



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF
MEDICAID & MEDICAL ASSISTANCE

TELEPHONE: (302) 255-9500

February 15, 2008

Schneider

Medicaid

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives
Room 2157, Rayburn House Office Building
Washington, DC 20515-6143

The Honorable Tom Davis
Ranking Minority Member
Committee on Oversight and Government Reform
House of Representatives
Room B350A, Rayburn House Office Building
Washington, DC 20515-6143

Dear Sirs:

Thank you very much for the opportunity to comment on recent regulatory actions regarding the Medicaid program. We, like most states, are very concerned about the negative impacts these regulations would have on Delaware's most vulnerable citizens: low-income children and individuals with disabilities. We look forward to working with your committee and other states to find ways to mitigate these potentially devastating requirements.

I would like to highlight three regulations that are especially troubling to our state. First, CMS 2287-P would eliminate federal reimbursement for certain school-related transportation costs. We feel that this rule is overly restrictive and merely shifts the financial burden of ensuring that children receive medically necessary services in school settings entirely to the states.

Second, CMS 2261-P redefines the state plan option for coverage of rehabilitative services. This proposed rule will severely curtail our ability to serve children and adults with developmental and behavioral disabilities in the most

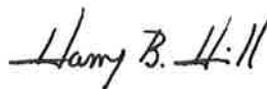
appropriate and effective manner. While we are still analyzing the impact of the new regulation, at a minimum, we expect to see a loss of millions of dollars in federal reimbursement for services that are currently approved by CMS. More disturbing is the potential for our consumers to ultimately receive services in more restrictive and costly settings

Finally, CMS 2237-IFC redefines case management and targeted case management services. We believe that CMS plans to apply these new requirements in a very broad manner that extends beyond the legislative intent of Congress. This interim final rule takes effect on March 3, 2008, only two months after the publication date. This timeframe for implementation is unrealistic and will be impossible for states to meet. This rule will have immediate and severe consequences for many individuals receiving services through our home and community-based waivers.

We have attached the information you requested in your letter of January 16, 2008. This is still preliminary, as we continue to analyze the impacts of these regulatory actions. We will continue to share new information with your committee as it becomes available.

In closing, I would like to convey Delaware's support for Congressional action to reverse or postpone the implementation of these rules. Thank you for your consideration and please let me know if you have questions or need additional information.

Sincerely,



Harry B. Hill
Director, DMMA

HBH/

cc: The Honorable Vincent P. Meconi
Secretary, Delaware Department of Health and Social Services

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2258-FC: Cost Limits for Public Providers

Description	Delaware Services	Potential Impacts
<p>A Final Rule was published in the Federal Register on May 29, 2007 by CMS. The rule reiterates that:</p> <ol style="list-style-type: none"> 1) only units of government may provide the state match 2) establishes minimum requirements for certifying public expenditures as the state share 3) limits reimbursement of public providers to actual cost 4) indicates that providers must receive and retain the total computable amount of their Medicaid payments 5) makes appropriate conforming changes to SCHIP regulations <p>Implementation of the regulation has been delayed for one year from May 25, 2007, the date of enactment of P.L. 110-28 (U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations, 2007) that imposed a moratorium on any action in the Final Rule.</p>	<ol style="list-style-type: none"> 1) With the exception of a small amount of state match, supplied by one of the in-state hospitals, that constitutes a bona fide provider donation for outstationed eligibility workers, all non-federal match for Medicaid claims is currently derived from state appropriations (Delaware does not provide health services at the local government level). 2) Most of the state match for Delaware Medicaid claims is appropriated directly to the Title XIX Single State Agency, which is the Delaware Department of Health and Social Services. Where the state match is currently certified by another agency of state government, steps are being taken to establish a routine process to document the provision of the state match via accounting and expenditure reports. 3) Delaware's Title XIX State Plan uses cost-based reimbursement methodologies for its public providers such as nursing homes, school-based health clinics and mental health services. 4) In Delaware, state tax revenues are appropriated to several state agencies for the purpose of providing or purchasing healthcare services. To the extent that those services are Medicaid allowable services provided to Medicaid eligible recipients, 	<ol style="list-style-type: none"> 1) This provision is expected to have no impact on Delaware. However, Delaware wishes to point out, as APHSA did in its letter to CMS dated 7/13/07, that CMS attempts to limit the definition of public funds as the source of the non-federal share of Medicaid expenditures is in direct violation of Section 5(b) of P.L. 102-234 which prohibited CMS from issuing such regulations. 2) Delaware was already planning to institute a certification process consistent with this new federal requirement before the new regulation was published. 3) This requirement is expected to have no impact on provider payments in Delaware because reimbursement methodologies for public providers are already cost-based. However, additional administrative expense will be incurred to comply with the new uniform cost reporting requirements for non-institutional providers. 4) Based on the relevant sections of the DAB decision referenced in the previous column, Delaware does not believe that CMS has the authority to enforce this requirement.

