$$\frac{\text{The number of weeks of instructional time offered in the program in the fall and spring semesters or trimesters}}{\text{The number of weeks of instructional time in the program's academic year}}$$

; or

In a program using quarters—

$$\frac{\text{The number of weeks of instructional time offered in the program in the fall, winter, and spring quarters}}{\text{The number of weeks of instructional time in the program's academic year}}$$

; and

* * * * *

Dated: June 24, 2009.

Daniel T. Madzelan,

Director, Forecasting and Policy Analysis.

[FR Doc. E9–15369 Filed 6–29–09; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 433, 440 and 441

[CMS–2287–F2; CMS–2213–F2; CMS 2237–F]

RIN 0938–AP75

Medicaid Program: Rescission of School-Based Administration/ Transportation Final Rule, Outpatient Hospital Services Final Rule, and Partial Rescission of Case Management Interim Final Rule

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This rule finalizes our proposal to rescind the December 28, 2007 final rule entitled, ''Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School;'' the November 7, 2008 final rule entitled, ''Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition;'' and certain provisions of the December 4, 2007 interim final rule entitled, ''Optional State Plan Case Management Services.'' These regulations have been the subject of Congressional moratoria and have not yet been implemented (or, with respect to the case management interim final rule, have only been partially implemented) by CMS. In light of concerns raised about the adverse effects that could result from these regulations, in particular, the potential restrictions on services available to beneficiaries and the lack of clear evidence demonstrating that the approaches taken in the regulations are warranted, CMS is rescinding the two final rules in full, and partially rescinding the interim final rule. Rescinding these provisions will permit further opportunity to determine the best approach to further the objectives of the Medicaid program in providing necessary health benefits coverage to needy individuals.

DATES: *Effective Date:* These regulations are effective on July 1, 2009.

FOR FURTHER INFORMATION CONTACT: Sharon Brown (410) 786–0673 or Judi Wallace (410) 786–3197, for issues related to the School-Based Administration/Transportation final rule.

Jeremy Silanskis (410) 786–1592, for issues related to the Outpatient Hospital Services final rule.

Jean Close (410) 786–2804 or Melissa Harris (410) 786–3397, for issues related to the Case Management interim final rule.

SUPPLEMENTARY INFORMATION:

I. Background

A. Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School

Under the Medicaid program, Federal payment is available for the costs of administrative activities as found necessary by the Secretary for the proper and efficient administration of the State plan. On December 28, 2007, we published a final rule entitled, ''Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School'' (hereinafter referred to as the School-Based Administration/Transportation final rule (72 FR 73635)), to eliminate Federal Medicaid payment for the costs of certain school-based administrative and transportation activities based on a Secretarial finding that these activities are not necessary for the proper and efficient administration of the Medicaid State plan and are not within the definition of the optional transportation benefit. Under the final rule, Federal Medicaid payments were not available for administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, or for transportation between home and school. Federal financial participation (FFP) remained available for covered services furnished at or through a school that are included in a child's individualized education program (IEP), and for transportation from school to a provider in the community for a covered service. FFP also remained available for the costs of school-based Medicaid administrative activities conducted by employees of the State or local Medicaid agency, and for transportation to and from a school for children who are not yet school age but are receiving covered direct medical services at the school.

The December 28, 2007, School-Based Administration/Transportation final rule became effective on February 26, 2008. Subsequent to publication of the final rule, section 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) imposed a moratorium until June 30, 2008, that precluded CMS from imposing any restrictions contained in the rule that are more stringent than those applied as of July 1, 2007. Section 7001(a)(2) of the Supplemental Appropriations Act of 2008 (Pub. L. 110–252) extended this moratorium until April 1, 2009; and section 5003(b) of the American Recovery and Reinvestment Act of 2009 (the Recovery Act) (Pub. L. 111–5) further extended the moratorium until July 1, 2009.

B. Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition

Outpatient hospital services are a required service under Medicaid. On November 7, 2008, we published a final rule entitled, ''Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition'' (hereinafter referred to as Outpatient Hospital Services final rule), to introduce new limitations on which treatments could be billed and paid as an outpatient hospital service, thereby altering the pre-existing definition of ''outpatient hospital services.'' The final rule became effective on December 8, 2008. Section 5003(c) of the Recovery Act precludes CMS from taking any action to implement the final rule with respect to services furnished between December 8, 2008 and June 30, 2009.

C. Optional State Plan Case Management Services

On December 4, 2007, we published an interim final rule entitled, ''Optional State Plan Case Management Services'' (hereinafter referred to as the Case Management interim final rule (72 FR 68077)), that revised current Medicaid regulations to incorporate changes made by section 6052 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171). In addition, we placed new limitations on the services and activities that could be covered and paid as an optional targeted case management (TCM) service or optional case management service.

The interim final rule became effective on March 3, 2008. Section 7001(a)(3)(B)(I) of the Supplemental Appropriations Act imposed a partial moratorium until April 1, 2009, precluding 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 law contained an exception for the portion of the regulation as it related directly to implementing the definition of case management services and targeted case management services. That partial moratorium was extended by section 5003(a) of the Recovery Act until July 1, 2009.

II. Provisions of the Proposed Regulation and Response to Comments

Since the publication of these final regulations, we have received additional public input about the adverse effects that could result from these regulations. In addition, the statutory moratoria indicate strong concern in Congress about the effects of these regulations. In particular, we have become aware that the provisions of these rules could result in restrictions on services available to beneficiaries and there is a lack of clear evidence demonstrating that the approaches taken in the regulations are warranted at this time.

On May 6, 2009, we published a proposed rule (74 FR 21230) in the **Federal Register** to rescind the November 7, 2008 Outpatient Hospital Services final rule; the December 28, 2007 School-Based Administration/Transportation final rule; and certain provisions of the December 4, 2007 Case Management interim final rule. The May 6, 2009 proposed rule solicited public comments on our proposal to rescind these rules and to aid our consideration of the many complex questions surrounding these issues and the need for regulation in these areas.

We received a total of 556 timely comments from State officials, school districts and consortia, educational organizations, child advocacy groups, health care organizations, school nurses, parents, teachers, school officials, providers, and other interested individuals. All comments were reviewed and analyzed. After associating like comments, we placed them in categories based on subject matter. The commenters were overwhelmingly supportive of our proposal to rescind the School-Based Administration/Transportation final rule, the Outpatient Hospital Services final rule, and portions of the Case Management interim final rule. Summaries of the public comments and our responses to those comments are set forth under the appropriate headings below.

A. Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School

We proposed to rescind the December 28, 2007 School-Based Administration/Transportation final rule in its entirety. The proposed rescission was based on concerns that the adverse consequences of the final rule may be more significant than previously assumed, and that the consideration of alternative approaches may be warranted. Since issuing the School-Based Administration/Transportation final rule, we became aware that the limitations on Federal Medicaid funding under the final rule could adversely affect State outreach and enrollment efforts in schools, and therefore limit services for families in need. We had previously assumed that, since such activities were within the scope of the overall mission of the schools, the activities would continue with funding from other sources available for educational activities. Conversely, we thought that State Medicaid agencies had sufficient resources to outsource its employees in schools to absorb these functions. In summary, we were concerned that the assumptions underlying the promulgation of the rule may have been invalid, and that implementation of the rule could adversely affect Medicaid beneficiaries. We requested comments on this issue.

Moreover, we were concerned that there is insufficient evidence on the need for the particular approach taken by the final rule. The oversight reviews that we cited in issuing the final rule, indicating some deficiencies in procedures for claiming school-based administrative expenditures and necessary transportation, were several years old and based on data collected more than 5 years ago. These claims did not reflect CMS guidance issued after the review data was collected; nor did they reflect the greater administrative oversight and technical assistance that we have made available more recently. Moreover, since CMS has tools at its disposal to address inappropriate claiming that could arise in any setting, we would continue to monitor claims and evaluate the efficacy of these tools in addressing any claiming issues even in the absence of this rule.

In light of these concerns, we proposed to rescind the provisions of the final rule while we further review the underlying issues and determine whether a different approach is necessary, and revise the regulations to remove the regulatory provisions added by the December 28, 2007 final rule. We proposed to apply the policies in effect before the December 28, 2007 final rule became effective, as set forth in the May 2003 Medicaid School-Based Administrative Claiming Guide which provides guidance to States on school-based administrative claiming and school transportation.

