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June 22, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

CMS-2279-P

Dear Administrator Norwalk:

On behalf of the five family medicine organizations we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) proposed rule entitled *Medicaid Program; Graduate Medical Education* (72 Fed. Reg. 28930, May 23, 2007.)

Our position on this proposed regulation is clear - we oppose any policy that would not allow Medicaid to fund graduate medical education. We urge the Agency to withdraw this proposed rule. In fact, we do not understand CMS's rush to publish this proposal when the Agency was well aware that Congress was in the process of acting to prevent such an administrative action. As the Agency is well aware, the President was just days away from signing into law a bill that included a one-year moratorium (H.R. 2206 - a FY2007 supplemental appropriations bill) prohibiting the Secretary of Health and Human Services from "take [ing] any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to ..."promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program."

In this proposal, CMS contends that "costs and payments associated with Graduate Medical Education programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program," and that "GME cannot be included as part of any payment methodology in the Medicaid State Plan."

We are providing a legal analysis (attached) asserting that the Agency is mistaken in its belief that there is no legal foundation for Medicaid to pay for graduate medical education. The preponderance of evidence is clearly weighted toward our view that it is entirely appropriate for Medicaid to continue to be able to pay for GME, as determined by each state.

In addition to our compelling legal analysis, we have several policy concerns with this proposal. We can not fathom how the Administration can choose to believe that it would be in the best interest of our nation as a whole, let alone the academic medical enterprise, to remove such large sums of money from teaching hospitals.

Financial Implications to Hospitals

We are concerned with the large financial insult to teaching hospitals that would result should this proposal ever be allowed to go forward. These funds can often make the difference between a positive or negative operating margin. We find it unseemly that a federal agency would try to prevent a willing partner in the graduate medical education enterprise from taking on a share of the burden of training the nation's doctors. Taken together with the other graduate medical education positions of CMS, the result is the effective denial of billions of dollars in Medicare and Medicaid funding to help teaching hospitals and residency programs defray the cost of medical education. Meanwhile, the Medicare Payment Advisory Commission has called for reducing IME funding factor by 1 percent and the Bush Administration's fiscal year 2008 budget calls for diverting $30 billion in capital funds and Medicare and Medicaid disproportionate share, or DSH, funds from hospitals and other health care facilities. We would like CMS to explain how the academic medical infrastructure would be able to support such a tremendous loss of funding?

Even if the Administration were correct in its legal analysis, we find it inconceivable to think that anyone truly believes a positive impact would result from the loss of this funding from the medical education enterprise.

Physician Workforce Implications

It is generally acknowledged that our nation will be seeing a physician shortage in the near future – particularly in the primary care specialties – and as a nation we have still not solved the maldistribution problem. As Medicare physician reimbursement is falling, or uncertain at best, costs are increasing as physicians are re-tooling to meet the health information technology demands and the new model of practice, and attention to new methods of assessing and improving the quality of physicians performance are being incorporated into practice, this is clearly a time when the cost of training physicians is going up. In addition, the aging of the baby-boomer generation is creating unprecedented growth of the Medicare eligible population and a demand for an increased production of physicians. In addition, we point out what CMS seems to have forgotten - that residents themselves provide a tremendous amount of direct patient care to Medicaid recipients. This role is particularly critical in underserved areas. Ignoring this critical patient care role ignores the impact this rule would have on access to care for Medicaid recipients if funding for training of a large number of the providers in teaching hospitals is eliminated. We can not see how a policy that would diminish the stability of the

production of physicians and care for the underserved in this country at this time would be to the benefit of the nation.

Policy Goals of Medicaid GME

States have used the ability of Medicaid to fund graduate medical education to help advance specific policy goals that are needed in their states. Many have been explicit about those goals, ranging from workforce questions to safety-net issues, and include the following:

- Encourage training in certain specialties (e.g. primary care)
- Encourage training in certain settings (such as underserved communities)
- Increase supply of health professionals serving Medicaid beneficiaries, and
- Improve geographic distribution of workforce.

From a policy perspective, we cannot understand CMS's lack of support for these laudable goals. While an extremely creative effort, we find it short-sighted at best to use a transparently poor legal argument to attempt cost-shifting or cost-savings. Rather, we would urge CMS's efforts at creativity be spent on finding ways to encourage such goals through graduate medical education policy, both within Medicare and Medicaid.

Conclusion

Should this proposal ever reach fruition, we can expect at best an uncertain future for the country's teaching hospitals and training programs. We can expect a massive disruption in physician training programs caused by the loss of revenue to hospitals and other providers and a breakdown of our already fragile safety net of care for un- and under-insured people. We urge CMS to withdraw this proposal.

Sincerely,

John Rogers, MD, MPH, MEd, President
Society of Teachers of Family Medicine

Rick Kellerman, MD, FAAFP, President
American Academy of Family Physicians

Mark Robinson, MD, President
Association of Family Medicine Residency Directors

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MEMORANDUM

TO: Ivy Baer, Esquire
Karen Fisher, Esquire
Association of American Medical Colleges

FROM: Mark H. Gallant

DATE: June 20, 2007

RE: **Proposed Rule: CMS-2279-P**

Background and Executive Summary

We have reviewed the May 2007 Proposed Rule concerning Medicaid expenditures for graduate medical education ("GME"), 72 Fed. Reg. 28930 (May 23, 2007), from a legal standpoint at the request of the Association of American Medical Colleges ("AAMC"), the National Association of Children's Hospitals, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, the American Academy of Family Physicians, and the Academic Family Medicine Advocacy Alliance.

