

TABLE 2.—CROP GROUP 13-07: SUBGROUP LISTING

Representative commodities	Commodities
Crop Subgroup 13-07-A. Caneberry subgroup.	Blackberry; Raspberry, red and black; wild raspberry; loganberry; cultivars and/or hybrids of these.
Crop Subgroup 13-07-B. Bushberry subgroup.	Aronia, berry; blueberry, highbush, and cultivars and/or hybrids of these; blueberry, lowbush; currant, buffalo; Chilean, guava; currant, black; and currant, red; elderberry, European, barberry; gooseberry; cranberry, highbush; Honeysuckle, edible; Huckleberry; jostaberry; Juneberry; lingonberry; Native, currant; salal; Sea, buckthorn.
Crop Subgroup 13-07-C. Large shrub/tree berry subgroup.	Bayberry; Buffaloberry; che; chokecherry; elderberry; Juneberry; Mountain pepper, berries; mulberry; Phalsa; pincherry; riberry; salal; serviceberry.
Crop Subgroup 13-07-D. Small fruit vine climbing subgroup.	Amur river grape; gooseberry; grape; kiwifruit, fuzzy; kiwifruit, hardy; Maypop, Schisandra berry.
Crop Subgroup 13-07-E. Small fruit vine climbing subgroup, except grape.	Amur river grape; gooseberry; kiwifruit, fuzzy; kiwifruit, hardy; Maypop; schisandra berry.
Crop Subgroup 13-07-F. Small fruit vine climbing subgroup except fuzzy kiwifruit.	Amur river grape; grape, Kiwifruit, hardy; maypop; schisandra berry.
Crop Subgroup 13-07-G. Lowgrowing berry subgroup.	Bearberry; bilberry; blueberry, lowbush; cloudberry; cranberry; lingonberry; muntries; partridgeberry; strawberry
Crop Subgroup 13-07-H. Lowgrowing berry subgroup, except strawberry.	Bearberry; bilberry; blueberry, lowbush; cloudberry; cranberry; lingonberry; muntries; partridgeberry.

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(22) *Crop Group 21*. Edible fungi Group.

(i) *Representative commodities*. White button mushroom and any one oyster mushroom or any Shiitake mushroom.

(ii) *Table*. The following is a list of all the commodities in Crop Group 21. There are no related subgroups.

CROP GROUP 21: EDIBLE FUNGI GROUP—COMMODITIES

Blewitt, *Lepista nuda* (*Tricholomataceae*)
 Bunashimeji, *Hypsizygus marmoreus* (*Agaricaceae*)
 Chinese mushroom, *Volvariella volvacea* (Bull.) Singer (*Pluteaceae*)
 Enoki, *Flammulina velutipes* (Curt.) Singer (*Tricholomataceae*)
 Hime-Matsutake, *Agaricus blazei* Murill (*Agaricaceae*)
 Hirmeola, *Auricularia auricular* (*Auriculariaceae*)
 Maitake, *Grifola frondosa* (*Polyporaceae*)
 Morel, *Morchella* spp. (*Morchellaceae*)
 Nameko, *Pholiota nameko*, (*Strophariaceae*)
 Net Bearing Dictyophora, *Dictyophora indusiata* (*Phallaceae*)
 Oyster mushroom, *Pleurotus* spp. (*Tricholomataceae*)
 Pom Pom, *Herichium erinaceus* (*Hydnaceae*)
 Reishi mushroom, *Ganoderma lucidum* (Leyss. Fr.) Karst. (*Ganodermataceae*)
 Rodman's agaricus, *Agaricus bitorquis* (Quel.) Saccardo (*Agaricaceae*)
 Shiitake mushroom, *Lentinula edodes* (Berk.) Pegl. (*Polyporaceae*)
 Shimeji, *Tricholoma conglobatum*, (*Tricholomataceae*)
 Stropharia, *Stropharia* spp. (*Strophariaceae*)
 Truffle, *Tuber* spp. (*Tuberaceae*)
 White button mushroom, *Agaricus bisporus* (Lange) Imbach (*Agaricaceae*)
 White Jelly Fungi, *Tremella fuciformis* (*Tremellaceae*)

[FR Doc. E7-9595 Filed 5-22-07; 8:45 am]

BILLING CODE 6560-50-S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 438 and 447

[CMS-2279-P]

RIN 0938-A095

Medicaid Program; Graduate Medical Education

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This 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.

