



SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

February 19, 2008

The Honorable Henry A. Waxman, Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House, Office Building
Washington, D.C. 20515

Dear Chairman Waxman:

This letter is in response to your request of State Medicaid Directors to provide information to the Committee on Oversight and Government Reform (Committee) on the impacts of seven regulatory packages proposed in 2007 by the Centers for Medicare & Medicaid Services (CMS). The Department of Health Care Services (DHCS), on behalf of the State of California, appreciates the opportunity to provide you with the requested information. DHCS is the single state agency which administers California's Medicaid program, known as Medi-Cal.

Specifically, you requested State level information on the analysis of the impact of the following proposed rules:

- Government Provider Cost Limits (CMS 2258-FC)
- Graduate Medical Education (CMS 2279-P)
- Upper Payment Limits on Outpatient Hospitals (CMS 2213-P)
- Health Care Provider Tax (CMS 2275-P)
- Rehabilitative Services Option (CMS 2261-P)
- School-Based Administrative and Transportation Services (CMS 2287-P)
- Targeted Case Management (CMS 2237-IFC)

The analysis is to include an estimate of the expected reduction in federal Medicaid funds over each of the next five years and how the proposed rules will impact Medicaid applicants and beneficiaries.

As you know, California serves approximately 6.7 million individuals on the Medi-Cal program. The fiscal impacts of these administrative actions have the potential of reducing federal reimbursements to California by several billion dollars annually. Many of these regulation packages were rejected by Congress as budget savings proposals because they simply eliminate federal funding for legitimate health care costs while passing those unfunded costs on to the States. For example, for more than 40

The Honorable Henry A. Waxman
February 19, 2008
Page 2

years Medicaid has helped fund the cost of graduate medical education, assisting in the development of physicians and paying for the cost of residents who treat many people on the Medicaid program. Without much explanation of the rationale, CMS now proposes to eliminate this longstanding funding. Hence, the moratoriums were adopted by Congress and signed into law by the President. The final outcome of these regulations will have long lasting effect on the nature of the Medi-Cal program and the budgets of the State, counties and school districts throughout the State.

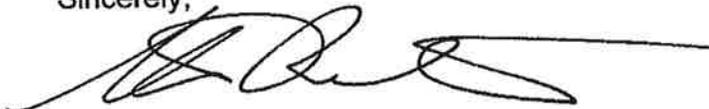
The reductions in federal funding are likely to lead to destabilization of an already fragile health care, safety-net system in California, which bears a heavy burden in rendering needed health care services to Medicaid beneficiaries and the uninsured. California has responded to the request for comments on all of the regulation packages to date and has indicated its' strong objection to these proposals, based on their potential negative effects to the Medi-Cal program and subsequent impacts on the stability of the State's health care safety net system.

Governor Arnold Schwarzenegger has written letters to Members of Congress highlighting the negative impacts the federal rules have on Medi-Cal and how the rules have gone beyond Congressional intent.

In conclusion, California strongly objects to the proposed regulations due to the significant impacts that will be incurred by the program both on a financial and humanistic level. California appreciates the opportunity to provide the Committee with this analysis for review and consideration in determining the appropriateness of CMS' actions and given the enormity of the impact borne by all State Medicaid programs and the populations served by the programs will bear.

If you have any questions, or if we can provide further information, please contact me at (916) 440-7400.

Sincerely,



Stan Rosenstein
Chief Deputy Director
Health Care Programs

cc: Ms. Sandra Shewry, Director
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The Honorable Henry A. Waxman
February 19, 2008
Page 3

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The Honorable Henry A. Waxman
February 19, 2008
Page 4

