



# FAX COVER SHEET

Date: 2/15/08	Sender: Michael Stickler
To: Andy Schneider	Office Name: DHS Director's Office
Office Name: Committee on Oversight and Government Reform	Address: 500 Summer Street NE, E-15
Address: 2157 Rayburn House Office Bldg	City: Salem
City: Washington	State: OR Zip: 97301-1097
State: D.C. Zip: 20515	Phone No.:
Phone No.: 202-225-5056	Fax No.: (503) 378-2897
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February 15, 2008

**House of Representatives  
Committee on Oversight and Government Reform**

Recent Medicaid regulatory changes by the Department of Health and Human Services (HHS) could significantly affect health care at the state and local level. These regulations do not require congressional approval and have been promulgated through rule alone.

Taken together, the overall effect will reduce federal Medicaid spending within Oregon by approximately \$877 million over the next five years. Most of these costs will simply be shifted onto the state and local governments, at a time when Oregon has less capacity to absorb added costs given the economic slowdown, reduction of timber revenue, weakening fiscal conditions, increased caseloads and an increase in client demand.

Oregon values the recent moratoriums implemented by Congress, but the regulations will soon take effect if further actions are not taken to postpone implementation. Without such action, to maintain essential services such as case management for children in foster care and rehabilitation services for people with serious mental illness Oregon may be forced to scale back other parts of our budget. In some cases, Oregon may be forced to cut services for Medicaid beneficiaries or cut payments to hospitals and other health care providers. Within Oregon the major uses of general funds are for Education, Human Services and Corrections with Human Services having the least "mandates", which translates into Human Services being the most vulnerable to lost funding issues and short term negative program actions, which often result in long term higher cost consequences.

Oregon will have three options for making up the loss of federal Medicaid funds: 1) cutting back on our Medicaid programs by reducing eligibility (and thereby causing more low-income people to become uninsured), cutting back on health benefits, and/or reducing payments to providers; 2) cutting back on other state programs and using those funds to replace the lost federal Medicaid dollars; or 3) raising taxes. If Oregon chooses the first option, low-income families, individuals with disabilities, and seniors could be dropped from Medicaid entirely or could face increased out-of-pocket costs or restricted access to providers.

**State of Oregon Impacts**

<b>Regulation</b>	<b>Impacts</b>	<b>Oregon Medicaid Reduction or Cost</b>	<b>Status</b>
<b>School-based Services CMS 2287-P (Dec. 28, 2007)</b>	The Federal reimbursement rate of 50/50 match for School Medicaid Administrative Claiming (MAC) over the past 3 years averaged 20 million dollars per year 10 million from Federal funds. Projected loss of Federal dollars coupled with inflation results in a loss to Oregon of \$53.4 million dollars over the next five	\$10.3 million FY 2009 \$54.8 million FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 by Congressional action

	<p>years. Elimination for federal reimbursement for Medically Necessary Transportation provided to children with disabilities pursuant to an IEP or IFSP under IDEA over the next 5 years = \$1.4 million.</p>		
<p><b>Rehabilitation Services CMS 2261-P (Aug. 13, 2007)</b></p>	<p>The definition of rehabilitative services as being those that are restorative may limit the State's ability to pay for necessary maintenance services to prevent more costly urgent or emergent interventions. Rehabilitation is often contingent on the individual's maintenance of the current level of functioning. In these instances, services that provide assistance in maintaining functioning are rehabilitative if they reduce possible deterioration or prevent the potential loss of a developmental milestone for children and are defined in the rehabilitative plan. The rule announces rehabilitation services will not be covered when furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as education or child welfare. This requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services. Adoption of the proposed rule would strain the provision of all education services by requiring the state to allocate more money from the general education fund to provide mandated IDEA services along with severe impacts to other child caring agencies. The rule announces rehabilitation services will not be covered when furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as education or child welfare. This requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services. Today, bundled services include sub acute treatment, day treatment services, respite care and treatment foster care. These are approved under codes created by the Healthcare Common Procedure Coding System (HCPCS) and approved by the CMS HCPCS Workgroup. If there are no methods for billing these services, they cannot be offered by the State Medicaid Program. This would have a detrimental effect on clients as they will not receive effective services appropriate to their needs in the least restrictive environment possible. Some clients may be diverted to other services such as outpatient services while others will be diverted to services such as acute hospital. This change would likely result in an increase in expenditures for hospitalization services.</p>	<p>\$72.9 million FY 2009 \$378.6 million FY 2009-2013</p>	<p>Delayed by Congressional action 6/30/08</p>