Specifically, we proposed to revise § 431.53(a) and § 440.170(a) to remove language indicating that, for purposes of Medicaid reimbursement, transportation does not include transportation of school-age children from home to school and back when a child is receiving a Medicaid-covered service at school. In addition, we proposed to remove § 433.20, which provides that Federal financial participation (FFP) under Medicaid is not available for expenditures for administrative activities by school employees, school contractors, or anyone under the control of a public or private educational institution.

Comment: Many commenters applauded CMS' decision to reconsider the merits of the School-Based Administration/Transportation final rule. Commenters stated that the final rule was ''bad public policy'' and that efforts to rescind the rule are an acknowledgment of the impact the final rule would have had on a myriad of stakeholders.

Response: We appreciate the commenters' support of our proposal to rescind the School-Based Administration/Transportation final rule. After careful consideration of the concerns raised by commenters, we agree that the final rule should be rescinded.

Comment: The largest number of comments in support of rescinding the School-Based Administration/Transportation final rule focused on funding issues, noting that rescission will enable school districts and many others to continue receiving the desperately needed Federal funds to support school-based outreach, enrollment assistance, and improved access to medical and transportation services. Many commenters stated that students who receive specialized transportation and medical needs require schools to expend large sums of money and that reducing or eliminating Medicaid funds would have had a major impact on their ability to serve this population. The majority of commenters who supported the proposed rescission stated that the loss of funds would have been devastating to the school district and to the students served. The commenters also indicated that staff and services would have been cut due to loss of funding.

Many commenters cited the economy in supporting the proposed rescission. ''In light of the recent budget problems,'' one commenter stated, ''school districts need all the resources they can get.'' Another commenter stated that it is especially important during this time of dire budget constraints to maintain the ability of school staff to provide outreach and continue to be able to be reimbursed. In addition, the commenters believe that this reimbursement is a wise investment.

Response: Since issuing the School-Based Administration/Transportation final rule, we have become aware that limitations on Federal Medicaid funding would have adversely affected State outreach and enrollment efforts in schools, therefore limiting services for families in need. We previously assumed that, since such activities were within the scope of the overall mission of the schools, the activities would continue with funding from other sources available for educational activities.

We agree that rescission of the School-Based Administration/Transportation final rule is necessary to ensure that Medicaid administrative activities in schools, and certain transportation services, will continue to be provided in schools with Federal Medicaid funding. We will continue to apply the policies set forth in guidance issued prior to that rule, including the 1999 letter to State Medicaid Directors concerning school-based transportation services and the 2003 Medicaid School-Based Administrative Claiming Guide.

We will continue to evaluate the efficacy of these tools in addressing school-based claiming issues and collaborate with education and Medicaid stakeholder groups to discuss ways to improve such tools.

Comment: Some commenters applauded the proposed rescission of the School-Based Administration/Transportation final rule because it would allow their school district to continue to help identify students that are in need of proper medical attention, as a service to the community, and provide needed services to eligible students. Other commenters stated that Medicaid funding not only leads to an increase in the number of children receiving health insurance, but also increases the number of students who receive vital health services. One commenter stated that the final rule would have only served to reduce school efforts to bring health services to medically compromised children in schools across the nation.

Response: We agree that rescission of the School-Based Administration/Transportation final rule is necessary to ensure that Medicaid administrative activities in schools, and certain transportation services, will continue to be provided in schools with Federal Medicaid funding. We will continue to apply the policies set forth in guidance issued prior to that rule, including the 1999 letter to State Medicaid Directors concerning school-based transportation services and the 2003 Medicaid School-Based Administrative Claiming Guide.

We will continue to evaluate the efficacy of these tools in addressing school-based claiming issues and collaborate with education and Medicaid stakeholder groups to discuss ways to improve such tools.

Comment: Some commenters stated that the proposed rescission will make it easier for States to fulfill requirements under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit specified in section 1905(a) of Social Security Act (the Act). They believe that the School-Based Administration/Transportation final rule contradicted Medicaid's requirements for EPSDT and CMS' previous guidance. The commenter indicated that this mandate requires States to inform families about the availability of EPSDT services and assist them in accessing services. In addition, commenters stated that many school systems have contracted with States so that school nurses and staff may inform families about EPSDT. Since schools are mandated to provide certain services for students with special needs, one commenter stated, the funds that support these services must not be cut off.

Commenters cited the *State Medicaid Manual* as not only encouraging State Medicaid agencies to coordinate EPSDT administrative activities with ''school health programs of State and local health agencies,'' but also offering FFP to cover the costs to public agencies of providing direct support to the Medicaid agency in administering the EPSDT program.

Response: We agree that rescission of the School-Based Administration/Transportation final rule is necessary to ensure that Medicaid administrative activities, and certain transportation services, will continue to be provided in schools with Federal Medicaid funding. We will instead reinforce the policies that preceded the issuance of that final rule.

Comment: Some commenters stated that the School-Based Administration/Transportation final rule would have had a negative impact on Medicaid outreach activities in schools. One commenter stated, ''* * * the practical effect of the final rule would [have been] to eradicate the successful efforts made by schools to identify and enroll low-income children with disabilities into Medicaid.'' A substantial number of commenters stated that schools provide a unique opportunity to enroll children in Medicaid because the bulk of the eligible that are uninsured children attend schools. Other commenters stated that schools serve as a safe haven and gateway to health care for some of the State's most vulnerable residents, special education students, and children in families whose circumstances have limited their access to health care.''

Another commenter stated that reimbursing schools for Medicaid administrative activities and health related services is an efficient and effective way of ensuring that Federal funds are directed to those schools that need them the most. Other commenters recommended that CMS continue its support for school-based Medicaid

administrative activities because it can be an effective way to reach children in need of services and to ensure adequate medical care for disabled students and their families, who are often low-income and uninsured.

Some commenters referenced the May 2003 CMS Medicaid School-Based Administrative Claiming Guide, which states that ''* * * the school setting provides a unique opportunity to enroll * * * and to assist'' Medicaid eligible children ''access the benefits available to them'' as evidence that school-based Medicaid administrative claims should remain eligible for FFP.

Response: We appreciate the commenters' support of our proposal to rescind the School-Based Administration/Transportation final rule, and of the policies set out in the 2003 CMS Medicaid School-Based Administrative Claiming Guide. After careful consideration of the concerns raised by commenters, we agree that the final rule should be rescinded, and the policies set out in the Medicaid School-Based Administrative Claiming Guide, will be reinforced.

Comment: Some commenters stated that, in supporting the proposed rescission of the School-Based Administration/Transportation final rule, asking outside agencies to provide the services that schools currently provide would be more costly to the State. Other commenters stated that, even if employees of State or local Medicaid agencies were given this task, it would be far less efficient and effective than the current approach to outreach and enrollment activities, which is valuable specifically because staff and employees of schools are familiar to and trusted by families.

Response: We agree that rescission of the School-Based Administration/Transportation final rule is necessary to ensure that needed Medicaid administrative activities and related funding will continue in school settings. We will reinforce the policies that preceded the issuance of that final rule.

Comment: Some commenters supported the proposed rescission of the School-Based Administration/Transportation final rule because they believe their State's claiming practices have improved considerably since the early 2000's and that the rationale for developing the final rule was based on old data and old practices. As one commenter indicated, the main reason cited by CMS was the concern that school-based administrative expenditures are recognized and claimed properly, consistent with Federal law. One commenter indicated that there have been no published audit findings to gauge States' compliance with the 2003 guidelines issued by CMS. Medicaid administrative funding for all schools should not have been eliminated for all schools due to the problems of a few schools, they concluded. The commenter believes CMS should focus its efforts on working with States to ensure proper claiming. The commenter also stated that CMS knows that schools provide critical administrative services to children in Medicaid.

Response: We agree that rescission of the School-Based Administration/Transportation final rule is necessary to ensure that needed Medicaid administrative activities and related funding will continue. We intend to provide additional guidance and greater administrative oversight and technical assistance. We will also focus on program and fiscal integrity to provide guidance and direction to avoid duplication and improper claiming.

