

Submitter :

Date: 06/22/2007

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2279-P-181-Attach-1.DOC

University Hospital

Health Alliance™

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 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.

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

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

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

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

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

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

Sincerely,

Susan Greenwood-Clark
Director, Medical Education
University Hospital, Inc.

Submitter : Mr. Gregg Knaupe
Organization : Texas Hospital Association
Category : Health Care Provider/Association

Date: 06/22/2007

Issue Areas/Comments

Background

Background

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

Comments by Texas Hospital Association

GENERAL

GENERAL

Sec Attachment

CMS-2279-P-182-Attach-1.WPD



TEXAS HOSPITAL ASSOCIATION

June 22, 2007

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

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

Dear Ms. Norwalk:

On behalf of its 500+ member hospitals and health systems, the Texas Hospital Association offers comment on the Centers for Medicare & Medicaid Services' proposed changes to Medicaid policy regarding federal reimbursement for graduate medical education. The proposed rule is subject to a year-long moratorium secured by P.L. 110-28, and the moratorium should preclude CMS from soliciting comments. THA recommends that CMS withdraw this proposed rule.

Since CMS has chosen to continue the rulemaking process, THA wishes to express its endorsement of a compelling comment letter already submitted to you by the American Hospital Association (AHA).

AHA argues that the proposed rule departs from long-standing Medicaid policy by no longer permitting matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs. The proposal reverses 40 years of agency policy recognizing GME as a covered medical assistance cost.

The agency's recent conclusion that FFP is unavailable to offset hospitals' GME costs is based primarily on the fact that (1) GME is not listed as a service in the Medicaid statute. CMS maintains that GME cannot be considered part of "hospital services" because (2) it is not included in the rates paid to hospitals for services under the Medicare inpatient prospective payment system. The agency's analysis is flawed on both counts

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.

The fact that FFP is available for other expenses not referenced in the Medicaid statute contradicts CMS’ position that FFP is unavailable for GME because it is not listed in the statute. CMS has singled out GME because it is a convenient budget-saving strategy.

Even if CMS were correct in reasoning that FFP should be available only for the items and services listed in the Medicaid statute, FFP still would be available for GME because it is part of inpatient and outpatient hospital services. CMS acknowledges that the Medicaid statute permits states flexibility to develop methods and standards for determining payment requirements for covered hospital services within reasonable estimates of what Medicare would pay for the services. Medicare pays for GME as a hospital service. CMS’ contention that 42 C.F.R. 412.2(2)(e) excludes GME from the inpatient PPS payment is inaccurate. GME is not on the list of “excluded costs.” GME is found in C.F.R.412.2(f) on the list of “additional payments to hospitals” along with other patient care-related costs. Hospitals receive Medicare payment for GME because it is a patient-related cost. As AHA argues, the fact that the GME payment is independent from the PPS payment is irrelevant to whether GME is reimbursable under Medicare. For example, capital costs are paid outside the inpatient operating PPS, and no one would argue that they are not reimbursable by Medicare.

CMS approves hospital payment methodologies as a condition of receiving federal funds. At least 47 states and the District of Columbia provide direct GME and/or indirect medical education payments under **approved** Medicaid programs. CMS’ past approval of state plan amendments providing for GME calls into question the current CMS proposal.

THA respectfully encourages CMS to withdraw the proposal. Texas is a growing state. Public policy should encourage, not punish, hospitals for supporting medical education programs that help train the medical leaders of tomorrow.

Sincerely,



Gregg Knaupe, J.D.
Vice President, Public Affairs

Copy: Dan Stultz, M.D., FACP, FACHE, President/CEO Texas Hospital Association

Submitter : Mrs. Martha Marsh
Organization : Stanford Hospital & Clinics
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-2279-P-183-Attach-1.PDF



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 Stanford Hospital and Clinics and the Stanford School of Medicine to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the May 23, 2007 proposed rule that seeks to eliminate Federal Financial Participation (FFP) matching funds associated with Medicaid Graduate Medical Education (GME) payments (See 72 Fed. Reg. 28930). Making this rule permanent would harm the financial condition of teaching hospitals and negatively impact their efforts to fulfill important teaching, patient care and other missions.

The proposed rule represents a major reversal of long-standing Medicaid policy. For decades, most state Medicaid programs have provided support to teaching hospitals who have taken on the responsibility to train future generations of physicians. 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. Stanford Hospital and Clinics, for instance, has received \$4.5 million dollars in payments in each of the last three years. We rely on these and other Medicaid payments to support the critical services we provide to our communities.

One of these critical services is to provide for the clinical education of future physicians. Our medical residents provide needed care to Medicaid and other patients as part of their training programs. We currently operate 75 accredited programs with an enrollment of 853 residents and interns. In FY 2006 alone we had more than 42,000 outpatient Medi-Cal (Medicaid) and Managed Care Medi-Cal visits. Medi-Cal patient days for that same period totaled 13,099.

Cal visits. Medi-Cal patient days for that same period totaled 13,099. Eliminating FFP for state Medicaid agency payments for GME could seriously weaken our graduate medical education program at a time of increasing need.

Stanford Hospital and Clinics and the Stanford School of Medicine maintain a strong commitment to public service and the communities we serve. We take seriously our role to support teaching, research and public service programs that benefit those communities. Given this important role 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,



Philip A. Pizzo, MD
Dean
Stanford University School of Medicine



Martha Marsh
President/CEO
Stanford Hospital and Clinics

Submitter : Mr. Roy Jeffus
Organization : Arkansas DHHS Division of Medical Services
Category : State Government

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-184-Attach-1.DOC

#184



Arkansas Department of Health and Human Services



Division of Medical Services

P.O. Box 1437, Slot S-401
Little Rock, AR 72203-1437

Fax: 501-682-1197 TDD: 501-682-6789

Internet Website: www.medicaid.state.ar.us

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 Arkansas Department of Human Services, Division of Medical Services (Arkansas Medicaid), 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,

Leslie Norwalk, Esq.

Page 2

June 22, 2007

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,

Roy Jeffus
Director

cc: Member of Congress/Delegation
John Selig, Director, Arkansas Department of Human Services
I. Dodd Wilson, Chancellor, University of Arkansas for Medical Sciences

Submitter : Ms. Cheryl H. Cohen

Date: 06/22/2007

Organization : Healthcare Financial Management Assoc - NJ Chapter

Category : Health Plan or Association

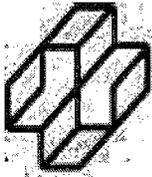
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-185-Attach-1.PDF



hfma new jersey chapter
healthcare financial management association

June 22, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-2279-P

Dear Ms. Norwalk:

The New Jersey Chapter of the Healthcare Financial Management Association (NJHFMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicaid Program; Graduate Medical Education*, Federal Register Vol. 72, No.99, 28930 (May 23, 2007). NJHFMA understands that CMS has chosen to continue to collect comments on this proposed rule in light of the fact that the proposal is subject to a one year moratorium, secured by P.L. 110-28, and this prohibits CMS from finalizing any of the proposed changes until May 2008.

NJHFMA strongly opposes CMS' proposed changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs. The proposed rule completely reverses over 40 years of agency policy recognizing GME as a covered medical assistance cost. The proposed rule which CMS claims is a clarification of existing GME policy will not permit matching federal dollars, otherwise known as federal financial participation (FFP), for hospitals' GME costs.

The basis for CMS' conclusion that FFP is unavailable for hospitals' GME costs is the fact that GME is not specifically listed as a service in the Medicaid statute. Also CMS claims 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 system. NJHFMA believes that CMS' analysis is flawed on both counts.

If these proposed changes are finalized, the cuts to the New Jersey Medicaid program will expand the financial difficulties already faced by the hospitals that serve the patients who are covered by the Medicaid program. And ultimately it is this already vulnerable population that

Ms. Leslie V. Norwalk, Esq.

June 22, 2007

Page 2 of 2

will be harmed by the proposed elimination of the federal funds supporting Medicaid GME programs.

Thank you for this opportunity to comment.

