COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING
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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

Schneider

Medicaid

February 15, 2008

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

Dear Representative Waxman:

Enclosed you will find our response to your January 16, 2008, request concerning the impact to the State of Colorado on recent regulations issued by the Centers for Medicare and Medicaid Services (CMS). The response has been prepared by the Colorado Department of Health Care Policy and Financing (the Department), which is responsible for administering the State's Medicaid, State Children's Health Insurance Program and other health care programs covering low-income populations.

Due to the volume of regulations released by CMS over the last year, the Department was unable to perform a comprehensive financial analysis for each rule. In addition, due to time constraints, the Department was only able to provide written comments to CMS for one of the proposed rules. The information provided in response to your request is the Department's best estimate regarding the impact on Colorado Medicaid and the State's safety net provider system; however, the Department is concerned that the resultant financial impact could be significantly greater than presented in this analysis and the national analysis provided by CMS.

The Department respectfully requests that the Committee on Oversight and Government Reform issue a permanent moratorium on the regulations under investigation, including the interim final rule on targeted case management and the proposed rule on revisions to procedures for the Departmental Appeals Board and other departmental hearings. Further, the Department asks that CMS be required to work with states prior to the reissuance of any of the associated regulations so that the actual impact on Medicaid and low-income populations can be better understood prior to implementation.

Thank you for your attention to this matter and for allowing the Department to submit comments.

Sincerely,

Joan Henneberry

Joan Henneberry
Executive Director

Enclosure

Cc: Honorable Tom Davis, Ranking Minority Member

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Enclosures for Letter to Committee on Oversight and Government Reform Concerning CMS Regulations

Cost Limit on Providers (CMS 2258-FC)

Summary: This regulation would make changes to public provider payment and financing arrangements with State Medicaid programs. As a result, the State of Colorado will experience significant negative impacts as the Department's ability to continue to fund public-owned hospital providers for serving low-income individuals would be greatly reduced. There are thirty-four (34) hospital providers that have been historically designated as public-owned in Colorado which are at risk under the regulations.

The Department performed a comprehensive analysis and submitted that analysis to CMS. In their responses to the Department's comments, CMS failed to address the Department's concerns. The Department's analysis is attached. The regulation is a Medicaid policy change that is expected to result in the loss of federal revenue of approximately $142.2 million per year in Colorado. As such, the regulations put the financial stability of the entire safety-net provider community in Colorado at risk.

Attachments: Letter and Comments Submitted to CMS dated March 15, 2007

Updated Impact Overview by Colorado Department of Health Care Policy and Financing dated March 12, 2007

Payment for Graduate Medical Education (CMS 2279-P)

Summary: This proposed regulation would eliminate all Medicaid payments for Graduate Medical Education (GME). As a result, this would eliminate supplemental funding to Colorado's teaching hospitals. These hospitals provide critical physician services to Medicaid and low-income populations. Approximately 1,157 fellows and residents in training, in 14 sponsoring institutions around the State, would be negatively impacted by the regulation. These fellow and residents provide medical services to over 100,000 Medicaid and low-income clients each year. The State's teaching hospitals report that they would not be able to continue their education programs at the current levels without the federal Medicaid funding. The regulation is a Medicaid policy change that is expected to result in loss of revenue of approximately $12 million per year in Colorado. This would represent more than a 25% decline in revenue to Colorado's teaching programs and would force the programs to reduce staff and stop serving Medicaid clients in

their outpatient clinics. As such, the regulation threatens the financial stability of these teaching programs and the safety-net provider community.

The Department has not performed a comprehensive analysis, so the estimated loss of revenue of approximately $12 million per year in Colorado should be considered partial. The Department did not submit comments to CMS regarding this regulation.

Attachment: Impact of CMS Proposed Rules Concerning Changes to Medicaid Graduate Medical Education Reimbursement

Payment for Hospital Outpatient Services (CMS 2213-P)

Summary: The proposed regulation would limit the definition of outpatient hospital services and place restrictions on upper payment limit methodologies for private outpatient hospitals and clinics. The Department is unable to perform a comprehensive analysis due to the lack of data and guidance provided by CMS. The Department predicts the rule would dramatically change the State's Medicaid reimbursement model for outpatient hospital services. Specifically, the payment for hospital based clinics, which are included in the provider's cost report, would need to be modified and will probably reduce the current payment to hospital providers.

The proposed regulation overlooks critical services for children performed in a hospital-based clinic. CMS is attempting to provide more clarity on what is and what is not a Medicaid outpatient hospital service, but the narrow Medicare definition included in the proposed regulation does not reflect the reality of the Medicaid program today and the significant role it plays for children. The Medicare definition for outpatient services is inappropriate for children because it was not developed to address their unique health care needs. The different health care needs of children and adults should be examined and changes made before the Medicare definition is adopted for the Medicaid population. If this is not done, important outpatient health care services for children could be threatened.

The proposed regulation would exclude services provided by entities that are not provider-based departments of a hospital. This new requirement could jeopardize the outpatient care provided in hospital-based clinics. The proposed regulation may also affect the calculation of Medicaid Disproportionate Share Hospital (DSH) payments. If services are no longer classified as outpatient hospital services, then they would no longer be included in the calculation of DSH allotment to hospitals that provide services specifically to children.

Due to lack of data, CMS says it is unable to estimate the impact of the proposed regulation. This is extremely troubling. Before a regulation of this magnitude is implemented, the impact should be specified and addressed. CMS does not

address the potential effect on children and children's providers of adopting a Medicare service definition. This change could impact the services hospitals are able to provide for children and therefore children's access to outpatient hospital services. CMS should explore the potential effects of these changes and any revisions needed to continue to provide quality and accessible health care services for children.

The Department was unable to perform a comprehensive analysis due to the lack of data and specific information, so the estimated loss of Medicaid revenue to hospital providers is not available. The Department did not submit comments to CMS regarding this regulation.

Provider Taxes (CMS 2275-P)

Summary: The proposed regulation seeks to clarify a number of issues in the original regulation regarding provider taxes, including more stringent language in applying the hold-harmless test. In addition, the new language affords CMS broader flexibility in identifying the relationship between provider taxes and payment amounts. The Department did review the proposed regulation, but since the Colorado Medicaid currently does not utilize provider taxes, there is no fiscal impact to the State. Due to the limitations imposed under Cost Limit on Providers (CMS 2258-FC), the Department is considering implementing provider taxes as an alternative financing mechanism to the use of certification of public expenditures.

In review of the regulation, the Department is concerned that CMS is eliminating the objective standards by which compliance with the hold harmless provisions for health care-related taxes can be measured. The re-interpretation of the definitions of "positive correlation," "Medicaid payment," and "direct guarantee" standards removes consistency and clarity in interpretation and application.

Since the Department does not utilize provider taxes, there is no financial impact data available. The Department did not submit comments to CMS regarding this regulation.

Coverage for Rehabilitative Services (CMS 2261-P)

Summary: The proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers. The Department is unable to perform a comprehensive analysis due to the lack of data on which current providers are unable to meet the proposed requirements.

Concerning Colorado's School Health Services Program, the proposed rule will increase time and effort required to develop rehabilitation plan, document comprehensive assessments/periodic reassessments, and maintenance of case records. This appears to be duplication of documentation for the Individualized Education Program (IEP) and 504 Rehabilitation plans. Further, there will be reduction in reimbursement for rehabilitative services in the schools based on the clarifying definitions of habilitation and rehabilitation services, and the limitation imposed on recreational and social activities of students with mental retardation or illness. As such, the regulation will have a financial impact on the reimbursement to participating school districts and may cause some school districts to stop participating in the Colorado's School Health Services Program.

The Department was unable to perform a comprehensive analysis due to the lack of data and specific information, so the estimated loss of revenue to Medicaid and Colorado's School Health Services Program is not available. The Department did not submit comments to CMS regarding this regulation.

Attachment: Impact of CMS Proposed Rules Concerning Coverage for Rehabilitative Services

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

Summary: The regulations was based on a determination that administrative activities performed by schools, and transportation of school-age children from home to school and back, are not necessary for proper and efficient administration of the State Medicaid plan, and are not within the scope of the transportation services recognized by the CMS. Colorado's School Health Services Program does not currently reimburse providers for administrative services and will not be impacted by the elimination of federal financial participation for administrative activities. However, current rules for the program allow participating school districts to claim for transportation services "when provided to and from the client's place of residence and the school and or to and from the site of service on the day a Medicaid covered service is provided". It is important to note that while some students are occasionally transported to an off-site location for treatment, the vast majority of services are provided by the district at the school-aged student's school site. As such, the regulation will have a significant financial impact on the reimbursement to participating school districts currently claiming for transporting students to school when a Medicaid service is rendered and may cause some school districts to stop participating in the Colorado's School Health Services Program.

The regulation is a Medicaid policy change that is expected to result in loss of federal revenue of approximately $1.4 million per year in Colorado. The Department did not submit comments to CMS regarding this regulation.

Attachment: Impact of CMS Proposed Rules Concerning the Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School

Targeted Case Management (CMS-2237-IFC)

Summary: This regulation places limitation on the Medicaid reimbursement for case management activities. The rule imposes the following changes, burdens and limitations on the Colorado's School Health Services Program providers. Colorado schools do not have the capability to determine whether a child received case management outside of the school system and the rule requirements for care coordination will increase the administrative burden of school providers. The Department is concerned that the rule disallows the provision of case management for students with a 504 rehabilitation plan. The rule limits targeted case management in the school setting to only those students where such services are prescribed on an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). CMS' position is that Section 1903c of the Social Security Act only authorizes Title XIX funding for Medicaid services to kids with disabilities because the services are included in the IEP/IFSP. The rule also eliminates reimbursement for IEP/IFSP planning and development. School districts are currently reimbursed for these activities under targeted case management.

