AAMC survey found that approximately 26 percent of the nation's Medicaid discharges are from COTH hospitals. CMS-2279-P estimates the proposed cut at \$140 million in funding for GME programs. We submit that this is a gross underestimate of the true impact of CMS-2279-P. Michigan's teaching hospitals stand to lose \$95.8 million if this policy is implemented and state dollars directed toward GME go unmatched. This will have a dramatic impact on teaching hospitals' ability to provide care to Medicaid and underserved populations.

CMS-2279-P states: "For purposes of Executive Order 13132, we find that this rule will not have a substantial effect on State and local government" (23). On the contrary, any reduction of funding to GME programs is a substantial burden to State and local governments that will ultimately deal with the repercussions of poorly funded GME programs.

It is suggested that the lost Federal dollars could be replaced by funding with State-only dollars (21). However, CMS-2279-P does not address the fact that State dollars are federally matched through current Medicaid funding for GME programs. In Michigan, the federal match is 57%. The loss in federally matched dollars reduces funding for Michigan GME programs by about \$94 million. Furthermore, Michigan's economy is in a state of crisis and is unlikely to have the means to finance additional GME program needs with State dollars at this time.

Loss of funding for GME programs due to the CMS-2279-P proposal and the economic circumstances in Michigan will affect other states as well. The Blue Ribbon Physician Workforce Committee found that although Michigan is the 7th largest 'teaching hospital' state, they are losing physicians to warmer climates and stronger economies in other areas of the country. In other words, Michigan's medical schools are providing educational resources to a disproportionate number of medical students and trainees than they are retaining as medical professionals to serve Michigan's healthcare needs. The benefits of

GME programs to Medicaid and underserved populations reach beyond state borders; therefore, the responsibility of funding GME programs should not be passed on from the Federal government to State and local governments or local healthcare systems.

CMS-2279-P makes it clear that States are not required to fund GME programs (22). However, if States pass the responsibility of funding GME programs to local healthcare systems, this does not lessen the burden to our communities. One teaching hospital in the Lansing area estimates this proposal would result in a reduction of \$2,933,220 in their GME payment, thus moving the hospital from an approximate \$3 million margin in GME to a negative cash status in less than one year. A reduction in funding of this magnitude could have a negative impact on the quality of GME programs, which as said before directly contribute to the quality of health services.

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

Thank you for your attention.

Sincerely,

Sheri L. Clarke, MPA
Administrative Director of Medical Education

cc: Senator Debbie Stabenow (senator@stabenow.senate.gov)
Senator Carl Levin (senator@levin.senate.gov)
Representative Mike Rogers (josh.finestone@mail.house.gov)

CMS-2279-P-6 Medicaid Graduate Medical Education

Submitter : Dr. Geoffrey Linz

Date & Time: 06/12/2007

Organization : Ingham Regional Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-6-Attach-1.DOC

Ingham Regional Medical Center
401 West Greenlawn Avenue
Lansing, MI 48910

June 11, 2007

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

Dear CMS Director:

GME is a fundamental component of providing quality health services, especially to Medicaid and underserved populations. According to the Association of American Medical Colleges (AAMC), 6% of the nation's hospitals are teaching hospitals, yet they provide 40% of the nation's hospital charity care. The Council of Teaching Hospitals and Health Systems (COTH) institutions contribute significantly to the care of Medicaid beneficiaries. An AAMC survey found that approximately 26 percent of the nation's Medicaid discharges are from COTH hospitals. CMS-2279-P estimates the proposed cut at \$140 million in funding for GME programs. We submit that this is a gross underestimate of the true impact of CMS-2279-P. Michigan's teaching hospitals stand to lose \$95.8 million if this policy is implemented and state dollars directed toward GME go unmatched. This will have a dramatic impact on teaching hospitals' ability to provide care to Medicaid and underserved populations.

CMS-2279-P states: "For purposes of Executive Order 13132, we find that this rule will not have a substantial effect on State and local government" (23). On the contrary, any reduction of funding to GME programs is a substantial burden to State and local governments that will ultimately deal with the repercussions of poorly funded GME programs.

It is suggested that the lost Federal dollars could be replaced by funding with State-only dollars (21). However, CMS-2279-P does not address the fact that State dollars are federally matched through current Medicaid funding for GME programs. In Michigan, the federal match is 57%. The loss in federally matched dollars reduces funding for Michigan GME programs by about \$94 million. Furthermore, Michigan's economy is in a state of crisis and is unlikely to have the means to finance additional GME program needs with State dollars at this time.