Respectfully submitted,

Cheryl H. Cohen

Cheryl H. Cohen, MBA, FHFMA
President, New Jersey Chapter of the
Healthcare Financial Management Association

Submitter : Dr. Joseph M. Molina
Organization : Molina Healthcare, Inc.
Category : Health Plan or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-186-Attach-1.PDF



MOLINA HEALTHCARE, INC.
One Golden Shore, Long Beach, CA 90802
Phone: 562•435•3666

June 22, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington DC 20201

Attention: CMS-2279-P

Dear Ms. Norwalk,

I write concerning the proposed rule [CMS-2279-P] in the Medicaid program that would no longer allow costs and payments associated with Graduate Medical Education to be federally reimbursable under the Medicaid program. Molina Healthcare, Inc. is concerned that this proposed rule could lead to an access problem for Medicaid beneficiaries that receive care in teaching hospitals. Furthermore, as we work to improve access to physicians and specialists in the Medicaid program, we are concerned that this proposed cut in funding that supports medical training could impede progress in this area.

As you know, teaching hospitals are an important part of the delivery system that serves Medicaid beneficiaries. Graduate Medical Education has been an approved cost component of Medicaid hospital services and is reimbursable under a state plan. Your proposed rule would no longer allow Medicaid to continue to support these important programs. We are concerned that this significant reduction in funding to teaching hospitals could adversely affect these institutions. Graduate Medical Education also facilitates medical training of physicians and physician specialists that care for beneficiaries. The proposed cut in funding could impact the workforce and make it even more difficult for beneficiaries to access care particularly in underserved areas. We urge you to reconsider your policy in the final rule. Instead, we request that CMS consider policies that would promote increased participation of teaching facilities and health professionals in the Medicaid program.

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of healthcare services to persons eligible to receive healthcare benefits through government sponsored programs, including Medicaid and the State Children's Health Insurance Program. The company currently operates health plans in seven states (California, Michigan, New Mexico, Ohio, Texas, Utah and Washington) providing services for over 1 million beneficiaries. Molina Healthcare also operates 19 company-owned primary care clinics in California.

Sincerely,

Joseph M. Molina, MD
President and CEO

Submitter : Ms. Lynn Waters
Organization : Greenville Hospital System
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-187-Attach-1.DOC



**GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER**

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 Ms. Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule CMS-2279-P, regarding graduate medical education (GME) payments in the Medicaid program, published May 3, 2007 in the *Federal Register*. I am the Director of Managed Care and Reimbursement for Greenville Hospital System (GHS) located in Greenville, South Carolina. Our main hospital, Greenville Memorial Hospital, is an 800 bed teaching facility which treats approximately 7,000 Medicaid and 1,500 charity-care inpatients per year.

We believe that this proposed regulation is one which should never have been written and request that CMS rescind the proposal. This rule proposes to bar federal financial participation (FFP) matching funds related to Medicaid GME payments. This proposal is a draconian measure that would significantly impair the ability of teaching hospitals to provide the highest quality of care and would especially adversely impact the care of the some of the most vulnerable in our population, Medicaid patients.

The Medicaid GME payments that our hospital receives are critical in helping us to provide the clinical setting for the training of about 140 physicians in areas such as

family medicine, surgery, pediatrics, internal medicine, orthopedics, and obstetrics and gynecology. These residents are instrumental in caring for all of our patient population, including Medicaid and uninsured patients.

Because states will not make the GME payments without receiving FFP, this represents a brutal cut in payments to the nation's teaching hospitals. Our hospital receives about \$3.3 million in Medicaid GME payments each year and these payments are essential in enabling us to provide the highest standard of care for our patients. If these payments are taken away, inevitably the persons affected most will be the most vulnerable part of our patient population.

As it frequently does, CMS has once again hidden behind the "clarification" explanation as a means to pretend that this is not a major change in policy. Medicaid agencies have been making GME payments for decades and have done so with the full blessing and FFP from CMS. Our hospital has received GME payments from Medicaid for many years and for all that time the Medicaid monies were matched with FFP. So it is disingenuous for CMS to characterize this as anything but a drastic reversal of policy.

We believe that this proposed rule is an irresponsible measure which will have the effect of diminishing the quality of care in our country for all patients. Teaching hospitals provide the clinical environment to train the nation's future physicians. The FFP on Medicaid GME payments is absolutely necessary in fulfilling that role. CMS should rescind this ill-conceived regulation.

Again, thank you for the opportunity to provide comments. If you have any questions, you may give me a call at 864-454-0829.

Sincerely,

Lynn J. Waters, CPA
Director of Managed Care and Reimbursement

Submitter : Dr. Carl Patow

Date: 06/22/2007

Organization : HealthPartners/Regions Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-188-Attach-1.DOC

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 Regions Hospital in St. Paul, Minnesota 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.

We believe 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. Teaching hospitals rely on these and other Medicaid payments to support our critical functions. Unlike medical services such as surgery and supplies, medical education is a cost of doing business at teaching hospitals that has been recognized in the Medicare cost report, which is also used by many states for the calculation of Medicaid medical services. One of these costs is GME.

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. 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 1,100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. Regions Hospital is a 427-bed Disproportionate Share Hospital (DSH) providing outstanding medical care, with special programs in heart, women's services, cancer, surgery, digestive care, seniors' services, behavioral health, burn, emergency and trauma. The health professionals at Regions Hospital are involved in teaching and research focused on improving health and medical care. As a safety net provider (we are a former county

hospital) and second highest provider of charity care in the state of Minnesota, stewardship and service are key components of our mission. In 2006, Regions provided more than \$41 million in uncompensated care to members of our community. In addition to the amount of charity care we provide, Regions' payer mix is heavily based on government programs. In 2006, government healthcare programs consisted of 55% of the hospital's reimbursement.

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. Last year, Regions had more than 500 physician resident rotate through our programs. 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 the proposed rule.**

Sincerely,

A handwritten signature in black ink, appearing to read 'Carl Patow', with a long horizontal flourish extending to the right.

Carl Patow, M.D., M.P.H.
Vice President, HealthPartners
Executive Director, HealthPartners Institute for Medical Education

Submitter : Dr. Warren Liang

Date: 06/22/2007

Organization : University Hospital, Inc./University of Cincinnati

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-189-Attach-1.PDF

#189



College of Medicine

Department of Psychiatry
University of Cincinnati Medical Center
PO Box 670559
Cincinnati OH 45267-0559
231 Albert B. Sabin Way

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

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

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

shortage. We already have noted shortages locally in specialties ranging from Cardiology to Dermatology to Orthopedic Surgery. Eliminating FFP for state Medicaid agency payments for GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

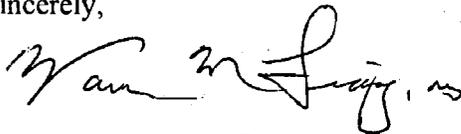
Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals'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

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Warren M. Liang, MD". The signature is fluid and cursive, with a prominent initial "W" and a long, sweeping underline.

Warren M. Liang, MD
Residency Training Director
Department of Psychiatry
University of Cincinnati College of Medicine

Submitter : Mr. Roy Jeffus
Organization : Arkansas DHHS Division of Medical Services
Category : State Government

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

#190

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

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

Submitter : Mr. James Taylor
Organization : University of Louisville Hospital
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

#191

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

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

Submitter : Dr. Bruce Vladeck
Organization : University of Medicine and Dentistry of New Jersey
Category : Academic

Date: 06/22/2007

Issue Areas/Comments

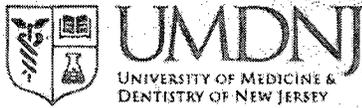
GENERAL

GENERAL

SEE ATTACHMENT

CMS-2279-P-192-Attach-1.PDF

CMS-2279-P-192-Attach-2.PDF



Graduate School of Biomedical Sciences
New Jersey Dental School
New Jersey Medical School
Robert Wood Johnson Medical School
School of Health Related Professions
School of Nursing
School of Osteopathic Medicine
School of Public Health

BRUCE C. VLADECK, PH.D.
Interim President

June 20, 2007

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

Attention: CMS-2279--P

Dear Administrator Norwalk:

I am writing on behalf of the University of Medicine and Dentistry of New Jersey (UMDNJ) 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 CMS has characterized the proposed rule as a "clarification," the reality is that it 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. Working in coordination with a network of affiliated hospitals, UMDNJ provides the educational and clinical resources for an extensive residency training system. These programs provide the clinical education of over 1,200 medical and dental students, as well as clinical research opportunities and comprehensive primary and specialty care experiences.