<p><b>Targeted Case Management CMS 2237-IFC (Dec. 4, 2007) *</b></p>	<p>Child serving agencies, including Child Welfare and the Oregon Youth Authority, will not be able to claim for case management services provided to Medicaid-eligible youth. This will require a reduction in services within these programs or elsewhere to meet the financial shortfall. Furthermore transition planning time will decrease for institutionalized clients, resulting in less preparation for community returns which could cause increases in institutionalization and longer stays. By limiting clients to a single Medicaid case manager this will reduce the effectiveness of client referrals by requiring case managers to support clients' outside their field of expertise. Other activities that have been historically viewed as administrative and claimed as such will no longer be reimbursed, having adverse impacts on rural communities' support structures which in turn could reduce client access. By mandating a move to a medical billing practice this will increase administrative burdens for community providers and could reduce face-to-face client time. With the exclusion of prior authorization by community case managers this will cause delays in services for needy clients.</p>	<p>\$52 million FY 2009 \$288-316 million 2009-2013</p>	<p>Interim final rule becomes effective 3/3/08</p>
<p><b>Government Provider Cost-Limits CMS 2258-FC (May 29, 2007)</b></p>	<p>This provision would require that statutory and regulatory criteria be considered when Oregon makes the initial determination about the governmental status of health care providers. This will be an additional administrative burden on the Department of Human Services (DHS) and could have a negative impact if CMS, upon review, determines the provider is not a unit of government. The provision that requires retention of payments could have an impact on DHS due to the assessment of intergovernmental charges. A further provision requires that revenue cannot exceed the costs of providing the Medicaid service and providers must submit annual cost reports to be reviewed by DHS. For those providers that must comply, the burden associated with this requirement is the time and effort for both the governmentally operated providers and DHS to prepare review and verify the cost reports. The associated cost of this rule is difficult at best to estimate. However, what can be said is that more time will be required in monitoring and documentation, which will in turn reduce the amount of face-to-face service time by providers to Medicaid clients. Additionally the administrative burden may cause smaller, typically rural providers to withdraw from providing Medicaid services.</p>	<p>\$6.2 million FY 2009 \$33 million FY 2008-2013, Cost to the state in administrative dollars.</p>	<p>Final rule issued; Implementation delayed by Congressional action until 5/25/08</p>

<p><b>Graduate Medical Education CMS 2279-P</b> (May 23, 2007)</p>	<p>State Fiscal year 2008/09 is based on the last year GME was paid to the six Oregon hospitals. Each year, the IME is rebased, based on CMS factors and the statistics of the most recently audited Medicare Cost Reports. For this forecast variables are best represented by an estimated percentage of increase. In the rebasing not only do CMS factors changes, but also the number of patient days, number of discharges and Intern and Resident Ratio; which are also reported in the hospitals audited Medicare Cost Report. The reasons to maintain Medicaid support for teaching hospitals are compelling. Teaching hospitals are where the nation's doctors, nurses and other health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that absolutely depends on reliable, long-term financial support. Each year, more than 100,000 resident physicians are being trained in numerous medical specialties at teaching hospitals around the country. As the nation's proving grounds for medical innovation and discovery, teaching hospitals are inherently more expensive to operate than other hospitals. And precisely because teaching hospitals are where medicine advances, these institutions are also where the most vulnerable patients are admitted for care. Teaching hospitals are an integral part of the traditional care for local communities. This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities. The Department of Human Services continues to advocate extensively against this rule. Oregon wholeheartedly agrees to share in the goal of a healthy Medicaid program, but we are opposed to the rule which we feel goes far beyond what is needed to attain federal financial stability. We believe this proposal would undermine the nation's already fragile health care safety net and further limit or eliminate access to health care for millions of low-income and medically fragile patients.</p>	<p>\$ 21.1 million FY 2009 \$110.7 million FY 2009-2013</p>	<p>Delayed by Congressional action until 5/25/08</p>
<p><b>Outpatient Clinic and Hospital Facility Services CMS 2213-P</b> (Sep, 28, 2007)</p>	<p>Oregon currently disallows these services during the settlement process and as such would not be negatively impacted by the passage of this rule.</p>	<p>No cost to Oregon can be associated with this rule.</p>	<p>Expected to be finalized in early 2008</p>

<p><b>Provider Tax CMS</b>                  2275-P (Mar. 23, 2007)* *</p>	<p>Oregon has a Medicaid Managed Care Organization (MCO) provider tax as well as a Nursing Facility tax. The MCO provider tax revenue is the state funding source for the Oregon Health Plan expansion population (OHP Standard). Approximately two-thirds of the expansion population (16,000 clients) is funded by Medicaid MCO provider tax revenue. For the tax rate change from 5.8% to 5.5% on Jan 1, 2008 to Sept 30, 2009 the loss of state funds will be \$10.7 million. With federal matching funds, that money could have covered an average additional 1700 people per month. The nursing facility Quality Assurance Assessment fee (also called the nursing facility provider tax) is used to partially pay the costs of Medicaid nursing facility care for Medicaid residents. If the tax is eliminated, the state will have two options: (1) replace tax revenue with General fund, or (2) substantially decrease nursing facility Medicaid rates from their current level.</p>	<p>\$8.5 million                  FY 2008 \$28.3 million FY 2008 and 2013</p>	<p>Effective                  1/1/08</p>
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Source: *Estimated Oregon reductions from all regulations, based on Regulations, Expiring Authorizations, and Other Assumptions in the Baseline,* February 4, 2008. \*The fiscal range presented assumes that 20%-50% of the clients served are complex enough to warrant multiple case managers. \*\* Managed Care Provider tax assumes the sun setting of the program in Sept. 2009 the Long Term Care Provider Tax does not sunset until July 1, 2014. The percentage reverts back to 6% in 2011.