In the summary of the Proposed Rule, the Centers for Medicare & Medicaid Services ("CMS") states that the "proposed rule would clarify that costs and payments associated with Graduate Medical Education programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program." 72 Fed. Reg. at 28930. See also 72 Fed. Reg. at 28933 ("This rule would clarify that GME is outside the scope of medical assistance, and that GME is not an allowable component of payment methodologies [under Medicaid]"). The Proposed Rule not only "clarifies" CMS' view that GME is not an authorized federal expenditure under Title XIX of the Social Security Act (the "Act"), but also would amend the regulations at

42 C.F.R. §§ 447.272 and 447.321 to preclude counting any costs incurred for GME for purposes of calculating the aggregate Medicare upper payment limits ("UPL") for inpatient hospitals.

In short, CMS' so-called "clarification" of the law is nothing of the sort. Rather, the Proposed Rule represents an abrupt reversal of CMS' own decades old recognition of GME as a covered cost of providing hospital services and patient care under Title XIX, and amounts to an invalid disavowal of federal coverage that could be legitimized only if Congress itself were to amend Title XIX to eliminate coverage of GME.

Analysis

(i) The States Have Broad Latitude to Define Medical Assistance, and the Fact That GME is not Separately Enumerated as a "Health Care Service" under Section 1905(a)(1)-(27) is Legally Inconsequential

As it repeatedly concedes in the preamble to the Proposed Rule, CMS has long "allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient services" through an extensive history of approving State Plan Amendments that include payment for GME. 72 Fed. Reg. at 28931, 28932. CMS proposes reversing its consistent, decades long view that GME is reimbursable under Title XIX based largely on the rationale that GME is not broken out separately as a "health service" under the "benefit package" defined by Section 1905(a)(1) through (27). 72 Fed. Reg. 28931, 28933. That rationale is easily dispatched.

In Section 1903(a)(1) of the Act, Congress authorized federal financial participation for funds "expended for medical assistance under a state plan." When a service is covered under Title XIX, CMS has an affirmative obligation, not merely an option, to federally match State medical assistance expenditures under the mathematical standards prescribed pursuant to Section 1901 of the Act. Section 1901 of the Act thus states that the "sums made available under this section shall be used for making payments to States … [under approved] State plans for medical assistance." Section 1902(a)(3) says that the Secretary "shall pay" the prescribed matching amounts out of monies appropriated therefore." As the Supreme Court has observed, "the purpose of Congress in enacting Title XIX was to provide federal financial assistance for all

legitimate state expenditures under an approved Medicaid plan." Harris v. McRae, 448 U.S. 297, 308 (1980), *reh'g denied*, 448 U.S. 917 (1980). Accord Department of Social Servs. v. Bowen, 804 F.2d 1035, 1040 (8th Cir. 1986) (HHS may not abdicate its responsibility to pay States for legitimate costs under Title XIX).

The notion that Congress prohibited FFP for GME because it did not list GME as a separate line item within Section 1905(a) of Title XIX is misguided. Under Title XIX the States have wide latitude to decide what specific items and services to cover under their MA programs, subject to broad parameters set by federal law. Section 1905 of the Act sets forth an array of medical assistance services that states may choose to provide, or must provide under their medical assistance programs pursuant to Sections 1902(a)(10)(A) and 1902(a)(13)(B). Inpatient and outpatient hospital services are among the services States are obligated to cover under their federally approved State Plans. Sections 1905(a)(1), (2). CMS' position that GME may not be funded under the Act because it is not "listed" within the array of medical services catalogued under Section 1905 incorrectly presumes that GME is a "medical service."

GME is not like the other types of "services" listed, which are categories of care (e.g., hospital; hospice; home health; lab), but more aptly is characterized as a *cost* of delivering "hospital services." The costs that may be included in rates for hospital services are the subject of a separate provision of the Act – i.e. Section 1902(a)(13)(A), 42 U.S.C. § 1396a(13)(A). As CMS recognizes, States are afforded broad "flexibility" under the Act, subject to a reasonable estimate of what Medicare could have paid for the service, to designate specific items and services covered under their medical assistance plans and "to develop their own methods and standards" of reimbursement. 72 Fed. Reg. 28932.[1]

Even if graduate medical education were viewed as a "service," one would not logically expect it to be separately enumerated as a line item under Section 1905(a) because it is a

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[1] Accord H.R. Rep. No. 158, 97th Cong. 1st Sess. 292, 293 (1981 amendments to the institutional reimbursement provisions of Title XIX were intended to give state "greater flexibility" and "greater latitude" in designing their reimbursement methods).

subsidiary component of a broader class of services, namely, hospital services. See, e.g., Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004) (incontinence supplies are covered within the broader category of "home health services"). In fact, CMS has spelled out what services comprise inpatient hospital services under Title XIX by regulation, along with specific exclusions. See 42 C.F.R. § 440.10(a) & (b). That regulation makes clear that such services include *any* services "ordinarily furnished by a hospital" that are "under the direction of a physician." This broad description clearly encompasses GME, which, conversely, is not excluded from the definition of inpatient hospital services by § 440.10(b).

That a particular component (like GME) of a broader service (like hospital services) need not be specifically listed under Section 1905(a) is apparent from the terms of Section 1905(a) itself. The last sentence of Section 1905(a) (following subparagraph (28)) that states: "No service (including counseling) shall be excluded from the definition of medical assistance solely because it is provided as a treatment service for alcoholism or dry dependency." "Counseling" is not separately enumerated in subsections (a)(1) through (a)(27), but (like GME) was plainly regarded by Congress as a covered service because it falls within the ambit of hospital services.

Additionally, in Section 1905(a)(28) Congress included a "catch-all" provision that states that the cost of "*any other medical care* … recognized under State law" may be reimbursed as medical assistance. Coverage of services under Section 1905(a) is viewed expansively, not restrictively. See generally Coe v. Hooker, 406 F. Supp. 1072 (D.N.H. 1976); Skubel v. Sullivan, 925 F. Supp. 930 (D. Conn. 1996), *aff'd as modified*, 113 F. 3d 330 (2d Cir. 1997) (rejecting Secretary attempts under Section 1905(a) to deny coverage of home health care services, noting Medicaid coverage is broader than Medicare coverage). These cases moreover predated the addition of the "catch-all" provision (which provision CMS ignores). Consistent with both the catch-all provision and the broad compass of covered services under the Act, CMS has identified both transportation services and durable medical equipment as a covered service (within the broader class of home health services), even though neither service is listed under Section 1905(a)(1) through (27). See 42 C.F.R. §§ 440.70(b)(2), 440.170(e).

