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# medicaid and the uninsured

January 2008

## Medicaid: Overview and Impact of New Regulations

### Overview

In the past year the Administration has moved forward with changes to the Medicaid program via rule making that have noteworthy implications for states, providers, beneficiaries and federal spending. Medicaid serves multiple and unique roles in the health care system. The program provides health coverage and long-term care supports to over 44 million people in low-income families and nearly 14 million elderly and disabled people. The program is jointly financed by the states and the federal government, but Medicaid is administered on a day-to-day basis by the states within the parameters of federal law and regulations. The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for interpreting and implementing the federal Medicaid statute through regulations and other guidance. In recent years, CMS issued new regulations and guidance to help implement two major pieces of federal legislation: The Medicare Modernization Act and the Deficit Reduction Act of 2005. In addition, the Administration has also proposed major regulatory initiatives that would change long-standing Medicaid policy by regulation rather than legislative action. In some cases, the policy changes had been first proposed as legislative changes and then rejected by Congress.

Taken together, six new regulations could result in an estimated \$12 billion reduction in federal Medicaid spending over the next five years according to the regulatory impact statements prepared by CMS. The Administration maintains that “each of these rules is vitally important to ensure the integrity of the Medicaid program....and that taxpayers are receiving the full value of their dollars that are spent through Medicaid.”<sup>1</sup> The Administration views the estimated five year reduction in federal Medicaid spending as a very small share of expected Medicaid spending over the next five years. However, members of Congress, states, beneficiaries and providers have raised concerns that these changes could have serious negative consequences and may be inconsistent with Medicaid policies enacted by the Congress. Congress has imposed moratoriums on four of the six rules discussed in the brief and the effect of these regulations was the subject of a Congressional Hearing on November 1, 2007.<sup>2</sup> Congressional action to block regulations with estimated federal savings has budget implications because of CBO scoring rules and PAYGO rules that require Congress to find offsets to pay for these changes.

While there is widespread agreement on the need to protect the fiscal integrity of the Medicaid program, critics argue that the cumulative effect of these regulations and other federal actions could adversely affect vulnerable beneficiaries, safety-net providers, and states in how they administer and budget for Medicaid. States have also raised concerns that estimated federal “savings” actually represents a shift in costs to states (i.e. states would have to either use state-only funds to maintain programs or terminate critical services). Because states must balance their budgets each year, this cost shift could significantly affect their ability to maintain services

for current beneficiaries or to use the Medicaid program as a foundation and building block to expand coverage to the uninsured. This cost shift to states would occur when many are already expected to face budget shortfalls due to the weakening economy.

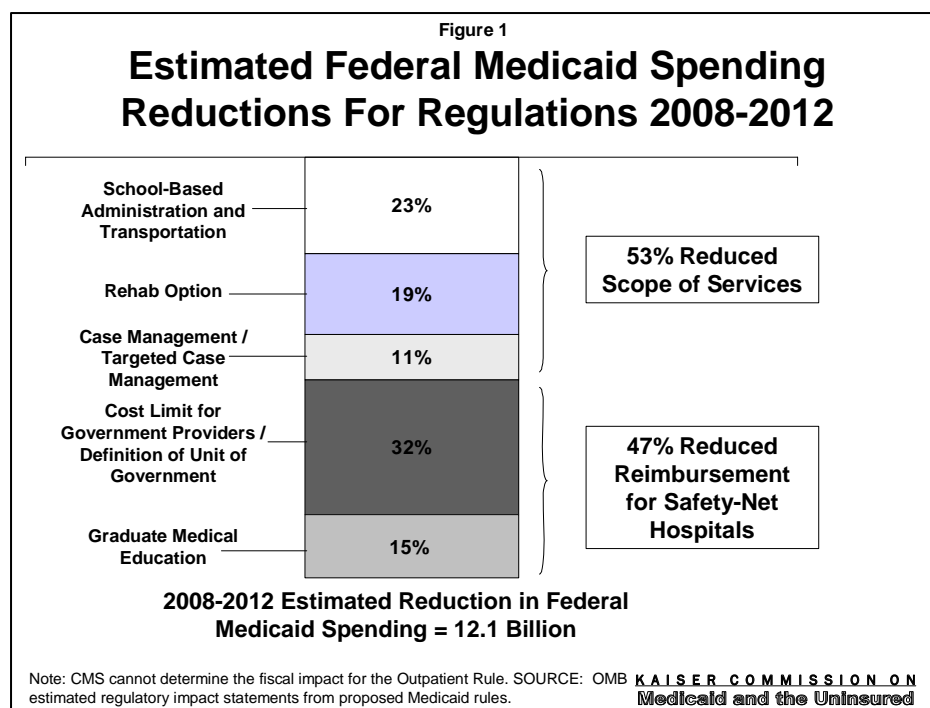
This brief focuses on six new regulations that have been the source of considerable controversy. The brief explains current policy, the proposed regulatory changes as well as the impact and issues with these changes. (Exhibit 1)