Further, it appears that the interim final rule does not just apply to Targeted Case Management (TCM), but also applies to Administrative Case Management (ACM). CMS indicates in the interim rule that Case Management services must be provided by a single Medicaid case management provider. This will have a negative impact in Medicaid funding for ACM activities performed by County Child Welfare/Core Services workers.

The regulation is a Medicaid policy change related to the Child Welfare that is expected to result in loss of federal revenue of approximately $1.85 million per year in Colorado. The Department was unable to perform a comprehensive analysis due to the lack of data and specific information, so the estimated loss of revenue to Medicaid and Colorado's School Health Services Program is not available. The Department did not submit comments to CMS regarding this regulation.

Attachment: Impact of CMS Proposed Rules Concerning Optional State Plan Case Management

Revisions to Departmental Appeals Board and Other Departmental Hearings

Summary: This proposed regulation would impact any appeal that the Department filed to challenge a disallowance or the imposition of a civil money penalty. As a result, it impacts the Department with respect to decisions made by CMS, for example, for disallowances of Federal Financial Participation (FFP) or for civil money penalties that CMS may impose on the Department. The rules change the procedures that govern appeals. There are a couple of significant changes which are cause for concern. The Departmental Appeals Board (DAB) currently has final review authority over a number of disputes between states and CMS. These rules would change that.

The proposed rule change limits the DAB's discretion by requiring the DAB to follow all "published guidance" of CMS that is not inconsistent with statute or regulation. Where no published guidance exists, the proposed rule change requires the DAB to consider as persuasive unpublished positions. In such a scenario, the DAB may be required to consider as persuasive a CMS argument based on a position that CMS took with respect to one state, and about which no other state may know. At the extreme, the proposed rule change would prevent a state from arguments based on anything other than the inapplicability of the CMS rule at issue. It would prevent a state from making arguments based on fairness principles.

The proposed rule changes the procedure of the appeals process by giving the Secretary of US Department of Health and Human Services a discretionary review of the DAB decision. As a result, the appeals process may or may not include a final agency decision issued by the Secretary. It injects uncertainty into the length of the procedural process.

If the Secretary exercises his discretion to review the DAB decision, the Secretary has the ability to change the DAB's fact-findings or legal conclusions without any procedural mechanism allowing the state to make arguments to the contrary. As a result, the State has no opportunity to present argument or evidence to the Secretary. In the worst-case scenario, the Secretary could change fact-findings or legal conclusions of the DAB on issues the State has not had an opportunity to litigate.

The Secretary's record review exists only to nullify the DAB's fact findings or legal conclusions where the Secretary so chooses. As a result, the Secretary's discretionary review nullifies the import of any DAB decision.

Assuming that the Secretary's review may result in a greater proportion of decisions in favor of CMS, the process becomes biased more in favor of CMS and becomes less favorable to the States.

Assuming the Secretary's review may result in a greater proportion of decisions in favor of CMS, the likelihood that a State will seek judicial review increases. As a result, the longer process will be more expensive for a State to litigate an issue.

The Department was unable to perform a comprehensive analysis due to the lack of data and specific information, so the estimated loss of revenue to Medicaid is not available. The Department did not submit comments to CMS regarding this regulation.

Attachment: Impact of CMS Proposed Rules Concerning Revisions to Departmental Appeals Board and Other Departmental Hearings

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

March 15, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2258–P
P.O. Box 8017, Baltimore, MD 21244–8017

Re: Colorado Department of Health Care Policy and Financing's Comments on CMS–2258–P

To whom it may concern:

The Colorado Department of Health Care Policy and Financing (the Department) has prepared the following comments and questions to the proposed regulation [CMS-2258-p] by the Centers for Medicare and Medicaid Services (CMS) entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State-Financial Partnership" (the Proposed Rule). Further, the attached analysis prepared by Department estimates the financial impact on the State of Colorado and safety-net providers.

The Proposed Rule which would make changes to public provider payment and financing arrangements with State Medicaid programs. As a result, the State of Colorado will experience significant negative impacts as the Department's ability to continue to fund public-owned hospital providers for serving low-income individuals would be greatly reduced. There are thirty-four (34) hospital providers that have been historically designated as public-owned in Colorado which are at risk under the Proposed Rule. The Proposed Rule is a Medicaid policy change that is expected to result in loss of federal revenue of approximately $142.2 million per year in Colorado. As such, the Proposed Rule puts the financial stability of the entire safety-net provider community in Colorado at risk.

The Departments requests that CMS formally respond to the following comments and questions:

1. Part 433. The Colorado Department of Health Care Policy and Financing drew $131.0 million in federal funds by using certification of public expenditures (CPE) under the upper payment limit for inpatient hospital services and Disproportionate Share Hospital (DSH) payments to fund the Colorado Indigent Care Program (CICP). It should be noted that Inpatient UPL payments are based upon services to the eligible Medicaid population, but providers are not eligible to receive these payments unless they agree to participate under the CICP. These funds allow the CICP to distribute federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to individuals living under 250% of the federal poverty level who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

Approximately 180,000 individuals received care through the CICP in FY 05-06. Under the proposed rule, approximately $128.4 million of those federal funds could no longer be drawn using CPE. *To preserve the safety net, the Department recommends that the rule be revised to allow current definitions of public providers to apply. Please explain why CMS would place the safety-net provider community and those individuals who received care through this community at risk by implementing the proposed rule.*

2. Part 433. *If the safety-net hospital system became insolvent because of the proposed rule, please explain what contingency plans CMS has considered and what safeguards CMS has implemented to protect Medicaid and low-income populations.*

3. Part 433. By placing recent expanded financial controls on how the certification of public expenditure is calculated and requiring reconciliations to a cost report, there are already substantial controls over the certification process. The Colorado Department of Health Care Policy and Financing believes that these controls adequately protect the State's and CMS' funding for Medicaid and Disproportionate Share Hospital payments. *Please explain how converting ownership status to private-owned for those providers who have been historically considered as public-owned by CMS under the proposed rules increases these financial controls.*

4. Part 433. CMS is proposing a September 1, 2007 effective date with no transition period. Based on this effective date, many States will have an immediate Medicaid budget shortfall. *The Colorado Department of Health Care Policy and Financing requests that CMS extend the transition period to January 1, 2008 to implement these regulations to allow providers to adapt and allow states to adjust their budgets.*

5. Section 433.50. The proposed rule states that health care providers must demonstrate they are a unit of government by showing that: 1) the health care provider has generally applicable taxing authority; or 2) the health care provider is able to access funding as an integral part of a governmental unit with taxing authority and that this governmental unit is legally obligated to fund the governmental health care providers expenses, liabilities, and deficits. The proposed rule goes on to state that a contractual arrangement with the State or local government cannot be the primary or sole basis for the health care provider to receive tax revenues.

   However, under the section titled Provisions of the Proposed Rule, CMS states that "In some cases, evidence that a health care provider is operated by a unit of government must be assessed by examining the relationship of the unit of government to the health care provider". CMS provides two situations where the health care provider would be considered governmentally operated. The first situation exists if the unit of government appropriates funding derived from taxes it collected to finance the health care providers operating budget, not to include special purpose grants, construction loans or similar funding arrangements. The second situation exists if the health care provider is included as a component unit on the government's consolidated annual financial report. CMS notes that this indicates the governmentally operated status of the health care provider.

Will these two situations, described above, be considered separately from the actual language in the proposed rule or will they be considered in addition to the language in the proposed rule when determining if a health care provider is governmentally operated?

6. Section 433.50. CMS noted that a tool, CMS Form 10172, to evaluate the government status of a provider would be required to be completed and submitted to CMS. However, it is unclear as to who is responsible for completing the form and what, if any, supporting documentation is required. In addition, this form in its current format does not require an official signature by an individual with that authority. *The Colorado Department of Health Care Policy and Financing requests that CMS provide more written guidance on the use of this form when final rules are presented.*

7. Section 447.206. The proposed rule establishes an initial rate, and then requires the Medicaid agency to perform two reconciliations on that rate – an interim to the "as filed" Medicaid Cost Report and a final to the "audited" Medicaid Cost Report. "As filed" cost reports are available six months after the close of the providers fiscal year and the "audited" cost reports may not be available for several years following the payment. Performing these reconciliations would be burdensome on the Medicaid agency and the providers. This draft rule forces all payments using certification of public expenditure to be retrospective, which many Medicaid agencies and Medicare have been attempting to eliminate over the years. *The Colorado Department of Health Care Policy and Financing requests that CMS modify this rule to allow a payment and corresponding CPE based on a current, inflated cost report without any reconciliation process. Any changes to costs will be captured in future cost reports, which is the philosophy behind a prospective payment system.*

8. Section 447.207. *Currently the Colorado Department of Health Care Policy and Financing offsets Medicaid expenditures using certification of public expenditures through the upper payment liming financing to outpatient hospitals, nursing facilities and home health agencies. The Department requests that this offset continue to be allowed, but only when applied to Medicaid expenditures.*

9. Section 447.271. The Provision of the Proposed Rule does not provide enough clarification on the modification of this rule and how it may impact providers who provide services at no charge, but are allowed to bill Medicaid for such services. *Does the modification of this regulation prevent a provider from billing Medicaid for those services the provider generally provides at no charge or generally provides to low-income populations at no charge? If that is CMS intent, please provide specific language to clarify.*

10. Sections 447.272 and 447.321. The Colorado Department of Health Care Policy and Financing has a concern that upper payment limit (UPL) calculations for inpatient hospital, outpatient hospital and nursing home providers will be different for public-owned and private-owned facilities under the proposed rule. *CMS should reconsider*

requiring the State to have different calculations and allow the Medicaid agency the option to use the same calculation for private-owned providers as used for public-owned providers.