CMS' position also is demonstrably incorrect in that GME costs plainly fall within the costs of hospital services under Medicare, and the Title XVIII reimbursement concepts were imported by Title XIX. From the enactment of Title XIX until 1981, Section 1902(a)(13)(A), like Title XVIII, provided for reimbursement of hospital services based on the "reasonable costs" of those services. This standard was congruent with the reimbursement standard used under Medicare – Title XVIII of the same statute – prior to the advent of the Prospective Payment System. The same words used in the same statute generally are given the same meaning and effect. Rowan Cos. v. United States, 452 U.S. 247, 250 (1981). Since GME unquestionably is a covered cost for hospitals under the Medicare "reasonable cost" reimbursement standard, it is deemed covered under the parallel terms of Title XIX of the same statute. Congress was clearly cognizant of the widespread use of Medicare cost reimbursement principles under Title XIX. For example, in a comprehensive survey of State Medicaid programs, the House Subcomittee on Health and the Environment noted that, with a few special exceptions, "[a]ll States use title XVIII standards for determining payments."[2]

From 1981 (when the Boren Amendment was enacted) until the Balanced Act of 1997 ("BBA") amendments,[3] Section 1902(a)(13)(A) required the States to "assure" CMS that their rates are "reasonable and adequate" to cover the costs of "efficiently and economically operated hospitals" (taking into account "quality," "safety" and "access"). The Boren Amendment also granted the States broad discretion to determine the costs they deemed to be "reasonable and adequate" by authorizing rates "determined in accordance with methods and standards developed by the State[s]." It is universally understood that the Boren Amendment was intended to further enhance the States' flexibility to craft hospital reimbursement schemes, not to restrict or limit the items or services the States might cover under the preexisting version of Section 1902(a)(13)(A).[4] The 1997 BBA amendments, which substituted the "public process"

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[2] Data on the Medicaid Program: Eligibility, Services and Expenditures, Fiscal Years 1966-77, 95th Cong., 1st Sess., Comm. Print 95-10 at 19 (1977).

[3] Pub. L. No. 105-33 (July 29, 1997).

[4] As CMS observed in declining to adopt highly formulaic regulations to implement the Boren Amendment, States that paid hospitals based on Medicare allowable costs – which include

requirements for the requirement imposed under the Boren Amendment, were designed to give the States even greater latitude to determine which hospital costs to reimburse. This delegation of specific ratesetting authority nowhere excludes GME costs from the costs of facility services. CMS' current theory is incompatible with congressional intent to expand – not limit – the States' flexibility to define cost coverage for hospitals through the various amendments to Section 1902(a)(13)(A).

(ii) Congress Clearly Has Indicated Its View That GME is a Covered Cost Associated With the Services Provided by Teaching Hospitals

Perhaps most importantly, the central premise of the Proposed Rule that GME was not intended to be funded under Title XIX is contrary to the plain language of the Act and its legislative history. It is therefore unsustainable under the seminal decision in Chevron U.S.A. Inc. v. NRDC, Inc., 467 U.S. 837 (1984). In Chevron, the Supreme Court formulated the standards for judicial review of agency regulations that purport to interpret provisions of law. Under the first prong of Chevron, the courts must determine if "Congress has directly spoken to the precise questions at issue" in the regulation. 467 U.S. at 842. If Congress has so spoken, either in statute or the legislative history, "the agency must give effect to the unambiguously expressed intent of Congress." Id. at 842-843. If Congress has not addressed the issue, a court must defer to the agency's regulatory interpretation, but only if it is "based on a permissible construction of the statute," and represents a "reasonable" interpretation of the law, taken in context. 467 U.S. at 844, 845.

Congress has repeatedly made explicit its intention to cover under Title XIX the costs incurred by teaching hospitals, including GME. In the recently enacted Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006) (the "DRA"), Congress amended § 1932(b)(2) of the Act to provide for a "default rate" based on the "rates paid to hospitals under this title, when emergency services are furnished to Medicaid managed care patients by a provider that does not

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GME – were already deemed to satisfy Section 1902(a)(13)(A), and the purpose of Boren Amendment "was to increase the States' administrative and fiscal discretion to set payment rates." 48 Fed. Reg. 56046, 56047, 56048 (Dec. 19, 1983).

have in effect a contract with the patient's Medicaid managed care organization. Id. at § 6085. The rate Congress prescribed in 2006, effective January 1, 2007, is as follows:

> The amounts (less any payments for indirect costs of medical education and graduation medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such [MCO] entity.

§ 1932(b)(2)(D) of the Act, 42 U.S.C § 1396u-2(b)(2)(A) (emphasis added). Were reimbursement by the States for GME (and IME) not authorized under Title XIX, there would have been no reason to exclude such payments from the amounts Medicaid managed care organizations must pay non-contracted hospitals under Section 1932(b)(2)(1). "It is an elementary rule of construction that effect must be given, if possible, to every word, clause and sentence in a statute," and that no clause or word should be "construed as superfluous, void or insignificant." Singer, Sutherland Statutory Construction, 6th Ed. (2000), § 46:06 at pages 181, 191 (and cases cited therein).

Congress, has thus "spoken directly" to the coverage of GME (and IME) under Medicaid in its most recent amendment of Title XIX, and left no doubt that it considers GME (and IME) to be payable by the states subject to federal matching under Title XIX. CMS' fundamental premise for the Proposed Rule, that GME is not meant to be covered under Title XIX, conflicts squarely with the plain terms of the Act, and thus fails under the first prong of Chevron. This provision in and of itself precludes CMS from going forward with the Proposed Rule as a matter of law, since it is founded on a premise that conflicts squarely with the plain terms of the Act.