As part of a supervised patient care team of health care professionals, these residents also 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

Leslie Norwalk, Esq.

June 20, 2007

Page 2

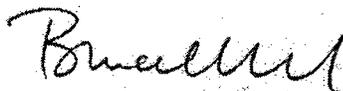
shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

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,



Bruce C. Vladeck, Ph.D.
Interim President

Submitter : Mr. Edward Burke

Organization : The University Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-193-Attach-1.PDF

Date: 06/22/2007



UNIVERSITY HOSPITAL

University of Medicine and Dentistry of New Jersey
www.TheUniversityHospital.com

Office of the Chief Financial Officer
Phone: (973) 972-3721
Fax: (973) 972-5993

150 Bergen Street, D-217
Newark, NJ 07103-2406

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-1279-P

Dear Administrator Norwalk:

I am writing on behalf of *The University 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.

University Hospital (UH) is a full-service acute care hospital, owned and operated by the University of Medicine and Dentistry of New Jersey (UMDNJ). As New Jersey's only state-owned acute care hospital, UH is the Safety Net Hospital and Family Physician for its local communities as well as for the region and state. It is the primary teaching hospital for the New Jersey Medical School (NJMS) and supports the largest medical and health sciences teaching program in the state. Given its dual role as the state's leading safety net hospital and training ground for future physicians, the proposed regulation would have a devastating impact on UH.

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. UH receives approximately \$7 M in Medicaid GME payments annually. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. As New Jersey's largest medical and health sciences teaching program, UH has residency programs in virtually every clinical specialty and provides exposure to high-risk patients. In addition to serving as the primary teaching hospital for NJMS, UH also serves as the locus for UMDNJ's New Jersey Dental School, School of Nursing and School of Health Related Professions and Allied Health. The elimination of Medicaid GME payments would affect University Hospital disproportionately compared to other NJ hospitals because of the size of its teaching program, resulting in a loss of \$34M over a five-year period. 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.

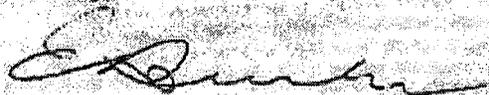
Because half of all Medicaid discharges are from the nation's nearly 1100 teaching hospitals and more than half of the nation's hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals' total financial resources. As New Jersey's leading safety net hospital, UH provides by far the largest level of charity care in the state, providing 70% (\$63M) more than the 2nd largest charity care hospital in the state. Medicaid and uninsured patients make up almost 60% of our payer mix. Many live in poverty in a city faced with high rates of substance abuse, HIV, TB, accidents and injuries, and infant mortality. The care is complex due to multiple medical comorbidities and complications. UH provides over 235,000 outpatient visits annually, including hard-to-access specialty care services. Our emergency department is the busiest in the state, approaching 100,000 visits annually, including psychiatric and pediatric emergency services.

Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care (e.g., burn care, trauma and cardiac care, and transplant services) takes 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.

UH is a regional referral center for highly specialized services, serving both the local and larger New Jersey community. UH thus provides the medically indigent population access to specialized care that would not otherwise be available to them. University Hospital is a State designated Level I Trauma Center for Northern New Jersey, a Regional Perinatal Center serving high risk women and newborns, and the state's only Medicare-certified Liver Transplant Center. UH operates highly specialized programs in neurology, neurosurgery, ophthalmology and orthopedics. UH has also played a major role in the development of New Jersey's emergency preparedness initiatives.

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,



Edward C. Burke,
Chief Financial Officer

Cc: Darlene L. Cox, MS, RN
President & CEO

Submitter : Mr. James Taylor
Organization : University of Louisville Hospital
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

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

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

Submitter : Mr. Roy Jeffus
Organization : Arkansas DHHS Division of Medical Services
Category : State Government

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2279-P-195-Attach-1.DOC



Arkansas Department of Health and Human Services



Division of Medical Services

P.O. Box 1437, Slot S-401
Little Rock, AR 72203-1437

Fax: 501-682-1197 TDD: 501-682-6789

Internet Website: www.medicaid.state.ar.us

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 Arkansas Department of Human Services, Division of Medical Services (Arkansas Medicaid), 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,

www.arkansas.gov/dhhs

Serving more than one million Arkansans each year

Leslie Norwalk, Esq.

Page 2

June 22, 2007

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,

Roy Jeffus
Director

cc: Member of Congress/Delegation
John Selig, Director, Arkansas Department of Human Services
I. Dodd Wilson, Chancellor, University of Arkansas for Medical Sciences

Submitter : Mr. Robert J. Del Tufo, Esq.
Organization : The University of Medicine & Dentistry of NJ
Category : Academic

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-196-Attach-1.PDF



Graduate School of Biomedical Sciences
New Jersey Dental School
New Jersey Medical School
Robert Wood Johnson Medical School
School of Health Related Professions
School of Nursing
School of Osteopathic Medicine
School of Public Health

Board of Trustees

June 19, 2007

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

Attention: CMS-2279--P

Dear Administrator Norwalk:

As Chairman of the Board of Trustees for the University of Medicine and Dentistry of New Jersey (UMDNJ), 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.

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.

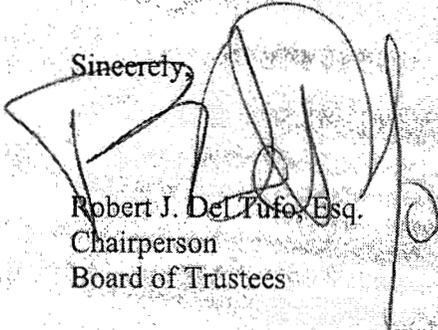
Medicaid GME payments help teaching hospitals sustain one of their core responsibilities: providing the clinical education of future physicians. Working in coordination with a network of affiliated hospitals, UMDNJ provides the educational and clinical resources for an extensive residency training system. These programs provide

the clinical education of over 1,200 medical and dental students, as well as clinical research opportunities and comprehensive primary and specialty care experiences.

Within a supervised patient care team of health care professionals, these residents also 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.

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 "Robert J. DeLufo". The signature is stylized and somewhat cursive, with a large initial "R" and "D".

Robert J. DeLufo, Esq.
Chairperson
Board of Trustees

Submitter : Mr. Donald Holt
Organization : Albert Einstein Medical Center
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

#197

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

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

Submitter : Mr. Bruce C. Vladeck, Ph.D.

Date: 06/22/2007

Organization : The University of Medicine & Dentistry of NJ

Category : State Government

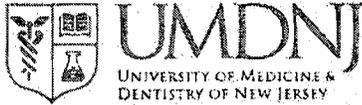
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2279-P-198-Attach-1.PDF



Graduate School of Biomedical Sciences
New Jersey Dental School
New Jersey Medical School
Robert Wood Johnson Medical School
School of Health Related Professions
School of Nursing
School of Osteopathic Medicine
School of Public Health

BRUCE C. VLADECK, PH.D.
Interim President

June 20, 2007

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

Attention: CMS-2279--P

Dear Administrator Norwalk:

I am writing on behalf of the University of Medicine and Dentistry of New Jersey (UMDNJ) 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 CMS has characterized the proposed rule as a "clarification," the reality is that it 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. Working in coordination with a network of affiliated hospitals, UMDNJ provides the educational and clinical resources for an extensive residency training system. These programs provide the clinical education of over 1,200 medical and dental students, as well as clinical research opportunities and comprehensive primary and specialty care experiences.

As part of a supervised patient care team of health care professionals, these residents also 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

Leslie Norwalk, Esq.

June 20, 2007

Page 2

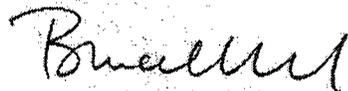
shortage in the near future. Eliminating FFP for state Medicaid agency payments for GME could cripple graduate medical education programs at a time when more physicians are needed throughout the country.

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,



Bruce C. Vladeck, Ph.D.
Interim President

Submitter : Mr. Mark Benton
Organization : N.C. Division of Medical Assistance
Category : State Government

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attached memo dated June 22, 2007 to Leslie Norwalk, Esq.

