Select Bush Administration Medicaid Rulemakings: Congressional and Administrative Actions

(name redacted)
Specialist in Health Care Financing

(name redacted)
Legislative Attorney

July 30, 2010

Congressional Research Service
7-....
www.crs.gov
RL34764

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

This report provides a summary of seven proposed, interim final, and final rules affecting the Medicaid program that were issued by the George W. Bush Administration during 2007 and 2008. These rules addressed Medicaid and graduate medical education, cost limits on public providers, provider taxes, rehabilitation services, case management, school-based administration and transportation services, and outpatient hospital services. Six of the seven rules (excluding the rule on outpatient hospital services) were under a congressional moratorium on further administrative action until April 1, 2009. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) extended the existing moratorium on the final or interim final regulations on case management services, provider taxes, and school-based administration and transportation services until July 1, 2009. In addition, P.L. 111-5 prohibited all administrative actions to implement the final rule on outpatient hospital services until after June 30, 2009. This law also included a "sense of Congress" that the Secretary of Health and Human Services (HHS) should not promulgate final regulations for the cost limit on public providers, graduate medical education, and rehabilitation services.

Other actions regarding these rules have occurred since they were first proposed or issued by the Bush Administration. The final rule affecting cost limits on public providers was vacated by a federal judge in May 2008. The Obama Administration has taken additional actions on the remaining rules. The three rules regarding school-based administration and transportation services, outpatient hospital services, and case management have been rescinded in part or altogether. Enforcement of a portion of the rule on provider taxes was delayed until June 30, 2010. Finally, two other proposed rules on rehabilitation services and payments for graduate medical education were withdrawn. These rules were not affected by the health reform legislation that became law earlier this year—the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), provisions of which were amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152).

Contents

Graduate Medical Education (GME) 1
Cost Limit for Public Providers 2
Provider Taxes 3
Rehabilitative Services 4
Case Management 4
School-Based Services 5
Outpatient Hospital Services 7
Conclusion 8

Tables

Table 1. Status of Medicaid Regulations 8

Contacts

Author Contact Information 9

Medicaid finances the delivery of primary and acute care medical services, and long-term care, for certain low-income populations, including more than 68 million individuals in FY2010. Combined federal and state spending exceeded $381 billion in FY2009. 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 within the Department of Health and Human Services (HHS) 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 were under a congressional moratorium preventing further administrative action until April 1, 2009. The seventh rule affecting outpatient hospital services was published as a final rule in the *Federal Register* on November 7, 2008, and became effective on December 8, 2008.

The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) extended the existing moratorium on the final or interim final regulations on case management services, provider taxes, and school-based administration and transportation services until July 1, 2009. In addition, P.L. 111-5 prohibited all administrative actions to implement the final rule on outpatient hospital services until after June 30, 2009. This law included a "sense of Congress" that the Secretary of HHS should not promulgate final regulations for the cost limits on public providers, graduate medical education, and rehabilitation services.

Since that time, these rules have been affected by other federal actions (see **Table 1**). The rule on cost limits for public providers was vacated by a federal judge. The Obama Administration has taken additional actions on the remaining six rules. The three rules regarding school-based administration and transportation services, outpatient hospital services, and case management have been rescinded in part or altogether. Enforcement of a portion of the rule on provider taxes has been delayed. Finally, the two proposed rules on rehabilitation services and payments for graduate medical education were withdrawn.

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).

In May 2007, CMS proposed a rule that would have eliminated federal reimbursement for both DGME and IME under Medicaid.[1] The rule would also have changed the way in which the Medicaid upper payment limit for hospital services is calculated, which would have further reduced the federal share of Medicaid costs for hospitals. In that rule, CMS argued that GME payments are not authorized in the Medicaid statute, are not included in the list of services

[1] Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Medicaid Program; Graduate Medical Education, 72 *Federal Register* 28930 (May 23, 2007).

considered to be "medical assistance," and are not recognized in the Medicaid statute as a component of the costs of hospital care. Opponents argued that the rule represented a reversal of long-standing Medicaid policy, that there were references to GME payments in both Medicaid statute and regulations, that GME payments have previously been explicitly recognized by CMS, and that the statute was broadly drafted and even accompanying regulations did not itemize every element of reimbursable costs.[2] However, this rule was withdrawn by the Obama Administration on October 8, 2009.[3]

