

CRS Report for Congress

Medicaid Regulatory Issues

November 26, 2008

Elicia J. Herz
Specialist in Health Care Financing
Domestic Social Policy Division

Vanessa K. Burrows
Legislative Attorney
American Law Division



**Prepared for Members and
Committees of Congress**

Medicaid Regulatory Issues

Summary

This report provides a summary of seven proposed and final rules affecting the Medicaid program that were issued by the Bush Administration during 2007 and 2008. Six of the seven rules are currently under a congressional moratorium on further administrative action until April 1, 2009. A description of possible administrative and legislative actions to modify these rules, which could be taken by the next administration or the 111th Congress, is also provided.

Contents

Graduate Medical Education (GME)	1
Cost Limit for Public Providers	1
Provider Taxes	2
Rehabilitative Services	3
Case Management	3
School-Based Services	3
Outpatient Hospital Services	4
Options for Administrative and Legislative Actions	5

List of Tables

Table 1. Status of Medicaid Regulations	8
---	---

Medicaid Regulatory Issues

Medicaid finances the delivery of primary and acute care medical services, and long-term care, for certain low-income populations, including nearly 63 million individuals in FY2008. Combined federal and state spending currently exceeds \$300 billion each year. It is the largest or second-largest item in state budgets, and is second only to Medicare in terms of federal spending on health care.

During 2007 and 2008, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, issued a number of regulations for this program. Seven regulations were the subject of considerable controversy in the 110th Congress. Each of these regulations, to differing degrees, would limit payments for certain services and/or affect payments to providers. As per the Supplemental Appropriations Act, 2008 (P.L. 110-252, Section 7001), six of these seven rules are currently under a congressional moratorium preventing further administrative action until April 1, 2009 (see **Table 1**). The seventh rule affecting outpatient hospital services was published as a final rule in the *Federal Register* on November 7, 2008, and will become effective, absent any congressional action, on December 8, 2008.

Graduate Medical Education (GME)

Most states make Medicaid payments to help cover the costs of training new doctors in teaching hospitals and other teaching programs. Historically, Medicare and most Medicaid programs have recognized two components of GME costs: (1) direct graduate medical education, or DGME (e.g., resident salaries, teaching supervision), and (2) indirect graduate medical education, or IME (e.g., higher patient care costs because of additional tests ordered by residents). CMS argued that GME payments are not authorized in Medicaid statute, are not included in the list of services considered to be “medical assistance,” and are not recognized in the Medicaid statute as a component of the costs of hospital care. The proposed rule would eliminate federal reimbursement for both DGME and IME under Medicaid. The rule would also change the way in which the Medicaid upper payment limit for hospital services is calculated, which would further reduce the federal share of Medicaid costs for hospitals. Opponents argued that the rule represents a reversal of long-standing Medicaid policy, that there are references to GME payments in both Medicaid statute and regulations, that GME payments have previously been explicitly recognized by CMS, and that the statute is broadly drafted, and even accompanying regulations do not itemize every element of reimbursable costs. (For more details, see CRS Report RS22842, *Medicaid and Graduate Medical Education*.)

Cost Limit for Public Providers

Intergovernmental transfers (IGTs) are one method used by some states to finance the non-federal share of Medicaid costs. Certain IGTs are specifically

allowed for funding the state share of program costs (e.g., local units of governments such as counties may contribute to the state share of Medicaid costs). Current federal law protects the ability of states to use funds derived from state or local taxes and transferred or certified by units of government within a state. Some states have instituted programs where all or portions of the Medicaid state share is paid by hospitals or nursing homes that (1) are public providers, but not units of government; or (2) are units of government, but the state share is returned to the provider sometimes through inflated Medicaid payments. The purpose of such financing arrangements is generally to draw down additional federal matching funds for which a state share may not otherwise be available.

