FISCAL SENATE AGENCY

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MEMORANDUM

DATE: April 21, 2008

TO: Members of the Senate Appropriations Committee

FROM: Matthew Grabowski, Fiscal Analyst
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RE: Impact of Proposed Federal Medicaid Regulations on the State of Michigan

On April 14, 2008, Department of Community Health (DCH) Director Janet Olszewski appeared before the House Appropriations Subcommittee on Community Health to provide an overview of the FY 2008-09 Executive budget recommendation for DCH and to highlight changes included in the Senate-passed bill. In her testimony, the Director called attention to pending Federal actions concerning both providers of Medicaid services and program beneficiaries. This memorandum provides a detailed summary of these proposed Federal regulatory changes in the Medicaid program and the potential fiscal impact of these changes on the State of Michigan.

Substantive changes to Medicaid regulations can produce a considerable fiscal impact at the state level. If and when the regulatory changes proposed by the Centers for Medicare & Medicaid Services (CMS) become effective, DCH estimates suggest that Michigan could lose as much as $3.9 billion in Federal revenues over a period of five years.

Such lost revenue could affect the State in three ways: In the case of special Medicaid payments, GF/GP savings would no longer be available and the reduction would result in a direct GF/GP cost increase to the State. In the case of certain specialized payments to hospitals such as Graduate Medical Education, the State could conceivably increase other payments to hospitals and suffer no net loss in Federal revenue and see no increase in State GF/GP costs. In the case of other services that could no longer be provided, such as case management and rehabilitative services, the State would no longer be able to provide such services and would actually initially see GF/GP savings. The recipients of such services would be greatly affected, however, and the question would arise as to whether the State should continue such services by using 100% GF/GP to support them.

On November 1, 2007, the U.S. House of Representatives' Committee on Oversight and Government Reform requested testimony on seven distinct regulations issued by CMS during 2007. While estimates provided by the Bush Administration suggest a total reduction in Federal payments to states of about $15.0 billion over the next five years, a recent inquiry conducted by the Committee itself indicates that the costs to states as a result of the new regulations could be closer to $50.0 billion over five years.[1]

[1] "The Administration's Medicaid Regulations: State-By-State Impacts", a report prepared for Chairman Henry A. Waxman, can be accessed at http://oversight.house.gov/features/medicaid08/.

Cost Limits for Public Providers (CMS 2258-FC)

CMS regulation 2258-FC, released on May 29, 2007, includes two provisions that significantly limit states' ability to obtain Federal Medicaid funds for provider reimbursement. First, the regulation proposes limiting reimbursement for publicly-operated providers to the actual costs associated with treating Medicaid patients. Pre-existing Medicaid regulations allow providers to receive payments in accordance with the Upper Payment Limits (UPL) standards, which assign variable reimbursement rates to different classes of providers. More importantly, these standards allow states to utilize special financing arrangements to secure additional Federal dollars for health care providers. Pursuant to regulation 2258-FC, a government-operated provider could no longer receive reimbursements exceeding the costs of services provided. This new requirement would force public providers to seek out alternative revenue sources, or consider cutting existing services.

The proposed regulation also includes a more restrictive definition of a "unit of government". In order to receive special Medicaid payments, providers must be categorized as entities of state or local government. According to regulation 2258-FC:

> *A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended [25 U.S.C. 450b].*

Of particular interest in this revised language is the prerequisite of taxing authority for public providers in receipt of Medicaid funds. It is conceivable, and perhaps even likely, that Medicaid reimbursements to certain public hospitals in Michigan will be reduced or eliminated altogether as a result of this proposed amendment. Estimates submitted to the Committee on Oversight and Government Reform by Medical Services Administration (MSA) Director Paul Reinhart indicate that CMS regulation 2258-FC could reduce Medicaid payments to Michigan providers by approximately $1.25 billion over the next five years. Although the regulation was scheduled to take effect on July 30, 2007, Congress approved a moratorium delaying any implementation of CMS 2258-FC until May 25, 2008.

This change would have a significant impact on special financing mechanisms, which use State psychiatric hospitals and certified public expenditures to public providers. The State presently realizes about $120.0 million in annual GF/GP savings from these mechanisms. Depending on how narrowly the term "unit of government" is defined, the State could be at risk for much or all of those savings and would face increased GF/GP costs of an equal amount.