**Exhibit 1**

<b>Regulations</b>	<b>Description</b>	<b>Estimated Federal Cost Impact 2008-2012</b>	<b>Status</b>
Cost Limit for Providers Operated by Units of Government	Rule would limit reimbursement for government providers to cost; narrow the definition of a unit of government and require providers to retain all Medicaid payments.	\$3.9 billion reduction	Final rule - 5/29/07. Moratorium through 5/25/08.
Graduate Medical Education (GME)	Rule would eliminate Medicaid reimbursement for GME (cost of medical residents)	\$1.8 billion reduction	Proposed rule - 5/30/07. Moratorium through 5/25/08
Rehabilitation (Rehab) Service Option	Rule would restrict the scope of rehab services that are eligible for federal Medicaid matching payments and eliminate coverage for day habilitation services for people with developmental disabilities.	\$2.3 billion reduction	Proposed rule - 8/13/07. Moratorium through 6/30/08
Administrative Claiming and Transportation Costs for School Based Services	Rule would prohibit Medicaid payments for administrative activities (including outreach, enrollment and support in gaining access to EPSDT services) performed by schools and transportation of school-age children to and from school.	\$2.8 billion reduction	Final rule- 12/28/07. Moratorium through 6/30/08
Outpatient Services	Rule would restrict the scope of Medicaid outpatient hospital services and clarify the outpatient upper payment calculation	CMS cannot determine the fiscal impact	Proposed rule - 9/28/07.
Targeted Case Management (TCM)	The rule restricts the scope of case management services and targeted case management (TCM) and specifies that federal Medicaid is not available for TCM if there are other third parties liable to pay for those services.	\$1.3 billion reduction	Interim final rule - 12/4/07

## New Medicaid Rules

The Administration proposed a series of new regulations that could reduce federal Medicaid spending by an estimated \$12 billion over the next five years, but critics believe at the cost of adversely affecting states, providers and beneficiaries (Figure 1). Implementation of regulations does not require Congressional action; however, if Congress determines that rules are inconsistent with Congressional statutory intent, then legislative action is required to bar the implementation of the regulations. Individuals or injured parties may also challenge rules in federal court if they allege that the rulemaking process did not comport with the Administrative Procedures Act (APA) or other federal laws, or if they allege that a rule exceeds the regulatory authority granted by Congress. The regulations discussed below are all in various stages of the regulatory process.



### 1. Medicaid Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Partnership

**Current Policy.** Under current policy, states are able to use intergovernmental transfers (IGTs) to finance their Medicaid programs. IGTs are transfers of public funds between governmental entities (i.e. counties to states) or within the same level of government (i.e. from a state university hospital to the state Medicaid agency). The federal Medicaid statute explicitly recognizes the legitimacy of IGTs involving tax revenues. Section 1903(w)(6)(A) of the Social Security Act specifies that "the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care

provider.” The state share of Medicaid spending must consist of public funds and no more than 60 percent of the state share may be from local funds.

The rules around Upper Payment Limits (UPLs) govern how states pay types and classes of providers. The current UPL regulations allow Medicaid payments to individual providers by type (hospitals or nursing homes) to exceed the cost of providing services at the facilities as long as aggregate payments do not exceed what Medicare would have paid for classes of providers by ownership (state, private or non-state public).

In the past, states have used IGTs in conjunction with other Medicaid special financing mechanisms such as UPL or DSH (disproportionate share hospital) payment arrangements to maximize federal Medicaid dollars. The GAO and OIG have done numerous reports on these issues over the years. Congress and various Administrations have implemented changes in the Medicaid statute and regulatory changes to address these financing arrangements. In 2000, Congress required CMS to issue regulations that would apply separate UPLs to local public providers.<sup>3</sup> In 2002, CMS issued another regulation that further lowered the UPL for local public hospitals.

***Proposed Regulatory Change.*** On May 29, 2007 the Administration released a final rule that would: limit reimbursement for government-operated providers to costs of treating Medicaid patients; narrow the definition of a unit of government, and require that providers retain the full amount of Medicaid payments that they receive.

***Impact.*** This regulation is expected to reduce federal Medicaid spending by \$3.9 billion over the next five years although some safety-net providers worry that higher levels of federal financing are at risk. CMS asserts that this rule is necessary to protect the fiscal integrity of the Medicaid program. CMS has made concerted efforts to address concerns about Medicaid financing practices. According to GAO, oversight actions taken by CMS from 2003 to 2006 resulted in 29 states ending inappropriate financing arrangements where providers did not retain all payments made to them and instead returned some to the states. While GAO found CMS actions consistent with Medicaid payment principles, there was a lack of transparency in the implementation of oversight activities.<sup>4</sup> CMS maintains that this regulation would help curb inappropriate financing arrangements and reduce improper Medicaid payments.

Members of Congress, the National Association of Medicaid Directors, the National Governors’ Association, the National Association of Public Hospitals and the American Hospital Association were among those opposed to these regulations. These groups are concerned that the regulation would have a “detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.” There are concerns that the cost limit for public hospitals cuts funding for safety-net providers, that the cost limit is arbitrary since non-government providers are not subject to the same limits and that these rules are inconsistent with provisions in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 that explicitly required CMS to issue a final regulation that applied an aggregate upper payment limit and not a limit based on an individual provider’s costs. Additionally, since the definition of cost is not included in this regulation, some worry that “allowable costs” might not

recognize all legitimate hospital costs and therefore place another limit on Medicaid reimbursement.