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2258-FC: Cost Limits for Public Providers (Continued)

Description	Delaware Services	Potential Impacts
	<p>state agencies may submit claims to Medicaid. Because the state has already appropriated 100% of the cost of providing the service, Medicaid payments made to those agencies are considered a reimbursement for services rendered and may be used by the state for any purpose it deems necessary, including depositing said funds as general revenue. Delaware does not believe that CMS has the authority to require states to make those funds available to the service providing government agency. This issue has been addressed in DAB No. 452 (1983) which reads in part, <i>“There is no requirement that private facilities earmark federal funds specifically for the payment of the costs for which the funds were claimed. Likewise, there is no requirement that the public facilities account for federal funds on that basis. The extensive body of regulations and Agency guidance which exists for Medicaid reimbursement has never set forth this particular distinction between private and public facilities. On the contrary, funds paid to states for allowable costs incurred or services rendered lose their character as federal funds once they are deposited in a state’s treasury. 43 Comp. Gen. 697, 699 (1964). Thereafter, the funds are available to the state to be applied wherever it chooses, so long as the costs for which the funds were paid were allowable and the state met the terms and conditions of the grant award”</i> (underline added).</p>	

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2279-P: Payment for Graduate Medical Education

Description	Delaware Services	Potential Impacts
<p>A Proposed Rule was published in the Federal Register on May 23, 2007 by CMS. The rule proposed to eliminate Medicaid funding for direct Graduate Medical Education (GME) expenses as a part of inpatient payment rates. The regulation would still allow an adjustment in payments to be made to teaching hospitals for Indirect Medical Education in recognition of the additional costs they incur when providing hospital services versus non-teaching hospitals.</p> <p>Implementation of the regulation has been delayed for one year from May 25, 2007, the date of enactment of P.L. 110-28 (U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations, 2007) that imposed a moratorium on any action in the Final Rule.</p>	<p>Delaware pays hospitals on two hospital-specific discharge rates, one for general admissions and one for nurseries. The costs on which the current rates were based were from 1994 and they have not been fully rebased since, only trended forward with an inflator. At the time the rates were developed, three Delaware hospitals had Graduate Medical Education programs.</p>	<p>Based on the three Delaware hospitals that had approved GME programs in 1994 and the proportion of their costs that was represented by GME at that time, we estimate that of the discharge payments made in State Fiscal Year 2006 (July 2005- June 2006), \$2.7 million would have been for GME costs. Under the new rules, once they go into affect, these costs would no longer to allowable and FFP would no longer be available for a portion of the discharge rate. Delaware assumes that we would need to continue to pay the hospitals at the current rates and would have to make up the federal share with state dollars.</p>

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2213-P: Payment for Outpatient Hospital Services

Description	Delaware Services	Potential Impacts
<p>A Proposed Rule was published in the Federal Register on September 28, 2007. The proposed rule attempted to more closely align the Medicaid definition of outpatient hospital services with the Medicare definition in order to improve states' ability to apply the upper payment limits test. CMS was concerned that where there was overlap in the definitions between outpatient hospital services and clinic services, states were paying more for clinic services than for the same service provided as a hospital outpatient service, depending on how they were categorized in the State Plan.</p>	<p>Delaware currently pays a percent of charges for outpatient hospital costs.</p> <p>Delaware currently bases its payment rates for clinic services, when performed in Ambulatory Surgical Centers, on the Medicare rates for those same services, sometimes paying less than the Medicare rates as budget constraints dictate, but never more than the Medicare rates.</p>	<p>In order to apply the requirement for Upper Payment Limits for outpatient hospital services, Delaware would have to use Medicare cost reports to compute what Medicare would have paid for the services. For clinic services that are not based on the Medicare rates, Delaware would have to calculate a reasonable estimate of what Medicare would pay by comparing CPT codes for equivalent Medicaid services. In order to perform this additional workload, an additional FTE would be required in the Medicaid Reimbursement Unit to analyze the cost data.</p>

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2275-P: Provider Taxes

Description	Delaware Services	Potential Impacts
<p>The Tax Relief and Health Care Act of 2006 (PL 109-432) reduces the maximum amount of provider taxes from 6% to 5.5% for the period January 2008 through September 2011. The rate reverts to 6% on October 1, 2011.</p> <p>A proposed rule was published by CMS on March 23, 2007.</p>	<p>Delaware has chosen not to impose provider taxes on its healthcare providers.</p>	<p>The proposed changes will have no immediate impact on Delaware. However, Delaware may wish to consider the imposition of provider taxes in the future and will comply with the applicable maximum tax revenue percentage at that time.</p>

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2261-P: Coverage of Rehabilitative Services