DATES: *Comment date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 22, 2007.

ADDRESSES: In commenting, please refer to file code CMS-2279-P. Because of staff and resource limitations, we cannot accept comments by facsimile (Fax) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues

in this regulation to <http://www.cms.hhs.gov/eRulemaking>. Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only:

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

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only:

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.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Dianne Heffron, (410) 786-3247.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.cms.hhs.gov/eRulemaking>. Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs, operated by the State under an approved State plan, that provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities. Under section 1903(a)(1) of the Act, federal grant funding, or 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 (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) of the Act. Included in this list, for example, in sections 1905(a)(1) and 1905(a)(2), 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.

Section 1902(a)(30) of the Act requires States to develop payment methodologies for services provided under the Medicaid State Plan that are consistent with economy, efficiency and quality of care. CMS has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services.

For the reasons we explain in more detail below, 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. Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services. GME is not a health service (in contrast to the activities of disproportionate share hospitals). Therefore, we are proposing in this issuance to preclude FFP in State payments for GME.

Inpatient Hospital Rates

States are responsible for setting inpatient hospital rates. Section 1902(a)(13) of the Act requires States to develop rates for inpatient hospital services in a public process. Section 1902(a)(30)(A) of the Act further requires Medicaid service rates to be consistent with economy, efficiency, and quality of care. These provisions afford States a great deal of flexibility in determining their inpatient hospital rates. States may use various reimbursement systems including diagnosis-related groups (DRGs), per diem, case rates, cost or other payment methodologies as long as the methodologies meet the regulations at 42 CFR part 447 subpart C. An important limitation States must adhere to is the upper payment limit (UPL) which describes a payment level above which FFP is not available. The UPL implements, in part, the statutory requirement for payment rates that are, "consistent with efficiency, economy, and quality of care" at section 1903(a)(30)(A) of the Act. The regulations at 42 CFR 447.272 and 447.321 define the UPL for hospital services. States must demonstrate that the rates they have developed to reimburse Medicaid hospital services do not, in the aggregate, and within three provider categories (government, non-State government, or private), exceed a reasonable estimate of what Medicare would have paid for the same services using Medicare payment principles.

Unlike Medicaid, the Medicare program has very specific and detailed statutory requirements regarding payments for hospital services. The current payment system for hospitals segregates payments made to hospitals into two basic payments; operating costs and capital costs of inpatient hospital services. Prospective Hospital Payments can be supplemented by direct medical education (DME) or indirect medical education (IME) payments. The requirements are set forth in section 1886 of the Act. This section defines costs, details the cost reporting process, delineates a few categories of hospitals that are paid directly on the basis of

reported costs and provides for the use of reported costs in the development of Medicare's prospective payment system for most hospitals. In particular, in section 1886(a)(4) of the Act, Medicare defines "operating costs of inpatient hospital services" as:

* * * All routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all service for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient. * * * Such term does not include costs of approved educational activities. * * *

Thus, Medicare expressly excludes costs associated with educational activities from the operating costs that can be included in the cost base used to develop the basic payment amounts under Medicare's prospective payment system for inpatient hospital services.

Medicare and Graduate Medical Education

With the creation in 1965 of the Medicare program, in anticipation of a need for additional physicians to treat a newly insured, aged-patient population, the costs associated with GME were included as reimbursable Medicare costs. The Office of the Inspector General (OIG) issued a report in 1994 entitled *A Study of Graduate Medical Education Costs* describing the origins of Medicare policy regarding GME as based on a physician shortage in the U.S. that existed in the 1950s and 1960s. Physician training was viewed as a public good and,

* * * Congress decided that Medicare should participate in educating physicians until communities shouldered the costs in some other fashion. Hence, it created Medicare GME funding for teaching hospitals.

