

**Submitter :** Mr. Donald Ching  
**Organization :** University of South Alabama Hospitals  
**Category :** Hospital

**Date:** 06/21/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

Elimination of Federal Financial Participation matching funds associated with Medicaid graduate medical education payments.

CMS-2279-P-111-Attach-1.DOC

# University of South Alabama Hospitals

P. O. Box 40190  
Mobile, Alabama 36640

(251) 434-3523

June 21, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of University of South Alabama Hospitals 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. The Medicaid financial support for our graduate medical education programs, which we have received for many years, currently amounts to approximately \$4 million annually. 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. The two hundred medical residents currently in our programs are engaged in a wide variety of medical specialties as well as primary care areas. Upon completion of our programs, many of our residents move on to practice in medically underserved areas across the United States. 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 own case, we provide over \$100 million in medical care to Medicaid and indigent patients each 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.

Our hospitals are unique in the Mobile region in that we not only provide services to safety net populations, but also provide services such as Level 1 Trauma, Burn Unit, Neonatal Intensive Care, and Kidney Transplant that are otherwise not available within 150 to 200 miles.

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,

Donald F. Ching  
Director, Hospital Financial Systems

**Submitter :** Mr. Loren Dyer  
**Organization :** Tampa General Hospital  
**Category :** Hospital

**Date:** 06/21/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2279-P-112-Attach-1.DOC



June 21, 2007

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

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

Dear Ms. Norwalk:

I am writing on behalf of Tampa General Hospital 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.

Tampa General Hospital (TGH) serves a 12-county region with a population in excess of 4 million, in West Central Florida. TGH serves as the primary teaching hospital for the University of South Florida (USF) College of Medicine. Since 1971, the College of Medicine has graduated nearly 1,700 physicians and prepared 2,000 doctors in specialty residency programs. Ranked among the nations top 100 research universities, USF and TGH are committed to developing advances in medicine through both clinical practice and research.

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.

Medicaid is currently the only other source than Medicare of graduate medical education funding in Florida. Florida includes graduate medical education as part of the Upper Payment Limits (UPL) program even though there is no statutory requirement that the state support graduate

Leslie Norwalk  
Centers for Medicare and Medicaid Services  
June 21, 2007

medical education through Medicaid payments. Historically, the State has funded graduate medical education programs in this way since 1992 when allocations were made to teaching hospitals in the UPL program.

These programs, approved by the Legislature and the Federal government, allow for appropriations that have exceeded 285 million to date since inception to the statutorily defined graduate medical education programs to support their missions in the State. Teaching hospitals rely on these and other Medicaid payments to support their critical functions and missions.

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.

Florida has six hospitals statutorily defined under section 408.07, Florida Statutes, as teaching hospitals: Jackson Memorial Hospital, Mount Sinai Medical Center, Orlando Regional Medical Center, Shands Hospital Gainesville, Tampa General, and Shands Hospital Jacksonville. There are a total of 256 approved allopathic programs with up to 3,205 residency slots and an additional 42 approved osteopathic programs with over 450 internship and residency slots across the state, with up to 70 percent of residents working in the six teaching hospitals.

**Florida consistently ranks among the lowest in the country in terms of residency slots per 100,000 population,** and needs approximately 2,700 additional slots to meet the national average. The federal Balanced Budget Act of 1997 made significant reductions in the funding for graduate medical education provided through the Medicare program. Because Medicare funding is a major source of support for most GME programs, the capacity and number of Florida GME programs, like those nationally, has remained essentially frozen since 1998. This stagnation has been particularly hard for Florida because the state is well below the national average, ranking 46<sup>th</sup> nationally, in GME positions per 100,000 population.

Residency programs are important in helping to meet physician workforce needs in Florida. Although different sources vary in their estimates of workforce needs and shortages, most GME stakeholders agree that there may not be enough physicians to fulfill demand in the immediate future. Florida's population is the fourth largest nationally, and Florida needs to evaluate how best to address physician workforce issues.

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 and in Florida.

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.

Leslie Norwalk  
Centers for Medicare and Medicaid Services  
June 21, 2007

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.

As the region's leading safety net hospital, Tampa General has reaffirmed its commitment to providing high quality health services to all residents evidenced in recent expansion projects including the new USF South Tampa Center for Advanced Healthcare at Tampa General. The new Center will be a 126,000-square-foot medical office building adding new service lines, diagnostic imaging, and other diagnostic procedures. TGH is in the process of completing a five-story addition of approximately 300,000-square feet that will provide a new emergency department and operating rooms, a new women's center, a new cardiovascular center, and a new intensive care suite, and a new digestive diseases center. This adds to services found nowhere else on Florida's West Coast such as a Level One Trauma Center, a Regional Burn Center, a solid organ transplant program, brain and spinal cord rehabilitation and ECMO, a life-saving technique for babies with severe breathing difficulties. As a teaching facility, Tampa General partners with academic and community institutions to support both the teaching and research missions.

TGH provides care to patients who meet certain criteria by reference to established charity care policies. Community benefit is provided through various means including providing charity care to the residents of Hillsborough County, providing trauma care on a regional basis and other services to the community on a charity basis. TGH maintains records to identify and monitor the level of charity care. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. For fiscal year 2006, Tampa General provided care in the amount of \$ 584 million.

All of this is threatened by impending physician shortages and the inability to meet patient load and need demands. The root of the problem lies in the way the federal government helps meet the demand for doctors. The Medicare program has traditionally paid for most physicians' residencies, the final step in a doctor's training. But in 1997, federal law capped the number of Medicare-supported medical residents for hospitals. A decade later, the number and geographical distribution of federally supported medical residents do not reflect recent population growth or shifts.

Florida with large numbers of elderly and baby boomers has been hit hardest. Florida would need an additional 2,700 residency positions to meet the national ratio of medical residents to 100,000 population. Statistically, doctors tend to remain in the area where they do their training; therefore, increasing the number of physicians-in-training in Florida is essential to increasing the physician workforce.

Leslie Norwalk  
Centers for Medicare and Medicaid Services  
June 21, 2007

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 CMS-2279—P in its entirety and to continue supporting GME.**

Sincerely,

Loren M. Dyer  
Director of Revenue & Reimbursement

Submitter : Dr. Pamela Lotke  
Organization : University of Arizona  
Category : Physician

Date: 06/21/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2279-P-113-Attach-I.DOC

## COMMENT LETTER ON MEDICAID GME PROPOSED RULE

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 from the U of A department of Ob/Gyn 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,

Pamela Lotke, MD MPH  
Assistant Professor of Clinical Ob/Gyn  
University of Arizona  
Arizona Health Sciences Center  
1501 N. Campbell Ave.  
Tucson, AZ 85724

**Submitter :** Mr. Jonathan Archey  
**Organization :** Ohio Hospital Association  
**Category :** Health Care Provider/Association

**Date:** 06/21/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2279-P-114-Attach-1.PDF



June 21, 2007

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

*Sent via electronic mail*

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

On behalf of the Ohio Hospital Association (OHA) and our more than 170 hospitals and health systems – representing more than four hundred medical residency programs statewide – we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services’ (CMS) proposed rule, CMS-2279-P, that would prevent hospitals’ Graduate Medical Education (GME) costs from being eligible for federal matching dollars under Medicaid. While Public Law 110-28 prevents CMS from taking steps to implement any rule reducing or eliminating Medicaid GME reimbursements until May of 2008, OHA views the proposed rule as misguided policy based primarily on short-term budgetary concerns rather than long-term public health priorities. OHA strongly opposes the rule’s finalization and implementation at any time in the future.