Loss of funding for GME programs due to the CMS-2279-P proposal and the economic circumstances in Michigan will affect other states as well. The Blue Ribbon Physician Workforce Committee found that although Michigan is the 7th largest 'teaching hospital' state, they are losing physicians to warmer climates and stronger economies in other areas of the country. In other words, Michigan's medical schools are providing educational

resources to a disproportionate number of medical students and trainees than they are retaining as medical professionals to serve Michigan's healthcare needs. The benefits of GME programs to Medicaid and underserved populations reach beyond state borders; therefore, the responsibility of funding GME programs should not be passed on from the Federal government to State and local governments or local healthcare systems.

CMS-2279-P makes it clear that States are not required to fund GME programs (22). However, if States pass the responsibility of funding GME programs to local healthcare systems, this does not lessen the burden to our communities. One teaching hospital in the Lansing area estimates this proposal would result in a reduction of \$2,933,220 in their GME payment, thus moving the hospital from an approximate \$3 million margin in GME to a negative cash status in less than one year. A reduction in funding of this magnitude could have a negative impact on the quality of GME programs, which as said before directly contribute to the quality of health services.

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

Thank you for your attention.

Sincerely,

Geoffrey M. Linz, MD, MBA
Chief Medical Officer

CMS-2279-P-7

Medicaid Graduate Medical Education

Submitter : Mrs. Diane Gamez

Date & Time: 06/12/2007

Organization : Ingham Regional Medical Center

Category : Individual

Issue Areas/Comments

Background

Background

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

#7

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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-8

Medicaid Graduate Medical Education

Submitter : Dr. Scott Stevens

Date & Time: 06/12/2007

Organization : Dr. Scott Stevens

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I wish to state my opposition to elimination of Medicaid funds to support graduate medical education. The United States is presently facing a physician shortage, especially in primary care specialties. If the use of Medicaid funds to support graduate education in Utah is eliminated, this could result in a reduction in primary care trainees in the State of 10-15 or more per annum, greatly exacerbating the State's shortage of primary care physicians, and contributing to this national problem.

Please do not eliminate this important source of support for training our future physicians.

CMS-2279-P-9

Medicaid Graduate Medical Education

Submitter : Ms. SHARON HALL

Date & Time: 06/13/2007

Organization : CHARLESTON AREA MEDICAL CENTER

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

RESPONSE TO CMS PROPOSED REGULATIONS FOR THE COUNTING OF RESIDENTS DURING ORIENTATION AND FOR VACATION AND SICK TIME

I appreciate the opportunity to respond to the proposed regulation regarding the counting of resident time spent while in orientation and while on vacation or sick leave.

Orientation:

I appreciate the consideration of CMS that orientation is a "prerequisite" for patient care. I believe this to be a correct and an appropriate position and agree with inclusion of orientation in the definition of patient care.. The purpose of orientation is to prepare the resident for clinical practice into their new environment. Typically, residents enter training from a variety of backgrounds and medical school experiences. Orientation not only provides an introduction to policies, procedures and clinical guidelines, it is intended to assure that each individual resident is ready for clinical assignment at their program "ready to care for patients. This year, for example, we have designed a comprehensive simulation training event which will create opportunity for residents to practice defined clinical procedures in preparation for their clinical roles with the hospital. The program, in addition, to working with policies and clinical guidelines, provides a baseline of each resident's capabilities so that a customized training experience is optimized. As such, orientation is most assuredly related to patient care and safety. While the bulk of residents coming into the organization come on or before the 1st of July of each year, a comprehensive orientation may occur at any point that a resident enters the environment. It is essential to meet JCAHO and other regulatory requirements.

A resident's orientation continues incrementally over the first few months of residency. While a comprehensive orientation is provided upon entry into program, a "mini" orientation may occur as residents are first assigned to specific services/rotations. At this time, they are oriented to the specifics of a rotation that includes an orientation to the location/facilities, policies and procedures as well as to the expected experiences and training objectives. More procedural based rotations may require structural practice sessions or simulation practice requirements to orient the resident to certain procedures and functions that will be common to the rotation before being assigned to work with patients. This may be done in a variety of scheduling formats, but generally will occur in the first day or so of the rotation assignment or may occur for specified intervals during the first week. Lastly, the amount of orientation time and instruction that is necessary can vary from individual to individual. The goal of orientation is to assure a positive patient experience and to optimize the potential of the resident to take care of their patients.

In summary, to treat orientation activities, no matter when they occur, as an extension of patient care and a "prerequisite" to safe patient care is very appropriate.