Although the DRA amendment is dispositive, other legislative pronouncements strongly buttress the conclusion that the Proposed Rule conflicts with the statute and Congressional intent. As noted, in 1981, through the enactment of the Boren Amendment, Congress amended Section 1902(a)(13)(A) of the Act, 42 U.S.C. § 1396a(a)(13)(A) to afford the States even greater flexibility in formulating payment methods and standards for facility services, including the adoption of prospective payment systems that might be "reasonable and adequate to meet the costs" only of "efficiently and economically operated" hospitals. In liberalizing this standard

from one based on the retrospective payment of all reasonable costs, the Conference Committee went out of its way to underscore the importance of covering the costs of hospitals that provide medical education to ensure that Medicaid beneficiaries would not be denied access to the sophisticated, "tertiary" level of care that is the province of teaching hospitals. The Conference Committee relevantly stated:

> 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 rules.

H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, *reprinted in* 1981 U.S. Code Cong. & Admin. News 1010, 1324 (emphasis added).

Given the pains the conferees took to emphasize their concerns that Medicaid payments take into account the "special situation" that exists in "teaching hospitals," it is inconceivable that Congress construed Title XIX as precluding coverage of GME (let alone IME). The "special situation" quite obviously, entails the added costs that "teaching hospital(s)" incur in the performance of "teaching." That Congress assumed these costs would be covered is supported not only by the direct reference to GME and IME in § 6085 of the DRA of 2005, but by the fact that although numerous opportunities existed for Congress to state otherwise, no steps were ever taken over the past 40 years to indicate that Title XIX did not cover GME or to limit payment of such costs.

(iii) CMS' Reinterpretation of Title XIX Would not Constitute a "Reasonable" One Under the Second Prong of Chevron Given the Legislative History and the Inconsistencies in CMS' Position

Even putting aside Congress' express description of GME as an expense that is reimbursable under Title XIX, the Proposed Rule could not pass muster as a "reasonable" interpretation of the statute under the second prong of Chevron. As noted above, Congress also has underscored its concerns about the importance of "teaching hospitals," ensuring that the tertiary levels of care they deliver are available to Medicaid recipients, and the dependence of

teaching hospitals on Medicaid reimbursements. Page 5-6, *supra.* An intentional "cost shifting" of GME "teaching" expenses from Medicaid to other payers, which would flow from the Proposed Rule, is not reasonably reconciled with those stated concerns.

Moreover, the "reasonableness" of an agency's interpretation of the law takes heavily into account whether that interpretation is one the agency has embraced on a consistent basis. See Thomas Jefferson Univ. v. Shalala ("TJU"), 512 U.S. 504, 516 (1994) quoting INS v. Cardoza-Fonseca, 480 U.S. 421, 446 n. 30 (1987) (stating that, while it need not be set in stone, "an agency's interpretation of a statute or regulation that conflicts with a prior interpretation is 'entitled to considerably less deference' than a consistently held agency view"). There is a heightened allegation for agencies to justify a clear departure from longstanding agency norms. Verizon Commc'ns, Inc. v. FCC, 535 U.S. 467, 503 (2002). In contrast with the facts in TJU, there is no question here that "[CMS] has interpreted [the controlling law and regulations] in an inconsistent manner." 512 U.S. at 515.

CMS' own routine approvals of State Plans that cover GME, over a forty (40) year span, directly contradict the position espoused in the Proposed Rule. CMS approval of a State plan constitutes an official interpretation of the Act.[5] CMS acknowledges in the Proposed Rule that "47 States and the District of Columbia reported using Medicaid funds to make GME payments under the Medicaid State Plan." 72 Fed. Reg. 28932. Stated otherwise, CMS has approved at least 47 State Plans or State Plan Amendments that include GME among the allowable costs of hospital services – decades of agency action which it would now portray as *ultra vires* through a supposed regulatory "clarification" of the law.

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[5] See, e.g., Commun. Health Ctr. v. Wilson-Coker, 311 F.3d 132, 134 (2d Cir. 2002); S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 595-96 (5th Cir. 2004); Rite Aid of Pennsylvania v. Houstoun, 171 F.3d 842, 847 (3d Cir. 1999) (all holding that CMS approval of State Plan Amendment constitutes a determination that the SPA conforms to governing statutory and regulatory requirements); 42 C.F.R. §430.15(a)(1) ("Determinations as to whether state plans, including plan amendments, and administrative practices under the plans… meet the requirements for approval are based on relevant Federal statutes and regulations").

CMS' inconsistency does not stop there. In comprehensively recodifying and amending the Medicaid managed care rules under Part 438 in 2002, CMS included a provision in the proposed rule (42 C.F.R. § 438.60) that would have precluded States from making payments directly to a provider for services provided under a contract with an MCO, PIHP or PAHP, except as otherwise provided for in statute or regulation. 66 Fed. Reg. 43614, 43666 (Aug. 20, 2001). Several commenters voiced concerns that this provision might preclude the States from directly paying providers GME on account of managed care patients. 67 Fed. Reg. 40989, 41004 (June 14, 2002). In response to the comments, CMS added a "new section 438.6(c)(5)(iv)," which requires States making payments for providers for GME costs under an approved State plan, "to adjust the actuarially sound capitation rates to account for the aggregate amount of GME payments to be made directly to hospitals on account of enrolles covered under the contract." 67 Fed. Reg. 41004-05 (emphasis added); accord 67 Fed. Reg. 41022-23. 42 C.F.R. § 438.60, as finalized specifically takes into account direct reimbursement for direct "payments for graduate medical education."