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CALIFORNIA MEDICAID IMPACTS - FEDERAL RULES

FEDERAL RULE	PROGRAM IMPACTS	FISCAL IMPACTS	POPULATION IMPACTS
<p>Government Provider Cost Limit (2258-FC)</p> <ul style="list-style-type: none"> Imposes new restrictions on payments to providers operated by units of government and clarifies that entities involved in the financing of the non-federal share of Medicaid payments must be a unit of government. Formalizes policies for certified public expenditures and other reporting requirements. <i>Congress has delayed the implementation of this regulation until 5/25/08</i> 	<ul style="list-style-type: none"> This proposal would have devastating impacts to California's safety net hospitals and would undermine the continuation of the hospital financing demonstration waiver that was negotiated just 2 1/2 years ago. The proposed definition of unit of government is an unwarranted limitation that could result in substantial problems for the viability of many of California's public providers that have historically been recognized by CMS as a unit of government eligible to receive federal reimbursement using certified public expenditures and intergovernmental transfers. This limitation could prevent a large group of public providers from continuing participation in the financing of Medicaid services, resulting in considerable reductions in the service capabilities of these entities. These proposed changes would undermine advances that have been made in public administration by withholding federal Medicaid funds validly earned by entities that can not point to the general taxes as their sole source (other than federal financial participation) of the cost of their operations. The rule ignores all of the gains achieved by public entities that have learned how to support their public missions by means other than increasing general taxes and would penalize these entities for relying on other revenue sources. While CMS has stated that this rule will not impact California, as written, it could result in significant payment disruptions for Alameda County and the University of California, which are currently approved by CMS to certify expenditures for claiming federal funding under the hospital financing demonstration waiver. It could also have impacts on federal claiming made by other State departments. 	<p>California estimates losing \$943.56 million annually; approximately \$4.7 billion over a 5-year period under this rule. This is based on the proposed definition of unit of government and the current certified public expenditures from Alameda County, the University of California, local educational agencies, School Based Medi-Cal Administrative Activities, and the Public Hospital Outpatient Supplemental Reimbursement Program (which was enacted by State law).</p>	<p>Unknown but likely significant</p>
<p>Graduate Medical Education (2279-P)</p> <ul style="list-style-type: none"> CMS seeks to "clarify" that costs and payments associated with Graduate Medical Education (GME) programs are not reimbursable expenditures for "medical assistance" under the Medicaid program because they are not in the statute. <i>Congress has delayed the implementation of this regulation until 5/25/08</i> 	<ul style="list-style-type: none"> Medi-Cal provides financial support to teaching hospitals facilities that train medical residents who are essential to maintaining the supply of new physicians and offers irreplaceable real world patient contact – all under the guidance of well qualified, experienced physicians. These teaching hospitals provide care to many of the most difficult medical cases and are often the primary health care link for low income, uninsured, underinsured and Medicaid recipients. Ironically, hospitals can replace the care provided by residents with higher cost care provided by physicians and the federal government will pay the higher prices. The proposed rule would eliminate federal funding to reimburse public and private hospitals for direct GME costs of interns and residents in the hospitals. Residents provide extensive care for Medi-Cal patients and having a strong residency program is vital to ensuring a supply of physicians to provide care in California in the future. The elimination of this funding could place critical care in jeopardy, create shortages of medical professionals, and reduce access to care. Eliminating this funding would lower the amount of money the State can pay hospitals (known as the "upper payment limit" which represents maximum amount a State can pay for these services). 	<p>California estimates the following impacts under this rule:</p> <ul style="list-style-type: none"> \$37.6 million for non-state government owned hospitals \$40.6 million for private hospitals \$22.2 million for State-owned hospitals 147.8 million for the 23 designated public hospitals under the hospital financing demonstration waiver 5-year estimates are \$739 million. Los Angeles County alone estimates it would lose \$166 million dollars annually. 	<p>Unknown but likely significant</p>
<p>Upper Payment Limits on Outpatient Hospitals (2213-P)</p>	<ul style="list-style-type: none"> This rule would deny California the ability to pay hospitals the same rates that Medicare currently pays hospitals thus resulting in negative impacts to public and private hospitals that 	<p>California estimates the following impacts under this rule:</p>	<p>Unknown but likely significant</p>

