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ADMINISTRATION'S MEDICAID REGULATIONS WILL WEAKEN COVERAGE, HARM STATES, AND STRAIN HEALTH CARE SYSTEM

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Over the last year, the Department of Health and Human Services (HHS) has issued a series of Medicaid regulations that could significantly affect health care at the state and local level.¹ These regulations, most of which alter longstanding Medicaid policies, do not require congressional approval. In fact, in some cases Congress has expressly declined to enact the very same changes that HHS is now making through administrative action.²

In addition, in December the Administration issued an interim final rule to implement a provision of the 2006 Deficit Reduction Act. The new rule goes well beyond Congress's intent in that legislation, and does so in ways that will jeopardize access to essential health services.³

Taken together, these regulatory changes will reduce federal Medicaid spending by more than \$15 billion over the next five years, based on estimates from the Office of Management and Budget.⁴ New estimates from the Congressional Budget Office indicate the reductions would be larger and

¹ For a detailed discussion of these Medicaid regulations, see "Medicaid: Overview and Impact of New Regulations," Kaiser Commission on Medicaid and the Uninsured, January 2008, <http://www.kff.org/medicaid/upload/7739.pdf>.

² In 2005, the Administration tried — and failed — to persuade Congress to restrict certain rehabilitative services as part of the Deficit Reduction Act in the same way that the Administration has now restricted these very same services. Testimony of Dennis Smith, Senate Committee on Finance, June 28, 2005, at <http://www.senate.gov/~finance/hearings/testimony/2005test/DStest062805.pdf>. In that same year, the Administration's budget included a legislative proposal that would have limited payments to public hospitals. Congress did not act on that proposal, and the Administration is now attempting to accomplish the same result through a regulation.

³ For discussion of this interim final rule, see Judith Solomon, "New Medicaid Rules Would Limit Care for Children in Foster Care and People with Disabilities in Ways Congress Did Not Intend," Center on Budget and Policy Priorities, revised, February 8, 2008, <http://www.cbpp.org/12-21-07health.htm>. The National Governors Association recently submitted comments to the Centers for Medicare and Medicaid Services to request that the agency consider revisions to make the interim final rule consistent with congressional intent. Letter from Raymond G. Scheppach, Executive Director, National Governors Association, to Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, February 4, 2008.

⁴ OMB's estimate of the federal savings that the regulations would produce are, for all regulations other than targeted case management and provider tax rules, taken from the President's Fiscal Year 2009 Budget, Analytical Perspectives, Table 25-6, "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008. Estimated federal savings for the targeted case management and provider tax regulations are based on the cost estimates of these regulations that the Administration issued in 2007.

could equal \$21 billion over five years.⁵ Most of these costs will simply be shifted to state and local governments, at a time when states have less capacity to absorb added costs given the economic slowdown and their weakening fiscal conditions.

The various regulations restrict how Medicaid pays for hospital services, graduate medical education, outpatient services, school-based health services, services for individuals with disabilities, and case management services.⁶ (See the Appendix for details.) While the direct impact will be greatest for Medicaid beneficiaries — particularly children and people with disabilities — the regulations will also have a substantial impact on educational services, the foster care system, and health care services such as trauma care and neonatal intensive care, upon which entire communities rely.

Congress has delayed some of the regulations, but they will soon take effect if Congress does not act swiftly to further postpone implementation.⁷ Without such action, states and localities that wish to maintain essential services such as case management for children in foster care and rehabilitation services for people with serious mental illness will be forced to scale back other parts of their budgets. In some cases, states and localities will be forced to cut services for Medicaid beneficiaries or cut payments to hospitals and other health care providers.⁸

Large Costs Will Be Shifted to State and Local Governments

All of the regulations will shift costs to states and localities by limiting federal support for services that have typically been supported partly by federal funds and are widely seen as important and necessary.