Payments for Graduate Medical Education (CMS 2279-P)

Since the 1960s, states have been able to use Medicaid funds to support Graduate Medical Education (GME) in the form of additional payments to teaching hospitals. These payments are intended to cover costs associated with providing training, salaries, and fringe benefits to prospective physicians (primarily residents) in a hospital setting. However, CMS set aside long-standing policy when issuing regulation 2279-P on May 23, 2007. According to the proposed rule:

> *[W]e do not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately. GME is not a health service that is included in the authorized coverage package. Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services.*

Because prospective physicians are presently receiving instruction in more than a dozen teaching hospitals in Michigan, the potential fiscal impact to the State's health care system is considerable. Moreover, insufficient funding for GME could ultimately lead to a shortage of trained physicians and inadequate supply of Medicaid service providers. A report released by the Association of American Medical Colleges (AAMC) cautions that the proposed regulation "could cripple graduate medical education programs at a time when they are attempting to expand to assure an adequate supply of physicians, both now and in the future." MDCH estimates suggest that Michigan would forfeit about $545.8 million over the next five years if CMS 2279-P is allowed to take effect. Congressional action has thus far resulted in a moratorium on the regulation until May 25, 2008.

The State presently spends roughly $170.0 million on GME payments, about $70.0 million GF/GP and $100.0 million in Federal dollars. Elimination of these payments would result in an annual savings of $70.0 million GF/GP. The State could conceivably increase Medicaid reimbursement to hospitals by an identical amount. This would result in no GF/GP savings and no net loss in Federal dollars. Such a change would modify the distribution of Medicaid payments to hospitals, with teaching hospitals losing revenue and non-teaching hospitals seeing a net gain, so there would be serious financial challenges faced by the hospitals, which lose revenue.

Rehabilitative Services (CMS 2261-P)

Existing Medicaid regulations offer states considerable flexibility in using available funds for rehabilitative services aimed at individuals with both physical and mental conditions. According to the Kaiser Family Foundation, 47 states and the District of Columbia currently provide an array of services permitted under the Medicaid rehabilitation option.[2] Much of the discretion that states are presently afforded, however, is in jeopardy due to another proposed regulation promulgated by CMS on August 13, 2007. CMS 2261-P narrows the range of rehabilitative services that would be eligible for Federal Medicaid dollars.

First, the proposed regulation distinguishes between "rehabilitation" services and "habilitation" services. Under this new classification, only those services defined as rehabilitative would be eligible for Medicaid reimbursement. Many services currently covered by the Medicaid rehab option, such as habilitation for individuals with mental retardation, therapeutic foster care, and vocational training would no longer meet the standards for "rehabilitation" services as defined by CMS. Second, the proposed regulation indicates that expenditures for room and board cannot be submitted as costs related to rehabilitation. In other words, while Medicaid rehabilitation services may be provided in a residential setting, only costs which are directly associated with patient rehabilitation are subject to Medicaid reimbursement.

[2] "Medicaid: Overview and Impact of New Regulations", a report by the Kaiser Commission on Medicaid and the Uninsured, can be accessed at http://www.kff.org/medicaid/7739.cfm.

DCH estimates that the loss of Federal funds in Michigan for rehabilitative services could approach $1.8 billion over a period of five years. In its response to the Committee on Oversight and Government reform, the Michigan Medical Service Administration commented as follows:

> *The worst case scenario under this regulation would result in either the state or beneficiaries/families becoming liable for the cost of medically necessary therapy services. Another likely result is that services would be reduced or not provided at all for some individuals.*

In enacting the *Medicare, Medicaid, and SCHIP Extension Act of 2007*, Congress postponed the implementation of CMS 2261-P until at least June 30, 2008.

Such a change would have a significant impact on services provided to the developmentally disabled by the Community Mental Health (CMH) system. While a precise estimate of the financial changes depends on how the regulations would be interpreted, it is conceivable that services to the developmentally disabled could be reduced by $400 to $500 million Gross per year. While the State would initially see a significant GF/GP savings from this change, those receiving the services would be greatly affected; there would likely be desire to restore said services. If services were restored, even at a reduced level, there would be a GF/GP cost increase roughly equivalent to the Federal funds lost of several hundred million dollars per year.

Payments for the Costs of School Administration and Transportation Services (CMS 2287-P)

Pursuant to the Individuals with Disabilities Education Act (IDEA), children with disabilities are entitled to receive health care services in school-based settings. Additionally, schools are often eligible to receive Medicaid reimbursement when providing services to students with special health care needs and for activities related to outreach and administration. In particular, K-12 schools are often appropriate providers of certain primary and preventative care services as required under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) component of Medicaid. CMS 2287-P would preclude schools from receiving Medicaid funding for administrative activities, as well as for transportation services provided to students. CMS attributes the need for new regulation to the "inconsistent application of Medicaid requirements by schools" and the determination that services should be limited to those "necessary for the proper and efficient administration of the state plan".