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<ul style="list-style-type: none"> • CMS seeks to invalidate the practice of States paying all-inclusive rates for outpatient services and applies the Medicare definition of outpatient services to Medicaid outpatient hospital services; restricts costs that can be counted in the upper payment limit. • Requires States to calculate a clinic upper payment limit by making a comparison on a procedure-by-procedure basis to the amount Medicare pays for equivalent services. • Effective 7/30/07; Congressional moratorium prohibits CMS from taking action to implement this regulation 	<p>provide safety net services for Medi-Cal beneficiaries and others by limiting outpatient hospital services and reducing payments for clinic services by changing the upper payment limit calculations.</p> <ul style="list-style-type: none"> • Outpatient hospitals provide significant health care services to Medi-Cal beneficiaries for both surgery, treatment and at the emergency room. Outpatient treatment is far less costly than inpatient care and taking away the ability to fully reimburse outpatient services will put pressure on hospitals to shift outpatient care to inpatient care in order to obtain proper reimbursement. California's emergency rooms are in a crisis status and this will lead to further instability if reimbursement for the cost of care in these areas is significantly reduced. • The proposed rule would also require California to calculate a clinic upper payment limit by making a comparison on a procedure-by-procedure basis to the amount Medicare pays for equivalent services. This is extremely burdensome and complex and its application may result in Medicaid rates that cannot assure access to services. Clinics are reimbursed at or near cost, to the extent that Medicare reimbursement is less than costs, the proposed upper payment limit calculations could lead to a reduction in Medicaid payments to clinics. 	<ul style="list-style-type: none"> • Loss of approximately \$266.41 million annually and \$1,332 billion over a 5-year period for outpatient hospital reimbursements. • Potentially puts at risk an unknown amount of the available federal funding of \$586 million of Safety Net Care Pool funds under the hospital financing demonstration waiver. • Reduces payments to hospitals under the Disproportionate Share Hospital (DSH) program resulting in California's hospitals being unable to claim the full DSH annual allotment of \$1.023 billion. • Reduces payments to ten California counties receiving Health Care Coverage Initiative reimbursements for 2007-2010 (\$180 million in federal funds each year) in order to expand health care coverage for low-income, uninsured individuals pursuant to the hospital financing demonstration waiver. 	
<p>Health Care Provider Taxes (2275-P)</p> <ul style="list-style-type: none"> • CMS seeks to clarify a number of issues in the original regulation, including more stringent language in applying the hold-harmless test. • The new language affords CMS broader flexibility in identifying relationships between provider taxes and payment amounts. • The tax rate will be temporarily reduced from 6 percent to 5.5 percent effective 1/1/08 – 9/30/11 	<ul style="list-style-type: none"> • Using broad interpretation of the "Medicaid payment" provision, CMS can find a violation in virtually any situation in which provider tax revenues are used to make Medicaid payments to taxed providers. • The health care provider tax rule has long been a financing mechanism available to States, which is clearly defined under law and existing regulation for more than 15 years. California has used health care provider "fees" to significantly improve the quality of, and access to, care in nursing homes and centers for the developmentally disabled. This financing mechanism is strongly supported by California's nursing home industry and centers for the developmentally disabled. • California currently imposes fees on three classes of providers: Intermediate Care Facilities for the Developmentally Disabled; managed care organizations that serve Medicaid beneficiaries; and certain freestanding nursing facilities. CMS's intended interpretation of the proposed rule could make each of these three existing fee programs non-approvable because the fee revenue is used to fund the non-federal share of increased Medicaid payments that, in some cases, pay the cost of the fee back to the fee payer. • It should be noted that the Governor's health care reform proposal, which was not supported by the California Senate was funded, in part, by fees imposed on hospitals. To the extent the 	<p>California estimates this rule puts at risk approximately \$540 million annually and \$2.7 billion over a 5-year period in revenue.</p>	<p>Unknown but likely significant</p>

CALIFORNIA MEDICAID IMPACTS - FEDERAL RULES

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	reform is advanced in the future, using a similar financing construct of imposing fees on hospitals, this rule would jeopardize such an approach.		
<p>Rehabilitative Services Option (2261-P)</p> <ul style="list-style-type: none"> • CMS seeks to clarify the definition of rehabilitative services and to determine the difference between habilitative and rehabilitative services. • <i>Congress has delayed the implementation of this regulation until 6/30/08</i> 	<ul style="list-style-type: none"> • The impact of this rule is dependant on how aggressively CMS chooses to interpret the rule's elements and could have some significant negative impacts. • Under California's State Plan, the following services are under the rehabilitative option: <ul style="list-style-type: none"> ○ Some prenatal services to pregnant women ○ Drug and alcohol treatment through the Department of Alcohol and Drugs (e.g. "Drug Medi-Cal") specifically impacting the multimillion dollar methadone treatment program ○ Adult Day Health Care ○ Rehab mental health services through the Specialty Mental Health Services Consolidation Waiver ○ Chronic dialysis services ○ Independent rehabilitative centers • Some or all services in these programs may be defined as "maintenance" services (or habilitation) as opposed to rehabilitation, and therefore disallowed under the rehabilitation option of the State Plan. • If CMS determines that the affected services are allowable Medicaid services, but are improperly classified under the rehabilitation option, CMS will encourage California to seek a new waiver or to use the 1915(i) Home and Community-Based Services State Plan option (as outlined under the Deficit Reduction Act [DRA], 2005) to operate the services. 	California estimates this rule puts at risk over \$1 billion annually and \$5 billion over a 5-year period for all of these services.	Unknown but likely significant
<p>School-Based Administrative and Transportation Services (2287-P)</p> <ul style="list-style-type: none"> • CMS seeks to eliminate funding for: (1) administrative activities performed by school employees or contractors or anyone under the control of a public or private educational institution, and (2) transportation from home to school and back for school-age children with an individualized education or family service plan. • <i>Congress has delayed the implementation of this regulation until 6/30/08</i> 	<ul style="list-style-type: none"> • Currently Medicaid Administrative Activities (MAA) is claimed by almost 800 school units representing more than 56 percent of the school districts in California. Under MAA, Federal reimbursements to the schools in FY 05/06 were approximately \$95 million dollars • Schools perform critical administrative activities, including outreach and enrollment of children into Medicaid programs. CMS has placed great focus on enrolling eligible but unenrolled children into Medicaid and State Children's Health Insurance Programs and CMS's action to cut funding for schools to enroll children contradicts their own position of having States enroll eligible children. • Because children attend school, schools are a logical place for States' to focus enrollment activities to meet the mutual State-Federal goal of enrolling all eligible children into these programs. • School-based medical transportation has been a covered Medi-Cal service under the State Plan since 1993. Federal reimbursements to the schools in FY 05/06 for school-based transportation were in excess of \$8 million. Although schools are obligated to provide medical transportation for students served under IDEA, schools will be forced by this loss of funding to reduce the regularity, frequency, and convenience of such services. Such reductions in service will be felt especially in low-income rural areas where medical care is least available. 	California estimates the following impacts under this rule: <ul style="list-style-type: none"> • MAA will lose approximately \$600 million in federal reimbursements over a 5-year period • School-based transportation will lose approximately \$52 million in federal reimbursements over a 5-year period. 	Unknown but likely significant

