

Submitter :

Date: 06/22/2007

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-141-Attach-1.DOC

#141

June 22, 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 Administrator Norwalk:

On behalf of the undersigned organizations, we are 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 (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, 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.

The nation’s nearly 1100 teaching hospitals provide more than half of the nation’s hospital charity care and are responsible for treating half of all discharged Medicaid

patients. Clearly, elimination of the federal GME match could have a ripple effect on other services offered to all 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.

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 this proposed rule.**

Sincerely,

American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Osteopathy
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Colleges of Osteopathic Medicine
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Emergency Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Obstetricians and Gynecologists
American College of Osteopathic Pediatricians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Preventive Medicine
American College of Rheumatology
American College of Surgeons

American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Medical Directors Association
American Osteopathic Academy of Addiction Medicine
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Osteopathic College of Dermatology
American Osteopathic College of Pathologists
American Osteopathic College of Proctology
American Osteopathic College of Radiology
American Osteopathic College of Rheumatology, Inc.
American Psychiatric Association
American Society for Clinical Pathology
American Society for Reproductive Medicine
American Society for Therapeutic Radiology and Oncology
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Clinical Oncology
American Society of General Surgeons
American Society of Hematology
American Society of Pediatric Nephrology
American Thoracic Society
Association of Departments of Family Medicine
Association of Family Medicine Residency Directors
Association of Osteopathic Directors and Medical Educators
Child Neurology Society
Congress of Neurological Surgeons
Infectious Diseases Society of America
Medical Group Management Association
North American Primary Care Research Group
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North America
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Interventional Radiology
Society of Teachers of Family Medicine
The Endocrine Society
The Joint Council of Allergy, Asthma and Immunology

Submitter : Mr. Mark Taylor
Organization : Spectrum Health Hospitals
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#142

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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 : cecil terry

Date: 06/22/2007

Organization : bjc

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-143-Attach-1.DOC

Barnes-Jewish Hospital DRAFT 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 on behalf of Barnes-Jewish 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.

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. Annually, Barnes-Jewish Hospital receives, as a component of its total Medicaid payments, \$27.5 million for the Medicaid portion of graduate medical education costs. While some of the reimbursement formulas have changed over the years, Missouri Medicaid has included the costs of approved intern-resident training as an allowable component of its cost reimbursement methodology. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

On page 28931 of the subject proposed rule, CMS presents an interesting analysis that would revise history and redefine terms, as commonly understood in the health care industry, and we believe, by Congress. In enumerating the "care and services" that may be included in approved State Medicaid plans, it is stated "Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance." This is true, because until this proposed rule was released, the costs of approved training programs for interns and residents has never been characterized as a "service," but only as a "component cost" of services provided to patients.

On page 28932, CMS quotes section 1886(a)(4) of the Act, which describes the "operating costs" which can be included the determination of the basic payment amounts under Medicare's prospective payment system (PPS) for inpatient hospital services, and implies that the exclusion of "costs associated with educational activities from the operating costs that can be included in the cost base used to develop the basic payment amounts" somehow changes the "character" of such costs.

While it is clear that Congress and the Medicare program separated the costs of approved educational activities from the PPS base costs, it is also clear that this "cost separation" was for the purpose of reimbursing these approved education costs differently than the other operating costs and to facilitate imposing limits on such costs for improved budgetary control. Historically, this treatment is not that different from the isolation of "inpatient routine service costs" for purpose of imposing reimbursement limitations on such "inpatient routine service costs" under the historical "cost" reimbursement methodology. The segregation of such costs did not change their character. Thus, even though GME costs have been separated from other operating costs for differing payment methods under the Medicare inpatient PPS and associated payment methods, such GME costs remain "component costs" of patient care services, especially for those reimbursement systems which continue to use the historical "cost" reimbursement method, which include Missouri and many other state 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. Each year Barnes-Jewish Hospital provides education for over 700 future doctors training in 19 primary specialty programs (including internal medicine, emergency medicine, neurological surgery, obstetrics and gynecology, diagnostic radiology, and general surgery) and over 20 sub-specialty programs (including cardiovascular disease, gastroenterology, hematology/oncology, nephrology, vascular and interventional radiology, and cardiothoracic 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. Barnes-Jewish Hospital is the largest volume provider of Medicaid days in the State of Missouri and is THE "safety net hospital" for the metropolitan St. Louis area. Annually, our Hospital provides care to over 54,000 Medicaid and charity patients, which includes approximately 69,000 inpatient days of care to Medicaid and Charity patients. The proposed reduction of funding of Medicaid services, regardless of what it is called,

significantly increases our Hospital's challenge to meet the hospital care requirements of our area's neediest patients, that is, Medicaid recipients and those with no health insurance of any kind.

It must be observed that interns and residents, especially those who have completed their initial year of training, are an important part of overall patient care staffing. If GME programs are reduced or discontinued as a result of inadequate funding, to maintain the same volume of patients and quality of care, teaching hospitals would be required to employ many more registered nurses and nurse practitioners at compensation levels that are significantly greater than the stipends paid to interns and residents.

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.

[INSERT A PARAGRAPH DESCRIBING YOUR HEALTH SYSTEM AND YOUR UNIQUE ROLE IN THE COMMUNITY. INCLUDE INFORMATION ON THE POPULATIONS YOU SERVE, FOCUSING BOTH ON LOW INCOME (MEDICAID AND UNINSURED POPULATIONS) AS WELL AS SERVICES YOU PROVIDE TO THE ENTIRE COMMUNITY. BE SURE TO MENTION UNIQUE SPECIALTY SERVICES (TRAUMA CARE, BURN CARE, NEONATAL INTENSIVE CARE, PSYCHIATRIC EMERGENCY CARE) THAT YOU OFFER, AS WELL AS YOUR ROLE IN PROVIDING BOTH PRIMARY AND PREVENTIVE CARE SERVICES AND ACTING AS A KEY REFERRAL SOURCE FOR HARD-TO-ACCESS SPECIALTY CARE SERVICES, PARTICULARLY FOR THE UNINSURED. YOU MAY WANT TO HIGHLIGHT YOUR ER AND THE NUMBER VISITS YOU PROVIDE. IF APPLICABLE, INCLUDE A SENTENCE HIGHLIGHTING YOUR CRITICAL ROLE IN THE LOCAL EMERGENCY RESPONSE SYSTEM. YOU MAY WISH TO INCLUDE ANY OTHER INFORMATION THAT ILLUSTRATES YOUR VALUE TO THE COMMUNITY IN THIS PARAGRAPH.]