For example, one regulation will eliminate all federal matching funds for various Medicaid-related activities designed to help low-income children — such as outreach, enrollment assistance, and health care coordination for these children — if the activities are performed by school personnel. The Administration concedes that these are proper activities in support of Medicaid; it simply does not want to help pay for them any longer when a state Medicaid program contracts with schools to

⁵ According to the recently revised Congressional Budget Office budget baseline, the cumulative estimated savings from the regulations are approximately \$17 billion over five years (FY 2009 – FY 2013). However, because CBO uses “probabilistic scoring” to reflect the possibility that some of these regulations may not, in fact be finalized and implemented, it has discounted the estimated savings derived from some of these regulations for purposes of its budget baseline. Without this discounting, CBO’s estimate of the savings that would result from implementation of all the regulations is \$21.1 billion over five years. Congressional Budget Office, Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO’s Baseline, February 29, 2008, at: <http://www.cbo.gov/budget/factsheets/2008b/medicaremedicaid.pdf>.

⁶ The Administration has also recently proposed a new regulation that overhauls administrative appeals, diminishing the likelihood of meaningful review while increasing Secretarial authority in an unprecedented way.

⁷ The rules affecting school-based services and rehabilitative services have been delayed until June 30, 2008. Two of the regulations affecting payments to hospitals — the elimination of payments recognizing the costs of graduate medical education and the limits on payments to the costs of providing services — are delayed until May 25, 2008. (See the Appendix for more details.)

⁸ See, for example, Maria Glod, “Area Schools Set to Lose Millions Under Medicaid Policy Changes,” *The Washington Post*, February 3, 2008.

provide them.⁹ This is a sharp departure from longstanding Medicaid practice. In fact, in 2000, three federal agencies published a guide to school-based health outreach noting that schools represent the “the single best link” for identifying and enrolling eligible low-income children in public health coverage.¹⁰ It also is inconsistent with statements the Administration issued when vetoing children’s health legislation last year that the Administration wants states to reach and enroll more of the poor children who are eligible for Medicaid but are uninsured.

Another regulation will prohibit states from claiming federal reimbursement for case management performed by child welfare agency workers or their contractors on behalf of children in foster care. These case management activities — which coordinate a child’s health care, educational, and social services — will still have to be provided. But federal Medicaid funds will no longer help to pay for them, even though most children in foster care are eligible for Medicaid and case management is a required service under Medicaid for children who need it.

States will have three options for making up the loss of federal Medicaid funds: 1) cutting back on their Medicaid programs by reducing eligibility (and thereby causing more low-income people to become uninsured), cutting back on health benefits, and/or reducing payments to providers (which already are lower than the payments that providers receive for treating most other patients); 2) cutting back on other state programs and using those funds to replace the lost federal Medicaid dollars; or 3) raising taxes. In states that choose the first option, low-income families, individuals with disabilities, and seniors could be dropped from Medicaid entirely or could face increased out-of-pocket costs or restricted access to providers.

Low-Income Children and People With Disabilities Will Have Fewer Health Care Services

The regulations will have a major impact on Medicaid beneficiaries. For example:

- The regulations will significantly limit Medicaid coverage for rehabilitation services provided to people with serious mental illness. They also will eliminate coverage for rehabilitation services that are “intrinsic elements” of other programs, such as foster care or child welfare.¹¹ The Administration claims that beneficiaries can get the services they need through these other programs and Medicaid support thus is not necessary. The reality is different. In most cases, the other programs have limited funds and rely on Medicaid to pay for rehabilitative services for Medicaid beneficiaries; without Medicaid funding, many beneficiaries will not receive these needed services.

⁹ For more details about how Medicaid has contracted with schools for various administrative services and how the new regulation will disrupt this practice, see Judith Solomon and Donna Cohen Ross, “Administration Moves to Eviscerate Efforts to Enroll Uninsured Low-Income Children in Health Coverage Through the Schools: Bipartisan SCHIP Bill Would Temporarily Block Such Action,” Center on Budget and Policy Priorities, revised October 1, 2007, <http://www.cbpp.org/9-17-07health.htm>.

¹⁰ United States Department of Health and Human Services, “Ready to Learn: A Guide for State Agencies Doing School-Based Outreach for Medicaid and SCHIP,” November 2000.

¹¹ See Judith Solomon, “Administration Moves to Withdraw Key Health Services from Children and Adults With Mental Illness and Other Disabilities,” Center on Budget and Policy Priorities, revised October 22, 2007, <http://www.cbpp.org/9-25-07health.htm>.