By the 1980s, the U.S. had a surplus of physicians and the alternative community sources for GME funding never materialized. The same OIG report indicated that there were attempts by the Congress and this agency to substantially limit or eliminate Medicare GME subsidies. Instead, the Medicare payment system for inpatient hospital services was completely altered in 1983, moving from cost reimbursement to a prospective payment system (PPS). The PPS included payments to hospitals for the costs of GME. The new system created two types of payments unique to teaching hospitals. The direct graduate medical education payment (DGME)

compensates teaching hospitals for the direct costs of their educational activities, as measured by the number of residents being trained and the historic cost of training residents. Additionally, qualifying teaching hospitals receive an indirect medical education (IME) adjustment to their per discharge payment under the Medicare IPPS (inpatient prospective payment system) to account for additional costs (other than the direct costs of the training program) that teaching hospitals incur in treating Medicare patients. This additional payment reflects the costs of providing care at teaching hospitals generally due to the added costs of "learning by doing" treatment methods, and is in addition to the basic prospective payment for inpatient services based on "operating costs of inpatient hospital services".

Medicare recognizes direct costs of approved educational programs in sections 1886(h) and (k) of the Act. Indirect medical education payments are provided for at section 1886(d)(5) of the Act. These sections address graduate medical education activities separate and apart from the other costs of providing inpatient hospital services. The statute provides specific instructions regarding which educational programs qualify a hospital for the additional GME payments and provides an explicit methodology to calculate the Medicare payment to an individual hospital for both its direct graduate medical education program and its indirect medical education payments.

Regulations at 42 CFR part 412 describe the prospective payment system. Again, direct medical education costs are identified as excluded from the other Medicare inpatient hospital operating costs used to develop Medicare's prospective inpatient rates. Direct graduate medical education is specifically prohibited as part of the inpatient PPS rate at § 412.2(2)(e). Indirect medical education is separately identified as a payment adjustment based on a formula at § 412.105. The costs that the IME adjustment reimburses a qualifying hospital for are included as inpatient hospital operating costs on the Medicare cost report. IME is an adjustment to the IPPS discharge rate. The IPPS rate is an "average" rate based on the efficient provision of inpatient care at all hospitals. The IME adjustment is intended to compensate teaching hospitals for the additional costs they incur when providing hospital services versus non-teaching hospitals.

Medicaid and Graduate Medical Education Generally

In a 2003 state survey conducted by the Association of American Medical Colleges, 47 States and the District of Columbia reported using Medicaid funds to make GME payments under the Medicaid State Plan. Of these, 35 indicated that the payments were included in their per diem inpatient hospital rates, and 15 stated using supplemental or a combination of supplemental and per diem payments to make GME payments. This same report, *Medicaid Direct and Indirect Graduate Medical Education Payment: A 50 State Survey*, indicates that while States view these Medicaid GME payments as critical to State GME policy implementation, they generally do not track these payments.

In large part, this inability to track Medicaid GME payments is due to the way in which these payments are made (which we discuss in more detail below). Basically, payments are made through increases in the rates paid for covered Medicaid services. This methodology assures Federal participation, but does not provide clear accountability. Funding intended by the States to support GME often becomes subsumed within MCO or hospital rates (including supplements to these rates) or inpatient disproportionate share hospital (DSH) payments. As a result, it is difficult to quantify Medicaid GME payments or monitor and measure the effect of Medicaid payments on GME programs.

Medicaid State Plan Payments

As previously stated, Medicaid law does not dictate detailed payment requirements for covered hospital services. Rather, States are permitted flexibility, subject to a reasonable estimate of what Medicare would have paid for the services, to develop their own methods and standards to determine the price they will pay for Medicaid covered services. States are required to include such payment methodologies in their State plans, and thus must submit their payment methodologies to CMS for review and approval. Once approved, States receive FFP for the Medicaid payments they make under the approved methodology.