11. Sections 447.272 and 447.321. *Will CMS define which provider costs and what specific Medicare/Medicaid 2552-96 worksheets and lines may be included in developing these new upper payment limits? Can costs for physicians and Graduate Medical Education be included when developing these upper payment limits?*

12. Section 447.207. *Is it allowable for the State to retain the federal share of a Supplemental Medicaid Payment when the federal share is used to support the Medicaid reimbursement, thus eliminating the need for a reduction in the Medicaid reimbursement?*

Sincerely,

/s/

Lisa M. Esgar
Senior Director, Operations and Finance Office

Attachment: Updated Impact Overview by Colorado Department of Health Care Policy and Financing, March 12, 2007

Updated Impact Overview by Colorado Department of Health Care Policy and Financing
March 12, 2007

Draft Rules
Centers for Medicare & Medicaid Services
42 CFR Parts 433, 447, and 457
[CMS–2258–P] RIN 0938–A057

Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

Summary Overview Analysis

1. The proposed rule:
   - Adds specific limitations on those providers which are considered public-owned by stating they must be a unit of government and that unit of government must have generally applicable taxing authority.
   - Requires that entities using certified public expenditure (CPE) to draw the federal share of Medicaid and Disproportionate Share Hospital payments must fit within the new definition of a public-owned entity.
   - Clarifies the documentation, which must be defined using a specified cost report, and reconciliation required to support the certified public expenditure (CPE).
   - Limits reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost, which must be defined using a specified cost report.
   - Requires providers to receive and retain the full amount of Medicaid, Supplemental Medicaid and Disproportionate Share Hospital payments.
   - Makes conforming changes to provisions governing State Child Health Insurance Program (SCHIP).

2. In FY 05-06, the Colorado Department of Health Care Policy and Financing drew $131.0 million in federal funds by using certification of public expenditures (CPE) under the upper payment limit for inpatient hospital services (Inpatient UPL) and Disproportionate Share Hospital (DSH) payments to fund the Colorado Indigent Care Program (CICP). Certification of public expenditure refers to a health care provider that is operated or owned by a unit of government certifying that local funds have already been spent. It should be noted that Inpatient UPL payments are based upon services to the eligible Medicaid population, but providers are not eligible to receive these payments unless they agree to participate under the CICP. Qualified health care providers who receive this funding render discounted health care services to individuals living under 250% of the federal poverty level who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan. Approximately 180,000 individuals received care through the CICP in FY 05-06.

3. Under the proposed rule, the Department believes that its ability to continue to fund hospital public-owned providers for serving low-income individuals through certification of public expenditures would be eliminated. As such, either the State would need to find an equivalent General Fund match to replace the current certification or the current federal funds distributed to providers would be eliminated. If the State could not provide the replacement General Fund match, the State and the hospital providers that receive these federal funds of approximately $128.4 million, would lose these federal funds.

4. Currently, there are thirty-four (34) hospital providers designated as public-owned in Colorado. Of those providers, three providers operate large facilities that provide integrated health care services (including primary, specialty, emergency, and inpatient hospital care) to Medicaid and low-income populations. Those three providers (Denver Health Medical Center, Memorial Hospital, and University Hospital) are an essential part of the State's safety-net and account for 92.3% of the federal funds distributed through certification of public expenditures. The remaining providers serve as a critical part of the State's safety-net provider community, mainly in rural areas.

   The Department believes that several of these providers, mainly those who are funded through a taxing district or county, would still be considered public-owned under the Proposed Rule, but because of the ambiguity in the Propose Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot state with complete certainty that any of these providers will still be considered public-owned under the Final Rule.

5. The proposed rule will also impact CICP payments to private-owned hospital providers, as there is fixed pool of General Fund available to fund current CICP payments. As more hospital providers are classified as private-owned, that fix pool of General Fund would be distributed over more providers. As large hospital providers, as Denver Health Medical Center, Memorial Hospital and University Hospital draw from that fix pool of General Fund, payments to other providers who currently classified as private-owned must significantly decrease. As such, payments to National Jewish Medical and Research Center, Parkview Medical Center, Platte Valley Medical Centers, San Luis Valley Medical Center, St Mary-Corwin Hospital, The Children's Hospital and all other private-owned hospital providers will decrease by an estimated 79.3%.

6. The Department is concerned about the timing of the rule. The proposed effective date of CMS' rule is September 1, 2007. The Department and public-owned providers have used certification to draw federal funds since FY 99-00. The abrupt end of this process would disrupt or even terminate the ability of low-income people to receive the necessary medical services offered through the CICP. Further, as public-owned hospitals have limited ability to cost-shift to other payers, the proposed rule puts the financial stability of the entire safety-net provider community at risk.

7. This rule would eliminate the Department's ability to retain the federal financial participation from the outpatient hospital, nursing facility, and home health agency public-owned upper payment limit payments. These federal funds are currently an offset to General Fund in Medical Services Premiums for Medicaid. The Department would need $13.8 million in General Fund per year, or would be required to reduce Medicaid payments to providers by $27.6 million, to offset the elimination of these financing mechanism.

In summary, under the proposed rule, Colorado estimates that the loss in federal funds would be at least $142.2 million per year as providers who have historically been identified as public-owned would be reclassified as private-owned, and would be forced to stop utilizing certification of public expenditures to draw federal funds related to uncompensated costs for Medicaid and low-income populations. There is a significant risk that Denver Health Medical Center, Memorial Hospital, and University Hospital will no longer have the ability to use certification to draw the available federal funds. The proposed rule puts the financial stability of the entire safety-net provider community in Colorado at risk.

Proposed Questions/Comments to CMS Concerning the Proposed Rule

1. Part 433. The Colorado Department of Health Care Policy and Financing drew $131.0 million in federal funds by using certification of public expenditures (CPE) under the upper payment limit for inpatient hospital services and Disproportionate Share Hospital (DSH) payments to fund the Colorado Indigent Care Program (CICP). It should be noted that Inpatient UPL payments are based upon services to the eligible Medicaid population, but providers are not eligible to receive these payments unless they agree to participate under the CICP. These funds allow the CICP to distribute federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to individuals living under 250% of the federal poverty level who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan. Approximately 180,000 individuals received care through the CICP in FY 05-06. Under the proposed rule, approximately $128.4 million of those federal funds could no longer be drawn using CPE. *To preserve the safety net, the Department recommends that the rule be revised to allow current definitions of public providers to apply. Please explain why CMS would place the safety-net provider community and those individuals who received care through this community at risk by implementing the proposed rule.*

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6. Section 433.50. CMS noted that a tool, CMS Form 10172, to evaluate the government status of a provider would be required to be completed and submitted to CMS. However, it is unclear as to who is responsible for completing the form and what, if any, supporting documentation is required. In addition, this form in its current format does not require an official signature by an individual with that authority. *The Colorado Department of Health Care Policy and Financing requests that CMS provide more written guidance on the use of this form when final rules are presented.*

7. Section 447.206. The proposed rule establishes an initial rate, and then requires the Medicaid agency to perform two reconciliations on that rate – an interim to the "as filed" Medicaid Cost Report and a final to the "audited" Medicaid Cost Report. "As filed" cost reports are available six months after the close of the providers fiscal year and the "audited" cost reports may not be available for several years following the payment. Performing these reconciliations would be burdensome on the Medicaid agency and the providers. This draft rule forces all payments using certification of public expenditure to be retrospective, which many Medicaid agencies and Medicare have been attempting to eliminate over the years. *The Colorado Department of Health Care Policy and Financing requests that CMS modify this rule to allow a payment and corresponding CPE based on a current, inflated cost report without any reconciliation process. Any changes to costs will be captured in future cost reports, which is the philosophy behind a prospective payment system.*

8. Section 447.207. *Currently the Colorado Department of Health Care Policy and Financing offsets Medicaid expenditures using certification of public expenditures through the upper payment liming financing to outpatient hospitals, nursing facilities and home health agencies. The Department requests that this offset continue to be allowed, but only when applied to Medicaid expenditures.*

9. Section 447.271. The Provision of the Propose Rule does not provide enough clarification on the modification of this rule and how it may impact providers who provide services at no charge, but are allowed to bill Medicaid for such services. *Does the modification of this regulation prevent a provider from billing Medicaid for those services the provider generally provides no charge or generally provides to low-income populations at no charge? If that is CMS intent, please provide specific language to clarify.*

10. Sections 447.272 and 447.321. The Colorado Department of Health Care Policy and Financing has a concern that upper payment limit (UPL) calculations for inpatient hospital, outpatient hospital and nursing home providers will be different for public-owned and private-owned facilities under the proposed rule. *CMS should reconsider requiring the State to have different calculations and allow the Medicaid agency the option to use the same calculation for private-owned providers as used for public-owned providers.*

11. Sections 447.272 and 447.321. *Will CMS define which provider costs and what specific Medicare/Medicaid 2552-96 worksheets and lines may be included in developing these new upper payment limits? Can costs for physicians and Graduate Medical Education be included when developing these upper payment limits?*

12. Section 447.207. *Is it allowable for the State to retain the federal share of a Supplemental Medicaid Payment when the federal share is used to support the Medicaid reimbursement, thus eliminating the need for a reduction in the Medicaid reimbursement?*

Analysis by Component

PART 433—STATE FISCAL ADMINISTRATION

§433.50 is amended

Overview Analysis: Section 1903(w)(7)(G) of the Social Security Act (the Act) identifies the four types of local entities that, in addition to the State itself, are considered a unit of government: a city, a county, a special purpose district, or other governmental units in the State. Currently, the interpretation of a "public-owned provider" is broad and not defined through rule. CMS has defined a public-owned provider, through correspondence and the State Medicaid Manual as: "Public Providers are those that are owned or operated by a State, county, city or other local government agency or instrumentality."

The Department considers a provider to be public-owned if the provider has a financial relationship with the governmental unit that may include one of the following: the provider receives operating revenues from the governmental unit, the governmental unit provides tax revenues to support bonds to construct the facility, the governmental unit has some financial obligation even if its daily operations of the facility have been assigned to private-owned company (such as Banner Health), and the liabilities and assets of the provider revert to the governmental unit upon bankruptcy.