Comment: Some commenters focused on alternative approaches to meet the objectives of the School-Based Administration/Transportation final rule in ensuring valid Medicaid claiming procedures. In support of the proposed rescission, several commenters suggested measures that could achieve the objectives set out in the final rule, to include: issuance of one national standard for claiming developed in conjunction with public school officials; one national office to provide clear, consistent guidance; consistency of regulation implementation for administrative claiming among all regional CMS offices; annual national training of State officials overseeing school claiming to ensure compliance; individual States to determine how to process claims and audit; and a national committee to study the best methods to deliver information and services to families in need.

Other commenters applauded CMS' decision to explore alternatives and use existing tools to address inappropriate claiming to the extent that any questionable practices continue. Commenters stated that there was insufficient evidence to support the approach of the final rule and encourage CMS to investigate other, more appropriate methods of fulfilling its oversight role. These commenters believe that CMS can accomplish this objective without eliminating critically needed Federal funding of school-based Medicaid administrative and transportation services. The commenters stated that CMS has already increased its administrative oversight following reports of improper claiming.

Many commenters recommended that CMS further promote sound Medicaid program operation through clear guidance and technical assistance specifically addressing the unique settings and circumstances in which school-based services are delivered. Several commenters recommended that CMS should simplify claiming for school-based administrative and direct medical services provided in the school setting. The commenters also stated that methodologies that allow schools to access funds legitimately available for Medicaid program services and administrative activities will provide the most effective means of serving beneficiaries while ensuring proper and efficient program administration.

Response: In the proposed rescission, we specifically requested alternative approaches from the public that would allow us to achieve the objectives of the School-Based Administration/Transportation final rule without eliminating funding for allowable school-based expenditures. We agree that consideration of alternative approaches with stakeholder input and transparency is warranted. We further agree that we already have tools at our disposal to address inappropriate claiming that could arise in any setting, including schools. We will continue to evaluate the efficacy of these tools in addressing school-based claiming issues and collaborate with education and Medicaid stakeholder groups to discuss ways to improve such tools.

B. Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition

We proposed to rescind the November 7, 2008 Outpatient Hospital Services final rule in its entirety. While we previously had perceived the rule as having little impact (because it affected only the categorization of covered services), we became aware that this perception may have been based on inaccurate assumptions. In particular, we assumed that, to the extent that covered services were no longer within the outpatient hospital benefit category, those services could be easily shifted to other benefit categories. However, after publication of the final rule, we received input indicating that such shifts may be difficult in light of the complexity of State funding and payment methodologies and health care service State licensure and certification limits. As a result, we became concerned that the Outpatient Hospital Services final rule could have an adverse impact on the availability of covered services for beneficiaries.

Therefore, we proposed to rescind the November 7, 2008 Outpatient Hospital Services final rule in its entirety and reinstate the regulatory definition of ''outpatient hospital services'' at § 440.20 that existed before the final rule became effective. Specifically, we proposed to remove the provisions at § 440.20(a)(4)(i), which define Medicaid outpatient hospital services to include those services recognized under the Medicare outpatient prospective payment system (defined under § 419.2(b)) and those services paid by Medicare as an outpatient hospital service under an alternate payment methodology. We also proposed to remove the requirement at § 440.20(a)(4)(ii) that services be furnished by an outpatient hospital facility or a department of an outpatient hospital as described at § 413.65. Finally, we proposed to remove the provision at § 440.20(a)(4)(iii) that limits the definition of outpatient services to exclude services that are covered and reimbursed under the scope of another Medicaid service category under the Medicaid State plan.

In addition, we proposed to withdraw § 447.321 of the proposed rule published on September 28, 2007 (72 FR 55158) upon which we reserved action in the final rule. These provisions contained regulatory guidance on the calculation of the outpatient hospital and clinic services upper payment limit (UPL).

Overall, many commenters offered general support for the rescission of the Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition as part of comments that specifically addressed other aspects of Outpatient Hospital Services final rule.

Comment: One commenter explained that the Outpatient Hospital Services final rule could result in access and quality issues for Medicaid physical therapy services. The commenter reasoned that since outpatient hospital services are a mandatory Medicaid benefit and physical therapy services are optional, outpatient hospital settings offer ''a bridge to care for thousands of physical therapy patients under their State Medicaid program'' in States that offered a limited physical therapy benefit. The commenter stated that removing physical therapy services from the definition of outpatient hospital services would cause access and quality of care to suffer.

Response: We understand the commenters' concerns. However, we never intended to restrict access to physical therapy services and States have some flexibility in defining optional Medicaid benefits. The provisions of the Outpatient Hospital Services final rule should not have limited the access to and the quality of physical therapy services. This action rescinding the Outpatient Hospital Services final rule will eliminate this confusion.

Comment: Several commenters stated that the clarification of Medicaid outpatient hospital services failed to recognize services that may be unique to individuals served under Medicaid, in particular services covered in children's hospitals. These commenters stated that the Medicare outpatient hospital definition is too restrictive to meet the needs of those served under the Medicaid program.

Response: The Outpatient Hospital Services final rule did not restrict the services which States could provide in outpatient hospital facilities or to individuals covered under the Medicaid program. The rule merely clarified which of those services could be defined as and reimbursed under ''outpatient hospital services.'' States would have continued to be able to reimburse for other services provided in the outpatient hospital facility, if those services were authorized under the State's approved Medicaid State plan. This final rule should alleviate any potential concerns with coverage limitations by reinstating the regulatory definition of ''outpatient hospital services'' at § 440.20 that existed before the previous final rule became effective.

Comment: A number of commenters offered concerns that the Outpatient Hospital Services final rule placed limitations on payment for Medicaid services or restricted States' abilities to move services from costly inpatient settings to less costly outpatient settings.

Response: The Outpatient Hospital Services final rule did not place restrictions on States' abilities to reimburse Medicaid providers, set payment rates within applicable upper payment limits, or provide services in outpatient settings. Medicaid outpatient hospital services are limited to a reasonable estimate of what Medicare would pay for Medicaid equivalent services in accordance with § 447.321. This is an aggregate test for State government-owned or operated, non-State government-owned or operated and private facilities. The rescission does not impact the UPL requirements for outpatient hospital or clinic services that are currently in the regulations.

We are fully supportive of States' efforts to provide quality services in low-cost settings. This final rule to rescind the previous rule should eliminate any potential issues with shifting services from more costly to less costly hospital settings.

Comment: A few commenters supported the proposal to withdraw the outpatient hospital and clinic UPL requirements that were proposed in our Outpatient Hospital Services proposed rule (CMS reserved action on these provisions as part of Outpatient Hospital Services final rule). These commenters explained that the proposed UPL requirements were overly restrictive and excluded several Medicaid costs typically paid by States through the outpatient hospital benefit.

Response: CMS appreciates the support of these commenters. However, we note that we will continue to require States to demonstrate that Medicaid outpatient hospital and clinic service payments, in the aggregate for State government-owned or operated, non-State government-owned or operated and private facilities, do not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. To do so, States will need to show that they are comparing the same scope of covered services.

Comment: Many rural health clinics commented that the Outpatient Hospital Services final rule would result in individuals seeking services through emergency departments ''at a higher cost to taxpayers.'' These providers also stated that excluding rehabilitative, school-based, and practitioner services from the outpatient hospital benefit would cut funding and services. Many of the rural health clinic providers were concerned that the final rule would eliminate the clinics' costs from a hospital's disproportionate share hospital (DSH) calculations. Several other commenters also raised concern that the clarification of the outpatient hospital services definition would reduce hospital DSH costs.

Response: The Outpatient Hospital Services final rule did not require any shifting of services to more costly settings or cut funding for Medicaid covered services. Rather, the Outpatient Hospital Services rule was limited to requiring States to distinctly define outpatient hospital facility services and other Medicaid benefits in the Medicaid State plan. This final rule should eliminate the concerns expressed by the clinics and other providers by reinstating the regulatory definition of ''outpatient hospital services'' at § 440.20 that existed before the final rule became effective.

Comment: One commenter stated concerns that the assumptions

acknowledged by CMS as inaccurate with respect to the Outpatient Hospital Services final rule were carried over into other Medicaid rulemaking. The commenter referenced the December 19, 2008 DSH reporting and auditing requirements final rule (73 FR 77904). The commenter did not specify which provisions of the rulemaking were carried over from the Outpatient Hospital Services final rule to the Medicaid DSH Auditing and Reporting final rule. However, the commenter requested that CMS clarify that States are not bound by any of the provisions or policies reflected in the subject outpatient hospital regulations when determining the uncompensated costs of services for DSH purposes.