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,
For Barnes-Jewish Hospital

Cecil E. Terry
Manager of Billing & Reimbursement Compliance
BJC HealthCare

Submitter : Mr. Joel Wernick
Organization : Phoebe Putney Memorial Hospital
Category : Health Care Professional or Association

Date: 06/22/2007

Issue Areas/Comments

Background

Background
See Attachment

GENERAL

GENERAL
See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule
See Attachment

CMS-2279-P-144-Attach-1.PDF

**PHOEBE PUTNEY
MEMORIAL HOSPITAL**

June 22, 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:

We are writing on behalf of Phoebe Putney Memorial Hospital and the Southwest Georgia Family Medicine Residency 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 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. 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. At Phoebe Putney Memorial Hospital, GME payments decreased by \$131,590 from 2005 to 2006. 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 Southwest Georgia Family Medicine Residency was funded by the Georgia Legislature in 1993 to alleviate the critical need for primary care physicians in rural Southwest Georgia. This Residency currently has 15 residents in training, accepting five new residents per year. The program has consistently placed more than 60 percent of graduates into practices in rural communities in Southwest Georgia. Currently, this region continues to face a growing need for primary care physicians in underserved areas. The Residency, which currently has a Sports Medicine Fellowship, plans to develop fellowships in geriatrics and emergency medicine to address the aging population and the specific growth in utilization of emergency services where residents have limited access to care (Phoebe currently has more than 55,000 EC visits annually). 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 especially here in our own state.

417 Third Avenue / P.O. Box 1828 / Albany, Georgia 31702-1828 / 229-312-1000 / www.phoebeputney.com

The nation's only winner of three prestigious VHA Awards
VHA Leadership Award for Clinical Effectiveness - 1997
VHA Leadership Award for Improving Community Health - 1999
VHA Leadership Award for Improving Supply Chain Management - 2001



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.

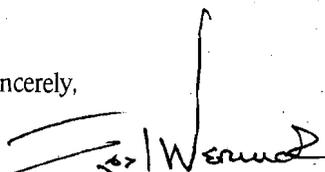
Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, 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.

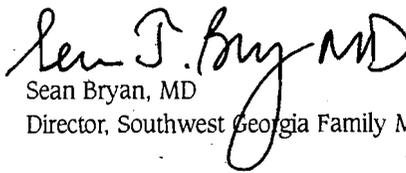
As a community hospital, Phoebe Putney Memorial Hospital fills a unique role as a teaching hospital in a rural region. Phoebe is the first off-site clinical campus for the Medical College of Georgia and as such gives future doctors a perspective on community hospitals in the practice of medicine. Phoebe is also one of six state-designated perinatal centers. More than 68 percent of births at Phoebe are Medicaid, and the hospital operates a 28-bed NICU. Special services include a maternal fetal medicine specialist who cares for mothers and babies in the region, many of whom are Medicaid recipients without access to prenatal care. Phoebe also is the regional referral center for cancer and cardiac services and treats more than 1500 new cancer cases annually.

The counties in Phoebe's service area are among the state's poorest, where residents have low access and many barriers to care. In Southwest Georgia 38 percent of residents receive Medicaid, compared to the state average of 25 percent. The unreimbursed Medicaid costs in 2006 were \$17.9 million, \$800,000 over 2005 unreimbursed costs. Phoebe provides more than \$23 million in indigent care annually, and more than \$87 million in total indigent, charity and community benefits. To meet the high levels of need in rural areas, Phoebe provides primary care in rural communities through hospital-owned clinics and at a critical access hospital in Sylvester, as well as through a management contract with a second critical access hospital in Cuthbert. Programs and partnerships outside the hospital walls also extend care to where residents live. They include women and men's health fairs that give many uninsured residents needed access to screenings and 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.

Sincerely,


Joel Wernick
President/CEO


Sean Bryan, MD
Director, Southwest Georgia Family Medicine Residency

Submitter : Leann Chilton
Organization : BJC Healthcare
Category : Health Care Professional or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-145-Attach-1.PDF

#145

STEVEN H. LIPSTEIN
President and Chief Executive Officer



June 22, 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:

As the president and chief executive officer of BJC HealthCare in St. Louis, Missouri, I write to respectfully request that the Centers for Medicare & Medicaid Services (CMS) 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). If this rule is finalized, the ability of academic hospitals to continue to fulfill their very important mission of training the next generation of physicians while providing patient care will be severely compromised.

The rule is characterized by CMS as a "clarification," however the proposed rule represents a significant reversal of long-standing Medicaid policy. For a number of years, the majority of state Medicaid programs have financially supported the higher costs of teaching hospitals. And, these state payments have been approved and matched by CMS and the Health Care Financing Administration (predecessor to CMS). A study by the Association of American Medical Colleges (AAMC), in 2005, found that 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. These payments are critically important to teaching hospitals being able to fulfill their missions.

BJC HealthCare is a 13-member, not-for-profit hospital organization with hospitals located in urban, suburban and rural Missouri and southern Illinois. We are submitting this letter to CMS because BJC includes a 1,100-bed adult teaching hospital, Barnes-Jewish Hospital, and a 235-bed children's teaching hospital, St. Louis Children's Hospital, that are affiliated with the Washington University School of Medicine. Both of our teaching hospitals are located in the City of St. Louis.

Barnes-Jewish Hospital and St. Louis Children's Hospital receive more than 133,000 emergency room visits a year and accept approximately 10,000 transfers from other hospitals. These hospitals are committed to providing quality care to all patients while providing outstanding clinical education for future physicians. The FFP for Medicaid GME payments helps to ensure that Barnes-Jewish Hospital and St. Louis Children's Hospital are able to fulfill that unique dual mission.

There are 1,060 residents, interns and fellows in training at BJC's two teaching hospitals and they are critical to the physician pipeline, not only for our hospitals, but for hospitals across the country. At a time when we are at the beginning of a nationwide physician shortage, it is important that we do all we can to increase the number of physician training opportunities. Annually, more than 450 interns, residents and fellows complete their training at Barnes-Jewish Hospital and St. Louis Children's Hospital. These physicians receive some of the most advanced training available in the nation in specialties including neonatology, transplant, emergency medicine and obstetrics and gynecology. Retention of the FFP is vital to ensuring our ability to continue training physicians needed in our community and throughout our country.

Continuing to provide funding for the mission of teaching hospitals is important to patient care at all hospitals. At Barnes-Jewish Hospital, St. Louis Children's Hospital and other teaching hospitals across the country there is important clinical research being done that helps to advance the future of medicine. Additionally, these hospitals provide highly specialized tertiary patient care including burn care, trauma and cardiac care, and transplant services that are sometimes not available at community hospitals and thus are a critical part of the region's referral network. Recognized for offering the most advanced, state-of-the-art services and equipment, teaching hospitals are called upon to care for the sickest patients. And, increasingly, teaching hospitals are looked to as front-line responders and are expected to be prepared in the event of a biological, chemical or nuclear attack. In St. Louis, Barnes-Jewish and St. Louis Children's Hospitals play pivotal leadership roles in disaster preparedness for the entire metropolitan area.

I urge you to consider the negative impact of the proposed rule on America's teaching hospitals directly and the impact on the entire hospital provider network in general. The proposed rule will have far reaching consequences and I respectfully ask that it be rescinded by CMS.