CMS-2279-P-199-Attach-1.PDF

#199



North Carolina Department of Health and Human Services
Division of Medical Assistance

2501 Mail Service Center • Raleigh, N. C. 27699-2501
Tel 919-855-4100 • Fax 919-733-6608

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Mark T. Benton, Director
William W. Lawrence, Jr., M.D., Senior Deputy Director

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 2279 - P
P.O. Box 8017
Baltimore, MD 21244-8017

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

Via: Electronic web submission

Dear Ms. Norwalk:

The North Carolina Division of Medical Assistance welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding changes to Medicaid policy as it relates to federal reimbursement for graduate medical education (GME) costs. North Carolina strongly opposes this CMS proposed rulemaking change to Medicaid policy. While P.L. 110-28 imposes a year-long moratorium on this rule change, we request that CMS withdraw this proposed rule.

North Carolina has fourteen non-state hospitals and two state institutions ranging in size from 101 to 475+ beds. During a calendar year these 16 teaching hospitals account of more than 41% of all Medicaid discharges in our state. The intent behind North Carolina's Medicaid Graduate Medical Education program is to defray partially the teaching costs associated with providing medical care to these Medicaid recipients.

CMS asserts that Medicare is authorized to reimburse the teaching hospital's GME cost associated with the care of Medicare's aged population. This reimbursement was authorized by congress with the intent of training new physicians in the art of medicine. North Carolina understands the need for this reimbursement program. However, Medicare only reimburses GME costs associated with geriatric medicine, and the vast majority of North Carolina's Medicaid recipients are not aged or disabled.



LETTER TO Norwalk, Esq., Leslie

June 22, 2007

Page 2 of 3

Of total discharges from North Carolina's teaching hospitals, 48.2% were related to obstetrical and newborn services. Pediatric recipients accounted for another 8.4% of services rendered at our teaching facilities. None of the GME costs associated with these services are covered by Medicare. However, these services are essential to North Carolina's Medicaid program, and the importance of training physicians in these medical services is equally as important as training in geriatric medicine.

While our teaching hospitals provided care to 41% of our Medicaid discharges, care for 58% of our Medicaid discharges was provided by North Carolina's non-teaching hospitals. This proposed reduction in funding also would have a negative impact on these non-teaching hospitals. Many of them participate with teaching facilities in programs where residents of the teaching facility receive part of their training at the community level. The proposed reduction in funding would reduce the number of residents in the community programs, affecting the quality and access to care for all Medicaid recipients in our state.

On page 12 of the propose rule, CMS asserts that state Medicaid programs are unable to track their GME payments. North Carolina does account for both direct and indirect medical payments. Based on our analysis, teaching hospitals annually would lose \$56 million in federal financial participation (FFP) if this proposed rule is implemented. Additionally, the FFP reduction in DSH payments to these hospitals would approximate \$28 million. As a result, the total annual reduction in payments to our teaching hospitals would be \$84 million. If these cuts in the North Carolina Medicaid program are made, many safety-net hospitals will face financial jeopardy, ultimately harming some our most vulnerable citizens, who are covered by the Medicaid program and served by these hospitals.

CMS claims this rule clarifies existing GME policy. But, it completely reverses more than 40 years of agency policy which recognizes GME as a covered medical assistance cost. CMS maintains that GME is not specifically listed as a service in the Medicaid statute, and that GME cannot be considered part of "hospital services" because it is not included in the rates paid to hospitals for service under the Medicare inpatient prospective payment system (PPS). North Carolina strongly disagrees with both assertions.

CMS cites section 1905(a) of the Social Security Act that "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...."

North Carolina disagrees. The statutory basis that allows services such as transportation to be eligible for FFP is unclear. Perhaps such services 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 "catch-all", Section 1905(a)(28). FFP is available for such services even though they are not referenced in the Medicaid statute. This contradicts CMS' position that FFP is unavailable for GME because it is not listed in the statute.

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.

LETTER TO Norwalk, Esq., Leslie

June 22, 2007

Page 3 of 3

Since Medicare pays for GME as a hospital service, state Medicaid payments for inpatient and outpatient services that include GME costs should remain eligible for FFP.

We feel that 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". 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.

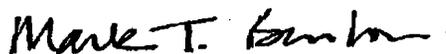
The proposed rule acknowledges that CMS must first approve hospital payment methodologies as a condition of receiving federal funds (FR Vol. 72, No 99 p 28932). CMS has approved North Carolina's state plan which provides for GME. This approval constitutes an official interpretation by CMS that our state plan meets governing statutory and regulatory requirements.

CMS' public acknowledgement and approval of GME payments does not rest with approval of the state plan. It also extends to its own rulemaking for Medicaid managed care plans. CMS' initial Medicaid managed care proposed rule (FR vol. 66, No. 161, pp 43628, 43666) declared that a state Medicaid program could not make payments directly to a provider for services available by an approved managed care entity. 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.

In North Carolina, the Graduate Medical Education FFP is pooled with state and county funds to help defray the teaching cost associated with treating its Medicaid recipients. Eliminating the FFP from this pool of funds would have limit funding for training new physicians and limit access of care to our Medicaid recipients.

The Division of Medical Assistance appreciates the opportunity to comment and express its concerns regarding the proposed rules. If CMS has any questions or needs clarification, DMA personnel will be pleased to respond.

Sincerely,



Mark T. Benton

Cc: Carmen Hooker Odom
L. Allen Dobson, Jr., MD
Dan Stewart
T. H. Galligan
Roger Barnes
North Carolina Hospital Association
National Association of State Medicaid Directors

Submitter : Mr. Donald Holt
Organization : Albert Einstein Medical Center
Category : Hospital

Date: 06/22/2007

Issue Areas/Comments

GENERAL

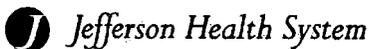
GENERAL

See Attachment.

CMS-2279-P-200-Attach-1.DOC

Albert Einstein Healthcare Network

Einstein



June 20, 2007

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

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

Dear Administrator Norwalk:

I am writing on behalf of Albert Einstein Medical Center (AEMC) 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. AEMC has received GME reimbursement for many years. The current fiscal year's GME reimbursement totals \$6,507,200. Teaching hospitals rely on this 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. AEMC operates 29 medical education programs encompassing over 325 full time equivalent physicians. Our facility is one of

the few remaining in the area that continues to train obstetric and gynecological physicians. In light of skyrocketing medical malpractice costs, 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, our hospital treated 6000 Medicaid cases and had pure charity care charges of \$57,369,000 in fiscal year 2006.

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,

Donald Holt,
Manager of Reimbursement

Submitter : Mr. Thomas Cockrell
Organization : South Carolina Hospital Association
Category : Health Care Provider/Association

Date: 06/22/2007

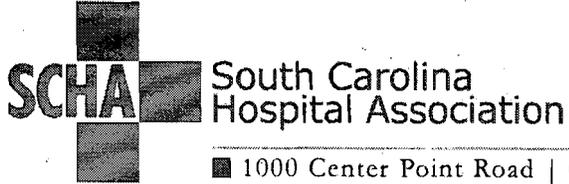
Issue Areas/Comments

GENERAL

GENERAL

(See Attachment)

CMS-2279-P-201-Attach-1.DOC



■ 1000 Center Point Road | Columbia, SC 29210-5802 | Ph. 803.796.3080 | www.scha.org

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
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 more than 60 acute-care hospitals and health systems in South Carolina, the South Carolina Hospital Association (SCHA) appreciates the opportunity to comment on the CMS proposed rulemaking changes to Medicaid policy regarding federal reimbursement of graduate medical education (GME) costs.

Foremost, SCHA believes the year-long moratorium on this proposed rule secured by P.L. 110-28 should preclude CMS from soliciting comments on it. Our association's primary recommendation is that this proposed rule be withdrawn, but since comments are continuing to be collected and the rule has not been withdrawn, SCHA is submitting the following comments in opposition of the policy changes in the proposed rule.

The proposed rule no longer permits federal financial participation (FFP) or federal matching dollars for hospitals' GME costs. This completely reverses a long-standing policy that recognizes GME as a covered medical assistance cost. As a result, \$2 billion federal dollars would be cut nationally and care and access for the vulnerable patients seeking care at our state's safety net hospitals could be placed in jeopardy.