Concerns were also raised about the more restrictive definition of a unit of government to a “unit of local government with generally applicable taxing authority” and the provisions that would require providers to retain the full amount of Medicaid payments that they receive. Both of these changes could limit states’ ability to finance their Medicaid programs by restricting their ability to use local funding from public entities that are allowed under current law. For example, the new definition of a unit of government is much more narrow than current law and could exclude some public hospitals. In recent years, a number of many public hospitals went through conversions to become “quasi-governmental” entities such as public benefit corporations or hospital authorities so that they would have more operating flexibility that is not generally available to state agencies.

*Status.* The effective date of the rule was July 7, 2007, but Congress imposed a moratorium on any action related to the regulation through May 2008.<sup>5</sup> CBO estimated that the moratorium on this rule and the Medicaid GME rule together would cost the federal government \$160 million.

## **2. Medicaid Graduate Medical Education**

*Current Policy.* States currently have a great deal of flexibility over the methodologies used to pay providers. Many states use Medicaid to support GME (Medicare requires reimbursement for GME). Medicare and Medicaid GME payments subsidize the costs of training medical residents. In 2005, 45 states and the District of Columbia provided GME payments under Medicaid.<sup>6</sup>

*Proposed Regulatory Change.* The President’s budget would eliminate Medicaid reimbursement for GME. The regulations say that state Medicaid plans “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.”<sup>7</sup> CMS states that the regulations “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.”

*Impact.* The regulatory impact statement estimates a reduction in federal spending of \$1.8 billion over 2008 to 2012 period. The Administration believes that GME is outside the scope of Medicaid’s role, which is to provide medical care to low-income populations...there is no explicit authorization under the Medicaid statute to subsidize the training of physicians.”<sup>8</sup> The Association of American Medical Colleges (AAMC) has filed comments stating that the rules “represent a major and abrupt reversal of long-standing Medicaid policy.”<sup>9</sup> The AAMC also contends that the proposed rule has no legal justification and could have a major negative impact on the health care system. Teaching hospitals represent twenty percent of all hospitals but 42 percent of all Medicaid discharges; therefore Medicaid represents a significant share of total revenues for teaching hospitals. AAMC further argues that eliminating federal Medicaid GME payments could “cripple graduate medical education programs at a time when they are attempting to expand to assure an adequate supply of physicians, both now and in the future.”

**Status.** CMS issued a proposed rule on May 30, 2007. Congress imposed a moratorium on any action related to the regulation through May 2008.<sup>10</sup> CBO estimated that the moratorium on this rule and the Medicaid GME rule together would cost the federal government \$160 million.

### **3. Medicaid Rehabilitation (Rehab) Service Option**

**Current Policy.** The rehab option is unique among Medicaid service categories for the flexibility it gives states regarding the scope and types of services, and the settings in which services can be provided. For this reason, states use the option to serve specific populations whose unique needs demand this flexibility, such as people with mental illness, people with developmental disabilities, and children receiving foster care. Currently, 47 states plus the District of Columbia provide services under the Medicaid rehabilitation option (rehab option). In 2004, an estimated 1.46 million individuals received services under the option at a total cost of \$4.9 billion. Nearly three-quarters of the beneficiaries (73 percent) receiving rehab services were people with mental health needs, and these beneficiaries represented 79 percent of all rehab spending.<sup>11</sup> An increased reliance on the Medicaid rehab option to provide services to individuals with mental illness over the past couple of decades appears to be tied to a decline in the use of state-funded psychiatric institutions which has led to an increase in the need for Medicaid-funded community-based mental health services. The President's New Freedom Commission on Mental Health in 2003 has supported this transition to consumer- and family-driven services that focus on recovery. A past State Medicaid Director's Letter (SMD) and other CMS policy guidance highlighted the evidence base for assertive community treatment (ACT) and related services and the ability of Medicaid programs to cover these services.<sup>12</sup>

**Proposed Regulatory Change.** The new rule would restrict the types of services eligible for federal matching payments under the Medicaid rehab option. The rule would impose an "intrinsic element" test which would restrict coverage of rehab option services when the services are determined to be an intrinsic element of another federal, state or local program, a statutory change proposed by the Bush Administration that was rejected by the Congress when enacting the DRA.<sup>13</sup> The rule also eliminates all coverage under the rehab and clinic services option for day habilitation programs.

**Impact.** The regulatory impact statement estimates a \$2.3 billion reduction in federal Medicaid spending over the 2008 to 2012 five year period. According to the Administration, "in recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a catch-all phrase...states have taken advantage of the ambiguity and confusion to bill Medicaid for a wide variety of services outside the scope of medical assistance...our proposed rule is clinically based and patient centered."<sup>14</sup>

States, advocates and beneficiaries and their families who rely on Medicaid rehab services argue that the new regulations would reduce federal financing for essential rehab services and limit states ability to define what constitutes a rehab services. Programs that offer assertive community treatment, psychiatric rehabilitation, and psycho-educational day programs that allow individuals with serious mental illness to live and work in the community could be prohibited under Medicaid if claimed as rehabilitation services.<sup>15</sup> Specifically, the regulation would



effectively prohibit federal Medicaid matching funds when the claim involves therapeutic foster care billed as a rehabilitation service. This service now covers specialized foster care placement for children with serious mental illness with specially trained parents as a cost-effective alternative to institutional placements for these children.

*Status.* The Administration issued a proposed rule on August 13, 2007. S. 2499, the legislation that extended the SCHIP program included a moratorium on any administrative actions (including this proposed rule) that would restrict Medicaid rehab option services through June 30, 2008.