Description	Delaware Services	Potential Impacts
<p>A Notice of Proposed Rulemaking (NPRM) was published on August 13, 2007 by CMS. The proposed rule is intended to clarify the definition of rehabilitative services and, in particular, distinguishes between rehabilitative and habilitative services.</p> <p>The Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173) includes a moratorium until June 30, 2008.</p>	<p>Delaware’s Medicaid State Plan includes rehabilitative services for two groups of individuals with disabilities:</p> <ul style="list-style-type: none"> ▶ Community Support Services for individuals who would benefit from services designed for or associated with mental illness, alcoholism, or drug dependence, excluding those services of an educational or vocational nature. ▶ Day Health and Rehabilitation Services for individuals who would benefit from services designed for or associated with the treatment of mental retardation or developmental disabilities. 	<p>Exclusion of federal financial participation (FFP) and possible loss of habilitation services will place undue hardship on individuals and their respective family members as well as lead to the need for services in more costly and restrictive settings.</p> <p>Adoption of the “intrinsic element” test presents challenges to current payment methodologies and would result in reduced federal funding.</p> <p>Proposed changes discourage the use of evidence-based and best practices (e.g. Assertive Community Treatment – ACT) which rely on team-based delivery of individual service components.</p> <p>Over 500 individuals with development disabilities, currently residing with their natural families, receive day services under the Medicaid State Plan. The estimated loss in federal funding for these services is \$3.25 million annually.</p> <p>The estimated loss in federal funding for adult behavioral health services is \$7 million annually. The estimated annual loss in federal funding for child mental health services is \$3.2 million.</p>

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2287-P: Payments for Costs of School Administrative and Transportation Services

Description	Delaware Services	Potential Impacts
<p>A Final Rule was published by CMS on December 28, 2007. This rule would eliminate funding for certain administrative activities as well as transportation from home to school and back for school-age children with an IEP or IFSP.</p> <p>The Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173) includes a moratorium until June 30, 2008.</p>	<p>The Delaware Medicaid program currently provides reimbursement to transport children to and from school in instances where a child receives a Medicaid-covered service in the school setting.</p>	<p>Delaware estimates an annual loss in excess of \$1.2 million for payments associated with transportation services for children who receive medically necessary services in school settings.</p>

**Committee on Oversight and Government Reform
Medicaid Regulatory Actions – Delaware Response**

CMS 2237-IFC: Targeted Case Management

Description	Delaware Services	Potential Impacts
<p>Section 6052 of the Deficit Reduction Act of 2005 (PL 109-171) established requirements for case management and targeted case management.</p> <p>An Interim Final Rule was published by CMS on December 4, 2007. This rule establishes a number of restrictions on the delivery, scope, and reimbursement of case management services. The effective date of the regulation is March 3, 2008.</p>	<p>Delaware’s Medicaid program does not currently offer Targeted Case Management services. Further, Delaware does not offer case management as an optional service under the Medicaid State Plan.</p> <p>It is our understanding, however, that CMS will apply the new restrictions to administrative case management services, home and community-based waiver programs, and demonstration waivers. Such expansive application of this rule could possibly impact a variety of services, including:</p> <ul style="list-style-type: none"> ▶ HCBS Waiver services for individuals with Developmental Disabilities ▶ HCBS Waiver services for the Aged and Disabled ▶ HCBS Waivers services for Assisted Living ▶ HCBS Waiver services for individuals with HIV/AIDS ▶ HCBS Waiver services for individuals with Acquired Brain Injury ▶ Administrative case management services for children with developmental disabilities and behavioral health needs. ▶ Services provided through commercial managed care organizations under a Section 1115 demonstration waiver 	<p>Given the uncertainty regarding the scope of the rule and the absence of clear guidance from CMS, it is extremely difficult to develop accurate fiscal impact estimates. However, the apparent intent of CMS to apply these requirements broadly raises concerns that a significant portion of our Medicaid population would be seriously and immediately impacted.</p> <p>Preliminary estimates from the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) indicate that Delaware could experience an annual loss of approximately \$200,000 in federal funding for case management services for over 1,200 individuals in the Aged/Disabled, Assisted Living, and Acquired Brain Injury waivers. An additional loss of \$200,000 annually is projected by the Department of Services for Children, Youth and Their Families (DSCYF).</p> <p>We are still in the process of developing estimates for the following groups:</p> <ul style="list-style-type: none"> ▶ 825 individuals in the Developmental Disabilities waiver ▶ 687 individuals in the HIV/AIDS waiver ▶ 100,000 individuals receiving managed care services through a Section 1115 demonstration waiver ▶ 1,372 children receiving early intervention services in conjunction with IDEA Part C.

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Five-Year Fiscal Impact Estimates

Regulatory Action	Year 1	Year 2	Year 3	Year 4	Year 5	Five Year Total
CMS 2258-FC	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
CMS 2279-P	\$ 2,700,000	\$ 2,794,500	\$ 2,892,308	\$ 2,993,538	\$ 3,098,312	\$ 14,478,658
CMS 2213-P	\$ 25,000	\$ 25,875	\$ 26,781	\$ 27,718	\$ 28,688	\$ 134,062
CMS 2275-P	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
CMS 2261-P	\$ 13,450,000	\$ 13,920,750	\$ 14,407,976	\$ 14,912,255	\$ 15,434,184	\$ 72,125,165
CMS 2287-P	\$ 1,200,000	\$ 1,242,000	\$ 1,285,470	\$ 1,330,461	\$ 1,377,028	\$ 6,434,959
CMS 2237-IFC	TBD	TBD	TBD	TBD	TBD	TBD
TOTAL	\$ 17,375,000	\$ 17,983,125	\$ 18,612,535	\$ 19,263,972	\$ 19,938,212	\$ 93,172,844