Sincerely,



Steven H. Lipstein
President & Chief Executive Officer

Submitter : Mr. Edward Goodman
Organization : VHA Inc.
Category : Health Care Provider/Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-146-Attach-1.DOC



June 22, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Attn: CMS-2279-P
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Attention: **CMS-2279-P**

Dear Administrator Norwalk:

On behalf of VHA Inc. ("VHA"), I 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.

VHA is a national alliance of leading not-for-profit health care organizations that work together to improve the health of the communities they serve. VHA delivers industry leading supply chain management services and enables regional and national member networks to improve clinical and operational performance and to drive sustainable results. Based in Irving, Texas, VHA has 18 local offices serving more than 2,400 health care organizations across the United States.

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

Leslie V. Norwalk, Esq.

June 22, 2007

CMS-2279-P

Page 2

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.**

In closing, on behalf of VHA and its members, I would like to thank CMS for providing us this opportunity to comment on the proposed rule.

Respectfully submitted,



Edward N. Goodman
Vice President, Public Policy

Submitter : Ms. Christine Neuhoff

Date: 06/22/2007

Organization : Shands HealthCare

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-147-Attach-1.DOC

Shands HealthCare

Legal Services

720 SW 2nd Avenue, Suite 360A Gainesville, FL 32601
352.733.0030 352.733.0052 fax

June 22, 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 Graduate Medical Education

Dear Administrator Norwalk:

I am writing on behalf of Shands HealthCare 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 Shands HealthCare system includes two of Florida's six statutorily defined teaching hospitals, a children's hospital, two specialty hospitals (psychiatric care and comprehensive rehabilitation), and four community hospitals. Shands' hospitals in Gainesville (Shands at the University of Florida) and Jacksonville (Shands Jacksonville) provide the primary sites for the University of Florida's clinical training programs. Finalizing this rule would erode the financial condition of teaching hospitals such as Shands at the University of Florida and Shands Jacksonville, and jeopardize their abilities to continue to fulfill their important teaching, research, education, and patient care missions.

Although characterized by CMS as a "clarification," the proposed rule actually 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. Florida is among the majority of states that support GME through their Medicaid programs. Indeed, Medicare and Medicaid are the only sources of GME funding in this state. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

In Florida, Medicaid pays hospital-specific per diem rates based on audited cost reports, which include the costs associated with GME. GME has been a recognized and reimbursed cost for over twenty years. Florida Medicaid has also included GME as part of the Upper Payment Limit (UPL), Low-Income Pool (under Florida's recently approved 1115 waiver), and Disproportionate Share Hospital (DSH) programs even though there is no statutory requirement that the state support graduate medical education through Medicaid payments. The State has funded GME programs in this way since 1992 when allocations were made to teaching hospitals through the DSH program. These programs, approved by the Florida legislature and the federal government, have allowed for appropriations of greater than \$285 million since inception to support the missions of teaching hospitals in the State. These programs are critical to Shands HealthCare, which houses and pays the expenses of 55 accredited graduate medical education programs training 550 residents and fellows in Gainesville, Florida, and 22 accredited graduate medical education programs training 300 residents and fellows in Jacksonville, Florida. Teaching hospitals such as Shands at the University of Florida and Shands Jacksonville 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 team of health care professionals, medical residents provide essential 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 federal Balanced Budget Act of 1997 made significant reductions in the funding for GME provided through the Medicare program. Because Medicare funding is a major source of support for most GME programs, the capacity and number of GME programs has remained essentially stagnant since 1998. Studies have shown that the location of a physician's residency program is a determinant factor in his or her ultimate practice location. Given Florida's booming population growth of more than twice the national average since 2000, the lack of growth in GME programs over that time period, and the aging of Florida's physician workforce, Florida stands on the brink of a catastrophic physician shortage. Indeed one-fourth of Florida's licensed physicians are over the age of 65, and half are over the age of 50. Only 10% of Florida's working physicians are under the age of 35. 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 is provided by these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. Shands at the University of Florida and Shands Jacksonville together with our community hospitals are key components of Florida's health care "safety-net," providing high-quality care for people who have little or no medical coverage. Indeed, Shands spends approximately \$150 million annually to provide charity and uncompensated care for Florida's needy

residents. Shands cares for nearly one out of every two of the Medicaid-eligible and uninsured patients in north Florida, assuming responsibility for more needy patients than any other health system in our area. Our ability to continue to assume this role is threatened by the impending physician shortages and the resulting deterioration of our ability to meet the demands of our population.

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.

Annually, Shands has more than 211,000 emergency room visits, 84,000 inpatient admissions, and more than 900,000 outpatient hospital visits. The Shands HealthCare system is the only not-for-profit system in the Southeast that operates two Level I Trauma Centers. In addition to specialized trauma care, Shands operates a specialty burn care unit, representing a critical element for our national public health emergency preparedness. Only 125 such units exist nationally. Shands also offers comprehensive pediatric care, including pediatric open heart and cardiac catheterization, pediatric intensive care, as well as Level II and III neonatal intensive care units. Other specialty services provided at Shands' facilities include psychiatric care, comprehensive rehabilitation, and transplant services for adult and pediatric patients in several disciplines including heart, lung, liver, kidney, pancreas and bone marrow. If this proposed rule becomes final as drafted, the resulting loss of funds for the Shands system would jeopardize our ability to provide these crucial services to the people of our state as well as our ability to fund residency programs in these areas.

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,

/s/

Christine L.S. Neuhoff*
Associate General Counsel

cc: Timothy Goldfarb, Chief Executive Officer, Shands HealthCare
Paul Rosenberg, Senior Vice President & General Counsel, Shands HealthCare

* Authorized House Counsel under Florida Bar Rule 17, not admitted in Florida. Member of the State Bar of California

Submitter : Mr. Gregg Redfield
Organization : Minnesota Hospital Association
Category : Health Plan or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-148-Attach-1.PDF



Minnesota Hospital Association

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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 the Minnesota Hospital Association's (MHA) 131 member hospitals and health care organizations, 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. We acknowledge the proposed rule is subject to a year-long moratorium secured by P.L. 110-28.

While MHA believes that the moratorium should preclude CMS from soliciting comments, we also recommend that the agency withdraw this proposed rule. However, CMS has chosen to continue collecting comments, noting that it cannot finalize any of the proposed changes until May 2008. Because CMS has not withdrawn the rule, MHA is submitting these comments with strong opposition to the policy changes proposed in this rule.

The proposed rule substantially departs from long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs. Although CMS claims this rule clarifies existing GME policy, it completely reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The agency's recent decision will result in a cut of nearly \$2 billion in federal funds out of the program. **If these cuts to state Medicaid programs are finalized, many safety-net hospitals will face financial jeopardy, ultimately harming some of our most vulnerable citizens, who are covered by the Medicaid program and served by these hospitals.**

Leslie Norwalk, Esq.
June 22, 2007
Page 2 of 4

The agency's belated conclusion that FFP is unavailable for hospitals' GME costs is primarily based on the fact that GME is not specifically listed as a service in the Medicaid statute. In addition, CMS maintains that GME cannot be considered part of "hospital services" because it is not included in the rates paid to hospitals for services under the Medicare inpatient prospective payment system (PPS). The agency's analysis is flawed on both counts.