- The regulations will eliminate coverage for therapeutic foster care, in which children are placed in a private home with foster parents who are specially trained to help them improve a child's condition. Therapeutic foster care has been proven effective in keeping children with serious emotional disorders out of psychiatric hospitals and residential care.
- The regulations will eliminate coverage for “day habilitation” programs, which are designed to help people with intellectual disabilities (formerly called mental retardation) and other developmental disabilities to acquire the skills they need to live in community-based settings and remain out of institutions.
- By eliminating Medicaid funding for school-based administrative activities, the regulations will likely increase the number of poor children who are eligible for Medicaid but remain uninsured, as well as the number of children with Medicaid coverage who do not get certain health care services they need.

Added Strains on Health System Will Affect Entire Community

The importance of the regulations goes far beyond Medicaid. Their impact will be felt across communities, as essential health care services become strained in a number of areas.

- Most states make supplemental Medicaid payments to public hospitals, both to cover part of the cost of providing care to the uninsured and to help these hospitals maintain services that benefit the entire community, such as neonatal intensive care and burn-treatment units. One of the regulations (in fact, the largest one, in terms of the amount of the federal savings it will produce) will significantly restrict the use of federal funds for this purpose. That will make it considerably harder for public hospitals to continue performing these tasks, even as the number of uninsured people seeking uncompensated care rises due to the economic downturn and mounting unemployment.
- If public hospitals are unable to sustain the level of care they provide to the uninsured, more costs will likely be shifted to private insurance companies, as health care providers raise their prices to recoup a portion of the costs for the uncompensated care they continue to provide.¹² This cost-shifting will prompt further increases in health care premiums that many employers and families already struggle to afford.
- Another regulation will eliminate federal Medicaid funding for the costs of graduate medical education provided by teaching hospitals. This means fewer doctors may be trained, which would place added burdens on the nation's health care delivery system at a time when the health care needs of an aging population are growing.

¹² A recent study by Families USA found that more than one third of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves. Of the remainder, roughly one-third is reimbursed by a number of government programs, and two-thirds is paid through higher premiums for people with health insurance. See Families USA, “Paying a Premium: The Added Cost of Care for the Uninsured,” June 2005, http://www.familiesusa.org/assets/pdfs/Paying_a_Premium731e.pdf.

Regulations Reflect Ideological Goal of Scaling Back Medicaid

By restricting Medicaid reimbursement in areas such as care coordination, case management, and rehabilitative services, the Administration's regulations seek to remake Medicaid in the image of commercial insurance that contains significant gaps in coverage for some people with serious health problems. As Diane Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured, explains, Medicaid has historically filled certain gaps that exist in Medicare and private health insurance in order "to offer the broad array of services needed by people with severe disabling conditions."¹³

In addition, Medicaid has always funded services that help low-income beneficiaries access health care services they need. In particular, Medicaid has always provided matching funds for activities that states are required to conduct as part of Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that low-income children enrolled in Medicaid obtain health care services they need.¹⁴ Some states have contracted with school systems so that school nurses can inform families about EPSDT and help families arrange care for their children. In many states, school staff help coordinate the health care of students, especially those who have special health care needs. The Administration's regulations eliminate federal matching funds for all of these activities if carried out by school personnel.

Conclusion

Recognizing the imminent harm the regulations pose, Congress acted on a bipartisan basis last year to delay implementation of the regulations concerning school-based and rehabilitation services, hospital payments, and graduate medical education payments. These moratoria will expire, however, within a few months. To prevent the Administration from making an "end run" around Congress to reshape Medicaid in ways that Congress never intended and in some cases expressly rejected, Congress will need to extend these moratoria and enact new moratoria to block the other harmful regulations.

¹³ U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, January 16, 2008.

¹⁴ Under EPSDT, states are supposed to ensure that all children enrolled in Medicaid receive regular check-ups, including vision, dental, and hearing exams, as well as necessary immunizations and laboratory tests and follow-up testing and treatment. States are required to inform families about the availability of EPSDT services and to help them access health care services for their children.

