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To: Interested Parties

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Re: Questions and Answers on the Moratorium

On June 30, the President signed the supplemental appropriations act into law (H.R. 2642, P.L. 110-252). Section 7001 of that Act places a moratorium on six Medicaid regulations, which prevents the Secretary of Health and Human Services from taking any action to enforce or implement these regulations until April 1, 2009. The impact of the moratorium varies based on the status of the regulation before the moratorium went into effect. For two regulations, the moratorium does not delay provisions of the rules implementing changes to the Medicaid statute enacted by Congress.

To date, the Centers for Medicare and Medicaid Services (CMS) has not provided states with written guidance on the moratorium. This memo sets forth our understanding of the intent and impact of the moratorium. We will update it as we learn more.

1. What is the effect of the moratorium on Medicaid regulations that was in the supplemental appropriations bill?

The supplemental appropriations bill delays implementation of six Medicaid rules until April 1, 2009. The supplemental appropriations bill did not delay implementation of either the August 17th SCHIP directive or the outpatient hospital Medicaid regulation (which has not yet been issued as a final rule, so it is not yet in effect). The impact of the moratorium on the six delayed Medicaid regulations is described below. The chart at the end of this memo includes additional information.

- ***Public Provider Hospital Financing:*** This regulation was issued in final form on the same day that an initial one-year moratorium was signed into law last year. Given the same-day issuance of the final rule, a court recently decided that the Administration issued the final rule improperly. Assuming the court ruling stands, this rule could not go into effect unless CMS reissues the rule in final form at the end of the current moratorium period. Because it is a major rule, the rule would not be effective until at least 60 days after it was published.
- ***Provider Tax:*** The regulation (which changes provider tax rules in ways that limit states' ability to raise federal Medicaid matching funds) went into effect in April of this year but has been retroactively delayed until April 2009, except for provisions that implement two changes that Congress recently made to the Medicaid statute. Without further action, the remaining parts of the regulation would go into effect on April 1, 2009.



- **Graduate Medical Education:** This regulation has not yet been finalized. Under the moratorium, CMS cannot issue a final rule until April 1, 2009.
- **Rehabilitation Services:** This regulation has not yet been finalized. Therefore, this rule will not go into effect unless and until CMS issues a final rule sometime after April 1, 2009.
- **School Based Services:** This regulation was issued in final form but, under the most recent moratorium, cannot be enforced until April 1, 2009. Without further action, the regulation would go into effect on April 1, 2009.
- **Targeted Case Management:** This regulation was issued in interim final form last December and went into effect in March. The status of this regulation is the most complicated, because the moratorium retroactively bars implementation of only certain parts of the interim final rule through March 31, 2009. The moratorium allows CMS to enforce the part of the rule that implements the statutory definition of case management (as amended by the Deficit Reduction Act) as long as it is no more restrictive than guidance provided to states in a January 19, 2001 State Medicaid Director letter (SMDL) from CMS (see below for more details). In other words, states must continue to follow the parts of the regulation that are consistent with the DRA, but they do not have to make changes to implement those parts of the TCM regulation that go beyond the DRA definition of case management and the SMDL. The questions and answers below elaborate on what this means for states.

2. Why does the moratorium allow some sections of the rule on case management/targeted case management (TCM) to be implemented?

In the Deficit Reduction Act of 2005 (DRA) Congress expanded on the definition of the case management benefit and made some other clarifications in the law relating to the benefit. However, the interim final rule that CMS issued in December 2007 went much farther than the changes Congress made in the DRA. For example, the interim final rule limited the amount of time states could provide case management for people moving from institutions to the community, prohibited federal matching funds for case management provided to children in foster care and a number of other programs, and limited state flexibility in structuring the case management benefit. In the moratorium, Congress allowed the changes it made in the DRA to go forward but applied the moratorium to these other changes where CMS went farther than Congress intended.¹

3. The TCM moratorium says that nothing more restrictive than case management rules in effect as of December 3, 2007 may be enforced by CMS. What does that mean for states?