As stated above, the Act identifies five types of entities that can be classified as a unit of government:

1. State
2. City
3. County
4. Special purpose district
5. Other governmental units within the state

Under the proposed rule, only these units of government may use CPE to draw the federal share of Medicaid expenditures. The proposed regulation seeks to place additional restrictions on the requirements under the Act by including the requirement that a unit of government have generally applicable taxing authority. Further, the funding for CPE must be directly derived from tax revenues. As such, for a provider to be considered public-owned, it must be operated by a unit of government with generally applicable taxing authority or have access to funding as an integral part of a government unit with taxing authority. As an integral part of a government unit, the governmental unit has a legal obligation to fund the provider's expenses, liabilities and deficits, so that a contractual arrangement with the state or local government is not the primary or sole basis for the health care provider to receive tax revenues.

Further, in the preamble to the Proposed Rule of the rule, CMS states: "*In recent reviews, we have found that health care providers asserting status as a '"special purpose district' or 'other' local government unit often do not meet this definition. Although the special purpose district or a unit of government with taxing authority may be required, either by law or contract, to provide limited support to the health care provider, the health care provider is an independent entity and not an integral part of the unit of government.* ***Typically, the independent entity will have liability for the operation of the health care provider and will not have access to the unit of***

government's tax revenue without the express permission of the unit of government. *Some of these types of health care providers are organized and operated under a not-for-profit status. Under these circumstances, the independently operated health care provider cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because of such arrangements.*"

In Colorado, providers under the authority of a taxing district must request the funds from the district as they have separate Governing Boards; county facilities must request and be allocated moneys from their county's budget; Denver Health must request tax revenue from the City and County of Denver; University Hospital must request General Fund from the General Assembly. All providers must have the express permission of the unit of government prior to receiving any tax revenue - presumably on a yearly or as needed basis. Following the strict interpretation of these comments, it appears to be CMS' intent to dramatically reduce the number of safety-net providers from inclusion in the public-owned definition.

Currently, the Department considers thirty-four (34) providers to be public-owned. In reading of the regulations, the Department has prepared the following analysis based on the revised definitional of a public-own provider.

- Of these public-owned providers, eighteen (18) receive operating tax revenues from a special district: Aspen Valley Hospital, Delta County Memorial Hospital, Melissa Memorial Hospital, Grand River Hospital District, Haxtun Hospital District, Spanish Peaks Regional Health Center, Weisbrod Memorial County Hospital, Kit Carson County Memorial Hospital, Kremmling Memorial Hospital, Southwest Memorial Hospital, Estes Park Medical Center, Prowers Medical Center, Rangely District Hospital, Heart of the Rockies Regional Medical Center, Southeast Colorado Hospital and LTC, St. Vincent General Hospital District, Wray Community District Hospital, and Yuma District Hospital.

  The Department believes that these providers would still be considered public-owned under the Proposed Rule, but because of the ambiguity in the Proposed Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot state with complete certainly that these providers will still be considered public-owned under the Final Rule. In FY 05-06, these providers used CPE to draw $2.4 million in federal funds.

- Of these public-owned providers, four (4) receive operating tax revenues from a county: Lincoln Community Hospital and Nursing Home, The Memorial Hospital (located in Craig), Pioneers Hospital, and Sedgwick County Memorial Hospital.

  The Department believes that these providers may still be considered public-owned under the Proposed Rule, but because of the ambiguity in the Propose Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot be certain that these providers will be considered public-owned under the Final Rule. In FY 05-06, these providers used CPE to draw $150,000 in federal funds.

- Of these public-owned providers, two (2) receive operating tax revenues directly from the State, and the State is obligated to fund the expenses, liabilities and deficits of these providers: Colorado State Hospital in Pueblo and Ft. Logan in Denver.

  The Department believes that these providers would still be considered public-owned under the proposed rules. In FY 05-06, these providers did not use CPE to draw federal funds.

- Of these public-owned providers, ten (10) will probably be converted into a private-owned by this proposed rule: Arkansas Valley Regional Medical Center, Denver Health Medical Center, East Morgan County Hospital, Gunnison Valley Hospital, Keefe Memorial Hospital, Memorial Hospital (located in Colorado Springs), Montrose Memorial Hospital, North Colorado Medical Center, Poudre Valley Hospital, and University Hospital.

  The Department believes that these providers may no longer be considered public-owned under the proposed rules, but because of the ambiguity in the Propose Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot state with complete certainly that all of these providers will be considered private-owned under the Final Rule. In FY 05-06, these providers used CPE to draw $128.4 million in federal funds. The federal payments would either be eliminated causing substantial decreases to these providers' revenue or the CPE would need to be replaced with General Fund.

  The reason why the Department believes that some of these hospitals may be considered private-owned is due to the business relationship between the hospital, the management firm and the city/county. For some these hospitals, the management firm acts as an intermediary between the hospital and the city/county. In addition, for many of these hospitals, employees are no longer considered city/county employees but private sector employees.

  Denver Health Medical Center may receive some general operating funds from the City and County of Denver, but the Hospital Authority which operates Denver Health Medical Center does not have generally acceptable taxing authority nor is the city "legally obligated to fund the health care provider's expenses, liabilities, and deficits."

  The University Hospital is currently considered a unit of government through its relationship with the Board of Regents of the University of Colorado. Nevertheless, there is no statutory requirement that the State, through the Board of Regents, is "legally obligated to fund the health care provider's expenses, liabilities, and deficits" of the provider, nor does the Board of Regents has have generally acceptable taxing authority.

  There would be a significant impact to the safety-net health care system in Colorado if these providers were converted to private-owned under this proposed rule and they were no longer able to use CPE to draw the federal match. The chart below demonstrates the impact at the provider level using FY 05-06 payments.

Facility Name	Inpatient UPL Payments	Disproportionate Share Hospital Payments	Total Payments (Federal Funds)
Arkansas Valley	$155,180	$1,113,050	$1,268,230
Denver Health	$21,451,088	$54,159,103	$75,610,191
East Morgan	$4,437	$45,812	$50,249
Gunnison Valley	$5,064	$12,785	$17,849
Memorial Hospital	$2,764,949	$6,980,867	$9,745,816
Montrose Memorial	$151,015	$381,277	$532,292
North Colorado Medical Center	$972,922	$2,456,407	$3,429,329
Poudre Valley	$637,822	$1,610,355	$2,248,177
University Hospital	$17,365,064	$18,164,981	$35,530,045
Total	**$43,507,541**	**$84,924,637**	**$128,432,178**

The proposed rule will also impact CICP payments to private-owned hospital providers, as there is fixed pool of General Fund available to fund current CICP payments. As more hospital providers are classified as private-owned, that fix pool of General Fund must be distributed over more providers. As large hospital providers, such as Denver Health Medical Center, Memorial Hospital, and University Hospital draw from that fix pool of General Fund, payments to other providers who are currently classified as private-owned must decrease. As such, payments to National Jewish Medical and Research Center, Parkview Medical Center, Platte Valley Medical Centers, San Luis Valley Medical Center, St Mary-Corwin Hospital, The Children's Hospital and all other private-owned hospital providers will decrease dramatically.

If all CICP providers were classified as private-owned and the entirety of $131.0 million in federal funds currently matched through CPE for was eliminated under the propose rule, payments to providers currently classified as public-owned would decease by an estimated 84.9% while payments to private-owned providers would decrease by an estimated 79.3%. The detail of this impact by provider using FY 05-06 payments as a proxy, is demonstrated in Table 1 of the attachment to this document.

Section 433.51 is revised

Overview Analysis: Basically, CMS is requiring that the Department have an approved form that documents the certification of public expenditures. There should be no fiscal impact. Any detail concerning the CPE process inferred from this regulation is provided in the analysis of another section of the rule.

PART 447 - PAYMENTS FOR SERVICES

Section 447.206 is added

Overview Analysis:

- 447.206 (c)(1). This general principle has been in place for many years, and enforced through the five financing questions the Department submits with each State Plan Amendment (SPA).

- 447.206 (c)(1) – (4). Historically, the Department has interpreted this to mean "reasonable cost" and has loosely provided a calculation of reasonable cost relative to the provider group. The Department has not based "reasonable cost" on information from the provider's Medicaid Cost Report in the past. CFR 92.22 defines Applicable Cost Principles. The new rule would limit the Department's ability to define "reasonable cost" and force the definition of cost to match the Medicaid Cost Report. The Department expects this portion of the rule to have any indeterminate impact, as the definition of cost using the Medicaid Cost Report is expected to be higher than the Department's current definition of "reasonable cost" but the result may vary by provider. However, the Department was already planning this action based on a recent CMS audit.

- 447.206 (c)(4). This would have an impact on School Based Providers. These providers currently use CPE, but no "Medicaid Cost Report" has been developed for this provider group. Even without this rule, the Department has been told by CMS that CPE for School Based Providers must reconcile to a cost report and the Department has been working on achieving this goal.

- 447.206 (d). Any payment that utilizes CPE must be based on a specific Cost Report. Historically, this has not been true for all of the Department's CPE payments. The Department believes that it may be prevented from using the CPE from one provider to support the payment of another provider (that is, pooling and redistributing upper payment limit funds). Overall, this requirement will not impact the aggregate of payments, but payments to some providers would decrease, as payments to others would increase.

  The Department would need to establish an initial rate, and then perform two reconciliations on that rate – an interim to the "as filed" Medicaid Cost Report and a final to the "audited" Medicaid Cost Report. "As filed" cost reports are available 6 months after the close of the providers fiscal year and the "audited" cost reports may not be available for several years following the payment. Performing these reconciliations would be burdensome on the Department and the providers. CMS should modify this rule and allow a payment and CPE based on a current, inflated cost report without any reconciliation process. Any changes to costs will be captured in future cost reports, which is the philosophy behind a prospective payment system. This draft rule forces all CPE payments to be retrospective, which the Department and Medicare have been attempting to eliminate over the years.