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<p>Targeted Case Management (2237-IFC)</p> <ul style="list-style-type: none"> • CMS seeks to define covered case management services as required by the DRA, Section 6032 and to clarify situations in which Medicaid will pay for case management activities • The DRA language excluded specific services from the definition and retained and clarified permissible case management services in the context of medical assistance. • The DRA language also requires public programs that reimburse for case management services to have primary responsibility for payment of targeted case management before Medicaid payments are made. The referenced public programs include child welfare, Title V programs, developmental disability programs and State mental health and substance abuse programs. • Effective 3/3/08 	<ul style="list-style-type: none"> • The rule, which becomes operative March 3, 2008 exceeds the intent and authority of the DRA and establishes a precedent that future administrations might use to establish similarly extreme regulations that would not normally be approved by Congress in statute. This overreaching authority includes the following changes beyond the intent of the DRA provisions: <ul style="list-style-type: none"> ○ Encompasses all forms of case as equaling that of targeted case management including care management, service coordination, and care coordination without the providing details about where, when and how these services have been might also fall under this category. ○ Implies that other unidentified terms as yet to be defined are subject to these provisions as well as any entity rendering any given range of case management services, using similar but different terms, ranging from medical case management to basic referral and linkage assistance provided by senior centers, community clinics, rural health clinics and community centers. ○ Limits transitional case management from 180 days to 60 days for individuals transitioning from institutions into community settings. ○ Requires all case management services to be comprehensive, under one Medicaid case manager, provided in 15 minute increments and does not allow the identified case manager to authorize any needed services. ○ Changing the reimbursement of administrative case management to that of TCM without the enhanced reimbursements currently afforded to skilled professional medical personnel i.e. paying all case management services at the 50 percent federal matching assistance percentage versus some at 75 percent federal matching assistance percentage when the services are provided by licensed and/or certified staff. • This one size fits all approach is very problematic given the diverse needs of the vulnerable populations served under Medi-Cal and may jeopardize the health outcomes of these individuals. • The change in the amount of allowable days for transitional case management services for individuals transitioning from hospitals back into the community is contrary to the Supreme Court Olmstead decision of 1999; policies issued by CMS in a State Medicaid Director's Olmstead Update #3 issued in 2001; and the threatens the success of Money Follows the Person grantees of which California is one. This grant provides enhanced federal funding to States to help with transition activities/services for individuals residing in long term care institutions who desire to transition back to home or into the community. • Medi-Cal's Targeted Case Management (TCM) program currently conducts nearly 300,000 encounters per year to six target groups of eligible beneficiaries through 134 local programs. This program has been under federal review since FY 2003-04; in light of that review, federal reimbursements for the cost of these TCM services have remained constant at approximately \$50 million per year. • The rule impacts all eight of California's TCM target groups; services to two targeted groups - Public Guardian and Adult Probation are eliminated; claims for these target groups constitute approximately 32 percent of total TCM claims. 	<p>Given the overreach of the regulations and its impacts to Medicaid targeted or case management service California has not been able to fully quantify the fiscal impacts of this regulation. However, based on the elimination of covered services for the three targeted groups, it is conservatively estimated that \$119 million in federal reimbursements will be lost over the next 5-year period.</p>	<p>Given the overreach of the regulations and its impacts to Medicaid targeted or case management service California has not been able to fully quantify the individual impacts of this regulation.</p> <p>Known TCM Impacts: Eliminates TCM services to two target groups: Public Guardian and Adult Probation. Potentially, California might conduct 100,000 fewer Medi-Cal beneficiary TCM encounters.</p>