Vacation and Sick Leave

As other recent clarifications and rulings have created an intense and substantial burden of documentation and tracking of resident time, to impose further tracking requirements that would result in immaterial impact on reimbursement payments seems unwarranted without particular benefit to CMS or to hospitals.

Residents are allotted varying levels of leave time according to PG year. Inconsistencies in resident promotion time, level of allotted vacation, and incongruent fiscal and academic year periods create more complication in applying the rule than may be realized. Additionally, although the bulk of resident time is taken over successive days, residents may take vacation time in less than one day increments to attend special family events, doctor's appointments, etc. This time, is currently not tracked since residents will typically be working at some point within a 2

CMS-2279-P-10 Medicaid Graduate Medical Education**Submitter :** Ms. SHARON HALL**Date & Time:** 06/13/2007**Organization :** CHARLESTON AREA MEDICAL CENTER**Category :** Other Health Care Provider**Issue Areas/Comments****GENERAL**

GENERAL

RESPONSE TO CMS PROPOSED REGULATIONS FOR THE COUNTING OF RESIDENTS DURING ORIENTATION AND FOR VACATION AND SICK TIME

Vacation and Sick Leave

As other recent clarifications and rulings have created an intense and substantial burden of documentation and tracking of resident time, to impose further tracking requirements that would result in immaterial impact on reimbursement payments seems unwarranted without particular benefit to CMS or to hospitals.

Residents are allotted varying levels of leave time according to PG year. Inconsistencies in resident promotion time, level of allotted vacation, and incongruent fiscal and academic year periods create more complication in applying the rule than may be realized. Additionally, although the bulk of resident time is taken over successive days, residents may take vacation time in less than one day increments to attend special family events, doctor's appointments, etc. This time, is currently not tracked since residents will typically be working at some point within a 24 hour period when this occurs. If CMS persists in forcing this new requirement, please consider creating a further clarification of this time as defined as leave time taken without patient care responsibilities within a 24 hour period.

In its explanation of current regulations, CMS proposed regulations have created further confusion and question. The proposed regulations also makes note of current practice that disallows the counting of residents while on extended leave time, such as maternity leave, or other disability leave which has the overall impact of extending the resident training beyond the initial residency period requirement (IRP). In reality, this "current practice" has not been enforced or recognized by the fiscal intermediary. In fact, the exact reverse has been applied for a number of years. The intermediaries have applied GME only as leave time is utilized, treating it as sick leave time while salaries and benefits have been incurred but have disallowed IME because residents have not been involved in patient care. The initial residency period is among the basic and first criteria checked on residents during an audit. Residents have not been counted beyond the IRP for any reimbursement, GME or IME. Our conclusion, therefore, is that the proposed regulation to exclude this time entirely or to delay counting of residents until they are beyond their IRP is a significant change in policy with significant impact as it has been enforced and defined during audit. Furthermore, extended leave resulting in an extension of the residency period is not common as residents planning maternity time will effectively utilize their accrued vacation allotment or are required to utilize all accrued vacation prior to using disability plan coverage. I strongly urge CMS to rescind its proposed regulation and to continue to allow the counting of resident leave time for both IME and GME as it is utilized.

In summary, the proposed rule creates a new policy that is based on an assumption that vacation and leave time is a third category of resident's time. While CMS has attempted to create parity in how the time is treated by reducing both the numerator and denominator affect of time counted, the resulting benefit to either CMS or to hospitals seems to be immaterial and therefore creates an unnecessary burden to enforce. Further, the

assumption that extended leave has resulting in counting time for GME and IME as the resident's initial residency period is extended is false; this rule creates further increased burden and a more significant change of policy than perhaps intended. As CMS continues to refine the policy, I am strongly urge the provision of clear instructions that are universally applied through its fiscal intermediaries and they should not be applied retroactively.



Via Christi
Wichita Health Network

929 North Sr. Francis
Wichita, KS 67214-3882

Tel 316-268-5000

Larry P. Schumacher
President and
Chief Executive Officer

CMSO
622689

07 JUN 2007

10:05 am

May 25, 2007

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

Ref: [CMS-2279-P] Medicaid Program; Graduate Medical Education 42 CFR Parts 438 and 447; RIN 0938-A095; (71 Federal Register 49506, May 2007.

Dear Dr. Norwalk:

The proposed rule to eliminate the Graduate Medical Education portion of Medicaid payments threatens to erode the ability of hospitals to sustain their residency programs. Via Christi Health System (VCHS) is the largest healthcare delivery system in Kansas serving the needs of all without regard to their ability to pay.