Thus, in sharp contrast with its 2007 "clarification" that payment for GME is "not authorized" under Title XIX, CMS in 2002 expressly and unqualifiedly referenced those GME payments in regulation, and further acknowledged that "GME payments have become a common payment practice in State Medicaid Programs." Ibid. In addition, CMS' reference to "GME payments on account of [Managed Care] enrollees" implicitly recognizes that GME is a cost related to the delivery of patient care.

In sum, CMS has a forty (40) year history of recognizing in multiple ways and contexts that GME is a valid and authorized expenditure under Title XIX. No change has occurred in the underlying law to remotely support the agency's complete reversal of field.

(iv) Case Law Further Supports the Conclusion that Coverage of GME is Authorized, if not Required, Under Title XIX

That GME is an allowable cost of hospital services under Title XIX also is consistent with judicial interpretations of the Act. Coverage of GME (and IME) under Title XIX was addressed directly by the U.S. Court of Appeals for the Third Circuit in West Virginia Univ.

Hosp. v. Casey, 885 F.2d 11 (3d Cir. 1989) (WVUH). In that case, a teaching hospital situated just across the border from Pennsylvania challenged Pennsylvania's use of differing payment methodologies for in-state and out-of-state hospitals. As an element of its claim, WVUH contended that Pennsylvania had violated the Act's requirement to pay "reasonable and adequate" rates to out-of-state hospitals by limiting GME payments to only those participating hospitals that are located in Pennsylvania. The Third Circuit agreed that Pennsylvania's bificurated payment system, including its denial of reimbursement of GME expenses for non-Pennsylvania hospitals, "violates federal law." WVUH, 885 F.2d at 35. In arriving at this conclusion, the Court took cognizance of the Conference Report language that is quoted above, as well as the House Report which together "reflect great sensitivity to the special needs of teaching and tertiary care hospitals." 885 F.2d at 26.[6]

Recognizing that IME is an inherent part of the "operating costs" of teaching hospitals, the Court of Appeals concluded that GME costs – like capital expenses – also fall within the "reasonable and adequate" costs of rendering "patient care." The opinion pertinently states:

> Teaching Hospitals, the District Court found and defendants do not contest, incur even greater costs than non-teaching hospitals in delivering the same service. 701 F. Supp. at 515. The court found that the bulk of a teaching hospital's direct medical education

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[6] House Rep. No. 158, 97th Cong., 1st Sess. 294, similarly states: "The Committee intends to recognize that facilities that provide teaching services . . . may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by States recognize the need to provide a full range of . . . tertiary care services to Medicaid beneficiaries . . .." These remarks reflect congressional concern about underpaying teaching hospitals, not the concern – espoused now by CMS – about a supposed overabundance of trained physicians. CMS construes the law as though Congress has expressed a desire to reduce physician training, but supports that supposition solely by reference to unattributed congressional sentiments gleaned from a 1994 OIG Report. 72 Fed Reg. 28932. Ironically, the very *OIG Report to which CMS points recognizes* that, "[s]ince the inception of the Medicare program, Medicare has shared in the allowable portion of reasonable costs hospitals incurred for GME" and that *"submitting legislation" would be necessary* to fundamentally change the statutouly protected status of GME payments. June Gibbs Brown, A Study of Graduate Medical Education Costs (A-09-93-00096) (July 28, 1994), at cover memo to Bruce Vladeck and pages 9, 18.

> (GME) costs is made up of residents salaries. And … residents spend about seventy-five percent of their time administering patient care. Thus, the court concluded, reimbursement of GME costs is in large part a reimbursement for patient care.
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> * * *
>
> Pennsylvania recognizes that a teaching hospital will not be adequately reimbursed for its teaching function if it is reimbursed at a rate deriving from the average indirect costs of teaching and non-teaching hospitals. Moreover, Pennsylvania acknowledges that the GME costs will necessarily shift those costs to another payer, and the failure of all payers to compensate for GME costs will eventually cause serious financial problems for teaching hospitals."

WVUH, 885 F.2d at 27 (emphasis added); see also id. at 16 ("GME" is a type of "cost reimbursement" for "costs associated with Medicaid").[7] While the Third Circuit did not expressly conclude that a state must always cover Medicaid's fair share of GME, it left no doubt whatsoever that GME is an authorized expenditure under Section 1902(a)(13)(A) of the Act which states may choose to cover and for which they may receive FFP.

Congress is deemed aware of judicial interpretation of federal law, and is deemed to ratify or acquiesce in such interpretations when it has the opportunity to amend the law to overcome a faulty interpretation but instead leaves the law intact.[8] Here, Congress not only took no action to override the Third Circuit's understanding of GME coverage, it echoed and expressly ratified the understanding that reimbursement of GME (and IME) was covered in § 6085 of the DRA of 2005, *supra.*

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[7] See also Thomas Jefferson Univ. v. Shalala, 512 U.S. 504 (1984) at 507-508 (approved GME program participants "learn by both treating patients and observing other physicians do so" and "GME programs take place in a patient care unit"); at 513 ("the Secretary interprets the regulation [42 C.F.R. 413.85] to allow for costs of educational programs traditionally engaged in by hospitals"); and at 528-529 (Thomas, dissenting) (the "salaries" and costs of "teaching physicians" and support staff "would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care").

[8] See Kay v. FCC, 443 F.2d 634, 646-47 (D.C Cir. 1970); In re NBW Commercial Paper Litig., 826 F.Supp 1448, 1459 (D.C. Cir. 1992).

(v) The Provisions of Medicare Law Discussed by CMS Conflict With, Rather Than Support, the Proposed Rule

As an alternative basis for its drastic reinterpretation of what is reimbursable under Title XIX, CMS claims in the Proposed Rule that GME is not properly recognized as a "patient care cost" because GME is reimbursed separately under Medicare, rather than as part of hospital "operating costs" embodied in the Medicare DRG rates. 72 Fed. Reg. 28931-32. To support this thesis, CMS relies heavily on the fact that Section 1886(h) of Title XVIII excludes GME from the base DRG rates (which encompass a hospital's operating costs). Even if it is assumed that GME is not an "operating cost," this rationale would be flawed.