A final rule issued by CMS clarifies the types of IGTs allowable for financing a portion of Medicaid costs, imposes a limit on Medicaid reimbursements for government-owned hospitals and other institutional providers, and requires certain providers to retain all of their Medicaid reimbursements. The rule also establishes documentation requirements to substantiate that a governmental entity is making a certified public expenditure (CPE) when contributing to the state share of Medicaid costs. Opponents of the rule argued that CMS overstepped its authority to limit IGTs, when Congress explicitly allows such transfers. Governors expressed fear that the rule would inappropriately shift costs to states at a time when some states were facing difficult fiscal situations. In addition to the moratorium on further administrative action on this rule, a federal court held, in May, 2008, that the rule had been “improperly promulgated” and remanded the rule back to CMS for further action. *Alameda County Medicaid Center v. Leavitt*, 559 F.3d 1 (D.D.C. 2008). However, the moratorium prohibits CMS from “tak[ing] any action (through the promulgation of regulation, issuance of regulatory guidance, or other administrative action)” with regard to the proposed and final rules prior to April 1, 2009. (For more details, see CRS Report RS22848, *Medicaid Regulation of Governmental Providers*.)

Provider Taxes

Provider-specific taxes have been used by many states over the last two decades to help pay for the costs of the Medicaid program. Under these funding methods, states collect funds (through taxes or other means) from providers and pay the money back to those providers as Medicaid payments, and claim the federal matching share of those payments. States are essentially “borrowing” their required state matching amounts from the providers. Once the state share has been netted out, the federal matching funds claimed may be used to raise provider payment rates, to fund other portions of the Medicaid program, or for other non-Medicaid purposes. Such taxes are required to meet a number of federal laws and regulations, some of which have been in flux recently. CMS issued a final rule that would (1) revise the threshold for determining if a tax program is required to undergo a test to determine whether a provider is being “held harmless” for the tax payment and clarify use of the term “revenues,” (2) clarify standards for determining the existence of a hold harmless arrangement, (3) codify one class of health care services permissible for establishing health care provider taxes, and (4) remove obsolete language. Opponents of this rule expressed concern that it reduces consistency and clarity, that its changes exceed the Secretary’s authority, and that it would impede a state’s ability to condition Medicaid reimbursements on payment of required taxes. (For more details, see CRS Report RS22843, *Medicaid Provider Taxes*.)

Rehabilitative Services

Medicaid rehabilitation services include a full range of treatments designed to reduce physical or mental disability or restore eligible beneficiaries to their best possible functional levels. Both the executive and legislative branches have addressed this benefit. For example, in recent annual budget submissions, the Bush Administration proposed administrative changes to reduce Medicaid rehabilitation expenditures. Congressional and executive branch oversight organizations have documented inconsistent policy guidance and states' practices for claiming federal matching funds that failed to comply with Medicaid rules. The current proposed rule was intended to more clearly define the scope of the rehabilitation benefit and identify services that could be claimed as rehabilitation under Medicaid. Opponents of this rule are concerned that it creates new administrative barriers and restricts access by tightening the definition of rehabilitation. Others argue this rule could reduce a key funding stream for community-based mental health services, resulting in reduced access to such services and increased reliance on institutional care for individuals with mental retardation and developmental disabilities. (For more details, see CRS Report RL34432, *Medicaid Rehabilitative Services*.)

Case Management

Case management services assist Medicaid beneficiaries in obtaining needed medical and related services. Targeted case management (TCM) refers to case management for specific beneficiary groups or for individuals who reside in state-designated geographic areas. The Bush Administration proposed legislative changes to reduce Medicaid TCM expenditures in recent annual budget submissions. In the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), Congress added new statutory language to both clarify and narrow the definition of case management and directed the Secretary of HHS to issue regulations to guide states' claims for federal matching dollars for TCM. A proposed rule was issued which became final in March, 2008. All Medicaid authorities, related to all case management services, including TCM and services delivered through waivers, are subject to this rule. It also directly addresses case management issues that previously might have been considered open to interpretation. Opponents of this rule argue that it is more restrictive than Congress intended in DRA, and would result in cuts to TCM services since alternatives to Medicaid funding are scarce. In addition, the new administrative requirements and complexities of the rule may increase state costs while decreasing provider participation and beneficiaries' access to quality medical care. (For more details, see CRS Report RL34426, *Medicaid Targeted Care Management (TCM) Benefits*.)