SCHA agrees with the American Hospital Association that CMS's analysis for the proposed changes is flawed. FFP is available for a number of services that are not referenced in the Medicaid statute, like transportation and durable medical equipment expenses. So should GME remain reimbursable through FFP.

FFP should also be available for GME costs because GME is part of hospitals' inpatient and outpatient services. The proposed rule states that Medicaid statute permits states flexibility to develop their own methods and standards for determining payment requirements for covered hospital services with reasonable estimates of what Medicare would pay for the services. Medicare pays for GME as a hospital service and state Medicaid payments for hospital services that include GME costs should also be eligible for FFP.

CMS has failed to justify the termination of federal funds to support Medicaid GME programs, so this proposed rule should be permanently withdrawn. South Carolina's teaching hospitals provide care to our state's most vulnerable citizens. It seems that GME has been singled-out for budget-saving purposes convenient for CMS, but costly to those patients.

Again, thank you for the opportunity to comment and please feel free to contact me at 803-744-3510 or tcockrell@scha.org should you have questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "T. D. Cockrell".

Thomas D. Cockrell, FHFMA
Chief Operating Officer

Submitter : Mr. Kenneth E. Raske
Organization : Greater New York Hospital Association
Category : Health Care Professional or Association

Date: 06/22/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2279-P-202-Attach-1.PDF



Greater New York Hospital Association

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
 Kenneth E. Raske, President

June
 Twenty-two
 2007

VIA ELECTRONIC MAIL

Leslie V. Norwalk
 Acting Administrator
 Centers for Medicare & Medicaid Services
 P.O. Box 8011
 Baltimore, MD 21244-8011

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

Dear Administrator Norwalk:

Greater New York Hospital Association (GNYHA), which represents approximately 100 teaching hospitals in the metropolitan New York region, including hospitals in New York, New Jersey, Connecticut, and Rhode Island, is writing to provide comments on the proposed rule issued by the Centers for Medicare & Medicaid (CMS), *Medicaid Program; Graduate Medical Education*, which was published in the *Federal Register*, vol. 72, no. 99, on May 23, 2007.

First and foremost, I wish to underscore that GNYHA submits these comments despite our strong belief that the gathering of public comments by CMS (hereafter, also "the Agency") under the Administrative Procedures Act has been invalidated since the issuance of the proposed rule. In recognition of the Agency's unusual interpretation of the Medicaid statute and the consequences to Medicaid patients' access to quality health care should such interpretation be permitted to proceed, the Congress placed a one-year moratorium on the implementation of this proposed rule with a special provision included within the *U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007* that was signed into law on May 25, 2007. GNYHA believes that this moratorium invalidates the comment period and that the Agency should formally withdraw its proposed rule. GNYHA is commenting, however, so that we can be on the record with CMS and other interested parties as to why the issuance of this proposed rule is contrary to the interests of patients served by the Medicaid program and the future health care delivery system.

Our comment letter focuses on the GME and health care delivery policy issues associated with the issuance of the proposed rule. In support of these comments, GNYHA also asked the law

firm of Katten Muchin Rosenman LLP to address specific legal issues raised by the issuance of this proposed rule. A legal memorandum from Katten Muchin Rosenman LLP prepared for GNYHA accompanies this comment letter.

General Comments on the Proposed Rule

The Agency proposes "to clarify that CMS will not consider funding for GME as expenditures for a covered Medicaid service" (*FR*, vol. 72, no. 99, page 28933). Considering that CMS has approved state plans for decades with GME costs identified and reimbursed under the Medicaid program, this is bewildering to the teaching hospital community. The proposed rule does not make clear why CMS has decided after all these years that GME costs are not eligible for Federal financial participation (FFP) so we must assume that this is being proposed purely as a cost-saving measure. If so, GNYHA respectfully submits that in addition to the fact that we believe this to be impermissible as a matter of law, it is also a poor decision as a matter of public policy.

CMS estimates a savings from the proposed rule of just \$140 million in FFY 2008, growing to \$460 million in FFY 2012, but notes that it has no accurate way of identifying precisely how much states may be paying in Medicaid GME each year. The Agency should understand that this is a severe underestimate of the impact of its proposed rule. In New York alone, the value of hospital payments with a GME label is \$1.2 billion per year (gross), half of which would be placed at risk were the proposed rule to be adopted.

Distinguishing Among Hospital Costs

According to the proposed rule, the Federal Medicaid statute states that FFP is available to the states only for "a percentage of amounts expended ... for medical assistance under the state plan," and does not explicitly provide for the payment of GME. The preamble to the proposed rule states, "GME is not a health service that is included in the authorized coverage package," nor is GME recognized as "a component of the cost of Medicaid inpatient and outpatient hospital services" (*FR*, vol. 72, no. 99, page 28931). Therefore, according to the proposed rule, states may not receive FFP for these costs.

GNYHA rejects the black and white distinction CMS attempts to make between GME costs and patient care costs. Graduate medical education is distinguished by the fact that the dominant model for the "education" in GME is the delivery of patient care by physicians-in-training under the supervision of a fully-trained physician (this distinguishes GME from *undergraduate* medical education, among other activities). Reading the preamble that accompanied the proposed rule, it is clear that CMS has drawn a distinction that exists only in a semantic sense within the context of the actual activities under discussion. The fact is that GME is clinical education that is so intertwined with direct patient care responsibilities that the distinction the Agency attempts to draw is unrecognizable to the physicians at teaching hospitals engaged in the enterprise. As such, we encourage the Agency to not make an inappropriate distinction that would put the patients that are served by the affected hospitals at risk and compromise quality and access to Medicaid patients.

Background on New York Medicaid's Support for GME

As noted, as a matter of law, we believe that CMS is simply wrong that FFP should not be available for GME. In addition, because of the means by which New York's Medicaid program identifies these costs and incorporates them into its reimbursement methodology, it is clear that they are integrally related to patient care.

Broadly speaking, the New York State Medicaid program labels components of hospital inpatient costs as "GME" for the purpose of identifying comparable costs across hospitals in a peer group and enabling the development of group average case payment rates. The hospital inpatient costs from which GME is identified for these purposes are 1981 allowable costs trended forward for inflation and other adjustments. The definition of direct GME includes salaried physicians as well as interns and residents and their supervising physicians, underscoring its relationship to direct patient care activity. The definition of IME is loosely based upon Medicare formulas to determine what portion of approved hospital costs should be excluded from the calculation of group average rates as non-comparable costs, along with capital and other costs that could legitimately vary among similar hospitals. Thus, New York's Medicaid program has for decades recognized the critical role that interns, residents, and supervising physicians play in delivering hospital care to Medicaid patients and applies the GME label to such approved patient care costs in order to facilitate rate-setting. That is, payments with a GME label do not constitute some sort of separate payment stream to teaching hospitals but derive from actual, approved costs of caring for Medicaid patients.

The teaching hospital community in New York relies on this funding in order to deliver high quality services to the Medicaid population, with the added benefits associated with training the next generation of physicians for that same population.

The Interplay Between Training Physicians and Caring for the Underserved

Access to care for the underserved is one of the greatest challenges that hospitals face and a health care delivery issue that they take very seriously. There are numerous reports documenting the difficulties in recruiting physicians to care for uninsured patients and patients with Medicaid. There are myriad reasons for this difficulty and policymakers and the provider community continues to work on long-term strategies to address this access to care issue.

It is imperative that CMS recognize that Medicaid's support for GME is not an academic question. GME enables program beneficiaries to receive care from talented young physicians-in-training who are supervised by experienced and highly qualified attending physicians. Without it, Medicaid patients would suffer dangerously curtailed access to needed health care services. This is because teaching hospitals provide disproportionate amounts of care to communities with poor physician reimbursement options (i.e., fewer commercially insured or Medicare patients) -- the dearth of private practicing physicians in such communities is well known -- and the presence of GME programs fills this gap. Through GME, physicians-in-training are provided with important training opportunities and at the same time actually care for and meet the health care needs of the Medicaid population. This exposure is a "win-win" in that it addresses critical access issues in the short term while helping to increase the supply of fully-trained physicians in the long-term who are available to work in traditionally underserved areas with a large proportion of Medicaid consumers. Medicaid must continue to pay its share of GME costs if

it is to continue to meet its mandate to provide access to quality health care services for its beneficiaries.

