



Minnesota Department of **Human Services**

February 15, 2008

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

Dear Chairman Waxman:

This is in response to your request of January 16, 2008. Thank you for the opportunity to share with you the impact the Centers for Medicare & Medicaid Services' (CMS) regulatory changes will have on Minnesota, our health care programs and our most vulnerable populations. We have significant concerns with all of the rules you have highlighted in your request. A common frustration with the proposed regulatory changes is the unnecessarily disruptive effect they will have on our beneficiaries and our health care programs.

Implementation of these rules will limit state flexibility to implement or maintain effective and innovative models of care, require us to fragment integrated care programs, and significantly increase the administrative complexity and therefore cost of our Medicaid program. In issuing the rules, CMS cites the need to protect the fiscal integrity of the federal commitment to Medicaid. Ironically, many of the agency's proposals will actually result in special needs populations receiving less effective models of care at increased state and federal cost.

It is also important to note that there is no definitive interpretation of the actual meaning, application or scope of the new policies implemented by these regulatory changes. In many cases the agency interpretation of a regulatory change outlines a policy that is larger in scope than the actual regulatory text could reasonably be read. In other cases, the regulatory text has been written so broadly and vaguely that it offers no security for states that attempt to comply with the rules. These ambiguities and outright contradictions mean that states cannot be certain what the ultimate fiscal and beneficiary impacts of their implementation would be. In the summaries below we have attempted to quantify the identifiable effects of the regulatory provisions based on what we consider to be a reasonable interpretation of the rules. However, if the agency ultimately exercises a broader interpretation, the fiscal impacts and disruptive effects on our beneficiaries and programs of care would be much more severe.

Cost Limit Rule CMS-2258-FC

State Fiscal Impacts – Implementation of this rule will result in significant loss of FFP in Minnesota. The provisions of this rule, when taken together, could virtually eliminate the ability of local governments that are also providers of health care services, to participate in the financing of the Medicaid program.

We also anticipate, but cannot yet quantify, a significant increase in administrative costs as we seek to determine provider costs in order to ensure that Medicaid payments to government-owned providers are limited to costs. This will be particularly burdensome for outpatient providers as CMS intends to require detailed time studies as the mechanism for determining Medicaid's share of each provider's costs. CMS' estimate that limiting payments to public providers to costs will result in savings is particularly puzzling given that cost-based payment systems were determined to be inefficient and abandoned by most payers over 20 years ago.

Beneficiary Impacts – Local government providers make up a significant portion of Minnesota's safety net for mental health and long term care services. The payment limits and cost documentation requirements for payments associated with local governments proposed in this rule impose an undue burden on states with large rural populations where local governments may serve as the only option to ensure access to needed care.

We estimate that this rule could result in the loss of about \$50 million in FFP per year.

Proposed Rule	SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 08-12
Cost Limit Rule	\$50.5	\$55.7	\$56.0	\$56.3	\$56.6	\$275.1

GME CMS-2279-P

State Fiscal Impact – Minnesota devotes significant resources to ensuring an adequate supply of well-trained practitioners which includes a commitment to support medical training programs. Graduate medical education is a real cost that should be recognized by Medicare and Medicaid.

Beneficiary Impacts – Medicaid beneficiaries are best served when there is an adequate supply of medical practitioners. Because Medicaid payment rates are generally below those of Medicare and private plans, any shortfall in the provider workforce would likely be felt first by our most vulnerable population. In addition, Title XIX imposes responsibility on states to ensure access to care. Prudent funding of GME is an important part of meeting that responsibility.

We estimate that the implementation of this rule would result in the loss of over \$47 million per year in federal funding for graduate medical education in Medicaid.

Provision	SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 08-12
Eliminate FFP for GME Costs in Medicaid	\$42.0	\$47.3	\$47.6	\$47.9	\$48.2	\$233.0

Definition of Outpatient Hospital Services CMS-2213-P

State Fiscal Impacts – We have not identified any significant loss of federal funding from this rule to date. We remain concerned about the potential for the new requirements regarding the calculation of the upper payment limits to generate new and unnecessary administrative costs.