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 clarified the types of IGTs allowable for financing a portion of Medicaid costs, imposed a limit on Medicaid reimbursements for government-owned hospitals and other institutional providers, and required certain providers to retain all of their Medicaid reimbursements.[4] The rule also established 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. An initial moratorium on further administrative action on this rule was included in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007.[5] After Congress passed this Act, but before the President signed it into law, CMS finalized the rule. A federal court found that the rule had been "improperly promulgated" because the Secretary's actions violated the congressional moratorium on "any action … to finalize" the proposed rule.[6] The court vacated the rule and remanded the matter to CMS.[7] The moratorium on

[2] See Memorandum from Mark H. Gallant, Cozen and O'Conner, to Ivy Baer and Karen Fisher, Association of American Medical Colleges (June 20, 2007), http://www.aamc.org/advocacy/library/teachhosp/corres/2007/062207.pdf (hereafter "Cozen and O'Conner/AAMC memo"); Letter from American Hospital Association, to Leslie Norwalk, Acting Administrator, CMS (June 20, 2007), at http://www.aha.org/aha/letter/2007/070620-cl-cms-2279-p.pdf, (hereafter "American Hospital Association letter"); Letter from National Association of Public Hospitals, to Leslie Norwalk, Acting Administrator, CMS (June 22, 2007), at http://www.naph.org/naph/advocacy/NAPH_Medicaid_GME_Comment_Letter_6-22-07.pdf (hereafter "National Association of Public Hospitals letter").

[3] HHS, Semiannual Regulatory Agenda, Completed Actions, Medicaid Graduate Medical Education, 74 *Federal Register* 64424, 64445 (December 7, 2009).

[4] HHS, CMS, Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 *Federal Register* 29748 (May 29, 2007).

[5] P.L. 110-28.

[6] Alameda County Medical Center v. Leavitt, 559 F. Supp. 2d 1, 3, 5 (D.D.C. 2008).

the rule was extended until April 1, 2009, in the Supplemental Appropriations Act, 2008.[8] The American Recovery and Reinvestment Act of 2009 included a statement that it was the "sense of Congress" that neither the proposed regulation or the "purported" final regulation, which was vacated by the district court, should be finalized.[9]

Provider Taxes

Provider-specific taxes have been used by many states 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.

In order to eliminate the "borrowing" practice, taxes are required to meet a number of federal laws and regulations, some of which have been in flux in the past few years. For federal reimbursement purposes, health-care related taxes must (1) be imposed on a permissible class of health care services, (2) be broad-based (i.e., apply to all providers in a class, not just Medicaid providers), (3) be uniform (i.e., all providers within a class must be taxed at the same rate), and (4) not involve "hold harmless" arrangements in which some or all of the taxes are returned to the provider either directly or indirectly.

In February 2008, 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.[10] Opponents of this rule expressed concern that it reduces consistency and clarity, that its changes exceed the HHS Secretary's authority, and that it would impede a state's ability to condition Medicaid reimbursements on payment of required taxes.[11]

This rule became effective on April 22, 2008, but was subject to a partial moratorium[12] until April 1, 2009, which was later extended by Congress until July 1, 2009.[13] The moratorium prohibited CMS from taking further action to implement provisions in the final rule that were more restrictive than the provisions in effect on February 21, 2008 (with the exception of statutorily

(...continued)

[7] Id. at 5.

[8] P.L. 110-252, § 7001(a)(1).

[9] P.L. 111-5, § 5003(d).

[10] HHS, CMS, Medicaid Program; Health Care-Related Taxes, 73 *Federal Register* 9685 (February 22, 2008).

[11] See, for example, Letter from American Public Human Services Association and the National Association of State Medicaid Directors, to Leslie Norwalk, Acting Administrator, CMS (May 22, 2007), http://www.nasmd.org/issues/docs/NPRM_Provider_Tax_Comments_APHSA_NASMD_2007_05_22.pdf.

[12] This partial moratorium until April 1, 2009, was imposed under P.L. 110-252, the Supplemental Appropriations Act of 2008.