OHA bases its opposition on four main objections. First, the proposed rule would reverse long-standing CMS policy upon which Ohio’s medical education system has come to depend. Second, the proposed rule would erode Medicaid beneficiaries’ access to care. Third, the proposed rule would weaken the nation’s future health care infrastructure, resulting in increased health care costs over the long term. Finally, the proposed rule represents a significant overreach of CMS’ authority and a major policy change that should be vetted through the legislative – not just the regulatory – process.

For more than 40 years, CMS has recognized GME as a covered medical assistance cost under both Medicare and Medicaid, eligible for full federal financial participation (FFP). State Medicaid programs and teaching hospitals depend upon the federal government maintaining its commitment to help cover these costs. If CMS reverses its commitment, teaching hospitals will be forced to find ways to cope. Many of Ohio’s teaching hospitals have reported to OHA that their primary option, unfortunately, will be to scale back or eliminate certain sub-specialty residency programs. Ironically, the programs most likely to be scaled back are those in which government officials and experts in the field have indicated a need to expand enrollment to meet future demand, such as geriatric medicine. From a cost containment perspective, upper payment limit safeguards already in place prevent States from reimbursing under Medicaid GME more than what Medicare GME would pay for similar services. In light of these points, the proposed rule illustrates that CMS seems less concerned in this instance with the ensuring the nation’s future medical needs are met and more concerned with budgetary expediency.

As evidenced by their eligibility for the program, Ohio’s Medicaid beneficiaries have neither employer-sponsored health insurance nor the financial means to purchase individual coverage. And since many private practice physicians cannot afford to offer services to Medicaid patients, it generally falls to Ohio’s hospitals to provide them lifesaving care. The majority of Medicaid patients, especially children and adults living in urban areas, depend upon GME hospitals for their health care. If the proposed rule is implemented, and since teaching hospitals would be forced to make available fewer residency specialties to their communities as a result, Medicaid patients’ access to necessary services will be significantly curtailed.



In fact, even if CMS were to maintain – but reduce – Medicaid GME reimbursement, children and adult Medicaid beneficiaries' access to care for many conditions will suffer. For example, under the *current* levels of GME funding, Medicaid patients in many urban and rural parts of Ohio must wait weeks or months to see a resident or specialist in rheumatology. Neither Ohio's medical education system, Ohio's Medicaid beneficiaries, nor Ohio's health care safety net could easily withstand the GME cuts entailed in the proposed rule.

Moreover, an assault of this magnitude on the nation's GME system would represent short-sighted public health care policy. Implementation of the proposed rule not only would further endanger Medicaid patients' access to care, but eventually would constrict all citizens' access to care. If our teaching hospitals are forced to reduce the number of residents being trained – especially at the cusp of what many experts predict to be a crisis in the supply versus demand of key specialists – Ohio and the nation soon will face a significant challenge in medical service availability. Loss of access to care early in a patient's condition and ever-longer waiting periods to see a specialist will result in increased time away from work, compounded chronic and acute health conditions, and of course, exponentially higher treatment costs for all.

Finally, the proposed rule represents a major overreach of CMS authority. It is not CMS' prerogative to dictate what States can deem to be an allowable cost under Medicaid when the Congress repeatedly has deemed allowable similar costs under the Medicare program. Such a departure from logic is inappropriate, and such a significant shift in health care policy should and must be debated in the appropriate venue: the federal legislature.

The OHA believes *CMS-2279-P* is seriously flawed and misguided policy. We urge CMS to permanently withdraw the proposed rule and continue to work with teaching hospitals to develop rational and appropriate GME reimbursement policies that support our shared goals of ensuring fiscal responsibility, increasing health care access, and preserving America's strong medical education infrastructure.

Sincerely,

A handwritten signature in black ink that reads 'Jonathan Archey'.

Jonathan Archey  
Manager, Federal Relations

**Submitter :**

**Date: 06/21/2007**

**Organization :**

**Category : Hospital**

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

We strongly urge CMS to rescind the proposed rule. See Attachment.

CMS-2279-P-115-Attach-1.WPD



*University of Iowa Hospitals and Clinics*

University of Iowa Health Care

*Hospital Administration  
200 Hawkins Drive, 1355 JCP  
Iowa City, Iowa 52242-1009  
319-356-3155 Tel  
319-356-3862 Fax  
[www.uihealthcare.com](http://www.uihealthcare.com)*

June 18, 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 Iowa Hospitals and Clinics (UIHC) 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 like the UIHC and jeopardize our ability 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. Here in Iowa, for example, in FY 07 the State provided the UIHC with \$2,311,677 for direct medical education expenses and \$4,084,034 for indirect medical education expenses. When federal matching dollars of \$3,915,902 and \$6,918,214 respectively are combined, Medicaid support for graduate medical education at the UIHC totals \$17,229,827. We 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. The UIHC is currently engaged in the training of approximately 500 residents and 200 fellows, a significant number of which are above our cap. This is done in recognition of the importance of local training for attracting new physicians to our state. Over 36% of Iowa's total physician population has completed a University of Iowa residency or fellowship. A change such as the one being proposed could

place the UIHC in a position of having to further subsidize residency and fellowship training or of reducing our commitment to graduate medical education and possibly negatively impacting Iowa's physician workforce.

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 own case, approximately 57% of the UIHC's payer mix falls outside of commercial or Blue Cross.

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. The case mix at the UIHC for all acute patients is currently in excess of 1.70. 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. As the only comprehensive academic medical center in the state of Iowa, what the UIHC can and cannot do has significant implications for those residing here.

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

Sincerely,

Donna Katen-Bahensky  
Senior Vice President for Medical Affairs &  
CEO, University of Iowa Hospitals and Clinics

Submitter : Dr. Bruce Goldberg  
Organization : Oregon Dept. of Human Services  
Category : State Government

Date: 06/21/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-116-Attach-1.PDF

#116



**Oregon**  
Theodore R. Kulongoski, Governor

**Department of Human Services**

*Office of the Director*  
500 Summer St. NE, E-15  
Salem, OR 97301-1097  
(503) 945-5944  
Fax: (503) 378-2897  
TTY: (503) 947-5330

June 21, 2007

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



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

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

Dear Administrator Norwalk:

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

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

*"Assisting People to Become Independent, Healthy and Safe"*  
An Equal Opportunity Employer

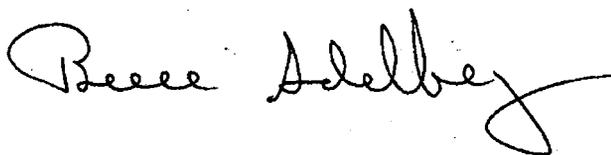


Leslie Norwalk, Esq.  
June 21, 2007  
Page Two

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Bruce Goldberg". The signature is written in dark ink and is positioned below the word "Sincerely,".