This proposal has drawn criticism from a variety of organizations committed to maintaining and/or expanding the availability of special services in schools. The National Parents and Teachers Association (PTA) has described Medicaid reimbursements as "a critical source of funding for special education". And according to a brief released by the Center on Budget and Policy Priorities, the proposed regulation "will likely increase the number of poor children who are eligible for Medicaid but remain uninsured, as well as the number of children with Medicaid coverage who do not get certain health care services they need."[3] The following excerpt from the MDCH response to the Committee on Oversight and Government Reform highlights the policy gap that could emerge if the proposed regulation takes effect:

[3] "Administration's Medicaid Regulations will Weaken Coverage, Harm States, and Strain Health Care System," a report by the Center on Budget and Policy Priorities, can be accessed at http://www.cbpp.org/2-13-08health.htm.

> *Since children are mandated to attend school and since clinicians are already available in the school setting, this service is ideal for providing the proper referral to other health care programs. Without administrative outreach, some children in the state may experience delays in service provision, fragmented care or no care at all.*

DCH estimates suggest that the termination of Medicaid reimbursements for these select school-based services would result in a loss of Federal revenues to the State of approximately $116.8 million over a five-year period, with a corresponding GF/GP cost if services are maintained. Here again, Congressional action has resulted in a moratorium on this proposal until June 30, 2008.

Case Management Services (CMS 2237-IFC)

As a result of amendments to the Social Security Act approved by Congress in 1981, states were given the option of providing targeted case management services to Medicaid beneficiaries in order to facilitate access to appropriate health care benefits. At present, the operative definition of case management services, which are eligible for Medicaid reimbursement, is included in the *Deficit Reduction Act of 2005* (DRA):

> *The term `case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.*

While the DRA elaborates on this description to specify an array of administrative services not eligible for Federal matching funds, CMS 2237-IFC includes additional prohibitions related to case management and care coordination. The regulation proposes significant restrictions on the availability of 'transitional' case management – services provided to individuals who are in the process of moving from an institution to the community. First, the period of coverage would be limited to 60 days; a significant reduction from the existing standard of 180 days of coverage. Second, providers of these transitional services would not receive Medicaid reimbursement until individuals in receipt of the services have successfully transitioned to the community. These restrictions have the potential to levy a significant burden upon both Medicaid providers and program beneficiaries. The latter provision could result in delayed and uncertain payments to providers, while the former would limit the options available to beneficiaries seeking transitional aid.

In addition, the proposed regulation would assign each beneficiary of case management services to a single case manager, potentially limiting access to the full spectrum of resources available. For example, an individual suffering from a co-occurring disorder could be assigned to a case manager with experience in mental health, but not substance abuse. It can be argued that this situation will be to the detriment of patient care. DCH also cautions that children served by school-based case management services would be at risk of losing access to care, since local school districts would be increasingly responsible for the costs of case management. In Michigan, CMS 2237-IFC could result in the loss of approximately $254.0 million in foregone Federal funds over the next five years. Again, if such services were continued the State would face increased GF/GP costs of a comparable value. The regulation was scheduled to take

effect on March 3, 2008, but state requests for clarification and Congressional action are likely to delay implementation.

Allowable Provider Taxes (CMS 2275-P)

Michigan has become increasingly reliant on the use of provider taxes, typically referred to as Quality Assurance Assessment Payments (QAAPs), to obtain additional Federal funding for hospitals, nursing homes, and other health care providers. The general structure of these arrangements is as follows:

1. The State imposes a tax upon a class of medical providers and collects the revenue.

2. A portion of the revenue collected by the State replaces GF/GP dollars as the non-Federal share of Medicaid funding. The GF/GP saving achieved by the State through the QAAP is often called gainsharing.

3. Remaining revenue generated through the tax is used to increase the reimbursement rates paid to the taxed provider group for services to Medicaid recipients. When the funding is used to increase provider rates, it generates Federal matching funds, about $1.40 Federal for every $1 in State expenditure. With a Federal match included in the rate increase, a provider group (as a whole) will receive more revenue in Medicaid reimbursement than it paid in taxes.[4]

Previous Medicaid regulations permitted states to levy provider taxes of up to 6.0% of net operating revenues on specific classes of providers (e.g. hospitals, nursing homes, managed care organizations). However, the proposed regulation would reduce this threshold to 5.5% of applicable revenues effect January 1, 2008. At face value, this proposal would reduce Michigan's ability to secure Federal matching funds via QAAPs and related mechanisms. Of added concern are revised standards proposed by CMS, which would be used to determine whether revenues stemming from a provider tax are eligible for the Federal Medicaid match (FMAP). In general terms, CMS would utilize a so-called "positive correlation" test to ensure that a provider tax is not directly correlated with Medicaid payments to the providers contributing the tax dollars. In other words, a provider tax must create winners and losers.