Since there is no express authority in the Medicaid statute for payments to support GME programs, to receive FFP for such payments, the payments must be made under the guise of payments made for covered Medicaid services under the approved Medicaid State plan. Usually the payments are part of the inpatient hospital Medicaid rate

structure. This is because the Medicaid inpatient UPL references Medicare payment principles as an integral part of the inpatient UPL calculation, and Medicare makes GME payments as a supplement to inpatient hospital service payment rates.

States routinely make payments to hospitals up to the maximum level permitted under the UPL, using methodologies that have a base payment rate and provide for supplemental payments to selected types of hospitals. This is possible because the base reimbursement rates are, in the aggregate, below the UPL for the particular category of provider. This creates a "gap" beneath the UPL that allows States to make the supplemental payments for select providers. Some or all of these supplemental payments may be directed at hospitals which operate GME programs.

There are limitations on the State's flexibility in designing their Medicaid programs and reimbursement under current regulations to provide funding for GME programs stemming from the absence of any direct authority to reimburse GME under Title XIX. Because this funding must be part of payment for medical services (either directly or included in comprehensive capitation rates paid to MCOs), this funding is not necessarily limited to teaching hospitals, linked to educational costs or measures, or coordinated with other sources of GME funding. Therefore, it is difficult for States to design Medicaid payments to correspond with the operation of GME programs in the State. This is particularly true in the case of GME programs that include significant training in non-hospital settings. As a result, there is generally no assurance that supplemental Medicaid payments for GME are actually effective in supporting these programs, or in furnishing any benefit to Medicaid program beneficiaries.

Under the Medicaid program, beneficiaries receive a defined benefit package consisting of a variety of mandatory and optional services provided to qualifying recipients. The statute creates a Federal/State partnership to share in the cost of providing these health care services to low-income populations. The current program structure supports State definition of eligible populations, coverage options, and reimbursement for covered services for these eligible individuals. This structure does not accommodate the State medical training policy and goals. The Federal government is also limited by its statutory authority to only evaluate and

monitor the efficiency and economy of Medicaid spending as it relates to rates paid for medical services and not for GME as no such authority to do so exists within current law.

This rule proposes to clarify that CMS will not consider funding for GME as expenditures for a covered Medicaid service. We distinguish 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. This rule would clarify that GME is outside the scope of medical assistance, and that GME funding is not an allowable component of payment methodologies included in a State's approved Medicaid State Plan or in any Medicaid managed care payment. This includes all payments under attachments 4.19-A and 4.19-B of a State's Medicaid State Plan. The rule would also provide that when calculating an inpatient UPL, States may not include additional payments Medicare makes to a hospital for direct educational costs as part of the reasonable estimate of Medicare payment. And the rule would provide that States may, as part of their UPL calculation, include Medicare payments for indirect medical education as these payments represent additional costs associated with providing services in teaching hospitals. CMS specifically seeks comments on the propriety of including Medicare IME adjustments as part of the UPL calculation.

States may not make any educational payments under the Medicaid State Plan but are able to recognize, as part of the inpatient hospital rate structure, the additional Medicaid covered service costs that teaching hospitals incur when delivering Medicaid covered services.

States that currently include GME payments as part of other services or administrative costs under the Medicaid State Plan must also cease claiming Federal funds for these educational program payments.

II. Provisions of the Proposed Rule

The provisions of this rule propose to clarify that, for purposes of Medicaid reimbursement eligible for FFP, GME is not an allowable cost or payment for medical assistance under the approved Medicaid State Plan. The provision would apply to all Medicaid providers and must be implemented in the first full State fiscal year following the effective date of the subsequent final rule.

We are proposing to modify the regulations at 42 CFR part 447.

Currently the general instructions regarding Medicaid State Plan requirements for payment methods for all Medicaid services are provided at § 447.201. We propose to add a new § 447.201(c) to indicate that GME cannot be included as part of any payment methodology in the Medicaid State Plan. We have included this clarification to address States that have included GME as part of their rate system for non-institutional services, institutional services, or as an administrative cost eligible for FFP.