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	<ul style="list-style-type: none"> • These provisions will also reduce federal funding for the State Departments of Social Services, Public Health, Developmental Services while further reducing funding for California's counties and school districts. This loss of funding will cause these local agencies to reduce staffing and restrict their provision of services to Medicaid beneficiaries. The loss of services has been shown to result in increased use of hospital emergency rooms, hospital stays, institutionalization, and incarceration. • Although it is difficult to project actual costs of these losses in TCM and other case management services, it is certain that low-income persons will suffer more illness and incur greater costs to the public than they would had TCM or case management services been available to them. 		

Schneider, Andy

From: Dave Lucas [Dave.Lucas@wdc.ca.gov]
Sent: Friday, February 22, 2008 1:32 PM
To: Schneider, Andy
Subject: FW: Congressman Waxman Request for State Level Analysis of Federal Regulations
Importance: High

See responses in Blue. I should add that the numbers for TCM are all that we can actually quantify at this point – we think the impact is substantially larger because of the vast breadth of the rule, but we have no way of quantifying it.

----- Original Message -----

From: Schneider, Andy <Andy.Schneider@mail.house.gov>
To: Dave Lucas
Sent: Thu Feb 21 16:19:43 2008
Subject: RE: Congressman Waxman Request for State Level Analysis of Federal Regulations

Dave: Three clarifying questions for the folks in Sacramento.

On the GME rule, I need a one-year (first year) number. The 5-year number is \$739 million. If I add up the 4 bullets above, I get \$248.2 million. Five times that, however, is \$1.241 billion, considerably more than \$739 million. Even 5 times \$166 million for LA is \$830, more than \$739 million. What one-year (first-year) number should I use?

The \$739 five year figure is for the 23 public hospitals - an extra bullet was added in which separated the \$739 figure from the public hospital 5-year totals. For GME, the one year estimates are \$248 million (without the LA figures) and \$1.24 billion over five years - without the LA estimates - these are the numbers you should use

On the School Admin and Transportation rule, I need a one-year (first year) number. The 5 year number is \$650 million. One fifth of that is \$130 million. However, the FY5-06 actuals cited are \$95 million and \$8 million, which total to \$103 million. What one-year (first year) number should I use?

In the descriptor for the CA impacts, we noted the \$95 million and \$8 million for FY 05/06 however the information in the fiscal impacts column is updated thus the \$600 million over 5 years for MAA and \$52 million over 5 years for transportation are the correct 5-year estimates that should be used, annualized at \$130 million.

On the TCM rule, I need a one-year (first year) number. I have \$119 over 5 years. Should I use \$24 million, or one-fifth of that, as my one year (first year) number, or something else? **the \$24 million per year for the five year total of \$119 is the number to use**

In one or more of these cases, you may not be able to estimate the first year loss, in which case I will just put down “Not specified”. Not a problem. But if you are able to estimate, it would be very nice to have.

Thanks, Andy

2/22/2008

From: Dave Lucas [mailto:Dave.Lucas@wdc.ca.gov]
Sent: Thursday, February 21, 2008 1:45 PM
To: Dave Lucas; Schneider, Andy
Subject: RE: Congressman Waxman Request for State Level Analysis of Federal Regulations

Please let me know when you received this. Thanks.

From: Dave Lucas
Sent: Thursday, February 21, 2008 1:43 PM
To: 'Schneider, Andy'
Subject: Congressman Waxman Request for State Level Analysis of Federal Regulations
Importance: High

Andy – sorry for the delay. Robert Pear of the NYT has requested this information for a story he is working on and we wanted you to know that we will be sharing these documents with him in short order as well.

Attached you will find California's response to the Chairman Waxman's request for a State level analysis of the fiscal and individual impacts of the following regulations:

- Government Provider Cost Limits (CMS 2258-FC)
- Graduate Medical Education (CMS 2279-P)
- Upper Payment Limits on Outpatient Hospitals (CMS 2213-P)
- Health Care Provider Tax (CMS 2275-P)
- Rehabilitative Services Option (CMS 2261-P)
- School-Based Administrative and Transportation Services (CMS 2287-P)
- Targeted Case Management (CMS 2237-IFC)

Please let Stan or I know if we can be of further assistance to you on this matter – We have also attached the word document of the scorecard in case the information is needed for incorporation into a larger document. Thank you