  The Department would need to submit a State Plan Amendment to change all the CPE payments to a cost-based payment methodology. Further, the payment methodologies for private-owned providers do not need to be cost based, so those calculations can remain the same but will now be different than the public-owned providers.

The Department submitted a CPE protocol and reconciliation process to CMS on October 2, 2006. The CPE protocol utilizes the health care provider's Medicare/Medicaid 2552-96 cost report for hospital providers and home health agencies and the Med-13 cost report for nursing facilities as supporting documentation for the CPE claimed by public-owned providers. The Department is currently responding to questions from CMS regarding this protocol and reconciliation process through a CMS request for additional information (RAI) for State Plan Amendment (SPA) TN 06-012.

The Department is working on developing a cost-based reimbursement for School Based Providers under the direction of CMS.

- 447.206 (e). This is a broad rule, and applies to ALL public-owned providers participating in Medicaid. Currently, not all public-owned providers participating in Medicaid have a "Medicaid Cost Report." Currently, the Department has identified that hospitals, nursing facilities, and home health agencies can provide a standardized Medicaid Cost Report. This rule will cause a burden on providers who may be considered public-owned, but do not produce a Medicaid Cost Report. Further, the Department has the responsibility to audit these cost reports. At this time, it is unknown what providers or groups of providers may be considered public-owned that will be impacted by this rule.

- 447.206 (f) and (g). Any payment over the provider's "cost" must be refunded to CMS. Historically, the Department has not refunded any FFP because the payment exceeded the provider's cost. There is a concern that the providers will need to start issuing refunds to the Department for overpayments, which will create additional accounting duties.

Section 447.207 is added

Overview Analysis: This proposed rule would eliminate the Department's ability to retain the federal match from the outpatient hospital, nursing facility, and home health public-owned upper payment limit (UPL) payments. The Department would need $13.8 million in General Fund to offset the elimination of this financing mechanism. The $13.8 million in federal funds could only be directed to hospital, nursing facility, and home health providers. This is no net gain to CMS under this rule, but a cost to the State and a potential gain to the providers.

Further, this rule may eliminate the Department's ability to retain 10% of the federal match in the School Based Program for administration. Under the Proposed Rule, all federal funds would have to be paid to the provider, so the Department's administration would need General Fund and a statute change to administer the program. The Department will analyze this further.

Section §447.271 is revised

The current rules states:

447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's

customary charges to the general public for the services.

(b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

Overview Analysis: The elimination of (b) will have an impact on School Based Providers. It appears that CMS does not like that the Department reimburses providers for services provided at no charge if those services are provided to a Medicaid client. CMS lost a decision before the Department of Health and Human Services' Departmental Appeal Board concerning "free care." This rule seems to be an attempt to reverse that DAB decision. This would cause a decrease to the federal payment to School Based Providers.

Section 447.272 is amended

Overview Analysis: The Department's current inpatient hospital and nursing facilities upper payment limit (UPL) calculations would need to revised for public-owned facilities and replaced with a UPL calculation that is provider specific and cost based. The Department expects this change to have an indeterminate impact, but have a positive impact on some specific providers. There is a concern that the UPL calculation will be different for public-owned and private-owned facilities.

Historically, the Department has not based "reasonable cost" on information from the provider's Medicare/Medicaid 2552-96 Cost Report. The proposed rule requires the UPL calculation for public-owned facilities and the calculation of CPE to be based on the provider's actual cost as reported in the Medicaid Cost Report. The proposed rule requires that in aggregate, Medicaid payments cannot exceed the UPL calculation or for a specific provider, the calculation of reasonable cost. As such, Denver Health Medical Center would not be able to receive a federal match on the SB 06-044 moneys through the Inpatient UPL (Major Teaching payment) as is being considered by the Department.

As shown in the table below, the Department expects this change to have an indeterminate impact, but have a positive impact on some specific providers.

Facility (FY 05-06 Data)	Uncompensated Inpatient UPL – Current Methodology	Uncompensated Inpatient UPL – Provider Costs, based on proposed rules
Denver Health Medical Center	$31,278,539	$46,484,439
University Hospital	$34,730,127	$27,367,670

Section 447.321 is amended

Overview Analysis: Same as Section 447.272. The Department's outpatient hospital UPL calculation will need to be revised for public-owned facilities and replaced with a UPL calculation that is provider specific and cost based. There is a concern that the UPL calculation will be different for public-owned and private-owned facilities. As shown in the table below, the Department expects this change to have an indeterminate impact, but have a positive impact on some specific providers.

Facility (FY 05-06 Data)	Uncompensated Outpatient UPL – Current Methodology	Uncompensated Outpatient UPL – Provider Costs, based on proposed rules
Denver Health Medical Center	$6,438,654	$7,454,247
University Hospital	$4,301,401	$6,901,745

PART 457- ALLOTMENTS AND GRANTS TO STATES

Section 457.220 is revised

Overview Analysis: Same as Section 433.51.

§457.628 is revised

Other regulations applicable to SCHIP programs include the following:

(a) HHS regulations in §433.50 through §433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider-Related Donations) and §447.207 of this chapter (Retention of payments) apply to States' SCHIPs in the same manner as they apply to States' Medicaid programs.

Overview Analysis: The Department does not use CPE under its SCHIP program (CHP+); therefore, there is no fiscal impact.

Attachment

Table 1

FY 2005-06 CICP Provider Payments

CICP Provider	FY 05-06 Total Payment Under Current Rules	FY 05-06 Total Payment Under Proposed Rules	Expected Actual Change in Total Payment	Expected Percent Change in Total Payment
Denver Health Medical Center	$75,698,495	$12,393,468	($63,305,027)	-83.6%
University Hospital	$35,551,623	$4,156,772	($31,394,851)	-88.3%
Arkansas Valley Regional Medical Center	$1,270,002	$207,878	($1,062,124)	-83.6%
Aspen Valley Hospital	$267,272	$43,808	($223,464)	-83.6%
Delta County Memorial Hospital	$353,596	$57,960	($295,636)	-83.6%
East Morgan County Hospital	$50,249	$8,236	($42,013)	-83.6%
Estes Park Medical Center	$158,248	$25,940	($132,308)	-83.6%
Gunnison Valley Hospital	$17,849	$2,926	($14,923)	-83.6%
Heart of the Rockies Regional Medical Center	$179,191	$29,372	($149,819)	-83.6%
Kremmling Memorial Hospital	$33,316	$5,462	($27,854)	-83.6%
Melissa Memorial Hospital	$21,275	$3,486	($17,789)	-83.6%
Memorial Hospital	$9,745,816	$1,597,462	($8,148,354)	-83.6%
Montrose Memorial Hospital	$532,292	$87,250	($445,042)	-83.6%
North Colorado Medical Center	$3,429,329	$562,110	($2,867,219)	-83.6%
Poudre Valley Hospital	$2,248,177	$368,504	($1,879,673)	-83.6%
Prowers Medical Center	$318,193	$52,158	($266,035)	-83.6%
Sedgwick County Memorial Hospital	$21,345	$3,498	($17,847)	-83.6%
Southeast Colorado Hospital and LTC	$42,136	$6,908	($35,228)	-83.6%
Southwest Memorial Hospital	$284,259	$46,596	($237,663)	-83.6%
Spanish Peaks Regional Health Center	$500,989	$104,982	($396,007)	-79.0%
St. Vincent General Hospital District	$39,349	$6,448	($32,901)	-83.6%
The Memorial Hospital	$129,139	$21,168	($107,971)	-83.6%
Wray Community District Hospital	$53,449	$8,762	($44,687)	-83.6%
Yuma District Hospital	$97,961	$16,058	($81,903)	-83.6%
Public Hospitals Total	**$131,043,550**	**$19,817,212**	**($111,226,338)**	**-84.9%**
Boulder Community Hospital	$867,186	$179,992	($687,194)	-79.2%
Colorado Plains Medical Center	$150,362	$31,210	($119,152)	-79.2%
Community Hospital	$96,714	$20,074	($76,640)	-79.2%
Conejos County Hospital	$111,704	$23,090	($88,614)	-79.3%
Exempla Lutheran Medical Center	$462,832	$96,064	($366,768)	-79.2%
Longmont United Hospital	$828,948	$172,056	($656,892)	-79.2%
McKee Medical Center	$1,390,956	$288,706	($1,102,250)	-79.2%
Mercy Medical Center	$519,774	$107,884	($411,890)	-79.2%
Mount San Rafael Hospital	$97,468	$20,228	($77,240)	-79.2%
National Jewish Medical and Research Center	$1,362,472	$282,452	($1,080,020)	-79.3%
Parkview Medical Center	$5,724,807	$1,187,222	($4,537,585)	-79.3%
Penrose-St. Francis HealthCare Systems	$2,156,552	$447,614	($1,708,938)	-79.2%
Platte Valley Medical Center	$2,105,606	$436,352	($1,669,254)	-79.3%
Rio Grande Hospital	$55,750	$11,574	($44,176)	-79.2%
San Luis Valley Regional Medical Center	$1,191,922	$246,678	($945,244)	-79.3%
St. Mary-Corwin Hospital	$3,547,650	$736,348	($2,811,302)	-79.2%
St. Mary's Hospital and Medical Center	$621,088	$128,912	($492,176)	-79.2%
St. Thomas More Hospital	$641,766	$133,202	($508,564)	-79.2%
Sterling Regional Medical Center	$272,414	$56,542	($215,872)	-79.2%
The Children's Hospital	$2,241,867	$463,174	($1,778,693)	-79.3%
Valley View Hospital	$451,063	$92,842	($358,221)	-79.4%
Yampa Valley Medical Center	$136,762	$28,386	($108,376)	-79.2%
Private Hospitals Total	**$25,035,663**	**$5,190,602**	**($19,845,061)**	**-79.3%**
All CICP Providers	**$156,079,213**	**$25,007,814**	**($131,071,399)**	**-84.0%**

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Impact of CMS Proposed Rules Concerning Changes to Medicaid Graduate Medical Education Reimbursement

CMS-2279-9
May 23, 2007 Federal Register

I. Summary

In the May 23, 2007 Federal Register, CMS issued a proposed rule (CMS - 2279 - P) that "would clarify that costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program." CMS states in the proposed rule that paying for GME activities is not allowable per the Medicaid statute since it is not included in the list of care and services that are within the scope of medical assistance under the Medicaid State plan.