The Costs Associated with Providing Care to the Indigent

To the extent that a motivation behind the proposed rule is to reduce program spending, GNYHA believes it is illustrative to consider the experience of New York teaching hospitals that have tried to maintain their service delivery missions while reducing GME costs. We mention this as an illustration that the GME costs that are at issue are not distinguished as nonpatient care costs that can be disallowed in the manner that CMS wishes to disallow them, and that it has been demonstrated repeatedly in the cases where teaching hospitals have reduced or attempted to reduce their number of physician residents that this strategy *does not* result in a decrease to the teaching hospital's overall costs.

In a widely reported and discussed demonstration project that was conducted among New York teaching hospitals by the Medicare program several years ago, 49 New York teaching hospitals attempted to reduce their number of physician residents, and the vast majority of the hospitals (86%) withdrew from the project because it was found to be impossible to reduce costs by decreasing the number of physician residents. The teaching hospitals withdrew from the demonstration project when they found that they had to incur such great additional costs to replace the service delivery component of the physician residents no longer in training. In other words, this strategy was not financially viable as a means to reduce costs and continue with their required service delivery missions. Additional costs associated with reducing residency training are generally incurred in hiring replacement staff such as full-time doctors, nurse practitioners, physician assistants, ancillary staff, and other clinical staff. Because these staff do not generally work as many hours as physician residents, the costs to the teaching hospital will often be greater than they would have been if the hospital had maintained the same number of residents.

The main finding of the demonstration project was that what GME is so related to patient care that the two can't be separated. The formal evaluation performed on the demonstration project for CMS found that the hospitals able to complete the demonstration project were those that experienced a significant decline in inpatient volume, and if inpatient volume did not decline, the hospitals were unable to deliver patient care services without residents.¹ In other words, if significant reduction in inpatient volume did not occur, there was no way for these teaching hospitals to provide the patient care service with fewer residents without adding great costs to the system. And that of course assumes that fully-trained physicians could be identified to care for the patients.

Accountability for New York Teaching Hospitals' Medicaid GME Payments

GNYHA notes that in the preamble to the proposed rule, CMS states that because of the fact that states generally "do not track these [GME] payments" (*FR*, vol. 72, no. 99, page 28932), there is little accountability for these expenditures. Within this same section, CMS states, "it is difficult to quantify Medicaid GME payments or monitor and measure the effect of Medicaid payments on GME programs."

¹ See *Evaluation of the New York State & 1997 Balanced Budget Act (BBA) Graduate Medical Education (GME) Demonstration and Payment Reforms: Final Report*, (August 2005), prepared by RTI International, page 75.

New York State representatives can address the issue of accountability for its Medicaid reimbursement system, but GNYHA does wish to weigh in on this issue on behalf of its teaching hospitals members. Data on Medicaid GME funding is collected and updated annually by the New York State Department of Health and includes the cost of direct GME in annual hospital cost reports; resident counts by hospital and specialty through an annual survey; and identification of annual Medicaid expenditures for GME. If CMS wishes to discuss a means of better accounting for legitimate hospital costs, GNYHA would be pleased to participate in that discussion. We do not believe, however, that wholesale elimination of FFP for GME costs should be the first step in addressing any concerns that the Agency might have.

The Impending Physician Shortage

Finally, we do wish to note that there is another critical health care policy issue associated with Medicaid GME funding that is glossed over within the preamble discussion. In the context of the preamble discussion of Medicare, the proposed rule references studies done in the 1980s that concluded that the nation had a surplus of physicians. For reasons unknown to us, the discussion ignores the numerous recent independent studies that have identified an impending shortage of physicians and called on all parties to ensure that medical education in all its forms is supported. Because it takes such a significant length of time to educate and train a physician to be able to act as an autonomous practitioner, it is critically important for all policymakers to ensure that no damaging policies are proposed if there is evidence that a physician shortage may be looming.

According to the U.S. Bureau of the Census, the elderly population in the U.S. is expected to *double* between 2000 and 2030. Because of this rise in the number of elderly, demand for physician visits is expected to increase by 53% between 2000 and 2020, according to an analysis performed by the Association of American Medical Colleges (AAMC), using data gathered from the National Ambulatory Medical Care Survey. These statistics bear out what independent researchers have been saying for some time: now is the time to start addressing the pending physician workforce shortage. Yet despite this growing evidence, the Agency seems unwilling to ensure that the situation does not get worse for the United States.

The Federal Council on Graduate Medical Education (COGME), an independent body charged with providing advice and recommendations to the U.S. Department of Health and Human Services and the Congress regarding the supply of physicians and financing policies to ensure an appropriate supply of physicians, issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, that recommended that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased. These recommendations were based on extensive research into physician supply trends, demand for services, and demographic trends. The COGME report's analysis indicated that while the supply of physicians is expected to increase over the next two decades, demand for services is likely to grow even more rapidly. According to the report, the three major factors driving the increase in demand will be the projected U.S. population growth of 18% between 2000 and 2020, the aging of the population as the number of Americans over 65 increases from 35 million in 2000 to 54 million in 2020, and the changing age-specific per capita physician utilization rates, with those under age 45 using fewer services and those over age 45 using more services. The

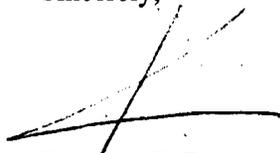
report notes that changing work patterns, such as decreases in working hours, could lead to greater shortfalls, while increases in productivity may moderate any shortfalls.

Recommendation

GNYHA strongly urges CMS to rescind this proposed rule so that the nation's teaching hospitals can continue to be supported to do the important mission that they do each and every day.

Should you wish to discuss these comments, please feel free to contact me at 212-246-7100.

Sincerely,

A handwritten signature in black ink, appearing to read "Kenneth E. Raske". The signature is written in a cursive style with a prominent horizontal stroke across the middle.

Kenneth E. Raske
President

Attachment

Katten

Katten Muchin Rosenman LLP

575 Madison Avenue
New York, NY 10022-2585
212.940.8800 tel
212.940.8776 fax

JOSEPH V. WILLEY
joseph.willey@kattenlaw.com
212.940.7087 direct
212.940.6738 fax

June 22, 2007

Mr. Kenneth E. Raske
President
Greater New York Hospital Association
555 West 57th Street
New York, NY 10019

**Re: CMS Proposed Rule [CMS-2279-P]
72 Fed. Reg. 28930 (May 23, 2007)**

Dear Mr. Raske:

You have asked us to review the above-referenced Centers for Medicare and Medicaid Services ("CMS") Proposed Rule, which would eliminate Federal Financial Participation ("FFP") for State Medicaid expenditures for Graduate Medical Education ("GME"), and to comment on CMS's legal authority to implement such proposal. As discussed below, there are very substantial bases for opposing the proposed elimination of FFP as inconsistent with and unauthorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. (the "Medicaid Act").

**The Proposed Rule Is a Reversal,
Not a "Clarification," of Prior CMS Policy**

CMS refers to the Proposed Rule as a "clarification" of its position that the Medicaid Act does not authorize FFP for GME expenditures (see 72 Fed. Reg. at 28933). In fact, CMS has completely reversed its prior longstanding position – that FFP is available for GME – without any change in the law authorizing the new position.

States historically have included GME as a component of payment for hospital services and have claimed and received FFP for such expenditures. Indeed, CMS acknowledges in the regulatory preamble that it "previously allowed States to include

Mr. Kenneth Raske

June 22, 2007

Page 2

hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services,” and cites a 2003 survey reporting that 47 States use Medicaid funds to make GME payments under the Medicaid State Plan. 72 Fed. Reg. at 28931-32.

Here in New York, the State Plan has long provided that hospital GME costs are included in the calculation of hospital rates. For example, State Plan Amendment (“SPA”) 81-36 (at Att. 4.19-A p. 47), approved by CMS effective January 1, 1982, provides that “The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided and such activities are directly related to patient care services.” SPA 96-06, approved March 1999, effective January 1, 1996, provides that “teaching hospitals shall receive direct reimbursement from the State for graduate medical education (GME) costs associated with inpatient services rendered to patients enrolled in Medicaid managed care plans.”