Agency Rationale

Medical Assistance:

CMS in the preamble to the proposed rule states:

"The care and services that may (or in some cases, must) be included within the scope of medical assistance under a Medicaid state plan are generally set forth in section 1905(a).... Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance.... we do not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately. GME is not a health service that is included in the authorized coverage package...."

The Medicaid statute, in Section 1905(a), defines the term "medical assistance" and lists the types of populations and services for which Medicaid will pay all or part of the costs. CMS' implementing regulations at 42 C.F.R. Part 440 expand upon this list of services. If CMS rigorously applies its rationale for not recognizing GME costs to other costs defined in Part 440, but not listed in Section 1905(a), some very significant costs would now be defined as "illegal" for purposes of FFP. For example, durable medical equipment (DME), such as walkers, wheelchairs, or hospital beds, is not listed in Section 1905(a). Nevertheless, DME is appropriately considered medical assistance eligible for FFP under the regulations (42 C.F.R. 440.70(a)(3)). Similarly, transportation or other travel expenses, including meal and lodging costs en route to and from medical care and expenses for an attendant to accompany a Medicaid beneficiary to ensure that he or she is able to receive medical examinations and treatment, are not included in Section 1905(a). Nevertheless, they also are appropriately included as medical assistance eligible for FFP in CMS' regulations (42 C.F.R. 440.170(a)).

The statutory basis that allows things like transportation expenses to be eligible for FFP is unclear. Perhaps these expenses are included under Section 1905(a)(28) or another provision of the Medicaid statute such as Section 1902(a)(4). If this is the case, then GME should be eligible for FFP by falling within a provision such as the "catch-all" Section 1905(a)(28). The fact that FFP is available for these expenses, even though they are not referenced in the Medicaid statute, contradicts CMS' position that FFP is unavailable for GME because it is not listed in the statute. It seems that CMS has singled out GME because it is a convenient budget-saving strategy.

Covered Hospital Services:

Even if CMS were correct in reasoning that FFP should be available only for the items and services listed in the Medicaid statute, FFP would still be available for GME because it is part of inpatient and outpatient hospital services.

In the proposed rule, CMS notes that the Medicaid statute permits states flexibility to develop their own methods and standards for determining payment requirements for covered hospital services within reasonable estimates of what Medicare would have paid for the services. Since Medicare pays for GME as a hospital service, state Medicaid payments for inpatient and outpatient hospital services that include GME costs are eligible for FFP.

CMS is inaccurate in stating that 42 C.F.R. 412.2(2)(e) excludes GME from the inpatient PPS payment rate. In fact, GME is not on the list of "excluded costs;" rather, it is found in C.F.R. 412.2(f) on the list of "additional payments to hospitals" along with other patient care-related costs such as outlier cases, capital and indirect medical education costs. Hospitals receive an additional Medicare payment for GME precisely because it is a patient-related cost. The fact that the GME payment is separate from the PPS payment is irrelevant to whether GME is a reimbursable hospital cost under Medicare. For example, capital costs are paid outside the inpatient operating PPS, yet no one would argue that they are not reimbursable by Medicare as a hospital cost.

Similarly, Medicare GME payments compensate teaching hospitals for the direct costs of their educational activities by measuring the number of medical residents trained. These medical residents, who work within a supervised patient care team of health care professionals, provide needed care to Medicare and Medicaid patients as part of their training programs. Research looking at interns' and residents' in-hospital time confirms this. In one study, residents, on average, spent 57% of their time on clinical or service-oriented activities (Magnusson A.R., *et al.*: "Resident Educational Time Study: A Tale of Three Specialties." *Academic Emergency Medicine*, July 1998; 5(7): pp 718-725). In another study, house staff (interns and residence) spent a majority of their time engaged in direct patient care activities – 81% of the interns' workdays, and 64.5% of the residents' workdays (Guarisco S., *et al.*: "Time Analysis of a General Medicine Service: Results from a Random Work Sampling Study." *Journal of General Internal Medicine*, May 1994; 9(5): pp 272-277).

Reversal of Long-Standing Policy

The proposed rule acknowledges that CMS must first approve hospital payment methodologies as a condition of receiving federal funds (FR Vol. 72, No. 99 p 28932). It also acknowledges a 2005 study commissioned by the Association of American Medical Colleges, which reported that 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. CMS' approval of the state plan amendments providing for GME constitutes an official interpretation that these plan amendments met governing statutory and regulatory requirements. Thus, the agency's proposed rule attempts to sweep aside its prior actions and interpretations.

Leslie Norwalk, Esq.
June 22, 2007
Page 4 of 4

CMS' public acknowledgement and approval of GME payments do not rest with state plan amendment review, but also extend to its own rulemaking for Medicaid managed care plans. In August 2001, CMS issued a Medicaid managed care proposed rule that declared a state Medicaid program could not make payments directly to a provider for services available by an approved managed care entity (FR vol. 66, No. 161 pp 43628, 43666). When the final rule was published in June 2002, the agency explained that, in response to public comment, it had "...modified that section to permit such payments to the extent the capitation rate has been adjusted to reflect the GME payment made directly to the hospital" (FR Vol. 67, No. 115 pp 41004, 41005, 41103). In fact, current rules (42 C.F.R. 438.60) specifically acknowledge that GME payments can be made directly to the provider as long as the GME payment amount is carved out of the managed care capitation payment.

There is no doubt that CMS' reversal of long-standing policy acknowledging GME as an allowable cost is based on flawed reasoning. **By failing to justify termination of the federal funds supporting Medicaid GME programs, CMS should permanently withdraw this proposed rule.** The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs, which, through their teaching function, provide care to some of our most vulnerable populations.

Sincerely,



Gregg Redfield, CMA
Vice President, Finance
Minnesota Hospital Association

Submitter : Ms. Kim Roberts

Date: 06/22/2007

Organization : Santa Clara Valley Health & Hospital System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-149-Attach-1.PDF

Dedicated to the Health
of the Whole Community



Kim Roberts
Chief Executive Officer
645 South Bascom Avenue, Suite 2221
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June 22, 2007

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

RE: CMS-2279--P

Dear Administrator Norwalk:

On behalf of Santa Clara Valley Medical Center, I am urging the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule which would 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 a significant portion of patients at Santa Clara Valley Medical Center (VMC). 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. It is estimated that this harmful rule would cost VMC in excess of \$5 million a year which would have a detrimental impact on our hospitals' ability to provide access to quality medical care for our Medicaid patients.

Over the past 40 years, 7,712 physicians have trained at VMC. Currently, 1 in 4 physicians practicing in Santa Clara County did part of their training at VMC. Thus, VMC plays a vital role in training our community's medical providers and should be supported in continuing to do so. Instead, the proposed rule would reverse the long-standing Medicaid policy to pay for the costs of direct patient services.