First, as the Third Circuit recognized in WVUH, *supra*, nothing in Title XIX limits FFP for hospital services to "operating costs," and nothing in the Proposed Rule suggests that "capital" costs – which, like GME, historically were reimbursed separately from operating costs – are somehow not allowable elements of providing hospital services under Title XIX. Under an "operating cost" limitation, Title XIX would equally exclude authority to cover capital costs, which would be absurd. The crux of the issue is not whether GME is an "operating cost," but whether is a reasonable cost related to the provision of patient care by a "teaching hospital." In fact, the very provision of the Act on which CMS relies *confirms* that GME is a reasonable and allowable cost of providing inpatient services.

Since the very inception of the Medicare program,[9] Congress provided for coverage of the allowable portion of direct costs of approved medical education programs based on the premise that "these activities enhance the quality of care in an institution."[10] Until the adoption of the prospective payment system ("PPS") in 1983, GME was included in Medicare cost reports in precisely the same manner as all other allowable costs of patient care. As the OIG has recognized, "[d]irect GME costs include salaries and fringe benefits for I&Rs, [and] teaching

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9 See OIG Report No. A-09-93-00096 at 9

10 H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965); see also Report to Congress, Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals at 4 (Aug. 1999).

physicians time spent supervising I&Rs in patient care services not billed [under Part B]."[11] The "allowable" portion of reasonable costs [of] hospitals for GME "do not include the portion of [D]GME costs allocated to research, nursery and other nonreimburseable costs centers."[12]

With the advent of PPS in 1983, Congress initially retained GME as a pass-through paid on the retrospective, reasonable cost basis. Beginning with FY 1986, Section 1886(h) of the Act established the prospectively determined, average per resident amount ("APRA") as the basis for reimbursing GME, in lieu of the prevailing retrospective, cost based pass through payments. Although CMS suggests that GME was separately authorized by Sections 1886(h) and (k) of Title XVIII of the Act – which have no counterpart in Title XIX – the coverage of GME as an allowable cost of patient care long preceded the enactment of these provisions, which merely provided for a prospective payment system for GME under Medicare. The creation of a prospective payment system for GME closely paralleled the use of a prospective DRG system for operating costs. The fact that GME was broken out from the base DRG rates under Section 1886(h) of Title XVIII was unrelated to the nature or character of GME as a patient care (or hospital) service, as the Proposed Rule suggests. Rather, a separate prospectively determined APRA was utilized in addition to the prospective base DRG rates because Congress decided to pay for GME on a prospective basis and established a prospective payment formula for GME that is different from that used to reimburse those costs included with the DRG rates.

Significantly, Section 1886(h)(l) begins by stating: "Notwithstanding section 1861(v), instead of any amounts that are other payable under this Title [XVIII] with respect to the reasonable costs of hospitals for direct graduate medical education costs [GME shall be reimbursed based on a fixed APRA]." (Emphasis added.) In other words, in limiting GME payments going forward under the APRA system to amounts that might not fully cover the Medicare's fair share (allocation) of those costs, Congress created an express *exception* for GME from the rule of Section 1861(v) to pay Medicare's full share of hospital patient care costs, and

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11 OIG Report A-09-93-00096, *supra* at 2

12 Id. at 9

against cost shifting.[13] Obviously, Congress viewed, and continues to view GME, as among the allowable costs of patient care encompassed by Section 1861 and to which the Medicare anti cost-shifting rules apply in the first place. Otherwise, it would have had no reason to except GME from the operation of Section 1861 in Section 1886(h)(1). Thus, a proper reading of Section 1886(h), in conjunction with Section 1861, refutes the very proposition CMS seeks to support by its reference to that provision by making clear that GME *is* a cost of patient care.

Congress also underscored its support for paying GME to providers under the Act through its enactment of § 4624 of the BBA. In amending Title XVIII by adding Section 1886(h)(3), Congress provided in the BBA for the removal of GME from the capitation payments made to Medicare Advantage Plans and provided, instead, for the direct payment of GME to hospitals on account of managed care patients by the hospitals' regular Medicare fiscal intermediaries. See also 62 Fed. Reg. 29901, 29938 (June 2, 1997) (CMS recognition of the need to remove IME and GME funding from the capitation pool in order to ensure these funding streams were paid directly to teaching hospitals).

CMS has also made clear its own understanding that GME represents a reasonable cost of providing care to hospital patients in adopting its regulations governing teaching physician reimbursement under Part B of Medicare, 42 C.F.R. § 415, *et. seq.* Those rules were formulated to limit the circumstances under which teaching physicians might separately bill Part B for rendering professional services to Medicare beneficiaries. They were designed to avoid "double dipping" owing to the fact that hospitals receive GME payments under Part A which in large part already compensates them for medical services provided to patients by interns and residents under the supervision of teaching physicians, both of whose salaries (for these patient care

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[13] See also Mercy Catholic Medical Center v. Thompson, 380 F.3d 142, 145 (3d Cir. 2004) (noting that "Medicare has paid its full pro rata share of all allowable graduate medical education costs and operating costs actually incurred [by teaching hospitals], consistent with the statutory requirement preventing shifting the costs of services incurred on behalf of Medicare beneficiaries to other patients and third party payers. 42 U.S.C. § 1395x(v)(1)(A) (emphasis added)"). As the Mercy case also discusses, CMS required intermediaries to reaudit the FY 1985 APRA "base year" costs owing to the fact that hospitals often classified operating costs, and costs that were properly reportable under the intern and resident cost centers interchangeably.

services) are funded by GME payments. In the preamble to the Final Teaching Physician Regulations, CMS observed as follows:

> It is important to distinguish between the services of interns and residents and the services of teaching physicians. Medicare fiscal intermediaries pay teaching hospitals for the services of interns and residents. Those services are described in sections 1861(b) and 1832(a) of the Act and are paid under the methodology established by section 1886(h) of the Act. Thus, the fiscal intermediaries are already paying teaching hospitals for services furnished to beneficiaries by residents . . . (emphasis added).