School-Based Services

As a condition of accepting funds under the Individuals with Disabilities Education Act (IDEA), public schools must provide special education and related services necessary for children with disabilities to benefit from a public education. Generally, states can finance only a portion of these costs with federal IDEA funds. Medicaid can cover IDEA required health-related services for enrolled children as well as related administrative activities. According to federal investigations and

congressional hearings, Medicaid payments to schools have sometimes been improper. To address these problems, CMS issued a final rule that restricts federal Medicaid payments for school-based administrative activities (e.g., outreach, service coordination, referrals performed by school employees or contractors), and for certain transportation services (e.g., from home to school and back for certain school-age children). Opponents of this rule argue that it will reduce the availability of, and access to, needed health care for children, is inconsistent with decades of approved state plan amendments allowing federal funding of these administrative and transportation services, and falsely assumes that health care administrative activities performed by school personnel are inconsistent with the proper and efficient administration of the state Medicaid plan because such activities improve children's health, reduce inappropriate medical care utilization, and thus ultimately save money. (For more details, see CRS Report RS22397, *Medicaid and Schools*.)

Outpatient Hospital Services

Under Medicaid, outpatient hospital (OPH) services are a mandatory benefit for most beneficiaries. OPH services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided under the direction of a physician or a dentist in the hospital. These outpatient facilities may be located on or off the hospital campus or in satellite facilities. States use a number of different reimbursement methods for different types of services provided in OPH departments and clinics. The proposed and final rules issued by the Bush Administration would limit the definition and scope of Medicaid outpatient services in a hospital facility, hospital clinic, or rural health clinic to include only those facility services (1) that Medicare pays for under its outpatient prospective payment system (OPPS) or is recognized by Medicare as an OPH service under an alternate payment methodology, (2) provided by an outpatient hospital facility, including only those entities that meet standards for provider-based status as a department of an outpatient hospital as defined in Medicare rules, and (3) not covered under the scope of any other Medicaid benefit category.

Opponents of this provision of the rule argue that it would exclude many of the costs that states now consider in calculating certain supplemental payments to qualifying hospitals (called disproportionate share or DSH payments), which would in turn limit such DSH payments to these hospitals. In addition, this provision would exclude federal matching funds for OPH programs that provide required diagnostic and treatment services for persons under age 21 that may not be covered under Medicare. Others argued that, because the OPH rule incorporates the new definition of hospital categories adopted in the final rule regarding cost limits on government providers (described above), this rule violated the moratorium on implementing any provision of the rule on cost limits for government providers. On the other hand, given this moratorium, CMS elected to exclude from its final OPH services rule the proposed regulatory language delineating methods for demonstrating compliance with the upper payment limit for Medicaid OPH and clinic services provided in privately operated facilities. Currently, there is no congressional moratorium on this final rule. Without other legislative action, this rule will become effective on December 8, 2008. (For more details, see CRS Report RS22852, *Medicaid and Outpatient Hospital Services*.)

Options for Administrative and Legislative Actions

The next administration may wish to change some or all of these Medicaid regulations. For final rules that have already been published in the *Federal Register*, the only avenue for changing or rescinding such rules is through the rulemaking process. The Administrative Procedure Act (APA) defines “rulemaking” to include the process for “amending or repealing a rule.”¹ Section 553 of the APA establishes the general procedures that an agency must follow when promulgating, and thus when amending or repealing, a rule.² Agencies must publish a notice of proposed rulemaking, provide an opportunity for the public to submit comments, and publish a final rule and a general statement of basis and purpose in the *Federal Register* “not less than 30 days before its effective date.”³ The APA permits agencies to forego notice and comment and to make a rule effective immediately under the “good cause” exception in 5 U.S.C. § 553. However, an agency’s use of the good cause exception is subject to judicial review.