With the exception of the definition of case management discussed above, the moratorium prevents CMS from doing anything to implement or enforce any version of TCM more restrictive than what was in place on December 3, 2007. Even though the interim final rule

¹ For more information, 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 March 6, 2008.



was in effect from March until the supplemental appropriations bill was signed at the end of June, the moratorium prevents CMS from forcing states to show that they were in compliance with the rule during that time period and CMS should not deny claims because a state was not in compliance with sections of the rule now subject to the moratorium during the months that the rule was effective. If the moratorium is lifted without further action, CMS could perhaps try to go back and disallow claims during the period the rule was in effect, but it is unlikely that a new Administration would attempt to do this and even more unlikely that Congress would let that happen.

4. What is the “Dear State Medicaid Director” letter on case management issued on January 19, 2001 (SMDL #01-013)?

The January 19, 2001 letter (SMDL) was sent to State Medicaid Directors and to State Child Welfare Directors. The purpose of the letter was to “clarify HHS policy on targeted case management services under the Medicaid program as it relates to an individual’s participation in other social, educational, or other programs.”

The SMDL defines the Medicaid case management and targeted case management benefit. It includes definitions of the components of case management, which are assessment, development of a care plan, referral, monitoring and follow-up. The definition was incorporated in the DRA and in the interim final rule.

The SMDL states that case management does not include direct services to which the individual has been referred. Specifically, activities relating directly to the provision of foster care services such as assessing adoption placements and interviewing prospective foster parents are not allowable case management activities under Medicaid. This list of foster care activities was incorporated in the DRA.

The SMDL allows states flexibility to define target groups for case management, including target groups based on “eligibility for, or participation in, a state social welfare program or other programs.”

The SMDL states that contact with individuals who are not eligible for Medicaid or not in the target group can be billed as part of Medicaid as long as the purpose of the contact is related to case management for the eligible individual.

The SMDL states that Medicaid is only liable for case management if there are no other liable third parties. Because the Title IV-E foster care program is not responsible for assessment, care planning and monitoring medical care and services, Medicaid can be billed for these activities as part of case management. However, Title IV-E does reimburse for other case management activities, including referrals to medical providers. The costs of case management activities for which Title IV-E programs are responsible are not billable to Medicaid. States must allocate the cost of case management between the two programs.

5. How does this SMDL affect what states can and cannot do now?

The moratorium allows CMS to implement the portion of the interim final rule implementing the DRA definition of case management as long as it is no more restrictive



than the January 19, 2001 SMDL. The definition of case management in the interim final rule at section 440.169(d) is consistent with the DRA definition and the definition in the SMDL as is section 440.169(e), which defines allowable contacts with non-eligible individuals in a manner that is consistent with the DRA and the SMDL. Therefore, these two sections of the interim final rule can be implemented.

What is clearly *more restrictive than* the SMDL (and therefore under moratorium) is the disallowance of case management for activities “integral to the administration of another non-medical program” including programs such as foster care, child welfare and protective services, and juvenile justice programs as set forth in section 441.18(c)(4). The SMDL also does not authorize the limitation to one case manager, require billing in 15-minute increments, or put any limits on case management provided as an administrative service.

6. What is the Dear State Medicaid Director letter issued on July 25, 2000 (Olmstead Update 3) and how does it affect what states can and cannot do now?

In 1999, the U.S. Supreme Court issued a landmark decision called *Olmstead v. L.C.* that held that states must operate their Medicaid programs in compliance with the Americans with Disabilities Act (ADA). States must furnish services in the most integrated setting appropriate to an individual’s needs that a state can reasonably accommodate. Following this decision, the Health Care Financing Administration (HCFA), predecessor to CMS, issued several guidance documents in the form of Dear State Medicaid Director letters to assist states in complying with this decision. Olmstead Update 3 was one of a series of letters to provide guidance to states. Many aspects of this letter relate to the operation of home- and community-based services waiver programs and are not directly relevant to the recent Medicaid rules and are not affected by the moratorium.

This letter, however, provided guidance to states with respect to using case management services to assist people with disabilities who reside in institutional settings to transition to community settings. The letter established a standard that permits states to provide transition case management services for up to the last 180 days on an institutional stay.