We propose also to modify §§ 447.257 and 447.304 to address that FFP is no longer available for any reimbursement that includes or specifically pays for GME. The current paragraph would be redesignated as paragraph (a) and a new paragraph (b) would be added providing that no FFP would be available for GME under the approved Medicaid State Plan.

We propose to modify § 447.272(b)(1) and 447.321(b)(1) to indicate that the term "Medicare payment principles" must exclude any Medicare payments associated with direct GME when calculating the Medicaid UPL.

We propose to modify § 438.6(c)(5) by removing paragraph (v) that addresses the coordination of GME payments under the State plan with capitated rates paid to a Medicaid MCO.

We propose to modify § 438.60 to provide that the limit on payment to other providers would not include an exception related to GME payments made to providers outside the capitation rate and under the Medicaid State Plan.

III. Collection of Information Requirements

This document does not impose any information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–534), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties, and Executive Order 13422) directs agencies to assess all costs and benefits of all available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant (\$100 million or more in any 1 year). This rule would surpass the economic threshold and is considered a major rule. This rule is estimated to reduce Federal Medicaid outlays by \$140 million in FY 2008, by \$290 million in FY 2009, by \$440 million in FY 2010, by \$450 million in FY 2011, and by \$460 million in FY 2012.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6.5 million to \$31.5 million in any 1 year. Individuals and States are not included in the definition of a small

entity. We are not preparing an analysis for the RFA because the regulation would not have a direct impact on small entities. In this case, the regulation would directly affect payments the States receive from the Federal government, and the impact on health care facilities is a secondary impact. States may choose to continue to fund direct medical education programs using State-only funding; this rule simply eliminates the availability of Federal Medicaid funding for such direct education programs. Additionally, most hospitals that would qualify as small entities would likely be unaffected by this rule as they are unlikely to offer medical education programs. Generally, medical education programs are sponsored by large hospitals offering a variety of medical specialties and services. As we are uncertain of the impact on small entities, we specifically request public comment on the impact of small health care facilities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this rule would not have a direct impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also

requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$120 million. This rule would not result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$120 million. This rule anticipates federal savings in excess of \$120 million but does not require States to replace that federal funding with state funding. There is no federal mandate to fund GME programs with State funding. Funding GME is not a required activity or enforceable duty arising from participation in Medicaid, thus any reduction in federal funding will not decrease the funding available for required activities under the Medicaid program.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement or cost on State and local governments, preempts State law, or otherwise has Federalism implications. For purposes of Executive Order 13132, we find that this rule will not have a substantial effect on State or local government. While this regulation would eliminate the ability of States to claim Federal Medicaid funding for direct GME, it would not impose any requirement that States pay for such GME. The rule would simply recognize that GME is not authorized under the Medicaid statute as an element of medical assistance that is eligible for Federal Medicaid funding.

B. Anticipated Effects

ESTIMATED REDUCTION IN FEDERAL MEDICAID OUTLAYS RESULTING FROM THE GRADUATE MEDICAL EDUCATION PROPOSAL BEING IMPLEMENTED BY THIS PROPOSED RULE—ANNUAL EXPECTED SAVINGS
[Amounts in millions]

Reduction in Federal Medicaid outlays in million dollars by fiscal year					
	2008	2009	2010	2011	2012
Graduate Medical Education Exclusion	\$140	\$290	\$440	\$450	\$460

Accounting Statement

As required by OMB Circular A–4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in the table below, we have prepared an accounting statement showing the classification of the expenditures associated with the provision of this proposed rule. This table provides our best estimate of the

reduction in Federal Medicaid outlays for the years 2008 through 2012 as result of the changes presented in this proposed rule. This rule only affects transfer payments between the Federal government and State governments.

Direct Graduate Medical Education (DGME)

1. Effects on State Medicaid Programs

Since Graduate Medical Education is not a Medicaid service authorized in Title XIX of the Act, States are not required to report GME costs on the form CMS–64–9. Instead, States that claim Federal funding for GME

generally do so as a portion of their inpatient hospital rates, inpatient hospital supplemental payments, MCO payments or, in limited instances, as part of a supplemental, non-institutional provider payment.