Response: The Outpatient Hospital Services final rule addressed different policies than those discussed under the Medicaid DSH Auditing and Reporting final rule. The rescission of the Outpatient Hospital Services final rule has no impact on the provisions of the DSH Auditing and Reporting final rule. The DSH rule provides guidance to States on those outpatient hospital service costs that should be included in DSH calculations, which is independent from the outpatient hospital service clarification provided in the Outpatient Hospital Services final rule. For further discussion of the DSH Auditing and Reporting provisions, we refer readers to the December 19, 2008 final rule (73 FR 77904). Any concerns over the potential impact of the Outpatient Hospital Services final rule on DSH should be alleviated by restoring the regulatory definition of ''outpatient hospital services'' at § 440.20 that existed before the Outpatient Hospital Services final rule became effective.

Comment: One commenter supports the rescission of the Outpatient Hospital Services final rule because the clarification to the outpatient definition resulted in an administrative burden to States and offered no real policy purpose.

Response: The proposed rescission acknowledged that we initially believed the Outpatient Hospital Services final rule would result in little administrative burden on States based on information we received through the State plan review process. Based on additional information from stakeholders, these assumptions appear inaccurate. The rescission should alleviate the concerns of the commenter by restoring the regulatory definition of ''outpatient hospital services'' at § 440.20 that existed before the Outpatient Hospital Services final rule became effective.

C. Optional State Plan Case Management Services

We proposed to rescind certain provisions of the December 4, 2007 Case Management interim final rule. In discussions with States about the implementation of case management requirements, we became concerned that certain provisions of the Case Management interim final rule may unduly restrict beneficiary access to needed covered case management services, and limit State flexibility in determining efficient and effective delivery systems for case management services.

In particular, we were concerned that the Case Management interim final rule may be overly narrow in defining individuals transitioning to community settings. Specifically, the interim final rule contained parameters specifying short-term and long-term stays and included limits on days of targeted case management services associated with these different lengths of stay. In addition, we were concerned that States' service delivery systems would be affected by the limitations in the interim final rule on payment methodologies, and on the provision of case management services by other agencies or programs.

We were also concerned that the Case Management interim final rule may have unintentionally impacted Federal Medicaid requirements with respect to administrative claiming, as the regulation was not intended to redefine the types of activities that are allowable as Medicaid administrative case management.

Many of these same issues were raised by public commenters, and we share their concern that beneficiaries and the program as a whole may be adversely impacted if these provisions were implemented. We believe that these same concerns were also reflected in the Congressional moratorium on the implementation of this rule and the administrative requirements and limitations included in the interim final rule. Therefore, we proposed to rescind certain provisions of the Case Management interim final rule.

Specifically, we proposed to remove § 440.169(c) and § 441.18(a)(8)(viii), because we were concerned that these provisions may be overly restrictive in defining ''individuals transitioning to a community setting,'' for whom case management services may be covered under § 440.169(a). We thought that, until we address the comments submitted on the Case Management interim final rule, States should have additional flexibility to provide coverage using a reasonable definition of this term. We also proposed to remove § 441.18(a)(5), which would have required case management services to be provided on a one-on-one basis to eligible individuals by one case manager. We believed that this provision may unduly limit States' delivery systems for case management services. We further proposed to remove § 441.18(a)(8)(vi) because the requirement for payment methodologies in this provision may be administratively burdensome, may result in restrictions on available providers of case management services, and generally may limit beneficiary access to services. For similar reasons, in § 441.18, we proposed to rescind paragraphs (c)(1), (c)(4), and (c)(5) that limit the provision of case management activities that are an integral component of another covered Medicaid service, another non-medical program, or an administrative activity. On the issues addressed by these rescinded provisions, we proposed to continue to apply the interpretive policies in force prior to issuance of the Case Management interim final rule.

We proposed to rescind parts of § 441.18(c)(2) and (c)(3) to remove references to programs other than the foster care program, because we are concerned that these provisions may be overly restrictive in defining State options for the delivery of case management services. We proposed to consolidate the remaining provisions of these paragraphs as paragraph (c) (*see* 74 FR 21237, May 6, 2009).

We proposed to retain the remaining provisions of the Case Management interim final rule, and finalize those provisions in a future rulemaking.

Most commenters supported the rescissions included in the Case Management proposed rule. The following section summarizes general comments about the rule or issues not contained in specific provisions included in the proposed rule:

General Comments

Comment: Many commenters asked CMS to rescind all provisions of the Case Management interim final rule. Many commenters expressed concern that the provisions would significantly limit State flexibility in providing case management in the most effective and efficient manner possible. In addition, the commenters stated the provisions would pose additional barriers and would be more burdensome for providers of case management services. Several commenters stated the restrictions on case management included in the interim final rule would

inevitably shift the financial responsibility for case management to school districts across the nation.

Response: Under section 6052 of the DRA, the Secretary of the Department of Health and Human Services was authorized to promulgate an interim final regulation to define case management and targeted case management services.

We agree with commenters that certain provisions in the interim final rule may limit State flexibility in structuring case management services. Therefore, we proposed to rescind certain provisions of the Case Management interim final rule which are discussed in this document. However, we do not have the authority to rescind the interim final rule in its entirety, as section 6052 of the DRA amended the statute directly by defining case management services in section 1915(g) of the Act. We disagree with comments contending that the proposed or interim final rules regarding Medicaid case management services would shift the financial responsibility for case management to school districts. It is important to clarify that Medicaid reimbursement remains available for targeted case management services and other covered services, which are included in an eligible child's Individualized Education Program (IEP) or Individualized Family Service Plan, consistent with section 1903(c) of the Act.

Comment: Many commenters indicated the final regulation should not apply to Home and Community-Based Services (HCBS) waiver programs operated under section 1915(c) of the Act. Several commenters expressed concern that the Case Management interim final rule would impede State efforts to end the institutional bias in Medicaid. The commenters expressed that it is contrary to a number of programs already implemented by the Administration such as the Money Follows the Person grant program and Aging and Disability Resource Centers grants, which provided States with the tools necessary to serve frail older people in their homes and communities. The commenters stated that States would have to revamp their existing programs in order to adhere to the rules set forth in the rule. The commenters stated the rule undermines State level efforts to streamline and provide more efficient and cost-effective targeted case management systems and home and community-based services through the aging services network under Medicaid and works against the Supreme Court's decision in Olmstead and the Older Americans Act.

Response: We clarify that the rule does not apply to those activities that HCBS waiver programs must perform to meet the statutory assurances and other requirements of section 1915(c) of the Act. These functions include—(1) an eligibility determination; (2) an evaluation of need that includes both an initial evaluation and periodic re-evaluations; (3) a written plan of care; and (4) monitoring of the plan of care to assure the health and welfare of each individual served through the waiver program. However, in those instances in which States elect to offer targeted case management service as a State Plan service under section 1915(g) of the Act to persons enrolled in a 1915(c) waiver program, the provisions of the interim final rule would apply.

We disagree that clearly defining case management and targeted case management services impedes State efforts to end institutional bias in Medicaid. In addition, we disagree that the rule is contrary to the Money Follows the Person grant program or Aging and Disability Resource Center initiatives which CMS and the Administration on Aging have promoted and funded. These initiatives are based on partnerships between the Federal government, State governments, and private organizations to serve and provide access to long-term care services and supports for older people and people with disabilities. These initiatives are not solely, or even primarily, dependent upon a funding stream under the Medicaid case management benefit.

To the extent that the basis for the commenters' concerns is that the rule restricts Medicaid beneficiaries to case management furnished through particular providers, these concerns are inconsistent with the Medicaid freedom of choice requirements in section 1902(a)(23) of the Act (and the exceptions authorized to ensure qualified providers), which provide individuals with a choice of qualified, Medicaid providers.

Comment: Several commenters submitted comments on provisions of the Case Management interim final rule, which were not included in the Case Management proposed partial rescission rule.

Response: The comment period for the December 4, 2007 Case Management Services interim final rule closed on February 4, 2008. We appreciate the submitted comments; however, these comments are beyond the scope of the Case Management proposed partial rescission rule. CMS will respond to comments received on the interim final rule in a future rulemaking document.