CMS’s new assertion that the Medicaid Act does not authorize FFP for GME is completely at odds with its prior approval of these and other State Plan Amendments. As CMS may lawfully provide FFP only for State expenditures authorized by the Medicaid Act (see 42 U.S.C. § 1396b(a)(1)), CMS’s approval of such Plan Amendments establishes that the agency has consistently interpreted the Act – until now – to authorize FFP for GME expenditures.

The Medicaid Act cannot reasonably be interpreted to have allowed FFP for GME expenditures for the last forty years, but not today. Such an abrupt reversal of position would undercut CMS’s plea for judicial deference to its new interpretation in the event of a challenge to the rule. See, e.g., *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (agency interpretations that conflict with earlier interpretations are entitled to “considerably less deference” than a consistently held view).

Mr. Kenneth Raske

June 22, 2007

Page 3

The Medicaid Act Authorizes FFP for GME

In the regulatory preamble, CMS distinguishes between the treatment of GME under the Medicare Act (which specifically mandates federal funding of GME), and the Medicaid Act (which does not). But it does not follow from the absence of a Medicaid Act mandate to fund GME that FFP is not available.

From the beginning of the Medicaid program in 1965 until 1981, the Medicaid Act provided, in § 1902(a)(13), that payment for inpatient hospital services be made on a reasonable cost basis – the same reimbursement methodology then applicable to such services under the original Medicare Act. Because the same cost reimbursement principles applied under both programs,¹ it is useful to briefly address how GME costs have been recognized under Medicare before turning to Medicaid.

(1) Medicare

Medicare initially made no distinction between direct medical education costs and other allowable costs of inpatient care.² In later years, when Congress mandated certain limits on routine hospital costs and established the inpatient prospective payment system

See, e.g., 34 Fed. Reg. 1244 (Jan. 25, 1969), adding a new Medicaid regulation at 45 C.F.R. § 250.30(b)(1), which provided: “For each hospital also participating in the [Medicare program], apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such hospital under title XVIII of the Act [Medicare].”

² See MedPAC’s August 1999 report, “Rethinking Medicare’s Payment Policies for [GME] and Teaching Hospitals” (the “MedPAC Report”), at p. 5: “Although they were accounted for separately, Medicare initially made no payment distinction between hospital costs that were directly attributed to operating approved training programs (residents’ stipends, compensation for teaching faculty and program administration staff, and allocated facility overhead) and other costs for patient care (those for nursing care or medical supplies, for example).”

Mr. Kenneth Raske

June 22, 2007

Page 4

("IPPS") in 1983, it singled out GME and certain other types of costs (e.g., capital, malpractice, etc.) for special accounting treatment,³ but Congress and CMS nevertheless continued to recognize an obligation to share in the costs of educational activities sponsored by participating providers that theretofore had been reimbursed on a reasonable cost basis. Indeed, in 1985, when Congress enacted a new prospective "base year per resident" methodology for reimbursing hospital direct medical education costs, the Medicare Act provision establishing the new methodology – § 1886(h)(1) – specified that it was an exception to the general requirement in § 1861(v) that hospitals be reimbursed for the "reasonable cost" of services. Section 1886(h)(1) provided:

"Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection." [Emphasis added.]

Thus, Congress clearly recognized that medical education costs are allowable costs of providing hospital services under Medicare.

Congress's separate treatment of GME (i.e., excluding medical education costs from the operating cost component of inpatient hospital rates and the establishment in 1985 of a separate reimbursement method for recognizing such costs) clearly was not intended, as CMS suggests (see 72 Fed. Reg. at 28932), to exclude GME from the definition of inpatient hospital services. Indeed, § 1861(b) of the Medicare Act expressly defines "inpatient hospital services" to include services provided by interns and residents-in-training under an approved teaching program. See 42 U.S.C. § 1395x(b)(6).⁴

³ For example, as CMS noted in the preamble, GME was not included in "operating costs" reimbursed under IPPS. 72 Fed. Reg. at 28932.

⁴ See also, e.g., Loyola Univ. of Chicago v. Bowen, 905 F.2d 1061, 1064 (7th Cir. 1990) (hospital was entitled to the reasonable costs of medical services provided to

Mr. Kenneth Raske

June 22, 2007

Page 5

(2) Medicaid

As noted, the Medicare reasonable cost payment methodology for inpatient hospital services also initially applied to Medicaid. As GME was considered an allowable cost under Medicare, and as Medicare cost principles applied to Medicaid, GME also was considered an allowable cost under Medicaid.

In 1981, Congress amended the Medicaid Act to remove the reasonable cost mandate and allow states greater flexibility in establishing Medicaid hospital rates,⁵ but in doing so it expressed a concern that the special costs of teaching hospitals be adequately recognized by states in setting such rates. A House Committee report accompanying the 1981 legislation states:

“The Committee intends States to recognize that facilities that provide teaching services or other specialized tertiary care services that may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by the States recognize the need to provide a full range of both primary care and tertiary care services to Medicaid beneficiaries and take into account the differences in operating costs of the various types of facilities needed to provide this broad scope of services Thus, while the Committee recognizes that in this time of economic constraint and reductions in Federal funds for Medicaid, States must be given the flexibility necessary to improve the Medicaid reimbursement mechanism, the Committee does not want such policies to result in arbitrary and unduly low

Medicare beneficiaries, which include the costs of approved medical education activities).

⁵ See § 2173 of the Omnibus Budget Reconciliation Act of 1981, Pub. Law 97-35.

Mr. Kenneth Raske
June 22, 2007
Page 6

reimbursement levels for hospital services.” H.R. Rep. No. 158, 97th Cong., 1st Sess. 294 (emphasis added).

The subsequent House conference report echoes the concern for teaching hospitals:

“The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates.” H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in U.S. Code Cong. & Admin. News 1010, 1324 (emphasis added).

Citing these legislative reports, the Third Circuit Court of Appeals in West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 29-30 (1989), held that Pennsylvania’s failure to include GME (and certain other costs) in payments to non-Pennsylvania hospitals violated the then-applicable Medicaid Act standard in § 1902(a)(13) that states must meet the costs of efficiently and economically operated hospitals in providing inpatient hospital services.

Section 1902(a)(13) was again amended in 1997 to give states even more discretion and flexibility in setting hospital rates. The 1997 amendments replaced the “reasonable and adequate” standard in place since 1981 with a requirement that rates be set through a public process. Nowhere in this delegation of rate-setting authority is there any indication that Congress intended to eliminate states’ authority to reimburse teaching hospitals for GME as a component of hospital rates, even though Congress was well aware of Medicaid GME expenditures.

Such Congressional awareness was most recently demonstrated by amendments to the Medicaid Act by § 6085 of the Deficit Reduction Act of 2005 (Pub. L. No. 109-171). Section 6085 added a new § 1932(b)(2)(D) to the Medicaid Act, which provides for a

Mr. Kenneth Raske

June 22, 2007

Page 7

“default rate” for emergency services furnished to Medicaid managed care patients by providers without contracts with the recipient’s managed care organization:

“The amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such [managed care organization] entity.”

This mandate – that medical education be carved out of Medicaid payments for these limited emergency services (clearly to avoid duplicate GME payments) – reflects a Congressional understanding that medical education costs otherwise may be (and are) included as a component of Medicaid payments to providers. If states were not authorized to include such medical education costs as a component of a Medicaid payment there would have been no reason for Congress to require the carving out of such costs for these limited services.

The Absence of a Medicaid Act Mandate To Fund GME Is Not Controlling

Contrary to CMS’s assertion in the Proposed Rule that GME is not a “component of the cost” of inpatient or outpatient hospital services (72 Fed. Reg. at 28931), GME has long been reimbursed by Medicaid as a component of such services – notwithstanding the absence of a specific statutory mandate to fund GME. The absence of such a statutory mandate does not mean that such funding is unauthorized; rather, it simply reflects the flexibility given to states under the Medicaid Act to establish the payment methodologies for hospital and other covered services – including the flexibility to include GME as a component of payment for hospital services.⁶

⁶ See 72 Fed. Reg. at 28931 (recognizing the “great deal of flexibility” given to States under the Medicaid Act in determining inpatient hospital rates).