II. Provisions of the Proposed Rule

A) Graduate Medical Education (GME) cannot be included as part of any payment methodology in the Medicaid State Plan.

B) Federal Financial Participation (FFP) is no longer available for reimbursement that includes or specifically pays for GME.

C) Medicare payment principles must exclude any Medicare payments associated with direct GME when calculating the Medicaid Upper Payment Limit (UPL).

D) Reimbursement to hospitals cannot include costs associated with GME.

E) CMS has stated that the proposed rule would have to be "implemented in the first full State fiscal year following the effective date of the subsequent final rule." A moratorium was recently passed that prevents this proposed rule from taking effect for one year.

III. Financial Impact of the Proposed Rule

The financial impact of this proposed rule has two main implications for the Colorado Medicaid program: (1) the inpatient and outpatient hospital reimbursement paid on a fee-for-service basis and (2) the calculation of the UPL.

A) Safety Net Financing Impact

The financial impact of this proposed rule was only determined for two hospitals, University Hospital and Denver Health Medical Center. These are the only two public hospitals that Medicare reimburses for Graduate Medical Education. Since these hospitals are public hospitals, they can certify their public expenditures. This rule may have a financial impact

on these hospitals since it will reduce their Inpatient Hospital Upper Payment Limit which in turn can eliminate or reduce Supplemental Medicaid payments made to these hospitals. The following table summarizes the financial impact using data from the Inpatient UPL for 2007.

	University Hospital	**Denver Health Medical Center**
Direct GME Payment (Worksheet E, Part A, Line 11)	$2,354,392	$988,459
Current UPL Including GME	$81,538,718	$103,792,706
Proposed UPL Excluding GME	$77,828,827	$98,467,791
Difference in UPL	**($3,709,891)**	**($5,324,915)**

This rule may also affect private hospitals' Inpatient Hospital Upper Payment Limits and therefore any Supplemental Medicaid Payments made to these private hospitals; however, this rule will have the biggest impact on University Hospital and Denver Health Medical Center.

The estimated loss to University Hospital and Denver Health Medical Center is $9,043,806 in total payments and $4,517,403 in federal funds.

B) Rates Impact

Currently, the Medicaid inpatient hospital base rates have a component associated with direct medical education costs. It is referred to as a GME add-on and is calculated for those hospitals that have a teaching program. The add-on is calculated from the Medicare cost report as a hospital's GME costs per discharge. Ten percent of the GME cost per discharge amount is added to that hospital's inpatient base rate. Out of the approximately eighty hospitals participating in Colorado Medicaid, nineteen are receiving a GME add-on for FY 07-08 inpatient hospital base rates.

Since the inpatient hospital rate methodology is tied to a budget neutrality calculation, removing the GME add-on would have a distributional impact of increasing the percent of the Medicare rate that EVERY hospital is receiving. Essentially, GME costs would be removed from those corresponding hospitals and the associated expenditures would then be distributed across all hospitals. The hospitals that would be the most negatively affected include National Jewish, St. Joseph's, Northern Colorado Medical Center, Denver Health Medical Center, The Children's Hospital, and University Hospital.

Using FY 05-06 inpatient hospital expenditures from *COLD Report M272700 – Provider Ranking by Payment List for the Period of 07/01/2005 - 06/30/2006,* each teaching hospital's total inpatient expenditures were multiplied by their GME percentage (the percent of the hospital base rate that is associated with the GME add-on). Since the GME add-on accounts for less than 1% of every GME participating hospital's inpatient base rate, a small percentage of TOTAL inpatient hospital expenditures are attributable to GME costs: $1,035,000 estimated for FY 05-06. The table below shows this calculation. If the GME add-on is

removed from the corresponding hospitals' inpatient base rates, that $1,035,000 would be redistributed among all hospitals as required under budget neutrality by an increased percent of the Medicare rate.

Hospital	FY 05-06 Inpatient Hospital GME Payments
SOUTHWEST	$1,277.35
WRAY	$316.43
COLUMBIA MED CTR OF AURORA	$543.06
COLUMBIA P/SL MED CTR	$50,159.53
COLUMBIA ROSE MED CTR	$37,055.29
DENVER HEALTH	$258,885.59
NATIONAL JEWISH	$463.32
NCMC	$59,788.38
NORTH SUBURBAN MED CTR	$1,205.29
PENROSE	$1,713.18
POUDRE VALLEY	$9,462.33
ST ANTHONY CENTRAL	$34,688.15
ST ANTHONY NORTH	$5,947.79
ST JOSEPH-DENVER	$44,290.36
ST MARY CORWIN	$21,863.97
ST MARY'S G J	$26,080.46
SWEDISH	$12,859.38
UNIVERSITY HOSPITAL	$197,764.14
CHILDREN'S HOSPITAL	$267,113.89
CRAIG REHAB HOSP.	$3,212.30
TOTAL	**$1,034,690.21**

Outpatient hospital reimbursement would also be impacted since GME costs are currently considered allowable and factored in during the cost settlement process. In order to determine the financial impact, the Department's contractor, Parrish, Moody, & Fikes would need to analyze the hospitals' GME outpatient costs and how it would affect the cost settlement process. Currently, IME is not included in the outpatient cost settlement as an allowable cost. The Department could potentially look into removing GME outpatient costs and including IME outpatient costs. IME is a component of the inpatient hospital base rates since it is part of the Medicare PPS rate.

Additionally, all participating teaching hospitals receive a quarterly GME payment based on the inpatient managed care days and outpatient managed care clients they serve. GME is currently being "carved out" of the managed care rates paid to Medicaid participating HMO's. The Department determines what each hospital's associated GME costs were for seeing managed care clients, and then reimburses the hospitals for that amount based on GME data from the most recently audited Medicare/Medicaid cost report. Over the past

year, the Department paid an average of $662,788 per quarter for GME costs associated with managed care inpatient days and outpatient charges for Medicaid clients. The majority of that amount was paid to The Children's Hospital, Denver Health Medical Center, and University Hospital. These three hospitals average over 75% of the quarterly GME payment based on managed care data. If the proposed CMS rule becomes final, these payments could no longer be made to teaching hospitals.

Further, Medicaid payments to resident teaching programs would lose the federal match. The Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program and providing physician services to Medicaid clients. The Advisory Commission on Family Medicine in the Department of Higher Education, Health Sciences Center administers the program. For FY 08-09 the total payment was $2,189,542. Under the proposed rule there would lose of $1,094,771 in federal funds.

IV. Summary of Impact

Modification to the Inpatient UPL: The estimated loss to University Hospital and Denver Health Medical Center is $9,043,806 in total payments and $4,517,403 in federal funds.

Inpatient Hospital Payments: The estimated loss to graduate medical teaching hospitals is $517,500 in federal funds.

Outpatient Hospital Payments: Not measured, as GME costs are currently considered allowable and factored in during the cost settlement process.

Medicaid GME Payments for Inpatient and Outpatient HMO Services: The estimated loss to providers, primarily The Children's Hospital, Denver Health Medical Center, and University Hospital, is $1,325,556 in federal funds.

Medicaid payments to resident teaching programs: The estimated loss to Family Medicine Residency Training Programs is $1,094,771 in federal funds.

The total expected loss to funding to providers is $11,981,633. This estimate excludes the federal funds to Outpatient Hospital providers, which has not been measured.

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

Impact of CMS Proposed Rules Concerning Coverage for Rehabilitative Services

CMS-2261-P

Basis of Rule: The proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers. The proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused on social or educational development goals in programs other than Medicaid.

The rule imposes the following changes, burdens and limitations on the School Health Services Program providers:

- Defines "qualified providers of rehabilitative services" to require that individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories.
- Requires that covered rehabilitative services for each individual be identified under a written rehabilitation plan, which includes specific treatment goals and is re-evaluated at least yearly.
- Requires that the written rehab plan include the active participation of the individual (or the individual's authorized health care decision maker) in the development, review, and reevaluation of the rehab goals and services.
- Requires that a *comprehensive* assessment of the individual's needs be included in the rehabilitation plan.
- Requires that the provider maintain case records (that include rehab plan) of the specific details regarding the individual, rehab service provided and the progress made toward functional improvement and attainment of the individual's goals. A revised plan is required if current plan does not demonstrate effectiveness in restoring the individual's functional level or reducing their disability within a year.
- Excludes FFP for expenditures for "habilitation services," including those provided to individuals with mental retardation or related conditions.
- Clarifies that habilitation services help individuals acquire new functional abilities rather than focus on restoring any lost function.
- Only permit recreational and social activities that are specifically focused on the improvement of physical or mental health impairment and achievement of a defined rehabilitation goal specified in the rehabilitation plan.
- Clarifies Medicaid reimbursement rules to allow coverage of non-Medicaid eligible parents and other individuals involved in a Medicaid beneficiary's treatment plan, e.g., for family counseling purposes

Concerns regarding imposed changes and restrictions of rule:

1. Burden of increased time and effort required to develop rehabilitation plan, document comprehensive assessments/periodic reassessments, and maintenance of case records. This appears to be a duplication of documentation for the IEP and 504 plans.
2. Potential reduction in reimbursement for rehab services in the schools based on the clarifying definitions of habilitation and rehabilitation services, and the limitation imposed on recreational and social activities of students with mental retardation or illness.