Comment: We received several comments in support of our proposal to remove § 440.169(c) and § 441.18(a)(8)(viii), which defined case management services for the transitioning of individuals from medical institutions to the community as well as related State plan requirements. Commenters indicated the provisions would have limited services to individuals transitioning to community settings and applauded CMS for recognizing the provisions were overly restrictive in defining individuals transitioning to community settings. One commenter stated that these provisions would place stricter limits on the duration of case management services when an individual is transitioning from a hospital or other institution to the community. One commenter expressed concern that these provisions would have imposed unrealistic and impractical deadlines on the amount of time needed to assist in the safe and orderly transition of such individuals. One commenter stated these provisions were at odds with the *Olmstead* v. *L.C.* decision.

One commenter requested clarification about transitional Targeted Case Management (TCM) services provided to residents of an institution for mental disease (IMD).

A commenter stated that prohibiting Federal financial participation (FFP) until the date individuals leave the institution would place a significant cost burden on case management providers under Money Follows the Person grant and waiver programs.

Response: Public comments on the rescission of § 440.169(c) and § 441.18(a)(8)(viii) support our contention that the definition of targeted case management for the purpose of assisting individuals residing in medical institutions to community living was overly restrictive. We agree with commenters that some target groups receiving case management services in institutions may need a period of longer than 60 days of services in order to successfully transition to community living. We considered the many comments that indicated the period for facilitating transition is impacted by individuals' changing health status as well as behavioral challenges, which may delay or prevent transition into the community.

Our rescissions provide States with the flexibility to determine the duration of this service, up to 180 consecutive days, to respond to the complexity of the needs and the current capacities of the supports needed to successfully transition individuals to the

community. Guidance from the July 25, 2000 State Medicaid Directors Letter, Olmstead Update No. 3, will continue to provide the parameters under which States may receive reimbursement for case management services for the purpose of transitioning from medical institutions to the community. Specifically, TCM, as defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution in order to facilitate their transition to community services and enable them to gain access to needed medical, social, educational and other services in the community. TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided. FFP is not available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.

Comment: One commenter supported our proposal to remove § 441.18(a)(4), which required that the State's plan provide that case management services will not duplicate payments made to public agencies or private entities under the State plan and other program authorities, for the same purpose. (We note that this provision was included among the provisions to be rescinded in the Case Management proposed rule's regulation text under Part 441.18; however, the proposed rule's preamble did not discuss this provision.)

Response: We acknowledge that this provision was included in the proposed rule's regulation text in error. We are retaining § 441.18(a)(4). While we believe that States must have flexibility in establishing Medicaid programs that best meet their unique circumstances as well as those of Medicaid participants, we are also concerned that consistent guidance has not been available regarding the circumstances under which FFP would be available. The requirement that FFP would not be available for duplicate payments to public or private entities for the same purpose arose from the conference report of the Consolidated Omnibus Budget Reconciliation Act of 1985 which accompanied the original authorization of case management under section 1915(g) of the Act. Subsequently, this guidance was reiterated in the *State Medicaid Manual* (SMM) at section 4302.2(F).

Comment: One commenter stated that CMS needs to make it clear to State Medicaid agencies that this rule does not provide a basis for States requiring a Federally Qualified Health Center (FQHC) to use its section 330 grant funds to cover any portion of case management services provided by the health center to its patients. The commenter stated that such a requirement would be inconsistent with the long standing recognition on the part of the Congress and the Department of Health and Human Services (HHS) that Medicaid and Medicare are first payers for Medicaid and Medicare covered services provided to Medicaid and Medicare patients of a health center.

Response: Federally Qualified Health Centers (FQHCs) will continue to be reimbursed in accordance with section 1902(bb) of the Act, under which States reimburse FQHCs through either a prospective payment system or an alternative reimbursement methodology. The Case Management proposed rule would not have an impact on FQHC reimbursement methodologies or grants received under section 330 of the Public Health Service Act.

Comment: We received many comments in support of our proposal to remove § 441.18(a)(5), which would require case management services to be provided on a one-to-one basis to eligible individuals by one case manager. The commenters expressed concern that the provision would limit the States' flexibility by prohibiting a State from providing a child with more than one case manager even when the complexity of the child's condition demands the expertise of more than one program. The commenters recognized the importance of limiting the number of case managers that may be involved; however, some individuals have multiple and complex needs that intersect with several service delivery systems of care. One commenter suggested States should be required to provide assurances in their State plans that case management will not be duplicative and to indicate a methodology that ensures that duplication does not occur.

Response: We agree with the commenters and have removed § 441.18(a)(5). Even though case management and targeted case management services are comprehensive services, we believe that more than one case manager may be responsible and accountable for facilitating access to needed services. In rescinding this provision, we recognize that case managers may need to draw on other practitioners with special expertise, and may also tap the resources of a larger organization for support and overhead. In addition, if case managers were on leave or vacation, others could be assigned as substitutes to facilitate continuity of care and services. In addition, we recognize that case managers may need to rely on other practitioners to provide support for particular tasks. That is, reimbursement would be available for services other than case management, including direct services provided to the individual, that may contribute to the case management process, such as assessments furnished under the benefit for physicians' services or psychologists' services under the rehabilitative services benefit.

By removing the one case manager provision, we recognize the advantages of a team approach to case management services. For example, a lead case manager could coordinate resources and expertise from providers of medical, education, social, or other services for the benefit of the individual in developing a comprehensive plan of care and facilitating access to services. To facilitate this service model, States may set differential rates to reflect case or task complexity that would ensure sufficient payment to reflect the costs that case managers may incur in consulting with other practitioners. States should ensure that differential payment methodologies are reflected in the State's Medicaid plan.

Comment: We received a few comments in support of our proposal to remove § 441.18(a)(6), which prohibited providers of case management services from exercising the State Medicaid agency's authority to authorize or deny the provision of other services under the plan. (We note that this provision was included among the provisions to be rescinded as described in the Case Management proposed rule's preamble; however, this provision was not listed among those to be rescinded in the proposed rule's regulation text under § 441.18.) The commenters stated this provision is administratively burdensome and may limit beneficiary access to services. One commenter indicated it should be left to the States to delegate the agency's authority to authorize or deny certain services to a case manager who is most familiar with the individual's needs.

Response: We acknowledge that this provision was included, in error, in the Case Management proposed rule preamble. We disagree with comments that this provision is administratively burdensome and have retained this

provision to clarify that the State Medicaid agency authorizes or denies services. The provision would not require the State Medicaid agency to review each individual's care plan. Operating agencies or other entities such as counties may approve service plans as part of day-to-day operations. However, the Medicaid agency, at a minimum, must review at least a sample of care plans retrospectively or employ other methods to ensure that plans have been developed in accordance with applicable policies and procedures and that the plans ensure the health and welfare of participants. This oversight activity is a critical element of the Medicaid agency's responsibility. Furthermore, the function of prior authorization requires the judgment of the Medicaid agency and may not be delegated to anyone other than a Medicaid agency employee. Prior authorization is a legitimate function of the State Medicaid agency, which is performed as an appropriate component of the administration of the State plan.

Comment: We received many comments in support of our proposal to remove § 441.18(a)(8)(vi) concerning the payment methodology for case management services. This provision would have required a payment methodology under which case management providers would be paid at rates calculated using a unit of service that would not exceed 15 minutes. One commenter recommended that each State be allowed to design its own reimbursement methodology, rather than having one mandated. One commenter expressed concern that the 15 minute unit requirement would be seen as the minimum standard of providing the service. Many commenters stated this provision was administratively burdensome and may limit beneficiary access to services. One commenter stated the 15 minute unit requirement may have resulted in additional costs for the State due to increased staffing needs, increased payments for case management activities, fewer controls, the need to restructure eligibility and service authorization and significant changes to information technology systems. A few commenters recommended CMS continue to allow flexibility in reimbursement methodologies. The commenters indicated that per diem, daily, weekly or monthly rates should be allowed as well as fifteen minute units.

A few commenters expressed concern that the proposed rule did not address the prohibition on payment methodologies that bill under a ''bundled'' rate. The commenters stated the continuation of this prohibition could lead to fragmentation in State systems, multiple providers duplicating activities, and decreased access to home and community based services through a single point of entry system. One commenter expressed concern that the 15 minute unit would have required extensive cost analysis with accompanying time studies in order to validate rates.

