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STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY

February 14, 2008

Henry A. Waxman  
Congress of the United States  
House of Representatives  
Committee On Oversight and Government Reform  
2157 Rayburn House Office Building  
Washington, D. C. 20515-6143

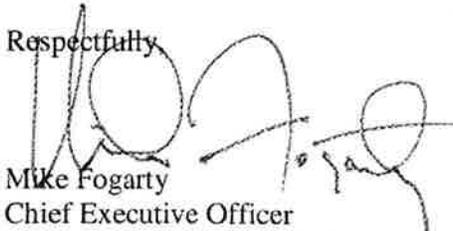
The Honorable Tom Davis  
Congress of the United States  
House of Representatives  
Committee On Oversight and Government Reform  
B 350 A Rayburn Office Building  
Washington, D.C. 20515-6143

Dear Senator Waxman and Representative Davis,

On January 16, 2008 the Oklahoma Health Care Authority (Oklahoma's Medicaid Agency) received a request from Senator Waxman regarding the costs of seven (7) proposed regulations promulgated by CMS. Our agency was asked to report on the costs to our agency of each regulation over a period of five (5) years. Enclosed is a document that details the costs of these proposed regulations as well as reasoning for the estimates provided.

We hope this is helpful to your committee. Should you have further questions please contact my assistant, Paula Guillion, at 405.522.7170.

Respectfully

  
Mike Fogarty  
Chief Executive Officer  
Oklahoma Health Care Authority

Enclosure

**Cost Limits for Public Providers (CMS 2258-FC)**

Five Year Financial impact: None

State-level effect: Oklahoma already fulfills this regulatory requirement.

**Payment for Graduate Medical Education (CMS 2279-P)**

Five Year Financial impact: \$250 Million in Federal Funds

State-level effect: The following are the initial effects to the State of Oklahoma if these GME program support systems are taken away:

- The effect to hospitals would be to remove support for infrastructure and administrative costs associated with the rotations of 1700 resident slots through 17 different hospitals. This would cause not only the loss of support for the expense of educating the physician force but would also cause a loss of access for the poor due to the fact that the payments are made based on resident-months weighted for Medicaid services rendered and the acuity of those services.
- The effect to education in general would be to reduce dramatically the support for medical education that enhances access through contractual arrangements that require the medical schools to:
  1. Maintain minimum levels of member months for Medicaid recipients in the delivery of primary care,
  2. Maintain levels at or below maximums established for emergency room utilization which in turn reduces the high level of expense and over use of this service and focuses attention on primary care as the resource to be used,
  3. Maintain levels of EPSDT screening rates that insure Medicaid children's access to quality preventative health and treatment services with the goal to identify health problems early and provide appropriate treatment. This will enhance children's lives as well as provide future savings by reducing healthcare costs associated with more costly services that can be avoided.
  4. Maintain minimum levels of "Specialty" physicians. Because of lack of available physicians in the specialty areas the OHCA has contracted with the schools to maintain levels that would make access available to the Medicaid population, which in turn should also create access for other populations.

**Payment for Hospital Outpatient Services (CMS 2213-P)**

Five Year Financial impact: None

State-level effect: Oklahoma already fulfills this regulatory requirement.

**Provider Taxes (CMS 2275-P)**

Five Year Financial impact: None

State-level effect: Oklahoma already fulfills this regulatory requirement.

**Coverage of Rehabilitative Services (CMS 2261-P)**

Five Year Financial impact: 42.5 Million Federal Funds

State-level effect: The coverage of Rehabilitative Services Regulations (CMS2261-P) will affect Oklahoma at this point with regard to two types of programs; TFC (Therapeutic Foster Care) services and PACT (Program for Assertive Community Treatment) services. Over the past 3-5 years, CMS has objected to two Oklahoma programs regarding rehabilitation services. The remainder of the proposed regulation will not affect Oklahoma as its program already addresses requirements to be imposed on states.

With respect to the two programs objected to by CMS:

- 1) Therapeutic Foster Care (TFC) bundled rate, OHCA went through a 3 year appeal process and CMS approved its state plan regarding the rate. However, the proposed regulation will likely require OHCA to unbundle its current rate and CMS will likely reduce payments to Foster parents (an objection noted by CMS during the state plan amendment appeal).
- 2) Program for Assertive Community Treatment (PACT) services will change from a per diem rate to a Fee-For-Service structure as of July 1, 2008; Oklahoma will lose federal funds as a result of the change from the per diem rate to the fee-for-service rate.

With respect to the following services Oklahoma's rehabilitative services already addresses these issues to be imposed upon states:

- 3) Treatment Plan requirements satisfying the regulation have been in place for a number of years; and
- 4) Service duplication issues have been addressed by the Prior Authorization process performed by OHCA's contractor, APS.

**Payments for Costs of School Administrative and Transportation Services (CMS 2287-P)**

Five Year Financial impact: None

State-level effect: Oklahoma has never implemented reimbursement to school districts for costs related to transportation or administrative services. As a result there is no impact to our state resulting from CMS's regulations.