Bruce Goldberg, M.D.  
Director

BG:FFP:tlemman

**Submitter :** Dr. David Bjorkman  
**Organization :** University of Utah School of Medicine  
**Category :** Academic

**Date:** 06/21/2007

**Issue Areas/Comments**

**Background**

Background

Medicaid funds are critical to fund Graduate Medical Education, provide an appropriate physician workforce and fulfill the needs of Medicaid patients.

**GENERAL**

GENERAL

Please see attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

The proposed rule would eliminate Medicaid support of Graduate Medical Education

CMS-2279-P-117-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 University of Utah School 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. 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.

The University of Utah is the only academic medical center in Utah, and for hundreds of miles in any direction. We train physicians for Utah and the entire Intermountain West. Utah, specifically, has a shortage of physicians, with only 165 physicians/100,000 population. The rural areas of the state have even fewer physicians. This shortage will worsen as the state population grows and our ability to train physicians is limited. Because of the cap on Medicare-funded residency positions we are unable to expand our programs to meet the current and future needs of the state. Medicaid funding for GME, as described above, is critical to our ability to train physicians for the future needs of our population. The proposed rule change would cripple our attempts to fulfill this critical mission.

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,

David J. Bjorkman M.D., M.S.P.H.  
Dean  
University of Utah School of Medicine

**Submitter :** Mr. Norm Botsford  
**Organization :** University Physicians Hospital at Kino  
**Category :** Hospital

**Date:** 06/21/2007

**Issue Areas/Comments**

GENERAL

GENERAL

See Attachment

CMS-2279-P-118-Attach-1.PDF



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

Attention: **CMS-2279—P**

Via electronic submission through <http://www.cms.hhs.gov/eRulemaking>

Dear Administrator Norwalk:

As the CEO of University Physicians Healthcare (UPH) that operates UPH Hospital at Kino Campus in Tucson, Arizona, I 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

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.

In July 2008, UPH Hospital in a consortium arrangement with The University of Arizona College of Medicine will be starting a new GME program that will culminate in 118 residents in the program at full capacity. With our rural emphasis, the program will be key in addressing the severe physician shortage in Arizona and throughout the nation. 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 one-half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than one-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.

UPH Hospital at Kino Campus, where residents will rotate as their primary site, is the former county hospital that provides a huge percentage of charity care and care to Medicaid recipients. Located in a medically underserved area, we concentrate on providing high quality primary care. However, with the implementation of our GME program, we will be able to supplement that care with state-of-the-art specialty care that is so vital to our patients.

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

Sincerely,



Norm Botsford  
President & CEO

**Submitter :** Dr. Bruce Chernof  
**Organization :** Los Angeles County  
**Category :** Local Government

**Date:** 06/21/2007

**Issue Areas/Comments**

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule  
See Attachment

CMS-2279-P-119-Attach-1.PDF



**Health Services**  
LOS ANGELES COUNTY

June 21, 2007

**Los Angeles County  
Board of Supervisors**

**Gloria Molina**  
First District

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Second District

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**Don Knabe**  
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**Michael D. Antonovich**  
Fifth District

**Bruce A. Chernof, MD**  
Director and Chief Medical Officer

**John R. Cochran III**  
Chief Deputy Director

**Robert G. Splawn, MD**  
Senior Medical Director

313 N. Figueroa Street, Suite 912  
Los Angeles, CA 90012

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Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

Dear Administrator Norwalk:

**CMS-2279-P**

I am writing on behalf of Los Angeles County Department of Health Services (LAC/DHS) 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 Los Angeles County/Department of Health Services 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 LAC/DHS \$43.2 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 LAC/DHS 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 LAC/DHS' 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 trauma, burn and emergency psychiatric care.

Leslie Norwalk, Esq.  
June 21, 2007  
Page 2

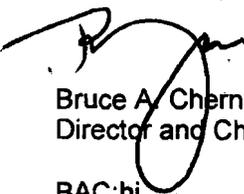
In addition, the decline in teaching new physicians will certainly lead to physician shortages which will also impede access to medical care for our patients. For decades, most state Medicaid programs, including California's, have supported the higher costs of teaching hospitals. CMS and its predecessor, 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, LAC/DHS 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 Medicaid 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 LAC/DHS case, for example, we provide annually approximately 223,000 Medicaid days and 193,000 uninsured days along with 45,000 Medicaid visits and 193,000 uninsured clinic visits.

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 LAC/DHS 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,



Bruce A. Chernof, MD  
Director and Chief Medical Officer

BAC:hj

c: Melissa Stafford Jones, President and CEO, CAPH  
Carol Meyer

Submitter : Dr. Mark Richardson  
Organization : Oregon Health and Science University  
Category : Academic

Date: 06/21/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-120-Attach-1.DOC

Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Office of Strategic Operations & Regulatory Affairs

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- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
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- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to

(800) 743-3951.

**Submitter :** Dr. KeriLyn Morgan  
**Organization :** Banner Good Samaritan Medical Center  
**Category :** Physician

**Date:** 06/21/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2279-P-121-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, Kerilyn Morgan.MD, am writing to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (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,

KeriLyn Morgan, MD

**Submitter :** Mr. Cal Calhoun  
**Organization :** Georgia Hospital Association  
**Category :** Health Care Provider/Association

**Date:** 06/21/2007

**Issue Areas/Comments**

**Background**

Background

Medicaid accounts for 17% of Georgia hospital costs; whose services are ordered by physicians. In the proposed rule, Georgia teaching hospitals will lose over \$40 million in payments if the rule is finalized. Statewide, Georgia hospitals only average a payment of about 82% (for \$1 billion of expenses) annually spent for inpatient Medicaid costs; and a payment of 80% of (\$500M annual expenses) costs for outpatient Medicaid costs. Teaching hospitals account for close to 40% of care statewide to the uninsured, which is almost \$990 million annually in Georgia. The uninsured account for about 10% of total Georgia hospital costs (higher at teaching hospitals) and only pay for approximately 10% of their statewide hospital medical costs. Medicaid DSH payments to Georgia hospitals only cover 26% of the cost of treating the uninsured, if no dsh payments were used to cover Medicaid payment shortfalls. Given that Medicare payments to Georgia hospitals by the federal government only cover 95% of the cost of treatment; and Medicaid only covers 82% of the cost of hospital treatment in Georgia, further losses in payments by the federal government threaten the financial stability of large safety net providers. Instability in these major referral hospitals threatens the very fragile fabric of health care services being accessed by all Georgia citizens.

**GENERAL**

GENERAL

The Georgia Hospital Association supports the recommendations submitted by the American Hospital Association, to include that teaching costs are a medically necessary, covered and reimbursable cost of treatment for Medicaid patients. Medicare, a 100% federally paid program covers and pays for medical education costs, so the intent of Congress is clear.

GHA believes CMS should permanently withdraw this proposed rule.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

CMS has proposed to no longer pay for the cost of training physicians to treat Medicaid patients.