#### **4. Medicaid School-Based Administrative Costs and Transportation To and From School**

*Current Policy.* Under current policy, Medicaid pays for a broad range of covered medical services (i.e., medical assistance) for Medicaid enrolled children, when furnished by qualified providers in settings considered lawful under state law. Schools are a frequent site for health care, particularly in the case of children who receive services through the IDEA. In addition, federal law gives states discretion to utilize other public agencies to carry out Medicaid administrative functions, including enrollment, outreach, and fulfillment of EPSDT administrative support functions, including transportation to the extent that they are “found necessary by the Secretary for the proper and efficient administration of the Medicaid program”. Transportation can be billed and paid as an administrative or medical assistance function. Where the administrative service is performed by a skilled health professional and requires skilled professional capabilities, a special administrative rate of 75 percent is permissible.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) specified that the Secretary of HHS could not prohibit Medicaid payments to States for covered medical assistance services provided to a child with a disability on the basis that these services are included in a child’s Individualized Education Program (IEP) or Individualized Family Services Plan (IFSP) established pursuant the Individuals with Disabilities Education Act (IDEA).

Guidance issued in May 2003, “Medicaid School-Based Administrative Claiming Guide” specified that a variety of activities were eligible for Medicaid reimbursement including: Medicaid outreach, facilitating Medicaid eligibility determinations, transportation in support of Medicaid covered services. In a May 21, 1999 letter to State Medicaid Directors, CMS expressed the policy that Medicaid payment for transporting Medicaid-eligible children to and from school was extremely limited, including only specialized transportation that is required under an IEP for children with disabilities, on a day when that child receives a covered medical service from a qualified provider at the school.

School-based administrative expenses and transportation has been a subject of oversight hearings by the Congress and reports by the HHS OIG and the GAO. Contingency fee consulting arrangements fueled some of the increase in school-based billing. CMS reports that eight states accounted for 80 percent of school administration claims.

**Proposed Regulatory Change.** This regulation would prohibit federal Medicaid payments for all administrative activities performed by schools and transportation of school-age children to and from school, including specialized transportation for Medicaid-eligible children on days when they receive covered Medicaid services at the school.

**Impact.** CMS estimates that this regulation will reduce federal Medicaid spending by \$3.6 billion over the 2009 to 2013 period (\$2.8 billion from 2009 to 2012) by shifting Medicaid administration costs away from Medicaid and onto state education budgets. CMS states that these functions are not necessary for the “proper and efficient administration of the State Medicaid plan.” CMS maintains that the regulation helps to address long-standing concerns about improper Medicaid billing by school districts for administrative costs and transportation services. This is a reversal of current law where states currently have discretion to use other agencies (including schools) to assist in administering Medicaid. The CMS rationale argues that it is never necessary for the proper and efficient administration of Medicaid to allow school personnel to perform some of these functions.

States “disagree with CMS’s proposal to eliminate all Medicaid administrative funding for all schools due to funding problems with a few schools...CMS should focus its efforts on working with states to ensure proper claiming...and CMS’s action to cut funding for schools to enroll children is contradictory to CMS’s position that states should enroll eligible children.”<sup>16</sup> States also maintain that they would not be able to afford to continue funding school-based administrative services without federal matching funds.

The National Association of School Nurses and other groups claim that Medicaid funds enable them to help facilitate Medicaid enrollment, to provide “frontline” care, and to assist children in accessing medical and dental health care which keeps them out of expensive emergency room facilities. These efforts help to keep children healthy and have them stay in school with improved school performance. The elimination of Medicaid administrative claiming would result in fewer school nurses and less outreach and assistance in applying for Medicaid which could result in higher rates of unmet health care needs for children.

**Status.** The Administration issued a final regulation on December 28, 2007. S. 2499, the legislation that extended the SCHIP program included a moratorium on any administrative actions that would restrict Medicaid payments for school based administration and transportation services through June 30, 2008.

## **5. Medicaid Outpatient Hospital Services Definition and Upper Payment Limit**

**Current Policy.** Current Medicaid law lists outpatient hospital services as a mandatory benefit. Regulations define outpatient hospital services as “preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished to outpatients.” Outpatients are patients of an organized medical facility who receives professional services for less than a 24 hour period. Payments for outpatient hospital and clinic services are subject to the aggregate upper payment limits for private providers, state providers and other government providers.



**Proposed Regulatory Change.** The proposed rule defines the scope of services that may be reimbursed under the outpatient hospital benefit for Medicaid. The revised definition of outpatient services would align the Medicaid definition of services more closely with the Medicare definition. The rule also clarifies how states may calculate the Medicaid upper payment limit for these services for private outpatient hospitals.

