



American Hospital
Association

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

June 20, 2007

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

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

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rulemaking changes to Medicaid policy regarding federal reimbursement for graduate medical education (GME) costs. As you know, the proposed rule is subject to a year-long moratorium secured by P.L. 110-28.

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 Because CMS has not withdrawn the rule, the AHA is submitting these comments with strong opposition to the policy changes proposed in this rule.

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



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

Agency Rationale

Medical Assistance:

CMS in the preamble to the proposed rule states:

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

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

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

Covered Hospital Services:

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

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

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

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

Reversal of Long-Standing Policy

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

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

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

Sincerely,

Rick Pollack
Executive Vice President