Submitter : Ms. Sara Rosenbaum  
Organization : The George Washington University  
Category : Academic

Date: 06/22/2007

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Department of Health and Human Services  
Centers for Medicare and Medicaid Services

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

June 22, 2007

Gentlepersons;

These comments regarding the above-captioned rule reflect my opinion and should not be read as the views of the George Washington University.

For more than 40 years Medicaid agencies have recognized the costs of graduate medical education as a reasonable cost incurred by hospitals whose covered medical assistance services are furnished in a teaching environment. Congress is well aware of this practice. Indeed, many Members have teaching hospitals in their states. Not only do the services furnished by these institutions (including my own here at GWU) play a vital role in the care of Medicaid beneficiaries, but moreover, the residency and professional training programs offered by teaching hospitals represent the type of essential community benefit that most civil societies make in their populations. One would imagine that, had lawmakers believed that recognition of the teaching costs associated with the provision of covered services amounted to a violation of federal law, they would have stepped in by now to stop the practice through legislation. More than 40 years of Congressional acquiescence to this policy would be considered by most observers to be significant evidence of their legitimacy.

CMS basic argument is as follows: (1) federal Medicare statutory law expressly recognizes teaching costs; (2) there is no similar provision in the Medicaid statute; (3) therefore, such costs must be disallowed under Medicaid. This syllogistic argument is both sophomoric and wrong.

To be sure, Medicare and Medicaid have parallel and overlapping broad missions, and in certain respects are designed to work in a legally unified fashion (e.g., coverage of dual enrollees and enrollment in the Medicare Part D low income subsidy provide just two examples). But to deduce from their parallel missions and occasional statutory integration that the two programs must function in legal lockstep is fundamentally incorrect. Medicare is a federally administered program that operates in accordance with a federally administered coverage payment design that has been carefully delineated by Congress.

By contrast, Medicaid is a state grant in aid program that functions as a broad legal entitlement, according states extensive discretion over coverage, payment, and administration design. The fact that a federally administered benefit explicitly recognizes certain costs while a broad grant in aid program is silent is utterly irrelevant in my view. These costs are the province of states to determine under federal Medicaid law. Indeed, the strongest legal evidence of this fact is the broad federal accounting principles that apply to federal grant in aid programs and that have done so since Medicaid's inception.

For the moment, Congress has halted this ill-considered proposal (yet more evidence of the Secretary's lack of authority to declare Medicaid teaching costs non-allowable under federal Medicaid law). My fervent hope, for the sake of Medicaid patients who depend on teaching hospitals, is that the Department will acknowledge this reality and withdraw the proposed rule.

Sincerely,

S/

Sara Rosenbaum  
Harold and Jane Hirsh Professor of Health Law and Policy  
Chair, Department of Health Policy

**Submitter :** Mrs. Brenda Jarrett  
**Organization :** Putnam General Hospital  
**Category :** Health Care Professional or Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

**Background**

Putnam General Hospital supports the recommendations submitted by the American Hospital Association, to include that teaching costs are a medically necessary, covered and reimbursable cost of treatment for Medicaid patients. Medicare, a 100% federally paid program covers and pays for medical education costs, so the intent of Congress is clear. GHA believes CMS should permanently withdraw this proposed rule.

**GENERAL**

**GENERAL**

CMS has proposed to no longer pay for the cost of training physicians to treat Medicaid patients.

**Provisions of the Proposed Rule**

**Provisions of the Proposed Rule**

Medicaid accounts for 17% of Georgia hospital costs; whose services are ordered by physicians. In the proposed rule, Georgia teaching hospitals will lose over \$40 million in payments if the rule is finalized. Statewide, Georgia hospitals only average a payment of about 82% (for \$1 billion of expenses) annually spent for inpatient Medicaid costs; and a payment of 80% of (\$500M annual expenses) costs for outpatient Medicaid costs. Teaching hospitals account for close to 40% of care statewide to the uninsured, which is almost \$990 million annually in Georgia. The uninsured account for about 10% of total Georgia hospital costs (higher at teaching hospitals) and only pay for approximately 10% of their statewide hospital medical costs. Medicaid DSH payments to Georgia hospitals only cover 26% of the cost of treating the uninsured, if no dsh payments were used to cover Medicaid payment shortfalls. Given that Medicare payments to Georgia hospitals by the federal government only cover 95% of the cost of treatment; and Medicaid only covers 82% of the cost of hospital treatment in Georgia, further losses in payments by the federal government threaten the financial stability of large safety net providers. Instability in these major referral hospitals threatens the very fragile fabric of health care services being accessed by all Georgia citizens.

Submitter :

Date: 06/22/2007

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See

Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Office of Strategic Operations & Regulatory Affairs

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- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to  
(800) 743-3951.

Submitter : Mr. Joseph Jaeger  
Organization : Monmouth Medical Center  
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2279-P-126-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 Monmouth Medical Center to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate federal financial participation (FFP) matching funds associated with Medicaid graduate medical education (GME) payments (See 72 Fed. Reg. 28930). 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. Monmouth Medical Center is one of the oldest and largest teaching hospitals in the state of New Jersey. We train over 100 residents each year, many in specialties where there are critical shortages, such as OB/GYN and General Surgery. We also train Pediatricians, Orthopedic Surgeons, Diagnostic Radiologists, Pathologists, and Dentists. 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.

Our residents aid the community immensely by providing outstanding care, conducting cutting edge research, and teaching patients, families, and the community about health and wellness. They are the primary care physicians for thousands of people, from the prenatal to the geriatric period. In fact, Monmouth only trains medical school graduates as general physicians, essentially those who provide the broadest range of care to the most people.

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,

Joseph Jaeger  
Associate Vice President, Academic Affairs  
Monmouth Medical Center

**Submitter :** Mrs. Cindy Siler  
**Organization :** The Rural Partnership  
**Category :** Other Health Care Professional

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

Background

With Medicaid GME funds contributing toward the provision of indigent and uninsured health care through the academic medical centers of our country, we have insured quality and even preventative care while utilizing the least expensive methodology.

**GENERAL**

GENERAL

The removal of Medicaid GME funding from the academic medical centers would have extremely serious repercussions to an already ailing system. It is statistically clear that the nation is not only experiencing a major primary care physician shortage in rural and underserved areas but also the future is looking even more dim for the supply of all types of physicians.

It seems that eliminating Medicaid GME funding to the teaching hospitals and other entities of care is taking the investment of funds from the stock with the highest utilization and most dividends to save money. This proposed rule will simply worsen the access and quality of the most efficient and effective means of health care provision available in the nation and in turn will put us back in the position to spend more money in emergency room care or worse: result in the lack of health care access at all for the most vulnerable populations. Why would CMS consider a ruling of such major proportion that it could harm our nation's already underserved population and the future of continued access to care for anyone. It does not seem to be a likely consideration of a thinking system to turnaround a method that is currently working. Maybe improvement or the addition of accountability is in order but not reversal.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

Why would the intent of Congress suddenly be reversed, which is the provision of this proposed rule, when Administration of the country are looking for more affordable mechanisms of care delivery.