Interns and residents at Santa Clara Valley Medical Center assume a necessary role in the provision of direct patient services. Utilization of residents and interns reinforces the workforce that is needed to render quality and cost-effective direct health care services to VMC's patients. If Medicaid declines to pay the costs of GME, safety net hospitals like

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

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

California's public teaching hospitals perform nearly half of all Medi-Cal discharges in the state and approximately half of all hospital care to the uninsured. As such, the proposed GME funding cut could also affect other services offered to Medicaid and other vulnerable patients by reducing teaching hospitals' total financial resources. At VMC, 38% of our patient population is covered by Medicaid and 30% are unsponsored patients.

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 Santa Clara Valley Medical Center 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. **I therefore urge CMS to rescind the proposed rule.**

Sincerely,



Kim Roberts

Santa Clara Valley Health and Hospital System - Chief Executive Officer

c: Melissa Stafford Jones
President, CAPH

Submitter : Mr. Gregg Redfield
Organization : Minnesota Hospital Association
Category : Health Plan or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-150-Attach-1.PDF



Minnesota Hospital Association

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June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
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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**

Déar Ms. Norwalk:

On behalf of the Minnesota Hospital Association's (MHA) 131 member hospitals and health care organizations, 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. We acknowledge the proposed rule is subject to a year-long moratorium secured by P.L. 110-28.

While MHA believes that the moratorium should preclude CMS from soliciting comments, we also recommend that the agency withdraw this proposed rule. However, CMS has chosen to continue collecting comments, noting that it cannot finalize any of the proposed changes until May 2008. Because CMS has not withdrawn the rule, MHA is submitting these comments with strong opposition to the policy changes proposed in this rule.

The proposed rule substantially departs from long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs. Although CMS claims this rule clarifies existing GME policy, it completely reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The agency's recent decision will result in a cut of nearly \$2 billion in federal funds out of the program. **If these cuts to state Medicaid programs are finalized, many safety-net hospitals will face financial jeopardy, ultimately harming some of our most vulnerable citizens, who are covered by the Medicaid program and served by these hospitals.**

Leslie Norwalk, Esq.
June 22, 2007
Page 2 of 4

The agency's belated conclusion that FFP is unavailable for hospitals' GME costs is primarily based on the fact that GME is not specifically listed as a service in the Medicaid statute. In addition, CMS maintains that GME cannot be considered part of "hospital services" because it is not included in the rates paid to hospitals for services under the Medicare inpatient prospective payment system (PPS). The agency's analysis is flawed on both counts.

Agency Rationale

Medical Assistance:

CMS in the preamble to the proposed rule states:

"The care and services that may (or in some cases, must) be included within the scope of medical assistance under a Medicaid state plan are generally set forth in section 1905(a)... Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance.... we do not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately. GME is not a health service that is included in the authorized coverage package...."

The Medicaid statute, in Section 1905(a), defines the term "medical assistance" and lists the types of populations and services for which Medicaid will pay all or part of the costs. CMS' implementing regulations at 42 C.F.R. Part 440 expand upon this list of services. If CMS rigorously applies its rationale for not recognizing GME costs to other costs defined in Part 440, but not listed in Section 1905(a), some very significant costs would now be defined as "illegal" for purposes of FFP. For example, durable medical equipment (DME), such as walkers, wheelchairs, or hospital beds, is not listed in Section 1905(a). Nevertheless, DME is appropriately considered medical assistance eligible for FFP under the regulations (42 C.F.R. 440.70(a)(3)). Similarly, transportation or other travel expenses, including meal and lodging costs en route to and from medical care and expenses for an attendant to accompany a Medicaid beneficiary to ensure that he or she is able to receive medical examinations and treatment, are not included in Section 1905(a). Nevertheless, they also are appropriately included as medical assistance eligible for FFP in CMS' regulations (42 C.F.R. 440.170(a)).

The statutory basis that allows things like transportation expenses to be eligible for FFP is unclear. Perhaps these expenses are included under Section 1905(a)(28) or another provision of the Medicaid statute such as Section 1902(a)(4). If this is the case, then GME should be eligible for FFP by falling within a provision such as the "catch-all" Section 1905(a)(28). The fact that FFP is available for these expenses, even though they are not referenced in the Medicaid statute, contradicts CMS' position that FFP is unavailable for GME because it is not listed in the statute. It seems that CMS has singled out GME because it is a convenient budget-saving strategy.

Leslie Norwalk, Esq.
June 22, 2007
Page 3 of 4

Covered Hospital Services:

Even if CMS were correct in reasoning that FFP should be available only for the items and services listed in the Medicaid statute, FFP would still be available for GME because it is part of inpatient and outpatient hospital services.

In the proposed rule, CMS notes that the Medicaid statute permits states flexibility to develop their own methods and standards for determining payment requirements for covered hospital services within reasonable estimates of what Medicare would have paid for the services. Since Medicare pays for GME as a hospital service, state Medicaid payments for inpatient and outpatient hospital services that include GME costs are eligible for FFP.

CMS is inaccurate in stating that 42 C.F.R. 412.2(2)(e) excludes GME from the inpatient PPS payment rate. In fact, GME is not on the list of "excluded costs;" rather, it is found in C.F.R. 412.2(f) on the list of "additional payments to hospitals" along with other patient care-related costs such as outlier cases, capital and indirect medical education costs. Hospitals receive an additional Medicare payment for GME precisely because it is a patient-related cost. The fact that the GME payment is separate from the PPS payment is irrelevant to whether GME is a reimbursable hospital cost under Medicare. For example, capital costs are paid outside the inpatient operating PPS, yet no one would argue that they are not reimbursable by Medicare as a hospital cost.

Similarly, Medicare GME payments compensate teaching hospitals for the direct costs of their educational activities by measuring the number of medical residents trained. These medical residents, who work within a supervised patient care team of health care professionals, provide needed care to Medicare and Medicaid patients as part of their training programs. Research looking at interns' and residents' in-hospital time confirms this. In one study, residents, on average, spent 57% of their time on clinical or service-oriented activities (Magnusson A.R., *et al.*: "Resident Educational Time Study: A Tale of Three Specialties." *Academic Emergency Medicine*, July 1998; 5(7): pp 718-725). In another study, house staff (interns and residence) spent a majority of their time engaged in direct patient care activities – 81% of the interns' workdays, and 64.5% of the residents' workdays (Guarisco S., *et al.*: "Time Analysis of a General Medicine Service: Results from a Random Work Sampling Study." *Journal of General Internal Medicine*, May 1994; 9(5): pp 272-277).

Reversal of Long-Standing Policy

The proposed rule acknowledges that CMS must first approve hospital payment methodologies as a condition of receiving federal funds (FR Vol. 72, No. 99 p 28932). It also acknowledges a 2005 study commissioned by the Association of American Medical Colleges, which reported that 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. CMS' approval of the state plan amendments providing for GME constitutes an official interpretation that these plan amendments met governing statutory and regulatory requirements. Thus, the agency's proposed rule attempts to sweep aside its prior actions and interpretations.