Beneficiary Impacts – The requirement that Medicaid programs standardize to the Medicare benefit and create mutually exclusive Medicaid categories of services would create a number of new problems. First, in a general sense, overlap between the various Medicaid mandatory and optional benefits is inherent in the medical system, inherent in the structure of Title XIX, and necessary to ensure access to care. For example, routine non-surgical dental services can be provided in a clinic setting for the majority of Medicaid recipients. However, developmentally disabled individuals or those with severe physical disabilities (such as those using ventilators) often need to be anesthetized and carefully monitored whenever any dental work is performed. Given the complexities involved in providing care to these special needs populations, it would be medically irresponsible to perform even routine dental procedures in a non-hospital setting. When medical necessity requires the resources of an outpatient hospital setting, payment commensurate with the use of those resources is appropriate even if the procedure is more commonly performed in a less intensive setting. However, Medicaid programs that allow such treatment decisions to be dictated by medical necessity and the best interest of the patients rather than fiscal incentives would be disadvantaged under this rule.

Provider Taxes CMS-2275-P

State Fiscal Impacts – CMS is proposing to significantly broaden the scope of the hold harmless provisions, and fundamentally alter the standards by which compliance with those provisions will be determined. CMS' changes to the interpretation of the hold harmless regulatory provisions are so over-broad that no state could ever be assured that even longstanding tax programs would not be found to be in violation of the new interpretations. This state of perpetual uncertainty means that all revenues raised with provider taxes are at risk for disallowance.

Beneficiary Impacts – This rule has the potential to completely eliminate the funding currently generated from Minnesota's longstanding provider taxes. Those revenues represent a significant part of the funding for our Medicaid programs.

Because of the ambiguity surrounding the interpretation of the hold harmless provision of this rule, we cannot quantify the fiscal impact.

Rehabilitative Services CMS-2261-P

State Fiscal Impacts – We believe that this rule will have fiscal impacts due to the provision prohibiting coverage for services that are deemed by CMS to be “intrinsic elements” of other programs and due to the new and more restrictive definition of a provider of rehab services. We cannot quantify those impacts due to the uncertainty of how these rules will be applied. We also anticipate increased state and federal costs as a result of CMS' prohibition on “bundled” payment rates. Minnesota currently pays a daily or monthly rate based on total program costs for certain community mental health programs under the rehab option. CMS policy would force us to disaggregate those rates and pay in 15 minute increments for each individual staff person within a program. We anticipate that this will increase both costs and administrative burden.

Beneficiary Impacts – Some of the provisions in this rule are helpful and will ensure that cases are adequately monitored and tracked for quality, effectiveness and outcomes. However, if the provider

qualification provisions are applied in a literal manner, access to many of our behavioral and chemical health programs could be affected. In addition, the prohibition on ‘bundled’ rates has the potential to make the provision of community-based mental health services administratively unfeasible and could result in reduced access to these necessary programs.

School-based Administrative Services CMS-2287-F

State Fiscal Impacts – Implementation of this rule would result in the loss of about \$10 million in FFP per year.

Beneficiary Impacts – Currently, Minnesota schools provide outreach, referral and coordination services so that a single manager is responsible for meeting medical, social, and educational needs for each child. With the loss of FFP, children and families will be faced with a return to the “silo” approach to meeting needs. The loss of schools as a locus for Medicaid enrollment will also result in many missed opportunities to identify and enroll Medicaid eligible children and families. Regarding transportation, this is simply a cost-shift to states.

Provision	SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 08-12
Elimination of school admin	-	\$7.7	\$8.1	\$8.5	\$8.9	\$33.2
Elimination of school transportation	-	\$1.6	\$1.7	\$1.8	\$1.9	\$6.9
	-	\$9.3	\$9.8	\$10.3	\$10.8	\$40.1

Targeted Case Management CMS-2237-IFC

State Fiscal Impacts – There is so much ambiguity in this rule that we have had a difficult time estimating the potential effects. There are two provisions which seem fairly clear; 1) child welfare workers will no longer be allowed to provide Medicaid case management services and; 2) the time frames for transitioning beneficiaries out of institutional settings will be restricted.