Submitter : Mr. Jerome Keller  
Organization : The Health Alliance of Greater Cincinnati  
Category : Health Care Professional or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-128-Attach-1.PDF

# Health Alliance™

#128  
Executive Offices  
3200 Burnet Avenue  
Cincinnati, OH 45229  
513-585-6000

June 18, 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 Health Alliance of Greater Cincinnati, an alliance of six acute care hospitals located in the greater Cincinnati area. Two of the hospitals are located in Northern Kentucky, three in Cincinnati and one in Hamilton, Ohio. We 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 cause great financial hardship to our teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other charitable missions, especially to the teaching and charity mission of University Hospital, which is the safety net hospital for the greater Cincinnati area.

Although characterized by CMS as a rule "clarification," the proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs including Ohio have supported the higher costs of teaching Hospitals. CMS and its predecessor HCFA have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, forty-seven states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs.

Our hospitals rely on these and other Medicaid payments to support our critical functions. In FY 2006 our Ohio hospitals received a total of \$19,644,000 of which \$17,529,00 went to University Hospital. Comparatively for the same period, our Ohio hospitals had a combined loss from the treatment of Medicaid patients of \$20,417,000.

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

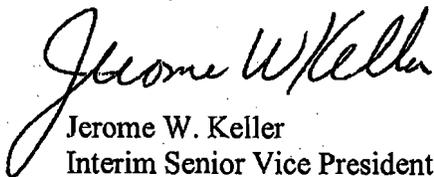
Leslie Norwalk, Esq.  
Centers for Medicare & Medicaid Services  
June 18, 2007 – Page 2

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. The Health Alliance hospitals currently train approximately 480 physicians. Eliminating Medicaid reimbursement for GME will force the downsizing and possible closure of 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 1,100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. University Hospital alone treated over 6,150 Medicaid inpatients in FY 2006 and provided over \$48 million in charity care.

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 issued on May 23, 2007 (See 72 Fed. Reg. 28930).**

Sincerely,



Jerome W. Keller  
Interim Senior Vice President and  
Chief Financial Officer

**Submitter :** Dr. Mitchell Rashkin  
**Organization :** University of Cincinnati  
**Category :** Physician  
**Issue Areas/Comments**

**Date:** 06/22/2007

GENERAL

GENERAL

See Attachment

CMS-2279-P-129-Attach-1.PDF



#129

College of Medicine  
Department of Internal Medicine

Pulmonary, Critical Care and Sleep Medicine  
University of Cincinnati Medical Center  
PO Box 670564  
Cincinnati OH 45267-0564

Phone (513) 558-4831  
Fax (513) 558-4858

June 21, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of 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.

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,



Mitchell Rashkin, M.D.

Fellowship Director

Professor of Medicine

Division of Pulmonary, Critical Care and Sleep Medicine

Submitter : Dr. William Roper  
Organization : UNC Health Care System  
Category : Hospital  
Issue Areas/Comments

Date: 06/22/2007

GENERAL

GENERAL

See Attachment.

CMS-2279-P-130-Attach-1.DOC



UNC  
SCHOOL OF MEDICINE

June 21, 2007

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

Attention: **CMS-2279-P**

Dear Ms. Norwalk:

I am writing to you, as a former Administrator of the Health Care Financing Administration and on behalf of The University of North Carolina Hospitals at Chapel Hill and The University of North Carolina School 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. Finalizing this rule will damage our financial condition as a teaching hospital and jeopardize our ability to continue to fulfill important teaching, patient care and other missions.

The proposed rule represents a major reversal of long-standing Medicaid policy. UNC Hospitals has received Medicaid GME dollars for decades. Last fiscal year we received approximately 15 million dollars in GME payments, and we rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help us meet our missions to provide high quality health care, to educate healthcare professionals, to advance health research and to provide community service. We are North Carolina's own academic medical center, and we serve as its safety net institution. As a public academic health care system, we rely on the GME Medicaid payments to help sustain our capacity to provide the clinical education of future physicians.

This has never been more important given the dramatic growth of our state's population and the predicted physician shortage. Our graduate medical education programs educate approximately 680 residents each year in a full complement of medical programs, specialties and sub-specialties: eliminating FFP for state Medicaid agency payments for GME could cripple these vital programs.

UNC Hospitals provides tertiary care to the most critically ill patients in our state, especially those on Medicaid and the uninsured. We have 724 licensed beds which include intensive care, intermediate care, burn intensive care, neonatal intensive care, primary and preventative care, and psychiatric care for adults and children, home health, level one trauma care, dental care, as well as other services. Last year Medicaid-supported and uninsured care surpassed 350 million dollars.

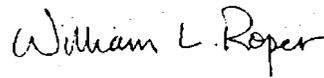
Given our central role in caring for the citizens of North Carolina, developing more advanced medical care, and educating future physicians and other healthcare professionals, it is

Page 2  
Ms. Leslie Norwalk, Esquire  
June 21, 2007

important that state Medicaid programs receive federal matching assistance for GME. **I urge the Agency to rescind the proposed rule.**

Thank you for your attention to this very important matter.

Sincerely,



William L. Roper  
Dean, UNC School of Medicine  
Vice Chancellor for Medical Affairs  
CEO, UNC Health Care System

WLR:mm

cc: Secretary Carmen Hooker-Odom  
Chancellor James Moeser  
President Erskine Bowles  
Ms. Karen Regan

Submitter : Dr. Francis McCormack  
Organization : University of Cincinnati  
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-131-Attach-I.PDF



College of Medicine  
Department of Internal Medicine

Pulmonary, Critical Care and Sleep Medicine  
University of Cincinnati Medical Center  
PO Box 670564  
Cincinnati OH 45267-0564

Phone (513) 558-4831  
Fax (513)558-4858

June 21, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of 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.

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,



Francis X. McCormack, M.D.  
Taylor Professor and Director  
Division of Pulmonary, Critical Care and Sleep Medicine

**Submitter :** Dr. Larry Shapiro  
**Organization :** Washington University Medical Center  
**Category :** Health Care Provider/Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2279-P-132-Attach-1.PDF

# Washington University in St. Louis

## SCHOOL OF MEDICINE

Executive Vice Chancellor  
for Medical Affairs and 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 School of Medicine at Washington University in St. Louis to urge the Centers for Medicare and Medicaid Services (CMS) to rescind the May 23, 2007, proposed rule eliminating federal matching participation under Medicaid for graduate medical education (GME) payments.

Through the Washington University Medical Center (WUMC), the School of Medicine works closely with Barnes-Jewish Hospital and St. Louis Children's Hospital in training 921 residents, interns and fellows through 73 training programs accredited by the Accreditation Council for Graduate Medical Education. Loss of federal support through Medicaid for this training puts these programs at risk and erodes our institutions' capacity to care for low-income families, the elderly and disabled.

The Washington University Medical Center supports the region's only American College of Surgeons-verified level I trauma center, is a leading provider of transplant services, and is highly involved with local health officials in planning for health events such as pandemic flu, natural disasters, and biological attacks. Given our clinical care, training and education missions, our physicians and residents provide around the clock care to some of the sickest patients. Maintaining this commitment only becomes more difficult if Medicaid payments decline.

If implemented, this rule will affect not only WUMC, but also the hundreds of other teaching hospitals across the 47 states that have provided such funding for decades. It is well known that the 1,100 teaching hospitals in the United States provide half of all Medicaid discharges, and these same institutions are the largest source of charity care in the country.