[13] This partial moratorium was extended until July 1, 2009, under P.L. 111-5.

required changes). Subsequently, CMS promulgated a final rule that delayed enforcement of certain changes to the hold harmless provisions in the provider taxes rule for one year (until June 30, 2010) in order to determine whether states needed further clarification or guidance, to evaluate the impact of the rule and alternative approaches, and to ensure appropriate implementation.[14]

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 annual budget submissions, the Bush Administration had 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. A 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.[15] Opponents of this rule were concerned that it would create new administrative barriers and would restrict access by tightening the definition of rehabilitation. Others argued 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.[16]

Congress placed a moratorium that prohibited the HHS Secretary from taking any action—such as finalizing the rule—to impose restrictions that were more restrictive than those in effect on July 1, 2007,[17] and extended the moratorium in a separate appropriations act.[18] A later law included a "sense of Congress" that the Secretary should not promulgate the proposed rule as a final rule.[19] This rule was withdrawn by the Obama Administration.[20] Several factors may have led to this withdrawal, including the "sense of the Congress" in P.L. 111-5, the complexity of the underlying issues and the public comments received, and the desire to assure that CMS has the flexibility to reevaluate the issues as well as explore options and alternatives with stakeholders.

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

[14] HHS, Medicaid Program; Health Care-Related Taxes, 74 *Federal Register* 31196 (June 30, 2009).

[15] HHS, CMS, Medicaid Program: Coverage for Rehabilitative Services, 72 *Federal Register* 45201 (August 13, 2007).

[16] See, for example, First Focus, CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs, Sara Rosenbaum, J.D. (March 2008), http://firstfocus.net/sites/default/files/r.2008-3.14.rosenbaum.pdf; Letter from Consortium for Citizens with Disabilities, to CMS (October 10, 2007) (Comment Letter on Proposed Medicaid Rehabilitation Rule), http://www.c-c-d.org/task_forces/health/CCD%20Comments%20final%20final.pdf.

[17] P.L. 110-173, § 206.

[18] P.L. 110-252, § 7001(a)(2).

[19] P.L. 111-5, § 5003(d)(3).

[20] HHS, CMS, Medicaid Program; Coverage for Rehabilitative Services; Withdrawal, 74 *Federal Register* 61096 (November 23, 2009).

groups or for individuals who reside in state-designated geographic areas. The Bush Administration had proposed legislative changes to reduce Medicaid TCM expenditures in annual budget submissions. In the Deficit Reduction Act of 2005 (DRA), 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.[21]

The Secretary issued an interim final rule with a comment period in December 2007 that became effective in March 2008.[22] All Medicaid authorities related to all case management services, including TCM and services delivered through waivers, were subject to this rule. It also directly addressed case management issues that previously might have been considered open to interpretation. CMS contended that specific guidance and definitions were needed to avoid further excessive federal outlays. The proposed rule was also intended to reduce previous confusion about the overlap between Medicaid TCM and similar services provided through other non-Medicaid programs. Opponents of this rule argued 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.[23] 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.[24]

P.L. 110-252 placed a partial moratorium on the interim final rule for TCM services until April 1, 2009, which was then extended to July 1, 2009, by P.L. 111-5. This moratorium precluded CMS from taking any action to impose restrictions on case management services that were more restrictive than those in effect on December 3, 2007 (the day before the interim final rule was published). An exception was made to the moratorium for the portion of the regulation related directly to implementing the definition of case management services and TCM.

Subsequently, CMS issued a final rule that rescinded certain provisions in the December 4, 2007, interim final rule on case management. [25] The rescission became effective on July 1, 2009. In general, changes made by the rescission were intended to address concerns that the interim final rule may unduly restrict beneficiary access to covered case management services and limit state flexibility in determining efficient and effective delivery systems for providing case management services.

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

[21] P.L. 109-171.

[22] HHS, CMS, Medicaid Program; Optional State Plan Case Management Services, 72 *Federal Register* 68077 (December 4, 2007).

[23] See footnote 16 for relevant references.

[24] See, for example, Letter from American Public Human Services Association and its affiliate, the National Association of State Medicaid Directors, to Kerry Weems, Administrator, CMS (February 4, 2008), at http://www.aphsa.org/home/doc/NASMDltr_TCMcmntFeb408.pdf.