The implementation of this rule will result in a significant loss in FFP as we will not longer be able to claim federal match on the case management services that are currently provided by child welfare workers to our at risk children. The rule will also create enormous disruptions to our waiver and integrated care programs. In addition, if the provisions of the rule are applied as broadly as CMS staff have indicated they will be, we will have to completely redesign all of our case management service programs, all of our waiver programs, our qualification requirements for case managers, and our claims systems.

Beneficiary Impacts – Again the ambiguity surrounding the interpretation, application and scope of this rule makes it difficult to project the effects the rule will have on beneficiaries. However, it is clear that process of transitioning consumers from institutional settings back into the community will be much more difficult if this rule is implemented.

We are also concerned about the impacts of the “one case manager” requirement. Congress recognized when it authorized the targeted case management benefit that there can be discrete subpopulations that have a unique set of shared needs. The “one case manager” requirement assumes either that beneficiaries would never fit into more than one targeted group or that case manager qualifications are

generic and never tailored to the specific needs of any targeted group. This simply isn't the reality. We are very concerned about the impact this requirement will have on our beneficiaries with multiple special needs.

Finally we believe that this rule creates considerable uncertainty around the process states use to monitor the health and safety of Medicaid waiver enrollees.

The estimates below are based on the loss of FFP associated with child welfare case management and the limitations on relocation coordination services. We expect significant additional losses as CMS fully implements this rule.

Provision	SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 08-12
Direct Care (441.18(c)(2))	\$7.5	\$45.8	\$48.1	50.3	\$52.8	\$204.5
Institutional Discharge (440.169)	\$1.2	\$1.2	\$1.2	\$1.2	\$1.2	\$6.0
	\$8.7	\$47.0	\$49.3	\$51.5	\$51.5	\$210.5

Changes to the Departmental Appeals Board Rules

Although you did not specifically highlight CMS' proposal to change the operation of the Departmental Appeals Board (DAB) in your request, we would like to share with you our concerns regarding this rule as well.

CMS has proposed to undermine the impartiality and independence of the Board by requiring it to defer to all agency interpretations of policy (including litigation positions) that are not in direct conflict with statute, even when those interpretations have not been disseminated or properly noticed. The rule would also provide for Secretarial review of all Board decisions. These changes would virtually ensure that the agency would prevail in every case with the result that states would have to appeal to the courts to prevail in even minor disagreements. This is not a fair, efficient or appropriate method for settling disputes between CMS and the states.

The very existence of an impartial review board serves to curb potential agency excesses by requiring the agency to develop at least a *pro forma* legal argument in support of its actions. The existence of an independent board also serves as an incentive for both states and the agency to settle rather than litigate many of the more minor disputes over policy and process. Eliminating this check on the agency will allow even more fearless decision-making by CMS leadership.

I hope this information helps in your evaluation of the proposed regulations. If you have any questions please contact Ann Berg, at (651) 431-2193.

Sincerely,



Christine Bronson
Medicaid Director

CMS Proposed Regulations: Fiscal Impacts to Minnesota
(Loss in FFP in millions)

CMS Regulation (\$ in millions)	SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 08- 12
Cost Limit (CMS-2258-FC)	\$50.5	\$55.7	\$56.0	\$56.3	\$56.6	\$275.1
GME (CMS-2279-P)	\$42.0	\$47.3	\$47.6	\$47.9	\$48.2	\$233.0
Definition Outpatient Hosp. (CMS-2213-P)	Not Quantifiable					
Provider Tax (CMS-2275-P)	Not Quantifiable					
Rehabilitative Services (CMS-2261-P)	Not Quantifiable					
School-based Administration (CMS-2287-P)	--	\$9.3	\$9.8	\$10.3	\$10.8	\$40.1
Targeted Case Management (CMS-2237-IFC)	\$8.7	\$47.0	\$49.3	\$51.5	\$54.0	\$210.5
	\$1010.	\$159.3	\$162.6	\$165.9	\$169.6	\$758.7