**Impact.** The NPRM states that due to a lack of available data, the fiscal impact of the rule cannot be determined. However, CMS believes that since the rule would clarify vague regulatory language it would not significantly alter current practices in most states and therefore would not have significant fiscal implications. Because OMB determined that the rule would not have a significant economic impact, it is not a “major rule” and therefore is not subject to a 60 day Congressional review prior to implementation once a final rule is issued. CMS says that the regulation “intends to prevent overlap between outpatient hospital services and other covered benefits....[which] could result in circumstances in which payment for services is made at the high levels of customary outpatient hospital services instead of the levels associated with the same services under other covered benefits.”<sup>17</sup>

Some groups commented that the changes to the definition of outpatient services would limit federal reimbursement for outpatient hospital services including early and periodic screening, diagnostic and treatment services (EPSDT) for children, physician services, dental care, physical, speech and occupational therapy services, diagnostic laboratory services, ambulance services, durable medical equipment and outpatient audiology services.<sup>18</sup> Some hospitals have indicated that they might need to cut back on these services if funding is reduced.<sup>19</sup> There were concerns raised that Medicaid beneficiaries will not be able to access some services in the community outside of the hospital outpatient department. The new more narrow definition could also affect a hospital’s disproportionate share hospital (DSH) payments.

**Status.** A proposed rule was issued on September 29, 2007.

## **6. Case Management**

**Current Policy.** Case management is an optional state plan option. Case management services help individuals to gain access to needed medical, social, educational and other services. Targeted case management (TCM) is an additional state plan option that permits states to provide case management services, without regard to Medicaid’s comparability requirement, to state-defined sub-populations of Medicaid beneficiaries. Case management is a required service for children who need it (through the EPSDT benefit). In FY 2006, an estimated \$2.8 billion was spent on Medicaid targeted case management services (\$1.6 billion in federal spending and \$1.2 billion in state spending). States currently are able to use 180 days of TCM services to help transition Medicaid beneficiaries from nursing homes to community based care, a policy that was issued in 2000 via a State Medicaid Director’s letter after the *Olmstead* Supreme Court decision which required states to provide services to individuals in the most integrated setting to meet a beneficiaries needs to be in compliance with the Americans with Disabilities Act (ADA).<sup>20</sup>

**Proposed Regulatory Change.** The DRA codified existing Medicaid policy to define case management services and targeted case management services, clarified that case management did

not include the “direct delivery” of underlying medical, educational, or social services to which an individual has been referred, listed examples of certain foster care services that do not qualify as Medicaid case management services (such as assessing adoption placements, serving legal papers, and administering foster care subsidies), and specified that federal matching dollars for case management services were only available if there were no other third party to pay for these services. The DRA required CMS to promulgate regulations to implement the provisions related to case management and targeted case management.

The proposed rule published by CMS addresses the provisions in the DRA but also includes some provisions not specified in the DRA legislation. To the extent that the proposed rule has generated controversy, this relates to the provisions not addressed by the statutory changes enacted by the Congress. The DRA did not address transitional case management, but the proposed rule would eliminate the post-Olmstead standard of 180 days of coverage to a maximum of 60 days of transitional assistance, with shorter coverage for short stays in an institution. Payment would also not be available unless and until an individual successfully transitioned to the community. Additionally, the proposed rule would impose a fixed limit of only one case manager per person, without regard to individuals with co-morbid conditions wherein one case manager may not be properly equipped to manage services across systems. For example, a person with an intellectual disability, mental illness, and HIV/AIDS could be assigned a case manager familiar with mental health services, but with no expertise in HIV/AIDS programs or services for people with developmental disabilities. The proposed rule would restrict access to services based on an integral component (ie intrinsic element) test; restrict states flexibility to determine payment methodologies by imposing payment based on 15 minute times increments of service, prohibit child welfare agencies and their contractors from serving as Medicaid case managers; and would restrict school-based case management services for some children with disabilities.

**Impact.** The change is expected to reduce federal Medicaid spending by \$1.3 billion over the next five years. This is greater than the CBO estimate of \$760 million for the provisions included in the DRA. Advocates for expanding access to community-based long-term services have asserted that the time limits on transitional case management and related payment restrictions will seriously undermine the success of the Money Follow’s the Person Initiative (a program designed to transition individuals from institutional care to community based care), a centerpiece of the President’s New Freedom Initiative which was a multi-pronged, nationwide effort to remove barriers to community based living released in 2001.

**Status.** CMS issued an interim final rule with comment period on December 4, 2007. The comment period ends February 4, 2008. The provision becomes enforceable on March 3, 2008.

## Discussion

While there has been a great deal of analysis on individual regulations, examining the regulations together raises some key questions for discussion and consideration.

**Regulatory Authority.** There has been considerable debate about whether CMS has the authority to issue these policy changes through regulations or if these regulations go beyond Congressional intent for the Medicaid program. The fact that Congress has imposed a moratorium on four of the six regulations discussed in this paper shows that there is considerable tension between Congress and the Administration related to the questions of regulatory authority and Congressional intent for Medicaid. Congress has delayed only three Medicaid regulations since 1981.<sup>21</sup> One of these regulations was related to nursing home reforms that ultimately led to the more comprehensive nursing home reforms included in OBRA 87.<sup>22</sup> CMS maintains that these regulations enhance the integrity and efficient administration of the Medicaid program; however, some members of Congress, states, providers and beneficiaries argue that this series of regulations represents an unprecedented assertion of Medicaid-policy making through the regulatory process. In many cases, the statutory authority and any existing regulatory policy underlying these recent regulatory changes has not been amended or modified for many years. The changes to the provider cost limits were included in the President's FY 2005 and FY 2006 proposed budgets as a legislative proposal, but given the significant opposition Congress did not consider legislation to make these changes to the Medicaid statute. The proposal then reappeared in the President's FY 2007 and FY 2008 budgets as a regulatory, rather than legislative, proposal.