For the six regulations currently under the congressional moratorium, either before or after April 1, 2009 (when the existing moratorium ends and both the final rules and the interim final rule would become effective), the agency could decide to use the notice-and-comment rulemaking process to repeal the six final rules. Additionally, the agency may use the notice-and-comment process to amend or repeal the outpatient hospital services rule not subject to this moratorium that will become effective on December 8, 2008. Agencies possess inherent authority to amend or repeal their rules.⁴ An interested party may also petition for the amendment or repeal of a rule pursuant to 5 U.S.C. § 553(e).⁵

An agency may decide to amend or repeal an existing regulation for a wide variety of reasons, ranging from a change in Administration, to a change in the statutory or regulatory environment, to a determination on the part of the agency that a different standard is preferable.⁶ Rule modifications are subject to substantive review by the courts. In *Motor Vehicle Mfrs. Ass’n v. State Farm Mutual Ins. Co.*, which addressed the rescission of a rule put in place by the Carter Administration, the Supreme Court established that heightened scrutiny is required in instances where an agency has abruptly changed a settled course of agency action, depending on the scope and impact of the modification of the rule: “an agency changing its course by

¹ 5 U.S.C. § 551(5).

² *Homemakers North Shore, Inc. v. Bowen*, 832 F.2d 408, 413 (7th Cir. 1987).

³ 5 U.S.C. § 553.

⁴ See *Committee for Effective Cellular Rules v. FCC*, 53 F.3d 1309, 1317 (D.C.Cir. 1995).

⁵ “Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.” 5 U.S.C. § 553(e).

⁶ See, for example, *Chevron U.S.A., Inc. v. Natural Resources Defense Counsel, Inc.*, 467 U.S. 837 (1984) (stating “[a]n agency interpretation is not instantly carved in stone,” *id.* at 863, and explaining that an agency is under a continuing obligation to ensure that a regulation is reasonable by evaluating “varying interpretations and the wisdom of its policy on a continuing basis.” *Id.* at 863-64).

rescinding a rule is obligated to supply a reasoned analysis for the change.”⁷ However, a change in an agency’s settled course of action is not fatal to the rule if a reasoned analysis is provided. As the Supreme Court said in *Nat’l Cable & Telecomms. Ass’n v. Brand X Internet Servs.*, “[u]nexplained inconsistency is, at most, a reason for holding an interpretation to be an arbitrary and capricious change from agency practice under the [APA].”⁸ The Court went on to cite both “changed factual circumstances [and] a change in administrations” as events that could lead an agency to reverse its previous policy, where the agency’s policy change may still receive deference from a reviewing court.⁹

Additionally, the next administration could issue a memorandum or other document directing the agency to not enforce the rules or to temporarily suspend the rules, as incoming presidential administrations have done soon after they assumed office. However, a rule’s suspension itself constitutes a rulemaking under the APA, therefore it is axiomatic that a suspending agency is required to comply with the APA’s notice and comment procedures in implementing a stay.¹⁰ Alternately, Congress could pass legislation to reinstate or extend the prior moratorium, to direct the agency not to enforce the rules, to direct the agency to repeal the rules, or directly override the rules. Congress could also withhold funding from the agency for the enforcement of the rules or take other measures through the appropriations process.¹¹

If the next administration were to change a final or interim final rule through administrative action (e.g., issue a new modified rule), it would not be legally required to come up with an offset in the FY2010 budget. However, the recent historical practice is that both the Clinton and Bush Administrations required agencies to propose administrative actions and pay for such actions in their HHS budget proposals (e.g., a corresponding savings appeared elsewhere in the budget). This was also required outside the process of developing a budget.

⁷ 463 U.S. 29, 41-42 (1983). This heightened scrutiny is known as the “hard look” doctrine. However, some courts have rejected the idea of applying heightened scrutiny to changes in settled agency policy. *See* *Center for Auto Safety v. Peck*, 751 F.2d 1336 (D.C. Cir. 1985) (“The Supreme Court has made clear that ‘the same test’ applies to the rescission or modification of a rule as to its initial promulgation — the ‘arbitrary or capricious’ standard of 5 U.S.C. § 706(2)(A) (1982) — and that there is ‘no difference in the scope of judicial review depending upon the nature of the agency’s action.’ *State Farm*, 103 S. Ct. at 2866. The same ‘presumption ... *against* changes in current policy that are not justified by the rulemaking record,’ *id.*, exists whether those changes consist of enacting a new rule or of revoking or modifying an old one. To overcome the presumption the agency ‘must examine the relevant data and articulate a satisfactory explanation for its action.’ *Id.*”).

