RESPONSES TO QUESTIONS FOR THE RECORD
House Oversight and Government Reform Committee
Hearing on Medicaid Regulations, November 1, 2007

1. Mr. Cooper requested the policy choices that could have been made instead of the six regs to save money in the Medicaid program (why the six regs were chosen and what other options were rejected).

The purpose of the six regulations was not simply to save money in the Medicaid program. Each of the regulations was intended to address specific issues, some of which involved fiscal integrity issues and would result in program savings. Two of the regulations, concerning rehabilitative services and case management services, contain substantial beneficiary protections that CMS believes will substantially improve the quality and accountability of Medicaid services. Two of the regulations address expenditures that are simply not authorized under the Medicaid statute, for school administration and transportation to and from schools, and for graduate medical education. And two regulations address the integrity of the State-federal partnership by ensuring that program funds are not recycled or diverted to effectively increase the federal share of responsibility.

CMS examined the impacts of regulatory changes and detailed the policy options contemplated in the discussion entitled "Alternatives Considered," covered in the preamble of the following regulations: 72 FR 29748 (Cost Limit for Governmental Providers); 72 FR 28930 (Graduate Medical Education); 72 FR 45201 (Rehabilitative Services Coverage); 72 FR 73635 (School-based Administration and Transportation); and 73 FR 9685 (Health Care Related Taxes). Specific alternatives considered were not detailed for the interim final rule on optional state plan case management services (72 FR 68077), a regulation promulgated under a Deficit Reduction Act requirement.

As is customary when developing regulations, CMS did weigh the options carefully before deciding on the policies contained in them. We ultimately undertook the rulemaking process in order to inform affected parties, allow for public input, and make clear that the requirements set forth are uniform, fair and consistent with the underlying statutory intent.

The Administration believes that all of these rules will help ensure that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid. They are rooted in the statutory construction of Medicaid as a matching program and some are the direct result of years of audits and recommendations by the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS), and the Government Accountability Office (GAO), as well as our experience in reviewing State plan amendments. These watchdog agencies, for the Executive Branch and Congress respectively, have sounded the alarm about the integrity of the program for years.

CMS believes that these rules are vital to inform policymakers about the nature of activities in the Medicaid program that are all too often hidden from view. When definitions of "rehabilitative services" and "targeted case management" are so broad that they are meaningless, or when the Federal government cannot identify precise spending on Graduate Medical Education or its direct benefits to the Medicaid population, public trust is eroded. These rules will help bring billions of dollars in taxpayer funds out of the shadows and will provide the accountability that is long overdue.

2. Mr. Engel requested a written response as to how public hospitals will be able to provide essential care to patients when faced with sweeping cuts to their funding, and who will pay for graduate medical education if $1.2 billion in Medicaid GME payments are eliminated.

While we appreciate your concerns and believe it is important for our nation to have access to a workforce of trained physicians, we also believe that CMS must abide by the statutory requirements set forth for the Medicaid program.

Under section 1903(a)(1) of the Social Security Act, federal financial participation (FFP), is available to States for a percentage of amounts "expended … for medical assistance under the State plan." The care and services that may be included within the scope of medical assistance under a Medicaid State plan are generally set forth in section 1905(a) of the Act. Included in this list, for example, are inpatient and outpatient hospital services. Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance. CMS does 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. Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services.

To address these concerns, CMS issued the proposed rule relating to Medicaid GME payments which you have referenced. States have the option of continuing to make GME payments to hospitals using other funding sources including state funds, national grants or requiring other local entities to participate in the funding of the state's medical education program.

The proposed rule addressing governmental providers will protect public hospitals from being required to return or refund some or all of their Medicaid payment. Instead, public hospitals will receive the full benefit of claimed Medicaid payments. This proposed rule will also provide that public hospitals may receive payment for the full cost of serving Medicaid patients, and so should not affect the ability of public hospitals to provide essential care to Medicaid patients. In addition, the Medicaid statute permits States to make additional payments to disproportionate share hospitals that may address the costs such hospitals may incur in serving uninsured patients.