However, federal Medicaid savings as a result of regulatory changes (proposed and final) get incorporated into the current law projections of Medicaid spending reflected in the CBO baseline. This downward baseline adjustment means that legislative attempts to stop or override the regulations require offsets (other spending cuts or revenue increases) to meet the PAYGO requirements that Congress reinstated in 2007. Thus, if members of Congress believe that the regulatory proposals are not in line with Congressional intent for Medicaid, the CBO scoring and PAYGO rules require them to "pay for" legislative efforts to block the regulations and continue current practices unless Congress decides to reverse policy and suspend PAYGO requirements. The need to find funding offsets makes it difficult to block the regulations and move other federal legislation forward.

**Purpose of the Regulations.** The Administration argues that these regulations will promote Medicaid fiscal integrity and that many of the policy changes follow-up on GAO and OIG Medicaid reports pointing to federal fiscal vulnerability. The regulations attempt to enhance fiscal integrity is generally achieved by either addressing improper payments, or by identifying specific functions that are not necessary for the "proper and efficient administration of a State Medicaid plan." While there is widespread support to promote Medicaid fiscal integrity, some members of Congress, states, providers and beneficiary groups are concerned that the overarching effect of the regulations is to limit the federal fiscal liability for Medicaid. Each of the regulations is expected to reduce federal Medicaid spending by directly limiting the level of provider reimbursement, restricting the scope of services eligible for federal match and by limiting states' ability to finance their Medicaid programs. These policy changes to enhance

fiscal integrity were not addressed as part of the DRA legislation that contained an entire chapter of the bill devoted to efforts to “Eliminate Fraud, Waste and Abuse in Medicaid and also created the Medicaid Integrity Program (MIP).

***Impact of the Regulations on Medicaid’s Key Roles.*** The Administration views these regulatory changes as promoting the purposes of Medicaid by enhancing the integrity of the program. However, states argue that many of the regulations could limit flexibility in administering the program and could impede the ability of the Medicaid program to fulfill some of its critical roles in the health care system such as providing support to safety-net providers or providing long-term care supports in the least restrictive settings. Giving states additional flexibility was a key theme of the Deficit Reduction Act which sought to give states more flexibility to structure benefit packages and impose cost sharing. Many of the regulatory changes significantly limit this state flexibility and some states contend that the regulations would prohibit payment methodologies or service delivery options that have been successful in their states. States claim that these federal actions have contributed to a deteriorating federal-state partnership in administering the Medicaid program.

The regulations imposing a cost limit for government providers, restricting reimbursement for GME and limiting the definition of hospital outpatient services could limit Medicaid reimbursement for safety-net hospitals. There has been analysis on each of these regulations separately, but the combined effect of the regulations could have major consequences for safety-net providers because Medicaid accounts for a disproportionate share of their revenues and unlike other hospitals, many safety-net hospitals do not have the ability to shift costs to other payers if they were to lose Medicaid revenues. Medicaid reimbursement cuts could hinder the ability of safety-net hospitals to serve both Medicaid and indigent patients and to operate and maintain access to care through the emergency rooms.

The new regulations related to rehabilitation services and case management services could limit the scope of Medicaid services available for individuals with disabilities and could reverse efforts to shift the delivery of long-term care services from institutions to the community. Unlike most commercial insurance packages, Medicaid provides both coverage and access to services that are critical supports for individuals with disabilities. Medicaid helps fill in the gaps not covered by private insurance with these types of services. Limiting federal reimbursement for these services hampers the programs ability to fill in these gaps and promote community based long-term care, contrary to the requirements of the Americans with Disabilities Act that were decided as part of the Olmstead Supreme Court.

***Impact of the Regulations on State Fiscal Capacity to Address the Uninsured.*** The school-based regulation is advanced as promoting fiscal integrity, but could hinder state efforts to enroll more children in Medicaid in attempts to reduce the number of uninsured. School district representatives assert that their outreach work has dramatically increased Medicaid participation, but without federal Medicaid funding these outreach activities will be curtailed or eliminated. Facilitating and promoting effective ways to help reach children who are eligible but not enrolled in Medicaid and SCHIP through the schools has proven to be effective, so limiting the ability of states to do this will constrain these programs.

Taken together, the new regulations could shift costs to states and limit fiscal capacity to administer the Medicaid program at a time when many states are entering another economic downturn and might need to allocate scarce resources to replace federal support just maintain critical services such as community-based mental health care. Since states must balance their budgets each year, allocating additional resources to maintain current programs would displace resources that might have been available for new initiatives, including covering the uninsured. During the last fiscal downturn, providing fiscal relief, in the form of an enhanced Medicaid match rate with the requirement that states maintain Medicaid eligibility levels proved to be an effective way to help states' fiscal situation and preserve Medicaid enrollment. The combined effect of the regulatory changes and the fiscal downturn could hinder states ability to build on Medicaid to expand coverage, promote community based long-term care and support safety-net hospitals.