Given the critical role of teaching hospitals, it is critical that state Medicaid programs receive federal matching assistance for GME. **We urge CMS to rescind the proposed rule.**

Sincerely,



Larry J. Shapiro, M.D.  
President, Washington University Medical Center  
Executive Vice Chancellor for Medical Affairs and Dean, Washington University School of Medicine

Submitter : Mr. David McClure  
Organization : Tennessee Hospital Association  
Category : Health Care Provider/Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-133-Attach-1.DOC



June 19, 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 Tennessee Hospital Association 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). The Tennessee Hospital Association (THA), represents over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals.

Tennessee's medical schools work together and with teaching hospitals to educate physicians and meet the healthcare needs in our state. Finalizing this rule would jeopardize the abilities of the schools and our teaching hospitals in Tennessee to continue to fulfill important teaching and patient care missions.

This proposed rule represents a major reversal of long-standing Medicaid policy. For decades and with CMS approval, the Tennessee Medicaid program has supported the higher costs of teaching hospitals and helped insure their abilities to provide charity care and care to TennCare enrollees. CMS and its predecessor, the Health Care Financing Administration, has approved and matched these payments.

In 1994, when TennCare was initially implemented, all GME funding was eliminated. Funding was restored in 1996 with an agreement to flow funds through the four medical schools after a transition period. The agreement was to base funding on the number of filled residency positions and to provide financial incentives to encourage primary care training and residency placements in

medically underserved areas. Over the transition, \$48 million in GME funding to teaching hospitals was replaced by funding to medical schools, with 100 percent of the funds flowing to medical schools beginning in 2000.

In the proposed rule, CMS states that section 1905(a) does not specifically list GME as a service that is to be funded with matching federal dollars. However the section actually says "medical assistance" means care and services and also includes physician services. In Tennessee care provided to enrollees, charity patients and the general public is provided by residents directly supported by the GME funding in Tennessee.

CMS further states that the GME payments originated at a time when there was a physician shortage in the United States and that the shortage no longer exists. According to HRSA there is currently a primary care physician shortage in underserved, typically rural, areas. HRSA projections to 2020 show a decline in several key specialties including preventive medicine and general surgery at a time when baby boomers will be most likely to access the healthcare system and the demand for those services will be greater than ever in the United States. Also, according to a survey of Tennessee hospital CEOs with over a 92% response rate, physician recruitment and retention are major issues for Tennessee hospitals.

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

CMS sites the lack of accountability for the funding as an additional reason for discontinuing the funding of Medicaid GME. In Tennessee, the dollars are accounted for by the medical schools and the state receives reports showing how the dollars were spent including which residents were subsidized by the funding. CMS can achieve accountability for GME dollars by requiring states to provide methodologies and distribution reports through the State plan process. However, instead, they are choosing to revise the federal code to not allow GME to be included in Medicaid State Plans.

While CMS acknowledges that most hospitals are not for profit and would be included in the definition of "small entities," they indicate that this rule has no impact on small entities and further state that most hospitals would likely be unaffected because most small hospitals do not have medical education programs. All but two of the hospitals in Tennessee that have benefited from the GME funding are not for profit and those two combined have never received more than \$300,000 of more than \$40 million distributed each year. Therefore, hospitals with teaching programs in Tennessee are small entities and will be significantly impacted by this change.

Further, CMS says the proposed rule will not impact small entities because it impacts federal funding going to the State and does not prevent the State from

replacing the federal funding with State dollars. CMS later states that for purposes of Executive order 13132, the rule will not have a significant impact on state or local government because it does not impose a requirement on the state to make up the lost funding to continue the support of medical education. In reality, one or the other, hospitals or the state, is significantly impacted, either the teaching programs in the State suffer because the State loses the federal money and does not replace it, or the state suffers because they have to find new state dollars to fund the loss of federal dollars. CMS's allegation that neither the state nor the hospitals are impacted is not true.

Teaching hospitals in Tennessee rely on these and other Medicaid payments to support critical functions. CMS states that teaching hospital will continue to be supported for taking care of high volumes of Medicaid and charity care patients through DSH. In Tennessee, hospitals do not receive a DSH payment and will be disproportionately impacted by the loss of support for their teaching functions.

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.

In Tennessee, 16 teaching hospitals bore 54% of the total cost of charity care in the state and 50% of the unreimbursed TennCare cost. These hospitals provided 43% of the TennCare admissions and the uninsured admissions and 51% and 49%, respectively, of the total days of care for those two groups. Because these same hospitals serve as the safety net for Tennessee providing the only Level 1 trauma, burn care and other high levels of services in their regions, a GME funding cut could severely impact essential services offered to TennCare and other patients by reducing teaching hospitals' total financial resources.

Given their important roles, the need to continue to replenish the supply of physicians in the United States, and the current and future financial uncertainty for America's teaching hospitals, it is important that state Medicaid programs

continue to receive federal matching assistance for GME. We urge the Agency to rescind the proposed rule.

Sincerely,

Craig A. Becker, President FACHE  
Tennessee Hospital Association

cc: Rick Pollack, AHA, Executive Vice President

Submitter : Ms. Betti Wilson  
Organization : Rural Health Association of Tennessee  
Category : Other Association

Date: 06/22/2007

**Issue Areas/Comments**

**Background**

Background  
GME Funding for Medical Education

**GENERAL**

GENERAL  
See attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

May 23, 2007 proposed rule that would eliminate the federal financial participation (FFP) matching the funds associated with Medicaid graduate medical education (GME) payments as posted in Federal Register 72, Reg. 28930).

CMS-2279-P-134-Attach-1.DOC

CMS-2279-P-134-Attach-2.DOC

Letterhead

June 21, 2007

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

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

Dear Administrator Norwalk:

On behalf of the Rural Health Association of Tennessee, we request that the Centers for Medicare and Medicaid Services (CMS) rescind the May 23, 2007 proposed rule that would eliminate the federal financial participation (FFP) matching the funds associated with Medicaid graduate medical education (GME) payments as posted in Federal Register 72, Reg. 28930).

These funds are crucial to the continued care of all of our citizens of Tennessee, as well as those in other states which would be in similar straits should the funding cease. Should the match funding be eliminated, Tennessee would be unable to fund its programs that train primary care physicians, as well as those in specialties. In light of the severe shortage of physicians that this country is experiencing now and will continue to experience as the "Baby Boomer" population ages, we urge you to rescind the rule.

The Rural Health Association of Tennessee is a nonprofit organization of individuals whose mission is to improve the health of rural Tennesseans by providing leadership on rural issues through advocacy, communication, education, and legislation.

Sincerely,

Betti Wilson  
President

**Submitter :** Mr. Peter Schonfeld  
**Organization :** Michigan Health & Hospital Association  
**Category :** Health Care Provider/Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

CMS-2279-P-135-Attach-1.PDF



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

June 22, 2007

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

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

Dear Ms. Norwalk:

On behalf of its 145 member hospitals, including approximately 50 teaching hospitals, the Michigan Hospital Association (MHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs.