[25] HHS, Medicaid Program; Rescission of School-Based Administration/Transportation Final Rule, Outpatient Hospital Services Final Rule, and Partial Recession of Case Management Interim Final Rule, Final Rule, 74 *Federal Register* 31183 (June 30, 2009).

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.[26] In the President's FY2008 budget proposal, the Bush Administration noted that Medicaid claims for services provided in school settings had been prone to abuse and overpayments, especially with respect to transportation and administrative activities. As of November 2007, the HHS Office of Inspector General (OIG) had published reviews of school-based claims in 22 states. Based on this and other research, both the HHS OIG and GAO reached similar conclusions.[27]

To address these concerns, in December 2007, CMS issued a final rule that restricted 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).[28] Opponents of this rule argued that it would 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.

Both congressional and administrative actions have subsequently affected this rule. First, a congressional moratorium on further action until June 30, 2008, was placed on this rule, precluding CMS from imposing any restrictions contained in the rule that were more restrictive than those in effect on July 1, 2007.[29] This moratorium was then extended twice, first to April 1, 2009,[30] and then again to July 1, 2009.[31] In addition, on June 30, 2009, the Obama Administration issued a final rule that rescinded the school-based administration/transportation rule in its entirety.[32] CMS indicated that this rescission was based on concerns that the adverse consequences of the former final rule may be more significant than previously assumed and that

[26] See Hearing before the Senate Finance Committee (June 17, 1999) (statement of William J. Scanlon, Medicaid Questionable Practices Boost Federal Payments for School-Based Services, GAO-T-HEHS-99-148); Hearing Before the Senate Finance Committee (April 5, 2000) (statement by Kathryn Allen, Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit, GAO/T-HEHS/OSI-00-87).

[27] See, for example, HHS OIG, Review of Medicaid Transportation Claims Made by the New York City Department of Education, A-02-03-01023 (September 2005); HHS OIG, Audit of LaPorte Consortium's Administrative Costs Claimed for Medicaid School-Based Services, A-06-02-00051 (January 2006); GAO, Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight, GAO/HES/OSI-00-69 (April 2000); *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net: Hearing before the Senate Finance Committee* (June 28, 2005) (statement of Kathryn Allen, Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight, GAO-05-836T).

[28] HHS, CMS, Medicaid Program; Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School, Final Rule, 72 *Federal Register* 73635 (December 28, 2007).

[29] P.L. 110-173, § 206.

[30] P.L. 110-252, § 7001(a)(2).

[31] P.L. 111-5, § 5003(b).

[32] HHS, CMS, Medicaid Program: Rescission of School-Based Administration/Transportation Final Rule, Outpatient Hospital Services Final Rule, and Partial Rescission of Case Management Interim Final Rule, 74 *Federal Register* 31183 (June 30, 2009).

consideration of alternative approaches could be warranted. CMS is presently applying the policies that were in effect before the December 2007 rule became effective, in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide,[33] which "provides guidance to states on both school-based administrative claiming and school transportation."[34]

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 have limited 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 paid for under its outpatient prospective payment system (OPPS) or that were recognized by Medicare as an OPH service under an alternate payment methodology, (2) provided by an outpatient hospital facility, including only those entities that met 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.[35]

Opponents of this provision of the rule argued that it would have excluded 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 have excluded 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 would have incorporated the new definition of hospital categories adopted in the final rule regarding cost limits on government providers (described above), this rule would have violated a moratorium on implementing any provision of the rule on cost limits for government providers. In light of these concerns regarding 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. This rule became effective on December 8, 2008.[36]

In June of 2009, the Obama Administration rescinded this rule in its entirety, primarily because of concerns that the rule would have adverse effects on the availability of covered services for Medicaid beneficiaries.[37] CMS had previously assumed that services no longer a part of the

---

[33] CMS, Medicaid School-Based Administrative Claiming Guide (May 2003), http://hrsa.dshs.wa.gov/mam/files/Guide/03-05macguide.pdf.

[34] 74 *Federal Register* at 31184-85.

[35] HHS, CMS, Proposed Rule—Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit, 72 *Federal Register* 55158 (Sept. 28, 2007); HHS, CMS, Final Rule—Medicaid Program; Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition, 73 *Federal Register* 66187 (November 7, 2008).