Because of the absence of a reporting obligation, the amount actually expended for Medicaid GME is not readily determinable. The Federal Government has no way to directly determine the number of States making GME payments, amounts States are spending or claiming as GME or the total number of hospitals receiving such payments. Any GME funding claimed would simply be reflected within total outlays related to a particular service category, such as inpatient hospital, on the form CMS 64.9. In addition, the impact of eliminating the Medicare DGME payment as part of a State's UPL calculation is difficult to determine because most states do not include their UPL methodology as part of their approved Medicaid State plan. States have the option of including this payment in their UPL calculation but it is not a requirement.

Estimates of the impact of eliminating Direct Graduate Medical Education as an allowable program cost or payment were derived from data on State GME payments from a survey conducted by the National Conference of State Legislatures (NCSL) and published in the Journal of Health Affairs in 2000. The NCSL GME estimates were trended forward by the Consumer Price Index to establish a project baseline of GME payments for FY 2008 through 2012. CMS also estimates an offset applied to these payments to account for behavioral changes, including the likelihood that States may replace a portion of their GME payments with other payments to hospitals to achieve a similar Federal spending level. The resulting net savings were calculated using an average Federal matching rate of 57 percent. CMS specifically seeks comment on the amount States pay and methods States use to pay for DME and IME in their Medicaid programs.

States have several options to address medical education funding. One option is to replace funding provided as the Federal share of a Medicaid GME payment with State-only funding or private sector funding. States may increase other generally applicable taxes to provide funding for general medical education.

States could also work through a better coordination of funding to more effectively leverage and coordinate all GME funding in a State, including Federal funding available through Area Health Education Centers (AHECs),

Medicare funding, grant funding, and State funding to more effectively manage health education policy and outcomes.

2. Effects on Other Providers

CMS currently cannot precisely estimate the total number of providers receiving Medicaid GME payments. States are not required to report this information nor are they required to make such payments to only teaching hospitals. The exclusion of the Medicare DGME payment when calculating a class of providers' applicable UPL could lower the ceiling for Medicaid payments available to a provider within that class but CMS cannot estimate the impact since States are not required to include the adjustment and CMS currently does not have information on how many currently do include it. However, States may pay providers up to the UPL, including the IME payment adjustment made by Medicare to compensate teaching hospitals for additional service delivery costs associated with providing care in teaching hospitals. Providers will continue to receive payments for covered Medicaid services, and hospitals that serve a disproportionate share of low-income patients will continue to be eligible for additional DSH payments. States may also provide State-only funding for direct educational costs thus alleviating any revenue loss associated with the Medicaid DGME exclusion.

C. Alternatives Considered

In developing this regulation, the following alternatives were considered. We considered the possibility of providing stronger review of State Plan reimbursement methodologies for graduate medical education. In addition, we considered developing standard parameters applicable to all Medicaid GME payments (for example, a requirement that payment should not exceed the unmet cost of the GME program, counting all GME revenue when determining unmet GME program cost). These alternatives would address our concern over the lack of oversight and accountability for Medicaid GME funding. They would also address concerns that federal payments for GME through three separate programs (Medicare, Medicaid, and AHECs) are not coordinated with overall program goals.

In evaluating these alternatives, however, we were limited by the absence of any statutory authority in the Medicaid program to make GME payments. Absent such authority, we believe we are limited in our ability to regulate such payments because the

payments have been made under some other category. In other words, because there is no direct statutory authority for GME payments under a Medicaid State Plan, there is little authority to regulate or oversee such payments if allowed.

As discussed above, States make GME payments through provider rates paid to reimburse medical services delivered. The existing statute and regulations addressing these payments do not provide CMS with the regulatory authority to require payment methodologies identified as GME to detail specific program requirements or apply any minimum program parameters for their approval.

In short, CMS lacks any express statutory authority to match Medicaid GME payments as program costs and therefore lacks clear regulatory authority to manage Federal participation in GME programs under current law.