The proposed rule is subject to a yearlong moratorium secured by P.L. 110-28. The MHA agrees with the American Hospital Association that the moratorium should preclude the CMS from soliciting comments and recommends that the agency withdraw this proposed rule. Because the CMS has not withdrawn the rule, the MHA is submitting these comments to indicate its strong opposition to the policy changes proposed in this rule.

The proposed rule departs from long-standing Medicaid policy and disallows federal matching funds, otherwise known as federal financial participation (FFP), for hospitals' GME costs. The MHA disagrees with the CMS claims that this rule clarifies existing GME policy. The proposed rule reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The agency's recent decision would result in a cut of at least \$100 million in federal funds from Michigan's Medicaid program, funds that provide access to care for Michigan's 1.5 million Medicaid enrollees. Michigan patients are heavily dependent on the more than 4,000 physician residents working in teaching hospitals and clinic sites throughout the state. Michigan's teaching hospitals provide 70 percent of the uncompensated and charity care delivered in the state. These

SPENCER JOHNSON, PRESIDENT

CORPORATE HEADQUARTERS ♦ 6215 West St. Joseph Highway ♦ Lansing, Michigan 48917 ♦ (517) 323-3443 ♦ Fax (517) 323-0946  
CAPITOL ADVOCACY CENTER ♦ 110 West Michigan Avenue, Suite 1200 ♦ Lansing, Michigan 48933 ♦ (517) 323-3443 ♦ Fax (517) 703-8620  
www.mha.org

same hospitals house 80 percent of all burn-care beds, 73 percent of neonatal intensive care beds and 78 percent of the Level-1 trauma care. Physician residents in Michigan are also involved in clinical trials and studies to develop advanced care for a wide range of illnesses and conditions.

The state and federal funds that make up Michigan's program are a relatively small investment for the value. The physician residents who deliver this care to the most vulnerable in our state are paid on average an annual salary of \$42,000 while working 60-80 hours per week. It would be impossible to replace care provided by these medical residents with house staff or nurses at the same rate of pay. The investment in GME also makes a difference in Michigan's physician supply. Eighty-one percent of all physicians practicing in Michigan did all or part of their residency in Michigan. GME funding is critical for training an adequate supply of qualified physicians for the future.

**If these cuts to state Medicaid programs are finalized, many safety-net and teaching 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.**

#### **Agency Rationale**

The agency's conclusion that FFP is unavailable for hospitals' GME costs is primarily based on the fact that GME is not specifically listed as a service in the Medicaid statute. In addition, the 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 (IPPS). **We believe the agency's analysis is flawed on both counts.**

In the preamble to the proposed rule, the CMS 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. The CMS' implementing regulations at 42 C.F.R. Part 440 expand upon this list of services. If the 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). They also are appropriately included as medical assistance eligible for FFP in the CMS' regulations (42 C.F.R. 440.170(a)).

The statutory basis that allows things such as transportation expenses to be eligible for FFP is unclear. Perhaps these expenses are included under Section 1905(a)(28), which defines medical assistance to include "any other medical care...specified by the Secretary," or another provision of the Medicaid statute such as Section 1902(a)(4), which lays out the requirements for state plans for medical assistance. 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 the CMS' position that FFP is unavailable for GME because it is not listed in the statute. It seems that the CMS has singled out GME because it is a convenient budget-saving strategy.

In the proposed rule, the 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.

The 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 percent 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 percent of the interns' workdays, and 64.5 percent of the residents' workdays (Guarisco S., *et al.*: "Time Analysis of a General

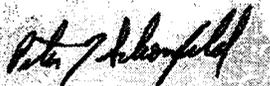
Medicine Service: Results from a Random Work Sampling Study." *Journal of General Internal Medicine*, May 1994; 9(5): pp 272-277).  
**Reversal of Long-Standing Policy**

The proposed rule acknowledges that the 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. The 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.

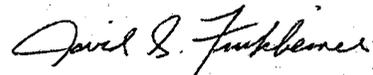
The CMS' public acknowledgement and approval of GME payments do not rest with state plan amendment review, but also extend to its own rulemaking for Medicaid managed care plans. In August 2001, the CMS issued a Medicaid managed care proposed rule that declared a state Medicaid program could not make 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 the CMS' reversal of long-standing policy acknowledging GME as an allowable cost is based on flawed reasoning. There is also no doubt that Michigan's investment in GME is a direct investment in care and services. We are equally certain that this is true for every other state making this investment. **By failing to justify termination of the federal funds supporting Medicaid GME programs, the CMS should permanently withdraw this proposed rule.** The Medicaid program has a responsibility to pay its share of the costs associated with GME programs, which, through their teaching function, provide care to millions of patients from our most vulnerable populations.

Sincerely,



Peter Schonfeld  
Senior Vice President, Policy



David Finkbeiner  
Vice President, Advocacy

**Submitter :** Mrs. Kim Duggan  
**Organization :** Missouri Hospital Association  
**Category :** Health Care Professional or Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

See Attachment.

#136

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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.

**Submitter :** Ms. Betti Wilson  
**Organization :** Rural Health Association of Tennessee  
**Category :** Other Association

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

Background  
GME Funding for Medical Education

**GENERAL**

**GENERAL**

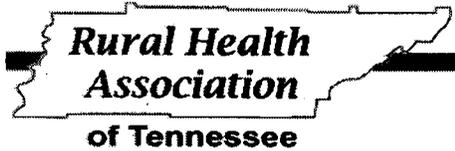
See Attachment, same as previously submitted but on letterhead.

**Provisions of the Proposed Rule**

**Provisions of the Proposed Rule**

Proposed rule would eliminate federal financial participation matching the funds associated with Medicaid graduate medical education (GME) payments as posted in Federal Register 72, Reg. 28930.

CMS-2279-P-137-Attach-1.DOC



PO Box 11675- Murfreesboro, TN 37129  
615-907-9707  
[www.rhat.org](http://www.rhat.org)

June 21, 2007

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

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

Dear Administrator Norwalk:

On behalf of the Rural Health Association of Tennessee, we request that the Centers for Medicare and Medicaid Services (CMS) rescind the May 23, 2007 proposed rule that would eliminate the federal financial participation (FFP) matching the funds associated with Medicaid graduate medical education (GME) payments as posted in Federal Register 72, Reg. 28930).

These funds are crucial to the continued care of all of our citizens of Tennessee, as well as those in other states which would be in similar straits should the funding cease. Should the match funding be eliminated, Tennessee would be unable to fund its programs that train primary care physicians, as well as those in specialties. In light of the severe shortage of physicians that this country is experiencing now and will continue to experience as the "Baby Boomer" population ages, we urge you to rescind the rule.

The Rural Health Association of Tennessee is a nonprofit organization of individuals whose mission is to improve the health of rural Tennesseans by providing leadership on rural issues through advocacy, communication, education, and legislation.