Response: We agree with commenters that the payment methodologies included in the Case Management interim final rule may be administratively burdensome and overly restrict service models employed by States, and therefore we are rescinding this provision. We believe States should have the flexibility to develop payment methodologies other than 15 minute units. By removing this provision, we are permitting billing units of 15 or fewer minutes, as well as hourly, daily and weekly units; however, States must continue to demonstrate the economy and efficiency of all billing units and rates. This policy is based on section 1902(a)(30)(A) of the Act, which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care.

Specifically, States will be required to demonstrate the development of each of the billing unit rates based on identified cost elements, including the salaries of the professionals providing the service, the percentage of time case managers spend on case management activities, substantiated overhead or indirect costs and the methodology used to allocate those costs to Medicaid. States may not always have access to commercial provider costs, and in such circumstances, States will be permitted to provide evidence that rates are market-based. Evidence may include the demonstration of commercial rates charged for case management-like services in the State or other demonstrations of rates for like services in the local health care market. CMS does not permit the use of fee-for-service rates paid to providers on a monthly basis. States seeking to use monthly rates are to meet the managed care requirements of 42 CFR part 438.

This rule does not address the issue of ''bundled'' payments. CMS will continue to work with States on an individual basis to establish an acceptable reimbursement methodology for TCM services.

Comment: We received a few comments specifically supporting our proposal to remove § 441.18(c)(1), which stated that case management does not include and FFP is not available for expenditures for services defined in § 440.169 when case management activities are an integral component of another covered Medicaid service.

Another commenter requested clarification that case management activities provided or arranged by a provider in a Primary Care Case Management (PCCM) program are allowable.

Response: We agree with the comments and have removed this provision. We will continue to apply existing interpretive policies regarding reimbursement for case management activities that are a component of another covered Medicaid service. Existing policies are summarized in the *State Medicaid Manual* at section 4302.A.1. and 4302.B. To include those activities as a separate benefit would result in duplicate coverage and payment. This activity would not be consistent with effective and efficient operation of the program.

To clarify, the rule does not apply to Primary Care Case Management (PCCM) services. PCCM services remain unchanged and are defined in § 440.168 of the Medicaid regulation.

Comment: We received several comments specifically supporting or disagreeing with our proposal to rescind parts of § 441.18(c)(2) and § 441.18(c)(3) and consolidate the remaining provisions of these paragraphs as paragraph (c). These provisions stated that case management does not include and FFP is not available for activities which constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, as well as activities integral to the administration of foster care programs, such as those described in proposed § 441.18(c)(1) through (c)(8). The commenters supporting the rescission of the provisions stated that the provisions would force States to fragment services provided to children in foster care, a situation that is contrary to the purpose of the case management benefit. One commenter did not support the rescission of 441.18(c)(3). The commenter stated case management is done appropriately when it is kept separately from the provision of direct services.

Several commenters supported the creation of the new paragraph 441.18(c). In addition, one commenter suggested the rescission of the ''making placement arrangements'' provision, found in proposed § 441.18(c)(8), because including the provision in the list of activities for which reimbursement under Medicaid would not be available would be overly broad and restrictive.

Response: We agree with commenters that the provisions of § 441.18(c)(2) and § 441.18(c)(3) in the interim final rule may be overly restrictive. By removing these provisions and revising the text of paragraph (c) under § 441.18, we are clarifying that case management does not include, and FFP is not available in expenditures for services defined in § 440.169 when the case management activities constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred, including, for foster care programs, services such as, but not limited to, activities integral to the administration of the foster care program, such as those described in proposed § 441.18(c)(1) through (8).

We disagree with the commenter's characterization of the ''making placement arrangements'' provision of § 441.18(c)(8) as overly broad and restrictive, and are retaining this provision on the list of activities for which FFP is not available.

Comment: We received many comments in support of our proposal to remove § 441.18(c)(4), which stated that case management does not include, and FFP is not available in expenditures for services defined in § 440.169 when the activities for which an individual may be eligible, are integral to the administration of another non-medical program. Many commenters stated the provision would contradict the Medicaid statute and other laws impacting children with disabilities. Additionally, the commenters expressed concern that the ''integral component'' test would create a new parallel third party liability standard. The commenters also expressed concern that this provision would deny the rights guaranteed to children with disabilities in the Individuals with Disabilities Education Act and section 504 of the Rehabilitation Act of 1973. One commenter expressed concern that the provision would shift significant costs onto the child welfare and foster care systems to continue to provide TCM services.

One commenter questioned the availability of FFP for TCM services provided by State child welfare workers to children in the foster care program. Several commenters indicated that the provision in the interim final rule prohibiting child welfare agencies as case managers went beyond the language in the DRA.

Another commenter questioned the availability of Medicaid reimbursement for educational services under section 504 of the Rehabilitation Act of 1973, which requires school districts to provide appropriate educational services to students with disabilities.

Response: We agree with commenters that § 441.18(c)(4) may have resulted in compromising Medicaid beneficiaries' eligibility for medically necessary services under the State plan, including medically necessary case management (and targeted case management) services that are not used to administer other programs. Therefore, we are removing this provision from the final rule. In doing so, we clarify that FFP will be available under the Medicaid program for medically necessary services.

When activities constitute the administration of non-medical programs or are authorized or funded by such programs, reimbursement under Medicaid is not also available, because it supplants or duplicates the funding of these programs. The claiming, under Medicaid, of the administration for non-medical programs compromises the integrity of the Medicaid program and is not consistent with the overall direction of section 6052 of the DRA and current policy. Current policy as expressed in section 4302.2 of the State Medicaid Manual indicates that payment for case management services under section 1915(g) of the Act must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

In response to the comment questioning the availability of Medicaid reimbursement for educational services under section 504 of the Rehabilitation Act of 1973, we note that these educational services are designed to meet the individual needs of such students to the same extent as the needs of students without disabilities. That is, such educational services provide an equal opportunity for students with disabilities to participate in or benefit from education aids, benefits, or services. These educational services are not medical assistance, nor do they meet the definition of Medicaid administration; therefore, FFP would not be available under Medicaid.

We disagree with commenters that this provision would deny the rights guaranteed to children with disabilities under the Individuals with Disabilities Education Act (IDEA). While Medicaid reimbursement would not be available for the administration of non-medical programs including IDEA administrative functions, reimbursement would continue to be available for covered Medicaid services furnished to a Medicaid eligible child and included in the child's IEP. Specifically, section 1903(a) of the Act states that payment for Medical assistance would not be restricted for covered Medicaid services furnished to a child with a disability because such services are included in the child's IEP or Individual Family Service Plan (IFSP). States may choose to include Medicaid-covered services provided in schools, such as Medicaid case management or targeted case management services, in their State plans, which are provided by school-based providers qualified to provide the services.

In response to the comment regarding whether FFP would be available for TCM services provided by State child welfare workers to children in foster care, we clarify that the activities of child welfare programs are separate and apart from the Medicaid program. Medicaid case management services must not be used to fund the services of child welfare programs. Children with medical needs who also receive child welfare services qualify for Medicaid targeted case management services when relevant criteria are met. Specifically, such services must meet the definition of Medicaid case management services, and must be provided according to a Medicaid State plan which assures participant protections are in place, and that participants have a choice of qualified Medicaid providers. We note that section 1915(g)(1) of the Act allows an individual's choice of provider to be limited for targeted groups consisting of individuals with developmental disabilities or chronic mental illness.

Comment: We received one comment that specifically supported our decision to remove § 441.18(c)(5), which specified that activities that meet the definition of case management services in § 440.169 and under the approved State plan cannot be claimed as administrative activities under § 433.15(b).

Response: We agree with the comment and are removing § 441.18(c)(5) from the final rule. By removing this provision, we are clarifying that nothing in this regulation impacts Federal Medicaid requirements with respect to administrative claiming, nor does this regulation redefine the types of activities that are allowable as Medicaid administration.

We will continue to apply the interpretive policies and statutory provisions in force before the issuance of the interim final rule. Specifically, section 1903(a)(7) of the Act and the implementing regulation at § 430.1 and § 431.15 state that for the cost of any activities to be reimbursable under Medicaid as administration, they must be ''found necessary by the Secretary for the proper and efficient administration of the plan'' (referring to the Medicaid

State plan). Allowable administrative activities under Medicaid are sometimes referred to, by States and others, as ''administrative case management'' (*State Medicaid Manual* section 4302 A.2. and State Medicaid Director Letter, July 25, 2000, Olmstead Update Number 3). Some examples of allowable administrative activities include Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services; utilization review; Medicaid outreach; training; transportation; and referral activities. These examples are not meant to be all-inclusive, and we may make determinations regarding whether these or other activities are necessary for the proper and efficient administration of the State plan.