Leslie Norwalk, Esq.
June 22, 2007
Page 4 of 4

CMS' public acknowledgement and approval of GME payments do not rest with state plan amendment review, but also extend to its own rulemaking for Medicaid managed care plans. In August 2001, CMS issued a Medicaid managed care proposed rule that declared a state Medicaid program could not make payments directly to a provider for services available by an approved managed care entity (FR vol. 66, No. 161 pp 43628, 43666). When the final rule was published in June 2002, the agency explained that, in response to public comment, it had "...modified that section to permit such payments to the extent the capitation rate has been adjusted to reflect the GME payment made directly to the hospital" (FR Vol. 67, No. 115 pp 41004, 41005, 41103). In fact, current rules (42 C.F.R. 438.60) specifically acknowledge that GME payments can be made directly to the provider as long as the GME payment amount is carved out of the managed care capitation payment.

There is no doubt that CMS' reversal of long-standing policy acknowledging GME as an allowable cost is based on flawed reasoning. **By failing to justify termination of the federal funds supporting Medicaid GME programs, CMS should permanently withdraw this proposed rule.** The Medicaid program has a responsibility to pay for its share of the costs associated with GME programs, which, through their teaching function, provide care to some of our most vulnerable populations.

Sincerely,



Gregg Redfield, CMA
Vice President, Finance
Minnesota Hospital Association

Submitter :

Date: 06/22/2007

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-151-Attach-1.PDF

UC Surgeons

University of Cincinnati Surgeons, Inc.

Amit D. Tevar, M.D.

Assistant Professor of Surgery
Director of Pancreas Transplant Program

College of Medicine

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Division of Transplantation

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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.

A member of

UC Physicians
Healing • Teaching • Leading

Clinical practice group of the
University of Cincinnati College of Medicine

151

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,



Amit D. Tevar, M.D.
Assistant Professor of Surgery
Director of Pancreas Transplant Program

Submitter : Mr. John Taylor
Organization : University Hospitals Health System
Category : Other Health Care Professional

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attached Comment Letter

CMS-2279-P-152-Attach-1.RTF

<http://www.cms.hhs.gov/eRulemaking>)

June 21, 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

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

Dear Ms. Norwalk:

As Director of Reimbursement for the University Hospitals Health System in Cleveland, Ohio, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) May 23, 2007 proposed rule. University Hospitals Health System owns 3 teaching hospitals, University Hospitals Case Medical Center, Rainbow Babies and Children's Hospital, and University Hospitals Richmond Medical Center, plus our residency programs are affiliated with 8 other hospitals in the Greater Cleveland area.

As a system, we are urging the May 23, 2007 proposed rule be rescinded. We disagree with the Centers for Medicare & Medicaid Services (CMS) proposal to seek elimination of federal financial participation matching funds associated with Medicaid graduate medical education (GME) payments. As it is written, finalizing this rule would erode the financial condition of our teaching hospitals and jeopardize our ability to continue to fulfill important teaching, patient care and other missions.

Although characterized by CMS as a "clarification," this proposed rule represents a major reversal of long-standing Medicaid policy. Ohio and 46 other states have supported the higher costs of teaching hospitals through their respective state Medicaid programs. CMS and its predecessor, HCFA, have continually approved these Medicaid programs and have matched these payments. Teaching hospitals rely on these and other Medicaid payments to support their critical functions as safety net hospitals for those patients least able to afford healthcare coverage.

The majority of Medicaid patients, especially the children and adults living in our inner city area, depend upon our teaching hospitals for their health care. University Hospitals Case Medical Center has a utilization of over 20% Medicaid, while Rainbow Babies and Children's Hospital has utilization of over 50% Medicaid.

Medicaid GME payments help our teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians needed in our community and throughout the nation. Our medical residents provide needed care to Medicaid and other patients as part of their training programs. Eliminating the federal

financial participation for Ohio's Medicaid payments for GME could cripple graduate medical education programs at a time when more physicians are needed nationally. There are rural areas within our region that are still experiencing physician shortages and the need for training the future physicians to fulfill those needs continues to grow.

Our system trains in excess of 700 residents annually in both adult and pediatric specialties. As proposed, this draconian Medicaid GME cut would eliminate approximately \$12 million in annual funding which equates to 200 residents – nearly thirty percent (30%) of our trainees. This cut will also affect preventative clinic services offered to Medicaid and other patients since the residents gain valuable experience with clinical rotations. A reduction in available residents would mean a reduction in available clinics.

As part of our education and research missions, our teaching hospitals care for some of our regions sickest patients. Our teaching hospitals provide an environment of clinical research and highly specialized patient care in areas such as cancer, cardiac care, and transplant services. We are also designated as one of the front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Given our important roles within Cleveland and the growing burden we face with the increasing Medicaid and uninsured populations, it is important that state Medicaid programs receive federal matching assistance for GME. **We again urge the rescission of the proposed rule.**

We appreciate the opportunity to comment on the proposed regulation changes.

Sincerely,

John E. Taylor
Director of Reimbursement
University Hospitals Health System
11100 Euclid Avenue
Mailstop LND 5022
Cleveland, OH 44106-5022

Submitter : Mr. Chris Traylor

Date: 06/22/2007

Organization : State of Texas

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-153-Attach-1.PDF



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

June 22, 2007

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

Dear Sir or Madam:

I am writing to offer comments on the proposed rule to clarify the costs and payments associated with the Graduate Medical Education (GME) program in regards to the Medicaid program as published in the Federal Register on May 23, 2007.

Texas teaching hospitals, which operate approved medical residency training programs, not only train physicians, they also provide care for the uninsured, conduct medical research, and educate medical students, nurses, and other healthcare professionals. Teaching hospitals treat patients with complex conditions and provide intensive and technologically sophisticated patient care. Due to these factors, teaching hospitals incur higher expenses than hospitals without teaching programs. While Texas has not made GME payments since state fiscal year 2005, Texas Medicaid has utilized GME payments in past years to recognize the higher costs incurred by these teaching hospitals.

If Texas were to make GME payments this year, the Texas Medicaid GME program could support 60 teaching hospitals with over 5,500 medical resident training slots. With expenditures of \$40 million in general revenue, payments would be made directly to teaching facilities for the costs of program administrative staff, allocated facility overhead costs, and salaries and fringe benefits for residents and teaching physicians.

The elimination of GME from FFP as proposed in this rule would significantly impact the State since teaching hospitals would have to bear higher costs while continuing to provide much needed services.

While we object to the proposed rule since it decreases the payment flexibility intended by Congress, we do support the exclusion of indirect medical education payments from the rule. Making the distinction recognizes the actual increased costs teaching hospitals incur while

Centers for Medicare & Medicaid Services

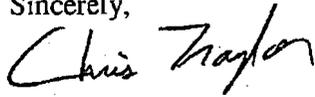
June 22, 2007

Page 2

fulfilling their mission to serve Medicaid patients. It is an important distinction that must be maintained.