The moratorium, with its reference to policies being not more restrictive than policies set forth in this letter, does not permit the federal government to limit access to medically necessary transition case management services for less than 180 days of an institutional stay. It does not permit payment for case management services to be withheld until an individual successfully completes a transition to the community, and it does not permit a limitation of only one case manager.

7. What sections of the interim final rule on case management are still in effect?

As explained above, the moratorium allows CMS to implement the sections of the interim final rule setting out the definition of case management and the section on contact with ineligible individuals (sections 440.169(d) and (e)). Section 441.18(c)(2) prohibits reimbursement under the case management benefit for the direct delivery of services to which the individual is referred. This is also consistent with the SMDL but only to the extent it is read as prohibiting reimbursement for activities to which an individual is referred not for the case management itself. In the preamble to the interim final rule, CMS used this



section of the DRA to justify its exclusion of all case management provided by foster care workers. This is not authorized under the moratorium. The prohibition on reimbursement for the direct delivery of services also does not prohibit reimbursement under another category of Medicaid service for covered services to which an individual is referred. For example, if a child is referred for speech therapy by a case manager, the speech therapy could not be reimbursed as part of case management, but it could be covered under the speech therapy category of services.

8. Given that the moratorium did not stop the entire interim final rule regarding case management and optional case management benefits, do states still have to make changes in their program and submit a new state plan amendment (SPA) to CMS?

The moratorium prohibits a broad range of actions by CMS, but it does allow implementation of certain provisions of the interim final rule as explained above. To the extent a state's existing state plan setting forth its definition of case management for one or more targeted groups is inconsistent with the definition in the interim final rule, CMS could require that the state submit a state plan amendment to align its definition with the interim final rule.

9. What if a state submitted a SPA to implement the interim final rule? What happens now?

States that want to return to previous practices that are not consistent with the interim final rule, such as allowing 180 days for case management for individuals making a transition from an institution to the community, could attempt to withdraw the SPA if it has not yet been approved. If a SPA has been approved, states could also submit an amended SPA. Regardless, the moratorium prohibits CMS from using audit procedures or taking any other administrative action against the state for not complying with the sections of the interim final rule that are subject to the moratorium.

However, the moratorium does not require states that have already changed their practice to revert to former policy. The case management benefit is optional (except as required under EPSDT for children) and in most respects states could structure the benefit in compliance with the interim final rule without violating federal Medicaid law. So, for example, while billing in 15-minute increments cannot be required while the moratorium is in effect, there is nothing that would stop a state from exercising its flexibility to bill in that manner.

10. Can a state still provide targeted case management to children in foster care?

Yes. The SMDL does not prohibit case management for children in foster care. It only states that case management does not include the direct delivery of foster care services and that for children who are entitled to foster care assistance under Title IV-E (about one-half of children in foster care), the state cannot bill Medicaid for referrals to medical providers. In most cases, the State will already have a methodology through its cost allocation plan that allocates costs between the different programs. If the state does not have a plan, CMS or the Division of Cost Allocation may require one. . The child would still get case management services. The moratorium prevents CMS from enforcing the flat prohibition



on targeted case management provided by child welfare or child protective services workers or contractors of child welfare agencies.

11. Can my state still provide targeted case management to Medicaid beneficiaries receiving services from other state programs, such as juvenile justice or public guardian programs?

Yes. As long as the moratorium is in force, case management services that meet the definition in the DRA can be provided to target groups such as individuals in juvenile justice or public guardian programs. As mentioned above, the January 19, 2001 SMDL allows states to use eligibility for or participation in other programs as the basis for defining the target population for case management.

12. What are the rules for states providing case management to children receiving special education under Part B of the IDEA and to infants and toddlers with disabilities under Part C of the IDEA?

Answering this question requires a little background on how these programs work and how Medicaid fits in:

Part B of the IDEA ensures that children with disabilities receive a free and appropriate public education beginning at age 3, which includes special education and related services. Related services can include services like speech and physical therapy that are necessary for the child to get the benefit of an education. These services are detailed in the child's individualized education program (IEP).