⁸ 545 U.S. 967, 981 (2005).

⁹ *Id.*

¹⁰ *See* *Council of the Southern Mountains v. Donovan*, 653 F.2d 573 (D.C. Cir. 1981); *National Federation of Federal Employees v. Devine*, 671 F.2d 607 (D.C. Cir. 1982); *National Resources Defense Council v. EPA*, 683 F.2d 752 (3d Cir. 1982); *Environmental Defense Fund v. Gorsuch*, 713 F.2d 802 (D.C. Cir. 1983); *Environmental Defense Fund v. EPA*, 716 F.2d 915 (D.C. Cir. 1983).

¹¹ *See* CRS Report RL34354, *Congressional Influence on Rulemaking and Regulation Through Appropriations Restrictions*, by Curtis W. Copeland.

The Congressional Review Act (CRA) permits the use of expedited procedures in the Senate to disapprove agencies' final rules. The CRA requires that agencies submit all final rules to Congress before they take effect. If Congress adjourns its annual session *sine die* less than 60 "legislative days" in the House of Representatives or 60 "session days" in the Senate after a rule is submitted to it, then the rule is carried over to the next session of Congress and is subject to possible disapproval during that session.

Final rules published after May 2008 may be able to be addressed by the 111th Congress via the CRA. Among the seven Medicaid rules described in this report, the CRA would apply only to the final rule on outpatient hospital services. Congress could also enact legislation that would repeal the other six Medicaid rules. If there was a legislative change to modify or negate such a final rule, PAYGO would apply for the Congressional Budget Office's scoring purposes, if budget enforcement rules are in effect.

For more information on administrative and legislative actions to change existing rules, see CRS Report RL34747, *Midnight Rulemaking: Considerations for Congress and A New Administration*.

Table 1. Status of Medicaid Regulations

Rule	Status and Publication Date	Effective Date for Final Rules	Estimated Net Reduction in Outlays over 5 Years
Medicaid Program; Graduate Medical Education	Proposed rule — 72 <i>Federal Register</i> 28930, May 23, 2007	Not applicable	\$0.8 billion
Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership	Proposed rule — 72 <i>Federal Register</i> 2236, January 18, 2007; and Final rule — 72 <i>Federal Register</i> 29748, May 29, 2007	July 30, 2007	\$9.0 billion for final rule
Medicaid Program; Coverage for Rehabilitative Services	Proposed rule — 72 <i>Federal Register</i> 45201, August 13, 2007	Not applicable	\$1.4 billion
Medicaid Program; Optional State Plan Case Management Services	Interim final rule — 72 <i>Federal Register</i> 68077, December 4, 2007.	March 3, 2008	\$1.5 billion
Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School	Proposed rule — 72 <i>Federal Register</i> 51397, September 7, 2007; and Final rule — 72 <i>Federal Register</i> 73635, December 28, 2007	February 26, 2008	\$4.2 billion for final rule
Medicaid Program; Health Care-Related Taxes	Proposed rule — 72 <i>Federal Register</i> 13726, March 23, 2007; and Final rule — 73 <i>Federal Register</i> 9685, February 22, 2008.	April 22, 2008	\$0.6 billion for final rule
Medicaid Program; Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition	Proposed rule — 72 <i>Federal Register</i> 55158, September 28, 2007; and Final rule — 73 <i>Federal Register</i> 66187, November 7, 2008.	December 8, 2008	\$0.3 billion for proposed rule

Notes: See Congressional Budget Office, *Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO's Baseline*, February 29, 2008. For proposed rules, CBO generally assigns a weight of 50% in its baseline to reflect the uncertainties of the administrative process. After a regulation becomes final, CBO fully incorporates the projected effects into the baseline (after any applicable moratorium ends). All rules listed in this table, except the rule on outpatient hospital services, are subject to a congressional moratorium on further action until April 1, 2009. The reduction in outlays reported in this table may be lower, given the subsequent extension of the moratoria assumed in CBO's analysis.