*This issue brief was prepared by Robin Rudowitz, Principal Policy Analyst, Kaiser Commission on Medicaid and Uninsured.*

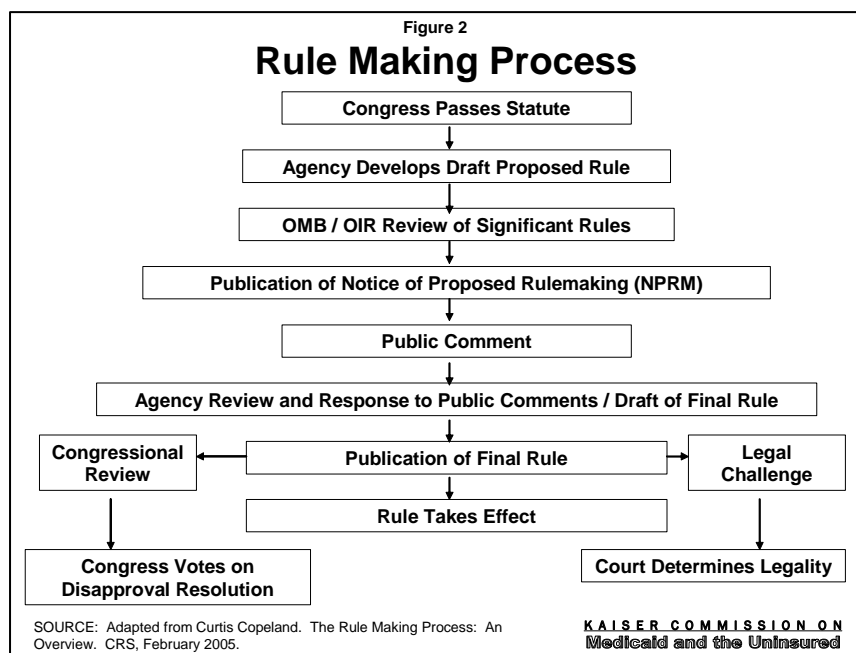
## Appendix A

*The federal Medicaid statute, found in Title XIX of the Social Security Act, is the foundation for providing health and long-term care coverage to 58 million low-income Americans.* This statute makes federal matching funds available for the costs of benefits and administration that are incurred by states with approved state Medicaid plans. Since Medicaid's enactment in 1965, Congress has made numerous statutory changes to the Medicaid program. Some of the most recent Congressional changes were contained in the Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006.

*CMS is the federal agency responsible for interpreting and implementing the federal Medicaid statute through regulation.* These interpretations are sometimes set forth in formal regulations found in Title 42 of the Code of Federal Regulations, Parts 430 to 456. Regulations, which are also referred to as “rules,” are one of the means by which federal agencies like DHHS implement federal statutes. There are relatively few provisions of the Medicaid statute that expressly require the Secretary of HHS to issue regulations.<sup>23</sup> The Secretary, however, has general authority to issue regulations “as may be necessary to the efficient administration of” the Medicaid program.<sup>24</sup> In issuing regulations, DHHS, like other federal agencies, is subject to the Administrative Procedure Act (APA) of 1946 (5 U.S.C. 551 et seq.).

The rulemaking process—the procedures that DHHS is required to follow in writing regulations—is complex. Not only must the agency satisfy the requirements of the Administrative Procedure Act (APA), it must also comply with the Regulatory Flexibility Act (RFA) of 1980 (P.L. 96-354); section 1102(b) of the Social Security Act (relating to the impact on small rural hospitals); the Unfunded Mandates Reform Act (UMRA) of 1995 (P.L. 104-4), and Executive Order 12866 (September 1993). In addition, all DHHS regulations are reviewed prior to issuance in proposed or final form by the Office of Management and Budget Office (OMB) of Information and Regulatory Affairs (OIRA). Many features of the rulemaking process are designed to ensure that those affected by a regulation have an opportunity to submit comments to the administering agency to inform its decisions before the regulation takes effect. If OMB estimates that a rule will have: an annual economic effect of \$100 million or more in one year; a major increase in costs or process for consumers individual industries or federal, state or local government agencies, geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation or on US competition then the rule is considered a “major rule.” A regulatory impact analysis (RIA) is required for all major rules. Major rules cannot take effect until 60 days after a final rule is published whereas rules that are not major can take effect whenever the agency specifies. (Figure 2)





***New rules are considered current law and incorporated into the CBO baseline which means that to meet PAYGO requirements Congress must find offsetting funds to block the implementation of rules that are expected to generate federal savings.*** The CBO baseline is an estimate of program spending assuming no changes to current law. The baseline is used by the CBO and Congress to “score” legislative proposals. In general, once the Administration issues a final rule, CBO assumes that the rule is part of the current law baseline. So, if a particular rule is expected to reduce federal spending, any legislation that would block the rule would require funding offsets (reductions in entitlement spending or increases in tax revenues) of the full cost of the rule (as re-estimated by CBO) to meet PAYGO requirements. For proposed rules, CBO assumes that there is a 50 percent probability that the rule will become final and part of current law. In these cases, Congressional efforts to block a proposed rule would cost half of the estimated cost of the regulation. PAYGO rules are self-imposed rules in Congress and Congress can decide to suspend PAYGO.