60 Fed. Reg. 63124, 63144 (col. 2) (Dec. 8, 1995). Accord id. at col. 1 (noting that, "contrary to the commenter's suggestion, teaching activities related to patient care were, or could have been included in the Part A base year costs"). The assumption in the Proposed Rule that GME expenses are not a cost of medical services is, therefore, also completely contrary to the basic premise of this entire chapter of Medicare regulations.

(vi) The Proposed Exclusion of GME Costs From the UPL Calculations Lacks a Reasonable Basis

The Proposed Rule also would correspondingly modify the upper payment limit ("UPL") regulations at 42 C.F.R. § 447.272 and § 447.321 to exclude consideration of GME. CMS directly ties this proposed limitation to its assertion that payment of GME conflicts with Section 1902(a)(30)(A) of the Act, which provides that Medicaid service rates must be "consistent with economy, efficiency, and quality of care." This proposal, however, focuses on the "economy" requirement to the exclusion of the "quality" requirement of Section 1902(a)(30)(A).

Heretofore, CMS always has construed the UPL rules – for which CMS has expressly relied on Section 1902(a)(30)(A) as its underlying authority[14] – to require payments that are consistent with efficiency, economy, and quality, and therefore encompassing all "amounts that would be paid … under Medicare judgment principles in subchapter B of this chapter." 42

[14] 42 C.F.R. §§ 447.200 and 447.300 (both identifying Section 1902(a)(30)(A) as the basis for Subparts B and F).

C.F.R. §§ 447.272(b) and 447.321(b). Costs "paid under Medicare, and under subchapter B plainly include all costs recognized under Section 1861(v) of the Act, not just "operating" costs.

This longstanding interpretation is consistent with Section 1861(v) of the Act and the "reasonable cost" regulations published in Part 413 of the Code of Federal Regulations. 42 C.F.R. 413.9 includes "general principles" for ascertaining what Medicare regards as the "cost of service . . . related to the care of beneficiaries." Subsection (b) states that this includes "both direct and indirect costs of providers of services" and prohibits cost coverage methodologies under which "the [provider's] costs with respect to individuals covered by the program will not be borne by individuals not so covered," and vice versa. Under the same Part of the regulations, CMS *lists* specific categories of properly *covered costs* which *specifically include* GME. 42 C.F.R. § 413.75 et seq.

Thus, CMS has always rightly treated GME as an appropriate, patient-care related cost of hospitals under Medicare, and – through the use of UPLs to set aggregate payment limits –under Medicaid. If anything, the UPL concept incorporates an expansive liberal view of what costs would be payable under Medicare, not the highly restrictive and subtractive view that would be taken – based on an erroneous and novel assumption of limits inherent in Section 1902(a)(30)(A) – under the Proposed Rule. [15]

Moreover, GME has been included in approved State Plans from the inception of the program, and the UPL regulations which include Medicaid coverage of GME costs under the authority of Section 1902(a)(30)(A), have been in effect for twenty (20) years. Congress is presumed to be aware of agency interpretations of federal law, and the failure to amend a law to overturn a stated agency interpretation amounts to a congressional ratification of the same. See Zemel v. Rusk, 381 U.S. 1 (1965); Bob Jones Univ. v. United States, 461 U.S. 574, 599-600 (1983); Haig v. Agee, 453 U.S. 280, 300-301 (1981); United States v. Board of Comm'rs of

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[15] See, e.g., HHS Departmental Appeals Board Dec. No. 1578 (May 29, 1996), *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 44, 484 (recognizing that, for purposes of UPLs, Medicare cost reimbursement principles are to be liberally construed, and may be applied without TEFRA limits on allowable costs).

Sheffield Alabama, 435 U.S. 110, 134 (1978). Congress was well aware of the UPL regulations.[16] Because Congress has repeatedly amended Title XIX – including amendments (such as the amendments to Section 1923) expressly limiting allowable costs – without taking steps to preclude Medicaid reimbursement for under well worn reasonable cost principle, or to exclude GME from UPLs, it is deemed to have ratified the coverage of GME and CMS' prior and less restrictive version of the UPL regulations.

CMS' central assumption that Title XIX covers only hospitals' "operating costs" also conflicts directly with positions taken by CMS on closely related issues. While the Proposed Rule would disavow GME as an allowable cost under Medicare on this basis, CMS recently has taken the opposite position in its implementation of hospital-specific Medicaid disproportionate share hospital ("DSH") limits under Section 1923 of Title XIX. Added to the Act by the Omnibus Budget Reconciliation Act of 1993, Section 1923(g)(1) limited hospital-specific DSH payments under a State Plan to "uncompensated costs," including costs of treating Medicaid patients that are unmet by medical assistance reimbursement. Under the more recently enacted Section 1923(j)(2) of the Act, States were required to audit the uncompensated care costs used to set the hospital-specific DSH limits including the unpaid allowable costs of Medicaid patient.

In implementing these provisions, HHS has issued a series of guidance to the states to underscore CMS understanding that at least those costs that were allowable under Medicare are considered allowable costs under Title XIX. In her widely disseminated August 17, 1994 "Dear Medicaid Director" communication, Sally K. Richardson, Director, Center for Medicaid and State Operations, advised that "the legislative-history of this provision makes it clear that States may include both inpatient and outpatient cost in the calculation of the limit [of the Cost of services to Medicaid Patients]" and that Medicaid costs are properly determined "under the Medicare principles of cost reimbursement." Id. at page 3. CMS (then HCFA) stated it:

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[16] See, e.g., Hearing Before the Sen. Comm. on Finance, 106th Cong., 2d Sess. (Sept. 6, 2000) at 6, 8, 20, 29, 40 (expressly reviewing UPL rules and acknowledging their incorporation of Medicare cost reimbursement principles).