If you need more information or have any questions about this letter, please contact Emily Zalkovsky, Policy Analyst in the Medicaid and CHIP Division, at (512) 491-1482 or by e-mail at emily.zalkovsky@hhsc.state.tx.us.

Sincerely,

A handwritten signature in cursive script that reads "Chris Traylor".

Chris Traylor
State Medicaid Director

Submitter : Mr. James T. Kirkpatrick
Organization : Massachusetts Hospital Association
Category : Health Care Professional or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

MS-2279-P-154-Attach-1.DOC

#154



MASSACHUSETTS HOSPITAL ASSOCIATION

June 21, 2007

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

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

Dear Ms. Norwalk:

On behalf of our member hospitals, health systems and the low-income Medicaid patients they serve, the Massachusetts Hospital Association (MHA) appreciates the opportunity to comment on the proposed rule regarding federal Medicaid reimbursement for graduate medical education (GME) costs. As you know, the proposed rule is subject to a yearlong moratorium but MHA wishes to submit these comments so that the federal government is aware of our serious objections to such policy. We urge you not to pursue this change in the future.

The proposed rule substantially departs from long-standing Medicaid policy of supporting GME costs which many states including Massachusetts have viewed as appropriate and decided to reimburse. This policy reverses over 40 years of federal support and recognition of GME as a covered medical assistance cost. The agency's recent decision will result in a cut of approximately \$40 million for Massachusetts hospitals annually.

A cut of this magnitude will undoubtedly put added financial pressure on an already fragile health care system in this state. As you know, the Commonwealth of Massachusetts is attempting a ground-breaking initiative to cover our state's uninsured, many of them who are low-income residents who cannot afford insurance. The financial impact on hospitals is quite uncertain at this time given the funding shifts from uncompensated care to new health insurance coverage. Hospitals and other health providers will need to be financial viable in order to meet the medical needs of all patients and will require the continued support of all payers including the federal government if Health Care Reform is to be a success.

We would also note that as part of Health Care Reform effort, state government acknowledged that Massachusetts acute hospitals have been historically underpaid and so it took steps to correct for this inadequacy. Any reduction in funding from the federal government in this area, which will most likely be "matched" by the state, will prevent this state from realizing one the critical components of our Health Care Reform initiative.

We understand that CMS considered this policy change because it noted that GME costs are not named in the Medicaid statute. In our opinion, this rationale seems flawed since many services are not precisely named in the statute but are nevertheless paid. The fact of the matter is that these are costs borne by many hospitals in the provision of care to Medicaid patients.

CMS recognizes these costs in the Medicare program where it pays an additional payment to qualifying hospitals. The Medicaid statute allows states 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. In Massachusetts, our state makes a payment for GME costs incurred in the inpatient setting. This practice should be viewed as appropriate given our state recognizes the need to support these hospitals services, has the discretion to determine provider specific payments, and is following similar payment practices of the Medicare program.

MHA cannot understand why CMS has at this time decided to reverse the long-stand policy and support of medical education in the Medicaid program. We cannot find any reasonable rationale behind the intent behind this change besides the withdrawal of financial support for hospitals that provide care to this low-income population. We urge you to reconsider this view and not propose this change in the future.

Sincerely,

A handwritten signature in cursive script, appearing to read "James T. Kirkpatrick".

James T. Kirkpatrick
Vice-President, Health Care Finance and Managed Care

Submitter :

Date: 06/22/2007

Organization : Children's National Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-155-Attach-1.PDF



June 22, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS 2279-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

ATTN: CMS-2279-P
Medicaid Program; Graduate Medical Education

Dear Sir/Madam:

On behalf of Children's National Medical Center (Children's) in Washington, D.C., we are submitting comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid proposed rule on Graduate Medical Education (GME) published in the May 23 *Federal Register*. Without federal Medicaid funding dedicated to GME, the ability of teaching hospitals, including Children's, to train the future providers would be seriously threatened. Therefore, we believe CMS should rescind the proposed rule.

We submit these comments on the proposed rule even though we believe the moratorium included in the FY 2007 Iraq War Supplemental Appropriation Bill precludes CMS from "taking any action (through promulgation of rule, issuance of regulatory guidance or other administrative action)," including closing or enforcing the comment period. Further, we believe that CMS does not have the authority to review or in any way act on any comments provided until the moratorium ends. However, because CMS intends to implement the comment period and a change in current practice would negatively impact our institution, we submit the following comments to ensure they are considered when the moratorium ends.

Comments on Proposed Medicaid GME Rule

The proposed rule would disproportionately affect children's hospitals. Because of our critical role in both delivering health care to children and training the future pediatric workforce, the proposed rule would negatively affect health care for *all* children.

Training and educating the next generation of pediatric health care providers is central to Children's C.A.R.E. mission - Care, Advocacy, Research and Education on behalf of all children. Our hospital and children's hospitals across the country play a key role in training the nation's pediatricians, pediatric specialists and pediatric researchers. In fact, children's

hospitals, both freestanding and those that operate within a larger medical center, devote, on average, more than 50 percent of our patient care to children assisted by Medicaid, and most provide graduate medical education training. Together, these children's hospitals represent less than five percent of all hospitals in the country but train most of the nation's pediatric workforce, provide hospital care for more than 40 percent of all hospitalized children and deliver virtually all of the subspecialty hospital care for children with serious illnesses such as cancer or heart conditions.

On average, Children's annually receives \$5 million in Medicaid GME support from our three primary service areas: the District of Columbia, Maryland and Virginia. Without this funding, maintaining and strengthening each of our 16 ACGME accredited pediatric training programs would be nearly impossible. The physicians trained at our institution go on to practice in our community and communities throughout the country in specialties such as cardiology, neonatology, child and adolescent psychiatry, neurodevelopmental disabilities and surgery to name just a few.

We recommend rescission of the proposed rule for several reasons:

- **CMS plans to end Medicaid GME funding without adequate justification, despite permitting the practice for decades.** For decades, states, with the approval of CMS or its predecessor the Health Care Financing Administration, have used Medicaid dollars to support graduate medical education. Despite this long history, the proposed regulation asserts that Medicaid does not have the authority to provide funding for graduate medical education. The regulation does not adequately explain this abrupt change in longstanding policy that provides critical support for teaching hospitals.
- **The loss of Medicaid GME funding would threaten our hospital's ability to train the next generation of pediatric providers.** Children's National Medical Center annually receives approximately \$5 million in Medicaid GME funding. It provides critical support to our training program. Without this dedicated funding, the costs of our training program would not be fully covered. If federal Medicaid GME funding ends, we would have to make serious decisions about the sustainability of our training program.

Our hospital is very dependent on Medicaid funding. Children covered by Medicaid account for nearly 50 percent of all inpatient days. Any decrease in Medicaid reimbursement, including the loss of Medicaid GME dollars, would have a profound impact not only on our training program but also on our services overall.