Part C of the IDEA focuses on infants and toddlers with developmental delays and other disabilities. The program provides early intervention and other services designed to address the child's needs. These services are detailed in the child's individualized family service plan (IFSP).

The Medicaid statute at section 1903(c) makes it clear that Medicaid reimbursement is available for covered Medicaid services that are included in a child's IEP or IFSP. The interim final rule interprets this section narrowly, and prohibits case management for children in special education unless case management is specified in the child's IEP. Thus, the interim final rule would prohibit case management delivered by a school nurse for a child in special education even if the activities were within the definition of Medicaid case management and were designed to coordinate the child's education, social and medical services. For infants and toddlers with disabilities receiving services under Part C, the preamble to the rule states that Medicaid reimbursement is available for service coordination, but not for any functions that are related to the development of the child's IFSP.

The moratorium prevents CMS from implementing the part of the rule that prohibits federal reimbursement for case management activities integral to other programs. This includes the restriction of case management for children in special education and infants and toddlers with disabilities. Therefore case management activities provided by school nurses or service coordinators should be reimbursed if they meet the definition of case management even if case management is not specified as a service in the child's IEP or IFSP.



Some children with disabilities may not need special education in order to receive a free and appropriate education, but they may need other accommodations to ensure that have access to an education equal to that of other children. Section 504 of the Rehabilitation Act of 1973 requires that school districts accommodate the needs of these children. The interim final rule prohibited reimbursement for case management provided to children with disabilities to meet the requirements of section 504. States should be able to continue to receive reimbursement for case management for these children as long as the activities meet the definition of case management in the DRA.

13. Can states expand case management services and add new groups?

Yes. States can add new target groups including those involved with other programs.

14. What if my state has already made changes in case management services and says it doesn't want to change back because the moratorium will expire on March 31, 2009 and the rule will go back into effect?

As mentioned above, states could continue to implement the changes that they have made to comply with the interim final rule. This is true because the case management benefit is optional and in most respects states could structure the benefit in compliance with the interim final rule without violating federal Medicaid law. Some states may therefore be reluctant to change their case management guidelines for the second time this year, especially if they anticipate having to fully comply with the interim final rule by next spring. However, there are good reasons for states to change course and revert to prior practice. First, complete compliance with the interim final through limits on case management for children in foster care, adults and children with mental illness and other vulnerable groups will disrupt services they need. Furthermore, advocates can point out that — given the upcoming change in administration — it is unlikely that the interim final rule will be allowed to go forward on April 1st exactly as is. Rather, either Congress or a new Administration is likely to act to extend the moratorium, revise the rule, or pass a legislative clarification to supersede the interim final rule.

15. Can CMS still try to get states to make changes in the services they provide under the rehabilitation option?

The moratorium prohibits CMS from imposing new restrictions on the scope of services states provide under the rehabilitation option. CMS maintains the authority (and responsibility) to administer the Medicaid program and ensure that states are complying with federal law and policies. In doing so, they can audit state programs, demand adequate documentation to justify payments for covered services, and take other actions consistent with their oversight role. The moratorium permits CMS to undertake these activities consistent with policies that were in effect on July 1, 2007. It does not permit CMS to use these administrative actions to effectively require states to make more restrictive changes to their rehabilitation programs.

**Status of Medicaid Regulations**

Regulation	Description	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.	Final rule issued; Congressional action delayed enforcement through 3/31/09
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.	Not yet final; Congressional action bars CMS from finalizing the rule until after 3/31/09
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.	Interim final rule became effective 3/3/08; retroactively delayed by Congressional action through 3/31/09, except for part of rule implementing definition of case management in DRA
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.	Final rule issued but later nullified by court ruling; Congressional action bars CMS from finalizing the rule until after 3/31/09
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.	Not yet final; Congressional action bars CMS from finalizing the rule until after 3/31/09
Provider Tax 73 Fed. Reg. 9685 (Feb 22, 2008)	Changes provider tax rules that will limit states’ ability to raise federal Medicaid matching funds.	Final rule issued; effective 4/22/08; regulation retroactively delayed by Congressional action through 3/31/09, except for provisions that implement two changes in the Medicaid statute
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.	Not yet final; not currently under moratorium