Sincerely,

Betti Wilson  
President

**Submitter :** Mr. Oliver Booker  
**Organization :** Monroe County Hospital  
**Category :** Critical Access Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

**Background**

Medicaid accounts for 17% of Georgia hospital costs whose services are ordered by physicians. In the proposed rule, Georgia teaching hospitals will lose over \$40 million in payments if the rule is finalized. Statewide, Georgia hospitals only average a payment of about 82% (for \$1 billion of expenses) annually spent for inpatient Medicaid costs; and a payment of 80% of (\$500M annual expenses) costs for outpatient Medicaid costs. Teaching hospitals account for close to 40% of care statewide to the uninsured, which is almost \$990 million annually in Georgia. The uninsured account for about 10% of total Georgia hospital costs (higher at teaching hospitals) and only pay for approximately 10% of their statewide hospital medical costs. Medicaid DSH payments to Georgia hospitals only cover 26% of the cost of treating the uninsured if no DSH payments were used to cover Medicaid payment shortfalls. Given that Medicare payments to Georgia hospitals by the federal government only cover 95% of the cost of treatment; and Medicaid only covers 82% of the cost of hospital treatment in Georgia, further losses in payments by the federal government threaten the financial stability of large safety net providers. Instability in these major referral hospitals threatens the very fragile fabric of health care services being accessed by all Georgia citizens.

**GENERAL**

**GENERAL**

This rule would result in a domino effect that will further exacerbate the shortage of physicians. I believe the teaching hospitals will cut residency positions, thus causing a concomitant in positions by medical schools.

We support the recommendations submitted by the American Hospital Association and the Georgia Hospital Association to include that teaching costs are a medically necessary, covered and reimbursable cost of treatment for Medicaid patients. Medicare, a 100% federally paid program covers and pays for medical education costs, so the intent of Congress is clear. We believe CMS should permanently withdraw this proposed rule.

**Provisions of the Proposed Rule**

**Provisions of the Proposed Rule**

CMS has proposed to no longer pay for the cost of training physicians to treat Medicaid patients.

**Submitter :** Ms. Holly Snow  
**Organization :** Piedmont Healthcare  
**Category :** Hospital

**Date:** 06/22/2007

**Issue Areas/Comments**

**Background**

Background

On behalf of Piedmont Healthcare and our four hospitals located in Atlanta, Fayetteville, Jasper, and Newnan, Georgia, we appreciate 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.

**GENERAL**

GENERAL

See Attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

While this policy change would have a limited impact on our GME payments, we are concerned that this proposed policy change could harm Georgia and the nation's most vulnerable health care teaching facilities and could undermine our state's safety net health care delivery system.

The proposed rule substantially departs from long-standing Medicaid policy by no longer permitting matching federal dollars 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.

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.

Submitter : Dr. Melinda Estes  
Organization : Fletcher Allen Health Care  
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-140-Attach-1.PDF



*In alliance with  
The University of Vermont*

MELINDA L. ESTES, M.D.  
President and Chief Executive Officer

June 21, 2007

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

Attention: CMS-2279--P

Dear Administrator Norwalk:

I am writing as President and Chief Executive Officer of Fletcher Allen Health Care, Vermont's teaching hospital affiliated with the University of Vermont, 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.

Currently, Fletcher Allen receives a GME settlement as part of our cost settlement for outpatient Medicaid services, which is settled based on the audited Medicare cost reports. The GME settlement recently has been approximately \$400,000 per year. Fletcher Allen and its predecessor organizations have been receiving Medicaid GME for at least the past fourteen years.

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. Together with Fletcher Allen, the University of Vermont College of Medicine trains 488 medical students, 115 graduate students, 84 post doctoral fellows and 280 residents in 37 different specialty programs. The University was ranked 7<sup>th</sup> in the April 2007 issue of *US News and World Report* for training primary care physicians, of which there is a shortage in Vermont and projected shortage nationwide. Eliminating FFP for state Medicaid agency payments for GME could impede 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 125 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 Fletcher Allen's case, we work to improve the health of the communities we serve and to address the health problems of medically under-served populations in our region. We do this in a number of ways, including:

- **Financial Assistance**

- *Charity care policy:* Fletcher Allen's patient assistance program provides a complete subsidy for charges for patients under 300% of the Federal Poverty Level (FPL). Charity care in FY 2006 was valued at \$7.5 million. This number represents the *actual costs* incurred by Fletcher Allen in serving low-income patients.
- *Discounts for uninsured patients:* Fletcher Allen also discounts its charges to patients who are not eligible for charity care, but who are uninsured. The discount amount is set annually and is based on the average discount given to all payers. In FY 2007 (the current fiscal year), that discount is 49% off of charges.

- **Community Programs**

Fletcher Allen provided almost \$2.3 million worth of community programs in FY 2006. These included a broad range of community health services (health education programs, community clinics and health screenings, support groups and health care support services); grants and donations (both in-kind and cash) to organizations with similar missions, like the Community Health Center of Burlington; community-building activities that help address the root causes of health problems, like poverty (for example, through participation in economic and workforce development initiatives); our community benefit operations (including our Community Health Improvement Department).

- **Subsidized Programs**

Many services are offered through Fletcher Allen despite a financial loss. These services include kidney dialysis, the genetics program at the Vermont Children's Hospital, and our FACT (our critical care ambulances). Fletcher Allen also supports many educational activities for nurses, nursing students, physicians, medical students, and other health professionals, as well as supporting research that is not completely paid for from other sources. The value of our subsidized programs in FY 2006 was \$18.4 million.

- **Medicaid and Other Public Program Underpayments**

Fletcher Allen experienced a shortfall in funding for Medicaid and other public program beneficiaries in FY 2006 of \$46.8 million. (NOTE: This does not include *any* shortfalls in payment from Medicare.) The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) estimates that the total "cost shift" (Medicare, Medicaid, bad debt and free care) for Fletcher Allen in FY 2007 will be \$80.1 million.

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

Fletcher Allen Health Care is Vermont's only academic medical center and is affiliated with the University of Vermont College of Medicine and College of Nursing and Health Sciences. Fletcher Allen sees 1.2 million patients annually and together with the University of Vermont received over \$82 million in research funding in 2006, which translates into over 1,100 clinical trials statewide. Fletcher Allen is unique in that we have two distinct health care delivery roles: community hospital for the residents of Chittenden County (approximate population of 150,000) *and* the regional referral center for tertiary and quaternary care for Vermont and northern New York (population of 1 million). Fletcher Allen has three main campuses in Chittenden County to meet the different needs of our patients; nine different primary care clinics in Vermont; more than thirty patient care sites in Vermont and New York; and, more than one hundred outreach clinics, programs and services in Vermont and New York. I would like to highlight several areas of clinical excellence for this institution that are unique to this state:

- The Vermont Cancer Center at the University and Fletcher Allen is one of thirty-nine NCI-designated comprehensive cancer centers in the nation. The VCC coordinates multidisciplinary approaches to cancer research, prevention, patient care, and community education.

- Fletcher Allen is the only Level I Trauma Center in Vermont. The organization also serves trauma patients throughout the northern New York region. Our Emergency Department receives more than 52,000 visits per year.
- The Vermont Children's Hospital at Fletcher Allen, a full-service hospital within a hospital, provides family-centered care to children throughout the region. Its Level III Neonatal Intensive Care Unit provides care for critically ill and premature infants.

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,



Melinda L. Estes, MD  
President and Chief Executive Officer