

**STATE OF CONNECTICUT**

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

February 25, 2008

The Honorable Henry Waxman, Chairman
Committee on Oversight and Government Reform
Congress of the United States
2157 Rayburn House Office Building
Washington, DC 20515-6143
Fax (202) 225-4784

Dear Congressman Waxman:

I am writing in response to your letter dated January 16, 2008 in which you requested Connecticut specific impacts of the regulations proposed by the Centers for Medicare and Medicaid Services (CMS). I am grateful for the opportunity that you extended to me to testify on these proposed regulations at the hearing that you held last fall.

Health Care Provider Tax

Current federal regulations provide states with a "safe harbor" on permissible provider taxes, recently lowered from 6.5% to 5.5%. Provider tax programs outside this range are subject to the "rule of 65s", whereby no more than 75% of the providers paying the tax can receive at least 75% of those tax payments back in the form of higher Medicaid rates.

The proposed regulations would grant more open ended authority to CMS to disapprove provider taxes, even if these criteria were satisfied. This expansion of federal authority, without new concrete criteria upon which the merits of a proposed tax program would be judged, is potentially disastrous to the states. Programs which have yielded hundreds of millions of dollars in federal revenue would now be called into question or subject to a disallowance based on review by either CMS or the Office of the Inspector General (OIG). In Connecticut our entire \$120 million nursing home user fee program (\$60 million in federal financial participation) would be at risk. That would remove \$60 million in funding to support skilled nursing facilities that are already hard-pressed to provide care for 18,000 Medicaid recipients every year.

Rehabilitation

The proposed regulation imposes strict new standards for what could be claimed as a rehabilitative, as opposed to a habilitative service. This definition ignores the need for developmental services provided to very young children that would fail to meet the definition of rehabilitation. In Connecticut, this immediately would end our claim for

federal financial participation (FFP) for the Birth to Three program that provides early intervention services for children with developmental delays. That claim amounts to \$9 million per year (\$4.5 million in FFP). Additional programmatic challenges could bring the total loss in FFP to \$20 million.

Graduate Medical Education

48 Connecticut believes that it not unreasonable for the Medicaid program to provide a hospital rate add-on to cover the cost of training residents who serve the Medicaid population. We have done so since the start of the Medicaid program and would continue to do so, but for the intent of this regulation. The total cost to Connecticut's teaching hospitals is 48 million a year (\$4 million in FFP).

Certified Public Expenditures (CPEs)

The proposed regulation poses major challenges for the establishment of rates at state facilities like Riverview Hospital. More importantly, it would require us to subject our extensive home and community based waiver services program for [persons with developmental disabilities to Medicare cost principles. While we do not object to using Medicare cost definitions and believe that we are largely in compliance today, completion of the paperwork to document that fact for our state Departments of Developmental Services (DDS) would be an enormous task and would place \$281 million in DDS waiver services (\$140.5 million in FFP) jeopardy during the implementation process.

Targeted Case Management

Connecticut is already substantially in compliance with the proposed regulations and is moving to implement billing in 15 minute increments. We continue to be concerned about the length of time that case management can be applied to discharge planning. Our nationally recognized nursing facility transition program has demonstrated that this process can take up to 1 year for individuals with a long term period of institutionalization. The proposed rule flies in the face of the philosophy behind the Money follows the Person program which CMS has awarded to Connecticut and other states with the express intention of moving the long-term care population into the community. Based on the changes in service definition we believe the total impact to Connecticut could be in the range of \$10 million a year

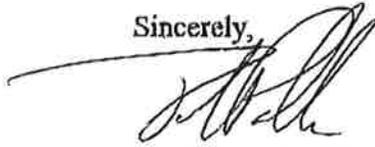
School Based Health

The proposed regulations would eliminate Medicaid funding for administrative activities at the schools. The impact on our rates would approximately \$10 million (\$5 million in FFP). But more important than the initial fiscal impact would be the effect that these regulations would have on school outreach. The administration intends to hold Connecticut and other states that cover children above 200% of the federal poverty level to an assurance that 95% of the Medicaid eligible children below 200% FPL are already

covered. One of the best places to conduct outreach to these children is through the schools, and Governor Rell has dedicated funds in a new initiative to do exactly that. But this rule would disallow FFP for eligibility determinations at the schools unless they were performed by staff of the Department of Social Services. DSS cannot afford to state-fund an outreach effort in 3,000 schools in 169 towns without the benefit of the federal match.

Thank you for the opportunity to respond. Please contact me at 860 424.5116 or at David.Parrella@CT.gov if you have any further questions.

Sincerely,



David Parrella, Director
Medical Care Administration

cc: Michael Starkowski, Commissioner
Gary Richter
Lee Voghel
Dsp/wa/ranFebruary 25.doc



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FACSIMILE COVER SHEET

DATE: 2/25/08

Pages including Cover Sheet 4

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COMMENTS: _____