VCHS operates two major acute care hospitals in Wichita, Kansas, and partners with the University of Kansas School of Medicine and HCA Wesley Health System in a consortium, the Wichita Center for Graduate Medical Education (WCGME) to provide medical training to 260 residents. These residents serve in a variety of roles by providing:

- Care for patients who are uninsured and/or indigent (over 134,000 patient visits to residency clinics in 2001)
- Emergency and trauma care
- In-hospital care of patients who are unassigned and/or indigent
- Code Blue response team
- Care to patients every day and every night

At least 50% of the 75 residents, who annually complete our program, *remain* in Kansas to serve in all areas of the state. Many locate in underserved areas that struggle to attract physicians to care for their residents.

Funding for this program comes from the State of Kansas and the participating hospitals. The Medicaid GME funding WCGME received in 2006 amounted to \$3.7 million yet our annual operating budget exceeds \$38 million. VCHS annually contributes 6.9 million to WCGME to support the program. Eliminating the federal portion of Medicaid GME payments would place the future of our medical education program in Wichita at risk.

Should this proposed rule become effective, we face having to close our residency program, cut back on residency slots, cut faculty positions, limit care to Medicaid and uninsured patients. We urge you to not implement this ill-advised rule at a time when the number of uninsured Americans continues to rise and the cost of healthcare threatens our viability as a safety-net provider in Kansas.

Sincerely,

A handwritten signature in cursive script, appearing to read "Larry P. Schumacher".

Larry P. Schumacher
President & CEO



929 North St. Francis
Wichita, KS 67214-3882

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Leslie L. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 45-G
Washington, DC 20201

09AKL11 20201



CMS-2279-P-11 Medicaid Graduate Medical Education

Submitter : Dr. Walter Hall

Date & Time: 06/15/2007

Organization : SUNY Upstate Medical University

Category : Physician

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

June 15, 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 SUNY Upstate Medical University Department of Neurosurgery 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 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. We currently have 9 neurosurgical residents in our training program and we alternate training one or two residents a year. There is currently a shortage of neurosurgeons in the United States for the population served and there is no anticipated increase in the number of neurosurgeons to be trained. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

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

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

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,

Walter A. Hall, M.D., MBA
Chair and Robert B. and Molly G. King
Professor of Neurosurgery
SUNY Upstate Medical University
Syracuse, NY 13210

CMS-2279-P-12 Medicaid Graduate Medical Education**Submitter :** Dr. Paul Cunningham**Date & Time:** 06/15/2007**Organization :** SUNY Upstate Medical University**Category :** Physician**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 the SUNY Upstate Medical University Department of Surgery General Surgery Resident program 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 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. We train five surgeons each year, two of which on average make a career in General Surgery. In our region there is a net loss each year for general surgeons. This is related to retirement. 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. We are the largest provider of surgical care for the Medicaid population in our region. One of our subspecialties - Pediatric Surgery - provides close to 100% of the surgical care for this population of patients.

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

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,
Paul R. G. Cunningham, MD

CMS-2279-P-12-Attach-1.DOC

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 SUNY Upstate Medical University Department of Surgery General Surgery Resident program 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 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. We train five surgeons each year, two of which on average make a career in General Surgery. In our region there is a net loss each year for general surgeons. This is related to retirement. 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. We are the largest provider of surgical care for the Medicaid population in our region. One of our subspecialties – Pediatric Surgery – provides close to 100% of the surgical care for this population of patients.

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

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,

Paul R. G. Cunningham, MD

CMS-2279-P-13 Medicaid Graduate Medical Education

Submitter : William Kauffman

Date & Time: 06/15/2007

Organization : Saint Louis University

Category : Academic

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.

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

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

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

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

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

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

Sincerely,

Eric D. Katz, MD
Program Director
Emergency Medicine Residency Program
Phoenix, Az

CMS-2279-P-15 Medicaid Graduate Medical Education

Submitter : Dr. Scott Henderson

Date & Time: 06/17/2007

Organization : Dr. Scott Henderson

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-2279-P-15-Attach-1.DOC

1000 Fourth Street SW
Mason City, Iowa 50401
June 17, 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 residents and faculty of the Mercy Family Medicine Residency Program in Mason City, Iowa, 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 our 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, including ours in Iowa, 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, like Mercy Medical Center – North Iowa, sustain one of their core responsibilities - providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, these medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

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

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

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

Sincerely,

Scott T. Henderson, M.D.