Appendix
Overview of Recent Regulations based on Office of Management and Budget (OMB) Cost Estimates

Regulation	Description	Medicaid Savings	Status
School-based Services 72 Fed. Reg. 73635 (Dec. 28, 2007)	Eliminates federal funds for outreach, enrollment assistance, coordination of health care services, and related activities by school personnel to enroll more eligible poor children in Medicaid. The rule also would reverse current policy that allows federal funds to be used to transport children to school if the children have special health needs and receive health care services at school.	\$635 million FY 2009 \$3.6 billion FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 by Congressional action
Rehabilitation Services 72 Fed. Reg. 45201 (Aug. 13, 2007)	Limits the types of rehabilitative services that states can cover with federal funds, including special instruction and therapy for children and other beneficiaries who have mental illness or developmental disabilities.	\$360 million FY 2009 \$2.5 billion FY 2009-2013	Delayed by Congressional action 6/30/08
Targeted Case Management 72 Fed. Reg. 68077 (Dec. 4, 2007)	Significantly limits federal Medicaid matching funds for case management services, going beyond changes to the Medicaid case management benefit that Congress enacted in the Deficit Reduction Act. The regulation will have a detrimental impact on beneficiaries, especially children in foster care and people with physical or mental disabilities or other chronic health conditions.	\$230 million FY 2009 \$1.3 billion FY 2008-2012	Interim final rule becomes effective 3/3/08
Hospital Cost-Limits 72 Fed. Reg. 29748 (May 29, 2007)	Limits payments to hospitals and other institutions operated by state or local governments to the cost of providing services to Medicaid beneficiaries. Also revises the definition of "providers" for purposes of Medicaid financing.	\$790 million FY 2009 \$5.7 billion FY 2009-2013	Final rule issued; implementation delayed by Congressional action until 5/25/08
Graduate Medical Education 72 Fed. Reg. 28930 (May 23, 2007)	Eliminates federal Medicaid funding for the costs of graduate medical education (GME) provided by teaching hospitals.	\$150 million FY 2009 \$1.8 billion FY 2009-2013	Delayed by Congressional action until 5/25/08
Outpatient Clinic and Hospital Facility Services 72 Fed. Reg. 55158 (Sep. 28, 2007)	Changes the definition of outpatient hospital services to significantly narrow the types of services states can cover under this benefit category, severely restricting reimbursement rates for such services as hospital-based physician services, routine vision services, annual check-ups, and vaccinations.	CMS declined to estimate the impact of this proposed rule due to lack of available data.	Expected to be finalized in early 2008
Provider Tax 73 Fed. Reg. 9685 (Feb 22, 2008)	Makes technical changes to provider tax rules that will limit states' ability to raise federal Medicaid matching funds.	\$115 million FY 2009 \$115 million in each of FYs 2010 and 2011	Final rule issued; effective 4/22/08
Departmental Appeal Board Procedures 72 Fed. Reg. 73708 (Dec. 28, 2007)	Requires the HHS Departmental Appeals Board (DAB) to consider administrative directives, in addition to regulations and the Medicaid statute when making determinations, suggesting that the DAB should apply new interpretations retroactively even when those new interpretations are not required by the underlying law. Also allows the Secretary to overrule decisions of the Board, greatly enhancing Secretarial authority.	CMS determined that this was not a major rule and therefore was not required to provide a cost analysis.	

Source: Estimated federal Medicaid savings from all regulations, other than targeted case management and provider tax, taken from the President's Fiscal Year 2009 Budget, Analytical Perspectives, Table 25-6, "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008. Estimated federal Medicaid savings from targeted case management and provider tax regulations are based on cost estimates of these regulations that the Administration issued in 2007.

The February 29 updated CBO budget baseline assumes the following estimated five-year federal Medicaid savings from these regulations: School-based Services: \$4.2 billion; Rehab Services: \$1.4 billion; TCM: \$2 billion; Hospital Cost-limit: \$9 billion; GME: \$800 million; Outpatient Hospital Services: \$300 million; Provider Tax: \$600 million. If finalized, the savings from the Rehab Services, GME and Outpatient Hospital Services rules would be double the figures just cited, because the estimates cited here discount the estimated savings for those regulations by 50 percent, based on CBO's assumption that there is only a 50 percent probability these regulations will actually be finalized and implemented. CBO has not provided year-by-year estimates of the federal savings from the regulations.