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Impact of CMS Proposed Rules Concerning the Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School

CMS-2287-F
December 28, 2007 Federal Register

Basis of Rule: *Rule was based on a determination that administrative activities performed by schools, and transportation of school-age children from home to school and back, are not necessary for proper and efficient administration of the State Medicaid plan, and are not within the scope of the transportation services recognized by the Secretary under 42 C.F.R. 440.170 (a), for the following reasons:*

1. *The activities or services support the educational program and do not specifically benefit the Medicaid program;*
2. *The activities or services are performed by school systems to further their educational mission and/or to meet requirements under the IDEA, even in the absence of any Medicaid payment;*
3. *The types of school-based administrative activities for which claims are submitted to Medicaid largely overlap with educational activities that do not directly benefit the Medicaid program; and*
4. *Transportation from home to school and back is not properly characterized as transportation to or from a medical provider.*

Under the rule, the following changes would apply to the costs of the following activities or services:

- *Federal Financial Participation (FFP) would no longer be available for the costs of school-based administrative activities under Medicaid. By administrative activities, we referred to activities that are not properly included in the scope of the covered service.*
- *FFP would no longer be available for the costs of transportation from home to school and back for school-age children with an IEP or IFSP established pursuant to the IDEA.*

Under the rule, CMS would continue to reimburse States for transportation and administrative costs related to:

- *Children who are not yet school-age and are being transported from home to another location, including a school, and back to receive direct medical services, as long as the visit does not include an educational component or any activity unrelated to the covered direct medical service.*

- *Transportation of school-aged children from school or home to a non-school-based direct medical service provider that bills under the Medicaid program, or from the non-school-based provider to school or home.*
- *Federal funding would continue to be available for administrative overhead costs that are integral to, or an extension of, a direct medical service and, as such, are claimed as medical assistance.*
- *School-based administrative activities, such as Medicaid outreach and eligibility intake, that are conducted by employees of the State or local Medicaid agency would remain eligible for FFP.*

Colorado's School Health Services Program does not currently reimburse providers for administrative services and will not be impacted by the elimination of FFP for administrative activities. However, current rules for the program allow participating school districts to claim for transportation services "when provided to and from the client's place of residence and the school and or to and from the site of service on the day a Medicaid covered service is provided".

Transportation claiming data for FY 06 and FY 07 is as follows:

FY	# of Unduplicated Students	Reimbursed Claim Amount
05-06	2,131	$1,544,408.59
06-07	2,178	$1,446,645.17

It is important to note that while some students are occasionally transported to an off-site location for treatment, the vast majority of services are provided by the district at the school-aged student's school site. As such, CMS' rule 2287 will have a significant financial impact on the reimbursement to participating school districts currently claiming for transporting students to school when a Medicaid service is rendered.

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Impact of CMS Proposed Rules Concerning Optional State Plan Case Management

CMS-2237-IFC (Interim Final Rule)

Rule Status: Current effective date of March 4, 2008, with comment period until February 4, 2008. The "one case manager" component of rule has a delayed compliance date of "the lesser of 2 years or 1 year after the close of the first regular session of the State Legislature that begins after this regulation becomes final".

Basis of Rule: This rule "*clarifies the situation in which Medicaid will pay for case management activities and also clarifies when payment will not be consistent with proper and efficient operation of the Medicaid program, and is not available*". Rule also implements changes made by the Deficit Reduction Act (DRA) of 2005, which redefined the term "case management services".

The rule imposes the following changes, burdens and limitations on the School Health Services Program providers:

- Specifies that case management activities include a *comprehensive* assessment and, at minimum, an annual reassessment.
- Specifies the development and periodic revision of a specific and comprehensive care plan based on information collected through assessment or reassessment.
- Requires that case management providers maintain case records that document specific information on individual, case management services and coordination activities.
- Individuals must be given free choice of case management providers and option to decline case management services. Option to decline services listed in care plan must be documented in individual's case notes.
- Requires case management services be provided by a single Medicaid case management provider on a one-to-one basis to eligible individuals.
- Provision added which clarifies that effective case management of eligible individuals may require some contact with non-eligible individuals. Contacts with non-eligible individuals for purpose of helping the Medicaid client gain access to services can be covered by Medicaid.
- Providers of case management services are permitted from serving as gatekeepers under Medicaid. Case managers may not authorize or deny the provision of other services under the plan for the individual.
- Specifies that case management benefit does not include, and FFP is not available for activities that are an integral component of another covered Medicaid service.

- Specifies that case management activities would not include administrative functions and activities required by IDEA, such as IEP development, review and implementation; scheduling IEP/IFSP team meetings; providing meeting notices to parents; and attending or conducting IEP/IFSP meetings.
- Clarifies that FFP is not available for any case management activities not included in an IEP or IFSP but performed solely based on obligations under section 504 of the Rehabilitation Act to ensure equal access to the educational program or activity.

Colorado's School Health Services Program concerns regarding imposed changes and restrictions of rule:

1. Burden of increased time and effort required to document comprehensive assessments/periodic reassessments, detailed care plan and maintenance of case records.
2. SHS Program providers no longer able to claim for IEP planning, development and IEP team meetings.
3. Rule disallows the provision of case management for students with a 504 plan.
4. Expectation that school case managers have the time and resources to proactively communicate to potential community providers that he/she is the designated case manager for student. HIPAA and Family Educational Rights and Privacy Act (FERPA) regulations will increase the difficulty of coordinating with community provider services provided to students.
5. Colorado schools do not have the capability to determine whether a child received case management outside of the school system.
6. The rule limits targeted case management in the school setting to only those students where such services are prescribed on an IEP or IFSP. CMS' position is that Section 1903c of the Social Security Act only authorizes Title XIX funding for Medicaid services to kids with disabilities because the services are included in the IEP/IFSP. CMS is currently restricting all Medicaid services provided in the school setting to kids with services prescribed in an IEP or IFSP. The rule also eliminates reimbursement for IEP/IFSP planning and development. Schools currently are reimbursed for these activities under targeted case management.

General Medicaid Program concerns regarding imposed changes and restrictions of rule:

1. Currently, targeted case management is billed with one code (T1017) that represents a 15-minute time unit. We anticipate this would require billing changes in MMIS.
2. The one case manager rule will create the need to make system changes to unbundle. This may impact overall cost in terms of actual service provided as well as the additional impact on auditing targeted case management billing.
3. One case manager is problematic when programs overlap. It does not seem logical that a single case manager can effectively coordinate services amongst different

professional disciplines while staying abreast of the many state and federal rules governing various programs. This may impact the quality and quantity of services received by the client. It seems reasonable that there could be a lead or primary case manager that could be differentiated by a varying rate from that of a case manager providing ancillary support.

4. CMS is proposing the client can refuse case management services. This is contradictory to the CMS requirement that a care plan must be developed for each client, which is a case management function. In addition, current standards in the DD Waivers require case management activity at a minimum of every other month with additional requirements in terms of face-to-face monitoring. Rules and Standards would need to be changed, including DHS Rule 16.400 for the Developmental Disability Waivers.
5. Providers would be expected to proactively communicate their status as the targeted case manager to other providers in order to coordinate and facilitate care for the client. However, HIPAA and other client privacy rules require a release from the client. This creates a barrier to care coordination for the client.

Concerns Submitted by Child Welfare
Cheryl Duncan, Child Welfare Budget Manager
Colorado Department of Human Services

On December 4, the Centers for Medicare and Medicaid Services (CMS) published interim final rules regarding case management and targeted case management. CMS claims that the rules are necessary to implement changes in the Medicaid statute that were made in the Deficit Reduction Act of 2005 (DRA). In fact, the rules make changes that go well beyond what Congress intended in the DRA. Implementation of the rules would have a detrimental impact on Medicaid beneficiaries, particularly beneficiaries who have physical or mental disabilities or chronic health conditions, by:

- Limiting case management services that are necessary to assist Medicaid beneficiaries in making successful transitions from institutional care to the community;
- Putting significant restrictions on case management services for children in foster care that would force states to provide services in a fragmented and inefficient manner;
- Restricting case management services for children with disabilities who need case management in order to receive a free and appropriate public education; and
- Limiting state flexibility to provide and pay for case management services in the way that would work best for beneficiaries.

According to CMS, the interim final rules would save $1.28 billion over five years, an impact well above the $760 million in savings projected by CBO when scoring the policy changes enacted by Congress in the DRA. This difference in the estimated impact on Medicaid spending

itself is one indication that the rules go beyond what Congress intended. The discussion below shows how the rules go farther and how the resulting cuts in funding for case management will affect Medicaid beneficiaries.

Background

In the Medicaid program, states may offer case management to adult Medicaid beneficiaries who need it and must provide it to child beneficiaries who need it.[1] States can target case management for particular beneficiaries based on their health care condition or where they live. When case management is designed for a specific group of beneficiaries, it is called targeted case management (TCM).

In enacting the Deficit Reduction Act, Congress made changes in the case management benefit, but the definition of the benefit did not change. Case management is defined as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services."

The DRA includes specific provisions regarding what services may be included in case management, such as assessment of the beneficiary's needs, development of a care plan, referral to other services, and monitoring and follow-up activities. The DRA also includes some clarifications on the scope of the benefit:

- Case management includes contacts with individuals who are not eligible for Medicaid when necessary to manage the care of the individual who is receiving case management services, but it does not include management of the ineligible individual's own needs;
- Case management does not include the direct delivery of a medical, social, educational or other service to which the individual is referred; the DRA includes a list of foster care services such as home investigations, transportation and arranging foster care placements as examples of services that are excluded;
- Federal funds are not available for case management if a third party is liable to pay for the service.