Mr. Kenneth Raske

June 22, 2007

Page 8

Nor is it controlling, as CMS asserts (72 Fed. Reg. at 28931), that GME is itself not a “health service that is included in the authorized coverage package” under Medicaid Act § 1905(a), which broadly lists 28 Medicaid-covered health services (including inpatient and outpatient hospital services). There is no requirement that every component of a payment rate itself be a covered health service under § 1905(a); indeed, GME is more appropriately viewed as a cost of providing a hospital service than a health care item or service in its own right. There are many such costs that a State may take into account in calculating Medicaid hospital rates – e.g., capital costs, malpractice costs, maintenance costs, utilization review activities, discharge planning costs, medical supply costs, etc. – that are themselves not “health services” listed in § 1905(a), but States clearly may and do take such services into account in setting hospital rates.

State Funding of GME is Consistent with § 1902(a)(30)(A)

Allowing FFP for GME is consistent with the applicable Medicaid payment standard for hospital services in Medicaid Act § 1902(a)(30)(A) – that payments be “consistent with efficiency, economy and quality of care.” Indeed, it has long been recognized by Congress, CMS, and others that GME in teaching hospitals enhances quality of care.

For example, Committee Reports accompanying the original Medicare Act state:

“Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended . . . that a part of the net cost of such activities . . . should be considered an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.” S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965) (emphasis added).

Mr. Kenneth Raske

June 22, 2007

Page 9

Similarly, the original federal regulation, 20 C.F.R. § 405.421 (eventually redesignated as 42 C.F.R. § 413.85), published on Nov. 22, 1966 (31 Fed. Reg. 14814), defined approved educational activities as “formally organized or planned programs of study usually engaged-in by providers in order to enhance the quality of patient care in an institution.” (See 57 Fed. Reg. at 43661 (Sept. 22, 1992), quoting 20 C.F.R. § 405.421(b)(1) (emph. added).) Construing § 405.421, the Court in Loyola Univ. of Chicago, supra, 905 F.2d at 1072-73, found that the costs of residents and interns working the University’s outpatient clinic under the supervision of faculty-physicians “contributes to and enhances the quality of patient care in the Hospital.”

In a 1992 proposed rule, CMS (then HCFA) noted that the original 1965 Medicare regulations were guided by the American Hospital Association’s “Principles of Payment for Hospital Care,” which stated that “In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community”. 57 Fed. Reg. at 43660 (emphasis added). (In the same rulemaking, CMS cited 1965 House and Senate Committee reports, which CMS noted “indicate that Congress favored including a part of educational expenses as allowable costs” (id. at 43661) – directly contrary to CMS’s current view announced in the Proposed Rule.)

Others, too, have noted the contribution of medical education to enhanced patient care in teaching hospitals. MedPAC stated in its 1999 Report (at p. xi): “MedPAC believes that Medicare’s payments should . . . recognize the value of enhanced patient care provided in teaching hospitals and other settings where residents and other health professionals train when the added value of patient care justifies its higher cost”. (Emphasis added.) The MedPAC Report goes on to state, at p. xii: “Compared with other hospitals, teaching hospitals treat patients with more complex conditions and provide patient care that is more intensive and technologically sophisticated.” See also The George Washington Univ. Issue Brief, National Health Policy Forum No. 764 at p. 4 (June 22, 2001) (noting that teaching hospitals provide services not generally available in

Mr. Kenneth Raske

June 22, 2007

Page 10

all hospitals, are specialty centers for advanced specialized care, and that they serve the community needs for primary care).

In sum, a State's determination to fund GME as a component of payment for hospital services is consistent with the § 1902(a)(30)(A) mandate that Medicaid rates for such services be consistent with quality of care.

**In Any Event, What Is Labeled GME
Is Fundamentally Patient Care**

Allowing FFP for GME as a component of inpatient and outpatient hospital care – mandatory covered services under Medicaid Act § 1905(a) – is consistent with even CMS's narrow interpretation of § 1905(a) because what is labeled "GME" is in fact fundamentally patient care. If such care was not furnished by interns and residents, it would have to be furnished by other practitioners (or not furnished at all, thus diminishing quality of care for Medicaid and other patients).

For example, MedPAC has recognized that "payments to teaching hospitals for the direct costs of operating approved medical residency programs should be viewed as payments for patient care, not as payments for training" (MedPAC Report at p. xi), and further:

"Reclassifying residents' stipends as payment for patient care is straightforward because residents provide care as they learn. In addition, economic theory suggests that the costs teaching hospitals record for faculty salaries and residency program overhead are also for patient care. These costs substitute for the additional wages hospitals would otherwise need to pay residents to provide care if they were not also furnishing them with graduate medical education." MedPAC Report p. xii.

Mr. Kenneth Raske

June 22, 2007

Page 11

Indeed, in West Virginia Univ. Hosps., *supra*, 885 F.2d at 27, the Court found that the bulk of a teaching hospital's direct medical education costs is made up of residents' salaries, and that residents spend most of their time furnishing patient care.

CMS itself has long recognized that residents furnish patient care services in hospitals. Intermediary Letter No. 372 ("IL 372"), issued April 1969, cites, for example, cases of residents performing surgical operations. *See* IL 372 at p. 2. A subsequent Part A Intermediary Letter No. 70-7 (and Part B Intermediary Letter No. 70-2), issued in January 1970), also notes that residents perform surgery without close supervision: "It is recognized that a resident in, say, general surgery is expected to handle independently a range of clinical problems and perform a range of operative procedures at some time during his senior year without immediate supervision." *Id.* at response to Question 8.

In 1995, when adopting new regulations governing payment for physician services in teaching hospitals, CMS, referring back to 1969 when IL 372 was first developed, stated: "It was recognized then and now that residents must furnish patient care services to develop their skills as physicians or other types of practitioners." 60 Fed. Reg. 63124, 63138 (Dec. 8, 1995). In the same rulemaking CMS noted that "to the extent that services are provided by interns and residents who are largely unsupervised, Medicare pays for the direct costs of those services through GME payments." *Id.* at 63144.

Similarly, a December 30, 1992 HCFA Memorandum from Director, Office of Payment Policy, Bureau of Policy Development (FQA-541), states (at pp. 1-2): "A service furnished by a resident without the presence of the attending physician is not covered as a physician's service to an individual patient. Medicare liability for paying for such a service is met through direct graduate medical education payments (hospital-specific per resident amounts) by the intermediary to the hospital."

In short, it is widely recognized that GME costs are fundamentally patient care costs, however they might be labeled.

Mr. Kenneth Raske

June 22, 2007

Page 12

CMS Proposes To Disallow FFP Even for Indirect Medical Education Expenditures That It Acknowledges Represent Payment for Health Care Services

The Proposed Rule purports to preclude FFP for “graduate medical education” (see proposed §§ 447.201(c) and 447.257(b)), which apparently refers to both direct GME and indirect medical education (“IME”). But such a broad application of the FFP preclusion would be at odds with CMS’s acknowledgement in the preamble that at least IME payments “represent an additional Medicare payment for health care services provided to Medicare beneficiaries in teaching hospitals.” 72 Fed. Reg. at 28933. (Based on this purported direct/indirect GME distinction, the Proposed Rule purports to exclude from the Upper Payment Limit calculation only direct GME payments; see proposed § 447.272(b) at 72 Fed. Reg. at 28936.)

This CMS acknowledgement – that IME payments in teaching hospitals represent payment for “health care services” – is surely correct, but it does not go far enough, as the same is true, for all the reasons discussed above, for all GME payments, direct and indirect.

For the reasons discussed above, GME historically has been appropriately recognized as a component of the costs of covered hospital services and included in Medicaid payments for such services. There are substantial bases for opposing CMS’s proposal to eliminate FFP for such GME payments as inconsistent with and unauthorized by the Medicaid Act.

Katten

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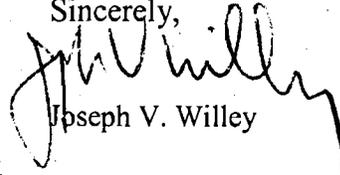
Mr. Kenneth Raske

June 22, 2007

Page 13

Please let me know if you have questions or wish to discuss these issues further.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Willey", written over the printed name.

Joseph V. Willey

JVW:ba