As reflected in prior guidance (State Medicaid Director Letter, December 20, 1994), a State may not claim costs as administration if the activities are an integral part or extension of a direct medical service. In addition, States may not claim as administrative activities the costs related to general public health initiatives, overhead costs, or operating costs of an agency whose purpose is other than the administration of the Medicaid program. Activities directed toward services not included under the Medicaid program, although these services may be valuable to Medicaid beneficiaries, are not necessary for the administration of the Medicaid program and therefore, are not allowable administrative costs. In addition, with regard to any allowable administrative claims, payment may only be made for the percentage of time spent that is actually attributable to Medicaid eligible individuals.

Payments for allowable Medicaid administrative activities must not duplicate payments that have been, or should have been, included as part of a direct medical service, capitation rate, or through another State or Federal program. It is the State's responsibility to ensure that there is no duplication of cost in a claim prior to submitting the claim to CMS.

The allocation methodology for costs claimed for the proper and efficient administration of the State plan must be specified in the State's approved public assistance cost allocation plan in accordance with subpart E of 45 CFR part 95 and ASMB C–10 (that is, the HHS Implementation Guide for A–87).

III. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rules for rescission. Two provisions of the final rule differ from the proposed rule:

We are retaining § 441.18(a)(6) under case management regulations. This provision was included among the provisions described in the proposed rule's preamble to be rescinded. However, this provision was not listed among those to be rescinded in the proposed rule's regulation text under § 441.18. Section 441.18(a)(6) would prohibit providers of case management services from exercising the State Medicaid agency's authority to authorize or deny the provision of other services under the State plan. Therefore, we are retaining this provision as it would clarify that the function of prior authorization requires the judgment of the Medicaid agency and may not be delegated to anyone other than a Medicaid agency employee. Prior authorization is a legitimate function of the State Medicaid agency, which is performed as an appropriate component of the administration of the State plan.

If the provision were rescinded, case managers would have the authority to authorize or deny services that could serve to restrict participant protections and rights that are afforded through the rules governing the fair hearings process under § 431.200. Participants should be free to accept or reject the advice of a provider of case management services. Furthermore, case management services are designed to assist eligible individuals to access needed services rather than limit this access.

We maintain that the reference to § 441.18(a)(6) in the preamble was a drafting error. We acknowledge that error and clarify that CMS intends to retain this provision. It states that although a Medicaid agency may place great weight on the informed recommendation of a case manager, it must not rely solely on case management recommendations in making decisions about the medical necessity of other Medicaid services that the individual may receive.

Retaining this provision clarifies that the State Medicaid agency authorizes or denies services. The provision would not require the State Medicaid agency to review each individual's care plan. Operating agencies or other entities such as counties, may approve service plans as part of day-to-day operations, and the Medicaid agency, at a minimum, must review at least a sample of care plans retrospectively or employ other methods to ensure that plans have been developed in accordance with applicable policies and procedures and the plans ensure the health and welfare of participants. This oversight activity is a critical element of the Medicaid agency's responsibility.

The second provision of the final rule that differs from the proposed rule concerns § 441.18(a)(4), which required that a State's plan provide that case management services will not duplicate payments made to public agencies or private entities under the State plan and other program authorities, for the same purpose. This provision was included among the provisions to be rescinded in the proposed rule's regulation text under § 441.18. (We note that the proposed rule preamble did not discuss this provision.)

CMS acknowledges that § 441.18(a)(4) was included in the proposed rule regulation text in error. We are retaining this section. While we believe that States must have flexibility in establishing Medicaid programs that best meet their unique circumstances as well as those of Medicaid participants, we are also concerned that consistent guidance has not been available regarding the circumstances under which FFP would be available. The requirement that FFP would not be available for duplicate payments to public or private entities for the same purpose arose from the conference report of the Consolidated Omnibus Budget Reconciliation Act of 1985, which accompanied the original authorization of case management under section 1915(g) of the Act. Subsequently, this guidance was reiterated in the *State Medicaid Manual* (SMM) at § 4302.2(F).

IV. Waiver of Delay in Effective Date

We ordinarily provide a 30-day delay in the effective date of the provisions of a notice in accordance with section 553(d) of the Administrative Procedures Act (APA), at 5 U.S.C. 553(d). We can waive the 30-day delay in effective date, however, if the Secretary finds, for good cause, that it is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the notice.

We find there is good cause to waive the delay in the effective date of this issuance because we find that, since the rescinded rules have been subject to Congressional moratoria and are not currently being implemented, it would be contrary to the public interest to implement them briefly and then change them back. Such sudden short-term changes would result in public confusion and administrative chaos. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, we waive notice and comment procedures.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this final rule as required by Executive Order 12866, the Congressional Review Act, the Regulatory Flexibility Act (RFA), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132 on Federalism. Executive Order 12866 (as amended) directs agencies to assess all costs and benefits of all available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

One of the three rules we proposed to rescind was estimated to save the Federal government, by reducing its financial participation in the Medicaid program, amounts in excess of this threshold, with corresponding increases in costs to States (or in some cases to local entities or to other Federal programs) that would essentially offset these savings. That is, the primary economic effect predicted under this rule was to change the sources of ''transfer payments'' among government entities rather than the levels of actual services delivered. For example, the RIA for the School-Based Administration/Transportation final rule regarding Medicaid reimbursement for school administration and transportation of school-aged children assumed that localities would continue to provide such transportation even though one source of funding was reduced. Rescission of these rules would simply restore the *status quo ante*. That is, the Medicaid program would not gain these savings and other Federal, State, or local programs would not lose the Medicaid funding.

We acknowledge that many commenters were concerned that these three rules would have additional and substantial adverse effects on service provision and that the conclusions of the original RIAs did not reflect on this point. As explained earlier in this preamble, we share some of those concerns.) Except for portions of the Case Management interim final rule, these rules have not yet taken ''real world'' effect because of the Congressional moratoria on enforcement. Accordingly, we believe that the proposed rescissions would have no economic effect, assuming that the situation before July 1, 2009 is taken as the ''counterfactual'' case.

In the alternative, it might be argued that the appropriate counterfactual is that rescinding these rules would create ''economically significant'' benefits and costs of the same magnitude but exactly the opposite of those analyzed in the original RIAs. For example, the School-Based Administration/Transportation final rule regarding school administration expenditures and costs related to transportation was estimated to reduce Federal Medicaid outlays by $635 million in FY 2009 and by a total of $3.6 billion over the first 5 years (FY 2009 through 2013). The proposed rescission would eliminate these Federal savings with a corresponding offset in State, local, and Federal funding increases that would otherwise be needed to maintain existing services.

In the current economic climate, and with the drastic budgetary reductions being made in most States, the assumption of an essentially offsetting change in spending responsibilities that leaves service provision unchanged is completely unrealistic. However, because these rules were proposed for rescission without ever having been enforced, no purpose would be served in re-estimating hypothetically the effects of the original rules or in estimating hypothetically the potential effects of more realistically estimated current responses.

Accordingly, we have decided for purposes of this rulemaking that the most straightforward assumption to make is that we are preserving the *status quo*, and that under the criteria of EO 12866 and the Congressional Review Act this is not an economically significant (or ''major'') rule.