> Believes this interpretation of the term "costs incurred" is reasonable because it provides states with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.

Id. The understanding that any costs that may be claimed on a Medicare cost report are regarded as allowable costs under Title XIX is also memorialized in Office of Inspector General audits under Section 1923. See, e.g., A-05-01 00099 (Audit of Payments to Univ. of Ill. at Chicago Hospital; Oct. 13, 2004); A-09-00054 (Audit of California; May 29, 2003).

The Proposed Rule offers no viable, reasoned explanation of why the same costs recently proclaimed to be allowable costs of medical assistance for purposes of calculating hospital-specific DSH limits under Section 1923 of the Act by both CMS and the OIG are, suddenly, not allowable costs under Title XIX. Accordingly, and for the above reasons, the Proposed Rule, including the proposed amendment of the UPL provisions, would not pass judicial muster even under the second prong of Chevron.[17]

(vii) It Would Be Even More Inappropriate for CMS to Modify its Treatment of IME

Finally, the Proposed Rule also solicits comments about the propriety of potentially excluding IME costs from the Medicare-based UPLs used to limit aggregate hospital payments under Title XIX. We comment briefly on this point, which goes beyond CMS' current rulemaking proposal, out of an abundance of caution.

In short, excluding IME costs from the UPL calculations would be even more untenable than the proposed change in treatment of GME. First, Section 6085 of the DRA of 2005 also explicitly reflects Congress' view that IME is an allowable expense under Title XIX. Further, the case law and relevant legislative history discussed above is particularly emphatic about the obligations of the States to consider the indirect impact of operating teaching programs on

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[17] See also Motor Vehicles Manuf. Ass'n. of the United States v. State Farm Mutual Ins. Co., 463 U.S. 29, (1983) (overturning Department of Transportation's regulatory about face on airbag and passive safety belt standards).

hospital operating costs. The House Report that accompanied the initial 1981 amendments to Title XIX mentioned expressly Congress' intention that Medicaid payments account for the fact that teaching hospitals "have operating costs which exceed these of a community hospital."[18] IME adjustments have long been the traditional means for quantifying the impact of teaching activities on "operating costs," and CMS has conceded as much in "distinguish[ing] direct GME payments from indirect medical education (IME) payments because IME payments (as defined under Medicare payment principles) represent an additional Medicare payment for health care services provided to Medicare beneficiaries in teaching hospitals." 72 Fed. Reg. at 28932 (col. 2).[19] Finally, CMS' own rationales offer no discernable basis to conclude that IME expenses are not authorized expenditures under Title XIX. On the contrary, CMS largely justifies excluding coverage of GME because it is excluded from the Medicare DRG rate which contains "operating costs." This rationale leads inexorably to the conclusion that IME is allowable as a cost of hospital care because it *is* a factor contributing to the operating costs of teaching hospitals.

Aside from these substantive bars, CMS could not in any case properly amend the IME coverage standards under the current rule as a procedural matter. A final rule must be a "logical outgrowth" of a proposed rule.[20] The actual scope of the Proposed Rule, and CMS' stated basis for excluding coverage, to which the commenters are responding, extends only to GME costs. If CMS were to issue a final rule that also restricted FFP relating to IME without first publishing a rule that actually proposed taking such action, it would violate the notice and comment rulemaking requirements of 5 U.S.C. § 553(b). A final rule that were to modify Medicaid's treatment of IME costs would not comprise a logical outgrowth of the Proposed Rule both because CMS has only actually proposed altering coverage of GME, and because, as noted, it

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[18] See H.R. Rep. No. 158, quoted at page 11 above.

[19] As Congress observed in creating the DRG system, the IME adjustment is used as a proxy to account for a number of factors which legitimately increase operating costs in teaching hospitals. House Ways and Means Comm. Rep. No. 98-25 (March 4, 1983); Sen. Finance Comm. Rep., No. 98-23 (March 11, 1983). See also R. Schweiker, Report to Congress: Hospital Prospective Payment for Medicare (Dec. 1982) at 48-49.

[20] See, e.g., Environmental Integrity Project v. EPA, 425 F.3d 992, 998 (D.C. Cir. 2005); Small Refiner Lead Phase-Down Task Force v. EPA, 705 F.2d 506, 546-47 (D.C. Cir. 1983)

would be contrary to the central premise of the Proposed Rule that Medicaid plainly *should* cover a hospital's "operating costs."

CMS, moreover, cannot avoid its notice and comment obligations under the APA on the basis that a change to the standards pertaining to IME are merely interpretative rules that may be published in final form under Section 553(b). Full notice and comment procedures and an amendment of the underlying regulation *is required* before an agency may reverse a clearly articulated prior interpretations.[21] CMS has apparently recognized as much in publishing a Proposed Rule to re-interpret whether allowable costs under Title XIX encompasses GME.

Conclusion

For the reasons stated above, we believe that coverage of GME (not to mention IME) costs incurred by hospitals is clearly authorized under XIX as a cost of patient care, as Congress has clearly recognized on numerous occasions. CMS does not have discretion under the Act to refuse to federally match State expenditures for medical education as part of their medical assistance programs. Rather, the elimination of FFP for GME expenses at this juncture would require an amendment of the Act itself. Because its proposal to amend the UPL regulations is founded on the same misperceptions about Title XIX, and is a radical but inexplicable departure from established agency norms, that proposal would fail for lack of a sustainable, reasonable basis.

[21] See, e.g., Sweet v. Sheehan, 235 F.3d 80, 90 (2d Cir. 2000); Paralyzed Veterans of America v. D.C. Arena, 117 F.3d 579 (D.C. Cir. 1997); Mt. Diablo Hosp. v. Bowen, 860 F.2d 951 (9th Cir. 1988); Nat'l Med. Centers v. Shalala, 826 F. Supp. 558 (D.D.C. 1993).