The Interim Final Rules Go Well Beyond the DRA

The rules issued by CMS include provisions that incorporate the changes and clarifications in the DRA, but they also go beyond what Congress required and intended. For example:

The rule limits case management services that are necessary to assist Medicaid beneficiaries moving from institutional care to the community: Current Medicaid policy allows states to provide TCM to assist in a transition of a Medicaid beneficiary from an institution to the community. Federal reimbursement is available for case management provided for up to the last

[1] Under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, states must provide all medically necessary services to children that can be covered under Medicaid.

180 days of the stay in the institution. This policy was issued in 2000 in response to the U.S. Supreme Court's *Olmstead* decision, which found that the Americans with Disabilities Act requires states to provide services in the most integrated community settings that are appropriate to beneficiaries' needs.[2]

The interim final rules significantly restrict this policy. Under the rules, federal matching funds would only be available for case management provided during the last 60 days of a stay in an institution that lasts 180 days or more and for only the last 14 days of a stay that lasts less than 180 days. These time periods will be insufficient for many people, especially those with complex health care needs, to complete a successful transition to the community.

Moreover, the rules would prohibit payment until an individual is actually living in the community. This policy would mean that some providers would be unable to deliver transition services, because they lack the financial capacity to wait for payment and they cannot take the risk that they will not be paid at all if the individual is unable to complete the transition to the community.

These limitations on case management would seriously undermine the "Money Follows the Person" demonstration, which is specifically intended to support efforts to move Medicaid beneficiaries from institutions to the community — and which was ironically a centerpiece of the President's *New Freedom Initiative*. Some state "Money Follows the Person" demonstration programs are allowing up to 180 days for case management services, as provided for under current federal Medicaid policy.

The rule puts significant restrictions on case management services for children in foster care. As noted above, the DRA includes a list of activities that may not be included in case management under Medicaid, because they are services that are part of the foster care services delivered by child welfare agencies. The interim final rules go substantially farther and would prohibit federal Medicaid funds for *all* case management services provided by child welfare and child protective services agencies and contractors of these agencies, regardless of whether the contractors are qualified Medicaid providers.

On April 5, 2006, Senator Charles Grassley (R-Iowa), then chair of the Senate Finance Committee, wrote a letter to Mike Leavitt, Secretary of the U.S. Department of Health and Human Services, to explain what Congress intended in the DRA in order to provide guidance to CMS on implementation of the case management provision. He wrote: "[Case management] services, which the Congress intended would be appropriately considered a Medicaid expense, are particularly important to children in foster care. These are children who have multiple social, educational, nutritional, medical and other needs." The letter cautions the Secretary that the "disallowance of reimbursement under Medicaid for services specified in the DRA for TCM for children in foster care. . . is in direct contradiction to Congressional intent."

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[2] Olmstead Update No. 3 issued by Health Care Financing Administration (precursor to CMS) on July 25, 2000.

According to the preamble to the interim final rules, case management services would be available to children in foster care only if they were provided by a Medicaid provider operating *outside* the child welfare system. As noted, the rule prohibits payment for case management services by child welfare agency workers or by any other provider that contracts with a state's child welfare agency. By restricting case management services in this way, the rules would force states to fragment services to children in foster care, a result directly contrary to the purpose of the case management benefit, which is to coordinate the medical, social and educational services that children in foster care need.

Almost half of all children in foster care have a disability or chronic medical problem, and up to 80 percent have serious emotional problems.[3] While the DRA was intended to restrict states from using the case management benefit to provide foster care services themselves, Senator Grassley's letter makes it clear that Congress did *not* intend to restrict case management services necessary to *coordinate* a child's medical, social, and educational services when coordination of these services is necessary to address a child's physical or mental health condition.

The rule would restrict case management services provided to children in school settings. As mentioned above, all children in Medicaid are eligible for case management services when the services are medically necessary. Some states provide medically necessary case management services to children with disabilities in school settings to ensure that they can receive a free and appropriate public education. The interim final rules would allow the provision of case management for children with disabilities in schools only when case management is designated as a required service in the child's Individualized Education Program (IEP) or an infant or toddler's Individualized Family Service Plan (IFSP). The rule specifically disallows the provision of case management when it is part of a child's plan under Section 504 of the Rehabilitation Act.[4] (Section 504 prohibits the denial of a free and appropriate education for children with disabilities regardless of whether a child is receiving special education services under the Individuals with Disabilities Education Act (IDEA).)

The rule takes away state flexibility to efficiently manage the Medicaid program. A central tenet of the federal-state partnership to operate Medicaid is that states must follow federal guidelines but retain broad flexibility in establishing payment rates and determining payment policies. Disregarding this tenet, the rules arbitrarily restrict state flexibility to determine payment methodologies in a way that could make Medicaid payments less efficient.

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[3] Studies cited in D. Rubin et al., "The Deficit Reduction Act of 2005: Implications for Children Receiving Child Welfare Services, Casey Family Programs, Washington, DC, December 2006.

[4] This appears to be a change from current policy. The Colorado state Medicaid plan includes case management for children with a Section 504 plan who have a disability and are medically at risk. http://www.chcpf.state.co.us/HCPF/State%20Plan/State%20Plan%20Files/Sup%201A%20to%203%201-A%20TN95003.pdf

The rules would prohibit states from making fee-for-service payments for case management services in any way other than paying for units of service that do not exceed 15 minutes. States often use case rates, per diem rates, or other payment methodologies to pay for case management. The highly prescriptive approach in the rules will make it difficult or impossible for states to provide case management as part of assertive community treatment (ACT), a comprehensive, evidence-based treatment program for people with serious mental illness programs that provides services 24 hours a day and 7 days a week. Paying for case management services on the basis of 15-minute increments would not work for programs like ACT where case managers must be on-call and ready to respond at all times.

The rules would also limit state flexibility by prohibiting a state from providing a beneficiary with more than one case manager even when the complexity of the beneficiary's condition demands the expertise of more than one program. In most cases, having one case manager would be beneficial to avoid duplication. But, if a beneficiary has multiple conditions — for example HIV/AIDS, mental illness and an intellectual disability — no one case manager may be able to coordinate housing, health care, and social needs across multiple systems.

Summary

It appears that the interim final rule does not just apply to Target Case Management (TCM), but also applies to Administrative Case Management (ACM). CMS indicates in the interim rule that Case Management services must be provided by a single Medicaid case management provider. This will have a negative impact in Medicaid funding for ACM activities performed by County Child Welfare/Core Services workers. The current SFY 2008 ACM Medicaid appropriation for Child Welfare/Core Services is $1,617,528, of which 50% is federal Medicaid ($808,764). However, Child Welfare and Core Services actual ACM expenditures are expected to be $3.7 million in SFY 2008. (*Child Welfare provides additional General Fund to claim the additional Medicaid).* If the rule is implemented for ACM by April 1, 2008, it is estimated that approximately $462,500 in Medicaid funding for Child Welfare related ACM costs would no longer be reimbursable for SFY 2008, and $1,850,000 for SFY 2009.

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Impact of CMS Proposed Rules Concerning Revisions to Departmental Appeals Board and Other Departmental Hearings

Basis of Rule: This proposed regulation would impact any appeal that the Department filed to challenge a disallowance or the imposition of a civil money penalty. As a result, impacts the Department with respect to decisions made by CMS, for example, for disallowances of FFP or for civil money penalties that CMS may impose on HCPF.

The rules change the procedures that would govern appeals. There are a couple of significant changes which are cause for concern. The Departmental Appeals Board (DAB) currently has final review authority over a number of disputes between states and CMS. These rules would change that.

The proposed rule change limits the DAB's independence from CMS in a couple of major ways. Currently, the DAB hears an appeal and issues a decision. The DAB in the past and currently has functioned as an independent decision-maker and was not bound by CMS' interpretations. The first issue with the proposed rule change is that it would limit the discretion of the DAB significantly. It would require the DAB to follow all "published guidance" of CMS that is not inconsistent with statute or regulation in its application of the rules to the matter in dispute.

By requiring the DAB to follow all published guidance, the new rules require the DAB to follow State Medicaid Director letters, the State Medicaid Manual, guidelines published on the CMS website, and all other documents that CMS decides to send out - most of which are not subject to the rule-making process, including the opportunity for notice, public comment and a hearing. The new rule effectively severely limits the DAB's ability to interpret regulations in the manner that it sees fit, and rather, will restrict the DAB's decisions to an application of any and all writings that CMS has issued that are not inconsistent with the rule or statute at issue. Additionally there is language in the background information for the proposed rule (although not specifically incorporated into the proposed language for the rule change) that the DAB should consider persuasive CMS' unpublished positions, where there is no "published" CMS guidance.

At the most extreme, the DAB could be forced to consider as persuasive a CMS argument based on a position that it took with respect to one state, and which no one else may have known about. As a result, the rules strictly bind the hands of the DAB and open the door to a CMS argument of, "It's a disallowance because we say it should be." The new rules could prevent a state from making any arguments based on fairness or at the extreme, the rule could limit a state from making any arguments other than those based on the inapplicability of the CMS rule at issue.

The second major proposed change involves the procedural process of an appeal. Currently, the DAB issues a final decision that the Department or another state could appeal through judicial review. The proposed rule change would modify the process, and allow the Secretary of Health and Human Services to review the DAB's decision and issue a final agency decision. The review

6. The Secretary's record review exists only to nullify the DAB's fact findings or legal conclusions where the Secretary so chooses. As a result, the Secretary's discretionary review nullifies the import of any DAB decision.
7. Assuming that the Secretary's review may result in a greater proportion of decisions in favor of CMS, the process becomes biased more in favor of CMS and becomes less favorable to the States.
8. Assuming the Secretary's review may result in a greater proportion of decisions in favor of CMS, the likelihood that a State will seek judicial review increases. As a result, the longer process will be more expensive for a State to litigate an issue.