***CMS may issue other guidance that does not follow the federal rule making process.*** Many written CMS policy interpretations are found not in regulations, but in other written guidance. A good deal of policy guidance appears in the State Medical Manual (SMM), which contains “instructions” for implementing provisions of Title XIX.<sup>25</sup> CMS policy interpretations also appear in letters to State Medicaid Directors (SMD Letters) or to State Health Officials (SHO)<sup>26</sup> and in memoranda from the CMS Central Office to CMS Regional Offices. These types of guidance are usually less transparent than the formal rulemaking process which typically requires a period for public review and comment. CMS is not required to give advance notice of SMM instructions, SMD Letters, or Regional Office memoranda. In some cases CMS may circulate a draft SMD letter to state officials for review.

***CMS determines if states are in compliance with federal law.*** Among other tasks, CMS reviews state requests for approval of program policy changes to determine whether they comply

with the federal Medicaid statute. For example, a state may wish to expand its Medicaid program to cover a service for which it has not previously paid, or it may wish to contract its program by eliminating coverage for a service. In either case, CMS would make the determination as to whether the state's proposed policy change complies with the federal Medicaid statute. CMS's determination is subject to review by federal courts.<sup>27</sup> In determining whether a state's proposed policy change complies with the state Medicaid plan requirements set forth in Title XIX of the Social Security Act, CMS often relies upon its own written interpretation of those requirements.

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<sup>1</sup> Testimony of Dennis Smith Before the House Committee on Oversight and Government Reform on the Administration's Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals and States. Nov. 1, 2007

<sup>2</sup> A summary the hearing and witness testimony can be found at: <http://oversight.house.gov/story.asp?ID=1578>

<sup>3</sup> Legislation was the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

<sup>4</sup> Testimony of Dr. Majorie Kanof Before the Committee on Oversight and Government Reform.. "Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight." November 1, 2007.

<sup>5</sup> Moratorium included in Section 7002(a)(1) of the US Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007

<sup>6</sup> "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey." Prepared by Tim Henderson, for the Association of American Medical Colleges (November 2006).

<sup>7</sup> 72 Fed. Reg. at 28930

<sup>8</sup> Testimony of Dennis Smith Before the House Committee on Oversight and Government Reform on the Administration's Regulatory Actions on Medicaid, Nov. 1, 2007

<sup>9</sup> June 22, 2007 letter from Robert Dickler of AAMC to Leslie Norwalk at CMS re: CMS-2279—P.

<sup>10</sup> Moratorium included in Section 7002(a)(1) of the US Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007.

<sup>11</sup> Jeff Crowley and Molly O'Malley, "Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues." KCMU, August 2007.

<sup>12</sup> SMD letter on Assertive Community Treatment Act, June 7, 1999 and Medicaid Support of Evidence-Based Practices in Mental Health Programs, Centers for Medicare and Medicaid Services, October 2005. Available at [http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP\\_Basics.pdf](http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf).

<sup>13</sup> See letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others dated July 7, 2006.

<sup>14</sup> Testimony of Dennis Smith Before the House Committee on Oversight and Government Reform on the Administration's Regulatory Actions on Medicaid, Nov. 1, 2007

<sup>15</sup> Testimony of Barbara Miller Before the House Committee on Oversight and Government Reform on the Administration's Regulatory Actions on Medicaid, Nov. 1, 2007

<sup>16</sup> Letter to Kerry Weems from APHSA and NASMD. RE: CMS-2287-P: Comments on Proposed Rule Medicaid Program: School-Based Administrative Costs and Transportation To and From School, 72 FR 51397. November 5, 2007.

<sup>17</sup> Testimony of Dennis Smith Before the House Committee on Oversight and Government Reform on the Administration's Regulatory Actions on Medicaid, Nov. 1, 2007

<sup>18</sup> Letter to Kerry Weems from the American Hospital Association Re: (CMS-2213-P) Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition of Upper Payment Limit (Vol 72, No 188) Sept. 28, 2007. October 29, 2007.

<sup>19</sup> Alice Dember. "Medicaid Cuts Could Cost Mass. \$100 million." Boston Globe, November 13, 2007.

<sup>20</sup> SMD letter on Olmstead Update 3, July 25, 2000. <http://www.cms.hhs.gov/smdl/downloads/smdl072500b.pdf>

<sup>21</sup> The three Medicaid moratoria are: Section 135 of TEFRA 82, P.L. 97-248, Section 2373(c) of DEFRA 84, P.L. 98-369, Section 6901(a) of OBRA 89, P.L. 101-239

<sup>22</sup> Josh Wiener et al., Nursing Home Care Quality: Twenty Years After the Omnibus Budget Reconciliation Act of 1987, Kaiser Family Foundation, December 2007. <http://www.kff.org/medicare/7717.cfm>

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<sup>23</sup> For example, of the 70 different state Medicaid plan amendments set forth in section 1902(a) of the Social Security Act, only seven expressly require the issuance of regulations (paragraphs (16), (25)(A)(i), (31), (33)(A), (36), (44), and (65)).

<sup>24</sup> Section 1102 of the Social Security Act, 42 USC 1302.

<sup>25</sup> In the view of CMS, SMM instructions are “official interpretations of the law and regulations and, as such are binding in state Medicaid agencies.” Forward, B. 1., *State Medicaid Manual*, available at <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Paper-Based Manual 45.

<sup>26</sup> SMD Letters are available at <http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage>

<sup>27</sup> Any State dissatisfied with the final determination of the CMS Administrator that an SPA is not approvable has a right to judicial review in the U.S. Court of Appeals for the circuit in which the State is located. 42 CFR 430.38(a).

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