[36] 73 *Federal Register* at 66188.

[37] HHS, Medicaid Program: Rescission of School-Based Administration/Transportation Final Rule, Outpatient Hospital Services Final Rule, and Partial Recession of Case Management Interim Final Rule, Final Rule, 74 *Federal Register* (continued...)

outpatient hospital benefit category would be shifted to other benefit categories.[38] Subsequently, comments on the rule suggested that such shifts may have been difficult, given complex state funding and payment methodologies, and state licensure and certification limits on health care services.[39]

Conclusion

In 2007 and 2008, the Bush Administration issued seven rules restricting coverage of and payments for certain services under the Medicaid program, as detailed above. Some of these policies were mandated by congressional changes to federal law. There was some support and some opposition to these rules from various interest groups. In addition, subsequent federal action came into play. One rule was vacated by a federal court. Congress also weighed in on six of these regulations through moratoria on further administrative action. Since that time, the Obama Administration has withdrawn, rescinded (in whole or in part), or delayed enforcement of these rules. Whether these rules will be subject to additional congressional or administrative change remains to be seen. This report will be updated if such actions occur.

Table 1. Status of Medicaid Regulations

Rule	Publication Date	Current Status
Graduate Medical Education	Proposed rule—72 *Federal Register* 28930, May 23, 2007; Withdrawal indicated in Semiannual Regulatory Agenda—74 *Federal Register* 644445, December 7, 2009	Withdrawn
Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership	Proposed rule—72 *Federal Register* 2236, January 18, 2007; Final rule—72 *Federal Register* 29748, May 29, 2007	"Improperly promulgated" final rule vacated, "sense of Congress" that Secretary should not issue final rule
Coverage for Rehabilitative Services	Proposed rule—72 *Federal Register* 45201, August 13, 2007; Withdrawa l—74 *Federal Register* 61096, November 23, 2009	Withdrawn
Optional State Plan Case Management Services	Interim final rule—72 *Federal Register* 68077, December 4, 2007; Partial Rescission—74 *Federal Register* 31183, June 30, 2009	Partial Rescission
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 *Federal Register* 51397, September 7, 2007; Final rule—72 *Federal Register* 73635, December 28, 2007; Rescission—74 *Federal Register* 31183, June 30,2009	Total Rescission
Health Care-Related Taxes	Proposed rule—72 *Federal Register* 13726, March 23, 2007; Final rule—73 *Federal Register* 9685, February 22, 2008; Final rule delaying	Partial Enforcement Delay until June 30,

(...continued)

31183 (June 30, 2009).

[38] *Id.* at 31186.

[39] *Id.*

Rule	Publication Date	Current Status
	enforcement of certain clarifications—74 *Federal Register* 31196, June 30, 2009	2010
Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition	Proposed rule—72 *Federal Register* 55158, September 28, 2007; Final rule—73 *Federal Register* 66187, November 7, 2008; Rescission—74 *Federal Register* 31183, June 30, 2009	Total Rescission

Source: Congressional Research Service.

Author Contact Information

(name redacted)
Specialist in Health Care Financing
/redacted/@crs.loc.gov, 7-....

(name redacted)
Legislative Attorney
/redacted/@crs.loc.gov, 7-....

EveryCRSReport.com

The Congressional Research Service (CRS) is a federal legislative branch agency, housed inside the Library of Congress, charged with providing the United States Congress non-partisan advice on issues that may come before Congress.

EveryCRSReport.com republishes CRS reports that are available to all Congressional staff. The reports are not classified, and Members of Congress routinely make individual reports available to the public.

Prior to our republication, we redacted names, phone numbers and email addresses of analysts who produced the reports. We also added this page to the report. We have not intentionally made any other changes to any report published on EveryCRSReport.com.

CRS reports, as a work of the United States government, are not subject to copyright protection in the United States. Any CRS report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS report may include copyrighted images or material from a third party, you may need to obtain permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

Information in a CRS report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to members of Congress in connection with CRS' institutional role.

EveryCRSReport.com is not a government website and is not affiliated with CRS. We do not claim copyright on any CRS report we have republished.