The RFA requires agencies to analyze options for regulatory relief of small entities if final rules have a ''significant economic impact on a substantial number of small entities.'' For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions, including school districts. ''Small'' governmental jurisdictions are defined as having a population of less than 50,000. Individuals and States are not included in the definition of a small entity. Although many school districts have populations below this threshold and are therefore considered small entities for purposes of the RFA, we originally determined that the impact on local school districts as a result of the final rule on School Administration Expenditures and Costs Related to Transportation of School-Age Children would not exceed the threshold of ''significant'' economic impact under the RFA, for a number of reasons. Most simply, the estimated annual Federal savings under this final rule were only about one eighth of one percent of total annual spending on elementary and secondary schools, far below the threshold of 3 to 5 percent of annual revenues or costs used by HHS in determining whether a proposed or final rule has a ''significant'' economic impact on small entities. Accordingly, regardless of the counterfactual, rescission of this rule would not have a ''significant'' impact on a substantial number of small entities. Our analyses of the final rules concluded that neither rule would have a significant impact on a substantial number of small entities. Accordingly, rescinding those final rules in whole or in part and preserving the *status quo ante* would likewise fail to trigger the ''significant'' impact threshold. We further note that in all three cases any impact of this rulemaking would be positive rather than negative on affected entities. Accordingly, the Secretary certifies that this final rule will not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. Of the three final rules we are rescinding in whole or in part, only the Outpatient Hospital Services rule would have had any possible effect on small rural hospitals. Our analysis of that rule concluded that it would have had no direct effect on these hospitals, and that any indirect effect as a result of State adjustments could not be predicted. Regardless, any effects of the proposed rescission on small rural hospitals would be positive, not negative. Accordingly, we are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this final rule would not have a direct impact on

the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This final rule contains no mandates that will impose spending costs on State, local, or Tribal governments in the aggregate, or by the private sector, of $133 million. Our analyses of all three final rules concluded that they would impose no mandates of this magnitude, and the rescissions create no mandates of any kind.

Executive Order 13132 on Federalism establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirements on State and local governments, preempts State law, or otherwise has Federalism implications. EO 13132 focuses on the roles and responsibilities of different levels of government, and requires Federal deference to State policy-making discretion when States make decisions about the uses of their own funds or otherwise make State-level decisions. The original final rules, however much they might have limited Federal funding, did not circumscribe States' authority to make policy decisions regarding school-based transportation and administration, case management, or hospital outpatient services. This final rule will likewise not have a substantial effect on State or local government policy discretion.

B. Anticipated Effects

As discussed above, one of the three final rules (School-Based Administration/Transportation final rule (72 FR 73635)) was predicted to have substantial effects on the availability of Federal Medicaid funds for the cost of activities that were arguably not the responsibility of Medicaid to fund. Consequently, the full rescission of the final rules relating to outpatient hospital and school administration and costs related to transportation of school-aged children between home and school will have little or no immediate fiscal impact due to the fact that the projected changes never took place. Likewise, the partial rescission of the Case Management interim final rule will have little or no immediate fiscal effect since certain projected changes never occurred.

C. Alternatives

We welcomed comments not only on the proposed rescission of each rule, in whole or in part, but also on alternatives that may more constructively address the underlying issues and their likely impacts on State beneficiaries of the Medicaid program. No comments were received concerning alternatives to rescinding the Outpatient Hospital Services rule in its entirety. Rescission of the entire rule was the only alternative suggested with respect to the partial rescission of the case management services interim final rule.

We received several suggestions for alternate approaches relating to the School-Based Administration/Transportation final rule related to transportation of school-aged children between home and school. Alternative suggested approaches included the issuance of one national standard for claiming developed in conjunction with public school officials and the creation of one national office to provide clear, consistent guidance. Other suggestions included annual national trainings of State officials overseeing school claiming to ensure compliance, the review of individual States to determine how to process claims and audit, and the development of a national committee to study best methods to deliver information and services to families in need. The suggestions also included CMS' further promotion of sound Medicaid program operation through clear guidance and technical assistance specifically addressing the unique settings and circumstances in which school-based administrative activities and services are provided. Stakeholders also suggested that CMS simplify claiming for school-based administrative and direct medical services provided in a school setting. We agree that these alternate approaches merit further consideration and will continue to explore with States how to best assure appropriate claiming related to the provision of Medicaid administrative, transportation, and medical services within the school setting.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 440

Grant programs—health, Medicaid.

42 CFR Part 441

Aged, Family planning, Grant programs—health, Infants and children, Medicaid, Penalties, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart B—General Administrative Requirements

■ 2. Section 431.53 is revised to read as follows:

§ 431.53 Assurance of transportation.

A State plan must—

(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and

(b) Describe the methods that the agency will use to meet this requirement.

PART 433—STATE FISCAL ADMINISTRATION

■ 3. The authority citation for part 433 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 433.20 [Removed]

■ 4. Remove § 433.20.

PART 440—SERVICES: GENERAL PROVISIONS

■ 5. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 6. Section 440.20 is amended by revising the section heading and paragraph (a) to read as follows:

§ 440.20 Outpatient hospital services and rural health clinic services.

(a) *Outpatient hospital services* means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that—

(1) Are furnished to outpatients;

(2) Are furnished by or under the direction of a physician or dentist; and

(3) Are furnished by an institution that—

(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) Meets the requirements for participation in Medicare as a hospital; and

(4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of ''outpatient hospital services'' those types of items and services that are not generally furnished by most hospitals in the State.

* * * * *

§ 440.169 [Amended]

■ 7. Section 440.169 is amended by removing and reserving paragraph (c).

■ 8. Section 440.170(a)(1) is revised to read as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) ''Transportation'' includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

* * * * *

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

■ 9. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 10. Section 441.18 is amended by removing and reserving paragraphs (a)(5), and (a)(8)(vi); removing (a)(8)(viii); and revising paragraph (c) to read as follows:

§ 441.18 Case management services.

* * * * *

(c) Case management does not include, and FFP is not available in expenditures for, services defined in § 441.169 of this chapter when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following:

(1) Research gathering and completion of documentation required by the foster care program.

(2) Assessing adoption placements.

(3) Recruiting or interviewing potential foster care parents.

(4) Serving legal papers.

(5) Home investigations.

(6) Providing transportation.

(7) Administering foster care subsidies.

(8) Making placement arrangements.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medical Assistance Program.)

Dated: June 5, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 17, 2009.

Kathleen Sebelius,

Secretary.

[FR Doc. E9–15345 Filed 6–29–09; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS–2275–F2]

RIN 0938–AP74

Medicaid Program; Health Care-Related Taxes

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This rule finalizes our proposal to delay enforcement of certain clarifications regarding standards for determining hold harmless arrangements in the final rule entitled, ''Medicaid Program; Health Care-Related Taxes'' from the expiration of a Congressional moratorium on enforcement from July 1, 2009 to June 30, 2010.

DATES: *Effective Date:* These regulations are effective on July 1, 2009.

FOR FURTHER INFORMATION CONTACT: Stuart Goldstein, (410) 786–0694.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1903(w) of the Social Security Act (the Act) provides for a reduction of Federal Medicaid funding based on State health care-related taxes unless those taxes are imposed on a permissible class of health care services; broad based, applying to all providers within a class; uniform, such that all providers within a class must be taxed at the same rate; and are not part of hold harmless arrangements in which collected taxes are returned, whether directly or indirectly. A similar hold harmless restriction applies to provider-related donations. Section 1903(w)(3)(E) of the Act specifies that the Secretary shall approve broad based (and uniform) waiver applications if the net impact of the health care-related tax is generally redistributive and the amount of the tax is not directly correlated to Medicaid payments. The broad based and uniformity requirements are waivable through a statistical test that measures the degree to which the Medicaid program incurs a greater tax burden than if these requirements were met. The permissible class of health care services and hold harmless requirements cannot be waived. The statute and Federal regulation identify 19 permissible classes of health care items or services that States can tax without triggering a penalty against Medicaid expenditures.

On February 22, 2008, we published a final rule entitled, ''Medicaid Program; Health Care-Related Taxes'' (73 FR 9685). This final rule amended provisions governing the determination of whether health care provider taxes or donations constitute ''hold harmless'' arrangements, codified statutory changes to the indirect guarantee threshold test and the definition of the class of managed care organization services, and deleted certain obsolete transition period regulatory provisions. The rule codified the reduction in the indirect guarantee threshold test in order to reduce the allowable amount that can be collected from a health care-related tax for the period of January 1, 2008, through September 30, 2011, as required by the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432). The rule also codified changes to the permissible class of health care items or services related to managed care organizations as enacted by the Deficit Reduction Act of 2005 (Pub. L. 109–171).

The February 22, 2008 final rule became effective on April 22, 2008. However, section 7001(a)(3)(C) of the Supplemental Appropriations Act of 2008, Pub. L. No. 110–252, imposed a partial moratorium until April 1, 2009, prohibiting CMS from taking any action to implement any provisions of the final rule that are more restrictive than the provisions in effect on February 21, 2008, with the exception of the change in the statutory definition of the class of services of a managed care organization and the statutorily-required change to the indirect guarantee threshold test. This moratorium was extended by