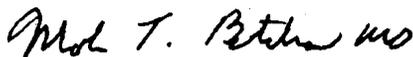
- **Ending Medicaid GME funding could exacerbate existing shortages of pediatric subspecialists.** Children's National Medical Center trains pediatricians and subspecialists who care for all children. Thanks to federal and state GME support, we have developed a branch of our pediatric residency program for pediatricians interested in community and public health. Given the significant health disparities that exist in our community, training doctors in this field will directly benefit children and families throughout the District of Columbia. These physicians receive additional training in health care policy, global health and the

role of the physician in society. Without GME support, we would not be able to maintain this critical program.

- A recent survey of acute care and specialty children's hospitals conducted by the National Association of Children's Hospitals and Related Institutions found critical shortages of pediatric providers, particularly pediatric subspecialists, throughout the country. Children's graduated approximately 30 general pediatricians and 40 pediatric subspecialty physicians this year from ACGME accredited programs. In hospital FY 2007, Children's is providing GME training for 158 pediatric residents and fellows. Because of GME funding, we have slowly but surely managed to increase the number of trainees 22 percent since FY 2000, from 122 to the current 158 FTEs. Any cut in GME funding provided through Medicaid could exacerbate existing shortages. These shortages affect all children, not just children insured by Medicaid.
- **The proposed rule would shift costs to the states and providers.** Under the proposed rule, the state Medicaid programs in our primary services area – the District of Columbia, Maryland and Virginia - could continue to pay for GME with state-only funds. This means that the state could shoulder all of the cost, reduce funding or end GME funding completely. Any reduction in GME funding by these jurisdictions would shift costs of training to Children's. Children's hospitals are critical trainers of pediatric providers and any attempts to cut back or end support for GME programs could have dire effects on the country's pediatric health care workforce. It is not fair for the federal government to simply shift the financial responsibility for GME to states and health care providers.
- **The proposed rule contradicts the significant flexibility states are currently allowed under the Medicaid program.** Since the repeal of the Boren Amendment in 1997, the federal government has given states significant flexibility to set provider reimbursement rates. This proposed regulation contradicts earlier policies allowing substantial flexibility in Medicaid payment to providers by prohibiting states from supporting graduate medical education through their Medicaid programs.

Due to the concerns expressed above, we believe CMS should rescind the proposed rule. We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Clare Kelly, Director of Government & External Affairs, at 202.884.2340 or clkelly@cnmc.org. Thank you for your consideration.

Sincerely,



Mark L. Batshaw, M.D.
Chief Academic Officer
Children's National Medical Center



Peter R. Holbrook, M.D.
Chief Medical Officer
Children's National Medical Center

Submitter : Dr. Jerry Wolinsky

Date: 06/22/2007

Organization : The University of Texas Medical School at Houston

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-156-Attach-1.PDF



THE UNIVERSITY of TEXAS
MEDICAL SCHOOL AT HOUSTON

MEDICAL SCHOOL

Jerry S. Wolinsky, MD
Interim Dean
Bartels Family Professor in Neurology
Opal C. Rankin Professor in Neurology

6431 Fannin, MSB G.150 713 500 5010
Houston, Texas 77030 713 500 0602 fax
Jerry.S.Wolinsky@uth.tmc.edu

June 22, 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 Texas Medical School at Houston 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

Dr. Jerry S. Wolinsky
June 22, 2006
Page Two

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,

A handwritten signature in black ink, appearing to read "J. Wolinsky", written in a cursive style.

Jerry S. Wolinsky, M.D.
Interim Dean

Submitter : Maureen McNally

Date: 06/22/2007

Organization : Froedtert Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-157-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
Submitted electronically at <http://www.cms.hhs.gov/eRulemaking>

Attention: CMS-2279--P

Dear Administrator Norwalk:

I am writing on behalf of Froedtert 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.

Although characterized by CMS as a "clarification," the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy. States like Wisconsin have a long-standing history of Medicaid program policies that acknowledge and support 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. At Froedtert, 241 residents and fellows receive graduate medical education opportunities each year. Froedtert contributes more than \$32 million each year to fund education and research activities, over and above the funding received through Medicare and Medicaid. The physicians trained go on to provide healthcare for patients in our community and state as well as across the nation. Froedtert is the only site in Wisconsin with an emergency medicine residency. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs around the country at a time when more physicians are needed.

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. Froedtert Hospital provided more than \$29 million in uncompensated care in 2006. Additionally, the cost of caring for patients in government programs, including Medicaid, exceeded reimbursements by more than \$50 million.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as trauma and cardiac care and transplant services take place. In keeping with our education and research missions, teaching hospitals offer the life-saving services and equipment. With residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest and most seriously injured patients. Teaching hospitals are also looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

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

Sincerely,

Maureen McNally
Director, Government Relations
Froedtert & Community Health
mmcnally@fmlh.edu

Submitter :

Date: 06/22/2007

Organization : The University of Texas System

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment.

#158

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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. Maxine Kessler
Organization : Boston Medical Center
Category : Hospital

Date: 06/22/2007

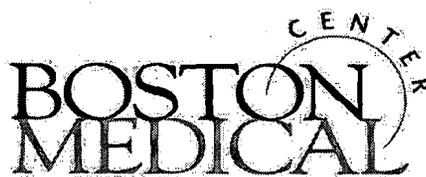
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-159-Attach-1.DOC



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

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 Boston 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 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,

Maxine Kessler
Designated Institutional Official
Director of Graduate Medical Education

Submitter : Dr. Jeffrey Gold
Organization : The University of Toledo
Category : Academic

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-160-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

Dear Administrator Norwalk:

I am writing on behalf of **The University of Toledo College of Medicine and the UT 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. 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 University of Toledo Medical Center received \$2,440,934 for Medicaid GME in 2006. 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 University of Toledo College of Medicine supports 19 graduate medical education programs, with 243 residents in training. In northwest Ohio the shortage of primary care physicians, to include family medicine, general internal medicine, Ob-gyn, and pediatrics is acute and on-going. In several sub-specialties, in particular those supporting pediatrics shortages are critical. Further, in the smaller and rural communities of northwest Ohio recruitment of general

surgeons is extremely difficult. 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, 13 % of our hospital care is provided to Medicaid patients. The charity care for F 007 is approaching \$14,000,000.

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.

At The University of Toledo Medical Center we provide not only health care for the Toledo area, but also serve as a tertiary referral center for hospitals in the surrounding region. We have a level 1 Trauma Center and provide helicopter transport for critically ill and trauma patients in the surrounding communities. We are the only hospital in the region with a kidney transplant program including a living donor program. We also provide geriatric psychiatric inpatient and outpatient care and pediatric psychiatric inpatient and outpatient care. Primary and preventive care is provided in our Internal Medicine, Pediatric OB/GYN and Family Medicine Clinics. Dental care for pediatric and adult patients is provided in the dental clinic. Multiple medical and surgical specialty clinics, as well serve the uninsured while serving as a teaching site for medical students, interns and residents.

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,



Jeffrey P. Gold, MD
Provost and Executive Vice President for Health Affairs
Dean of the College of Medicine