**Targeted Case Management (CMS 2237-IFC)**

Five Year Financial impact: \$195 Million in Federal Funds

State-level effect: *Single Case Manager Requirement §441.18(a)(6)*

Under § 441.18(a)(6), all case management services to an individual must be provided by a single case manager. The regulations note that although an individual may fall within multiple target groups and be eligible for more than one State Plan case management

service, "a decision must be made concerning the appropriate target group so that the person will have one case management provider." Each target group requires the presence of knowledgeable case managers with experience and knowledge of the specific system of care serving the individuals in the target group. These case managers are essential to assuring that the individuals receive comprehensive and effective care. No single case manager under the current system can possess the requisite knowledge across all areas in which a member could potentially need services. When, for example, a pregnant woman with mental illness and a physical disability must receive case management services from only one provider, it is unlikely that the provider will have the requisite knowledge required to assess the needs of the individual and to further be able to recommend all appropriate services, thereby limiting the potential resources that are available to the individual.

*Definition for Case Management Transitioning §440.169(c)*

In January, 2000 CMS transmitted the first in a series of letters describing the Supreme Court's decision in the case of *Olmstead v. L.C.* At that time, CMS observed the fact that Medicaid may be of great assistance to States in fulfilling their civil rights responsibilities under the Americans with Disabilities Act (ADA). CMS also promised to review federal Medicaid policies and regulations to identify areas in which policy clarification or modification would facilitate states' efforts to enable persons with disabilities to be served in the most integrated settings appropriate to their needs. As a point of clarification/modification, in the *Olmstead Update No. 3* (July 25, 2000), CMS stated:

- 1) Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition.

Under § 440.169(c), case management services are re-defined for the transitioning of individuals from institutions to the community. The IFR states that individuals may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration and only 14 days for those individuals with an institutional stay of less than 180 days.

The new regulations do not recognize the amount of time required to successfully transition an individual back into the community. Many individuals who have been institutionalized for any length of time are returning to a community in which they have no home, no family and no community connections. For these individuals, transition planning requires creating for them an entirely new life in the community. The timelines imposed by the new regulations do not take into account the realistic timeframe needed to

establish the community ties and resources required by an institutionalized individual for a successful transition back into the community. It is our belief that such a drastic change in this arena will result in irreparable harm to an already fragile population.

*Exclusions §441.18(c)(1-4)*

The IFR specifically excludes case management activities provided by child welfare/child protective services workers as well as workers in the probation/parole system stating case management in these situations are the direct services of another program and are therefore not Medicaid case management. Not only does this overly broad exclusion extend to workers in these systems, but also to contractors of the agencies providing these much needed services.

OHCA's sister agencies have policies and systems in place to properly allocate costs between the various activities conducted by their staff. These policies and systems have been developed consistent with federal regulations and definitions. Consequently, only the costs associated with those activities that meet the federal definition of TCM are charged to Medicaid.

Individuals in the State's custody tend to have complicated issues and needs which require a high level of coordination between various systems of care. Without the federal funds traditionally appropriated to states for TCM services in these settings, the State's ability to coordinate effective care for individuals in custody will be severely crippled.

*Compliance Dates*

The IFR was published on December 4, 2007 with an implementation date of March 3, 2008. Compliance with the terms of the IFR will require major budgetary, policy and systems changes for the Oklahoma Health Care Authority and many of our sister agencies. Achieving compliance with many components of the IFR in such a short period of time will be a nearly impossible challenge for many of our partners. The only provision mentioned regarding a delayed compliance date falls within the section discussing the single case manager requirement. We respectfully request that if the IFR is implemented as it is currently written, the states be given a more forgiving date within which to achieve compliance. We are of the opinion that the delayed compliance date applicable to the single case manager provision is a much more reasonable and realistic timeframe within which to work.

*Tribal Medicaid Administrative Match*

Additionally, the proposed Oklahoma Tribal Medicaid Administrative Match (TMAM) cost allocation plan was submitted to CMS in June 2006. It has not yet been approved, nor has Oklahoma been allowed to implement a TMAM program. Thus, no claims or financial data are available to generate an estimate on financial impact. However, after discussion with other states (Washington and California) which currently have similar TMAM programs waiting approval, the estimated negative financial impact

would be approximately 40-50% of all TMAM claims. Thus, the same impact would probably apply to the Oklahoma program.

The impact on the Oklahoma TMAM program would be:

- Per the proposed cost allocation plan administrative case management claiming is allowable for referral, coordination, and monitoring of Medicaid covered services. These activities would be excluded under the revised definition of case management; these are located in the current plan under code 9: this includes identifying and referring patients/tribal members who may be in need of Medicaid family planning services. Subsequently, code 10, which is limited to general administration not directly assignable to Medicaid program activities but may be included in the tribe's approved indirect cost rate, would also not be unavailable under the new case management definition.
- The anticipated effect to tribal Medicaid Administrative Match claiming would be a significant reduction in allowable billable codes
- TMAM is typically known as an outreach and linkage program; however, the changes to targeted case management would eliminate linkage activities to other programs leaving only outreach activities as claimable administrative costs.

TOTAL OKLAHOMA FINANCIAL IMPACT OVER FIVE YEARS- 487.5 Million  
Federal Funds