OMB—STATEMENT OF ACCOUNTS

	Annualized monetized transfers (in millions per year)
Non-discounted	\$356
3%	351
7%	345

The savings reflect a reduction in payments from the federal government to the States.

D. Conclusion

For these reasons, we are not preparing an analysis for either the RFA or section 1102(b) of the Act because we have determined that this rule would not have a direct significant economic impact on a substantial number of small entities or a direct significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 438

Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 438—MANAGED CARE

1. The authority citation for part 438 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—General Provisions**§ 438.6 [Amended]**

2. Section 438.6 is amended by removing paragraph (c)(5)(v).

Subpart B—State Responsibilities

3. Section 438.60 is revised to read as follows:

§ 438.60 Limit on payment to other providers.

The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act or in 42 CFR.

PART 447—PAYMENTS FOR SERVICES

4. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart B—Payment Methods: General Provisions

5. Section 447.201 is amended by adding a new paragraph (c) to read as set forth below.

§ 447.201 State plan requirements.

(c) The plan must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system (including costs or payments claimed as administrative costs).

Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

6. Section 447.257 is amended by:
A. Designating the existing paragraph as paragraph (a).
B. Adding a new paragraph (b) to read as follows:

§ 447.257 FFP: Conditions relating to institutional reimbursement.

(b) FFP is not available in expenditures for graduate medical education in hospitals and long-term care facilities.

7. Section 447.272 is amended by republishing the heading to paragraph (b) and revising paragraph (b)(1) to read as follows:

§ 447.272 Inpatient services: Application of upper payment limits.

* * * * *

(b) *General rules.* (1) “Upper payment limit” refers to a reasonable estimate of the amount that would be paid for the services furnished by the groups of facilities under Medicare payment principles in subchapter B of this chapter. For purposes of the Medicaid upper payment limit calculation, direct graduate medical education payments are not an allowable component of a Medicare payment and must be excluded from the calculation.

* * * * *

Subpart F—Payment Methods for Other Institutional and Non-Institutional Services

8. Section 447.304 is amended by:

A. Revising paragraph (b) to read as follows:

§ 447.304 Adherence to upper limits; FFP.

* * * * *

(b) FFP is not available in expenditures for graduate medical education.

* * * * *

9. Section 447.321 is amended by republishing the heading to paragraph (b) and revising paragraph (b)(1) to read as follows:

§ 447.321 Outpatient hospital and clinical services: Application of upper payment limits.

* * * * *

(b) *General rules.* (1) “Upper payment limit” refers to a reasonable estimate of the amount that would be paid for the services furnished by the groups of facilities under Medicare payment principles in subchapter B of this chapter. For purposes of the Medicaid upper payment limit calculation, direct graduate medical education payments are not an allowable component of a Medicare payment and must be excluded from the calculation.

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(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: May 11, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: May 17, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–2576 Filed 5–18–07; 4:38 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION**47 CFR Part 54**

[WC Docket No. 05–337, CC Docket No. 96–45, FCC 07–88]

High-Cost Universal Service Support; Federal-State Joint Board on Universal Service

AGENCY: Federal Communications Commission.

ACTION: Notice of proposed rulemaking.

SUMMARY: In this document, the Commission seeks comment on the Federal-State Joint Board on Universal Service’s recommendation that the Commission adopt an interim cap on support for competitive Eligible Telecommunications Carriers.

DATES: Comments are due on or before June 6, 2007. Reply Comments are due on or before June 13, 2007.

ADDRESSES: You may submit comments, identified by WC Docket No. 05–337 and CC Docket No. 96–45, by any of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Federal Communications Commission’s Web Site:* <http://www.fcc.gov/cgb/ecfs/>. Follow the instructions for submitting comments.
- *People with Disabilities:* Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by e-mail: FCC504@fcc.gov or phone: 202–418–0530 or TTY: 202–418–0432.

For detailed instructions for submitting comments and additional information on the rulemaking process, see the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Ted Burmeister, Attorney, Wireline Competition Bureau, Telecommunications Access Policy Division, (202) 418–7400, TTY (202) 418–0484.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission’s *Notice of*