Although CMS has consistently asserted the need for disparate impact of provider taxes, the proposed standards and conditions could create an environment in which CMS has the discretion to "construe almost any provider tax as impermissible". This according to a DCH impact analysis suggesting that the proposed regulation would reduce Federal revenues to Michigan by $10.0 million in 2008 with an equivalent increase in GF/GP costs. The State could incur additional losses in the near future, but we are currently unable to forecast other potential fiscal impacts. CMS 2275-P is scheduled to take effect on April 22, 2008, but Congressional action may prevent immediate implementation.

[4] This description of QAAPs is borrowed from an August 2007 article written by SFA Analyst David Fosdick, which can be accessed at http://www.senate.michigan.gov/sfa/Publications/Notes/notes.html.

Redefine Outpatient Hospital Services (CMS 2213-P)

Pursuant to Section 1905(a)(2)(A) of the Social Security Act, Medicaid beneficiaries are entitled to receive a range of outpatient hospitals services. However, the Act does not provide an enumerated list of covered services or attempt to distinguish between acceptable and unacceptable benefits. With proposal 2213-P, CMS attempts to provide a more detailed description of what constitutes 'outpatient hospital services' subject to Medicaid reimbursement. In doing so, CMS proposes to align Medicaid standards more closely with Medicare paradigms.

The regulation in question also calls for a revision of Upper Payment Limit (UPL) standards to achieve approximate parity between this payment methodology and Medicare payment principles. Regarding this initiative, Michigan may already be ahead of the curve. According to DCH comments:

> *Michigan recently converted its outpatient reimbursement methodology to Medicare's outpatient perspective payment system (OPPS) structure. Furthermore, in order to obtain CMS approval for an outpatient supplemental payment during fiscal year 2005, the state was required by CMS to revise its outpatient upper payment limit (UPL) calculation methodology.*

Based upon preliminary analysis, Michigan does not anticipate any loss of Federal Medicaid funds as a result of this proposal. CMS has not yet indicated when states will be expected to comply with 2213-P, and Congressional action is likely to dictate the future course of this matter.

Conclusion

If the proposed Federal regulations are implemented, Michigan will face significant challenges. In the case of special financing and QAAP programs, the State would see immediate increases in GF/GP costs. In the case of Graduate Medical Education payments, the State could increase other payments to hospitals for no net cost, but this would shift funding from teaching hospitals to non-teaching hospitals. In the case of rehabilitative services, the State would face a choice between discontinuing such services to a vulnerable population or paying for the services using 100% GF/GP, at a cost of several hundred million per year. No matter what choices are made, State finances and services would be greatly affected by the proposed regulations.

Addendum

In testimony presented to the House Appropriations Subcommittee on Community Health on Wednesday, April 16, 2008, MSA Director Paul Reinhart pejoratively referred to these proposed regulations as the "seven deadly regs". The same day, The U.S. House of Representatives' Committee on Energy and Commerce supported H.R. 5613, the *Protecting the Medicaid Safety Net Act of 2008*, with a unanimous 46-0 vote. The legislation, sponsored by Committee Chairman John Dingell (D-MI), would impose additional moratoria on the proposed CMS regulations outlined here; such action would prevent any implementation of new standards and policies until April 1, 2009. While H.R. 5613 has not yet been scheduled for consideration on the floor of the House of Representatives, a statement released Wednesday by Chairman Dingell indicates his intention to move the bill forward in a timely fashion.

On April 3, U.S. Senator John Rockefeller (D-WV) introduced S. 2819, the *Economic Recovery in Health Care Act of 2008*, a companion bill to H.R 5613. This bill would also prohibit CMS from taking any action on the contested Medicaid regulations until April 1, 2009, and provide additional financial aid to states struggling with budget shortfalls. S. 2819 has been referred to the Committee on Finance, which is likely to hold hearings on this matter in the very near future. The Bush Administration has indicated its strong opposition to both the House and Senate bills, suggesting that a protracted battle over Medicaid financing may be forthcoming.

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