

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES



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February 15, 2008

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

Subject: Administration's Regulatory Medicaid Actions

Dear Mr. Chairman:

This letter represents Montana's response to your request regarding the new proposed Medicaid regulations. Included in this response is the expected reduction in federal Medicaid funds to Montana for the next five years and the effects of this reduction on Medicaid applicants and beneficiaries in our state. Due to unresolved questions and concerns regarding the regulations, we are unable to determine the fiscal impact on all of the regulations requested. The impacts we have listed below are only estimates as the exact fiscal and client impacts will not be known until the state begins to make programmatic changes to comply with the regulations.

Montana agrees with your assessment that it is difficult to quantify the impact these proposals will have on the State and beneficiaries. I hope our brief analysis below will provide you some needed information for your review.

Cost Limits for Public Providers (CMS 2258-FC)
Federal Medicaid Fiscal Impact: \$8,600,000

This regulation has significant impact on nursing home providers by limiting Montana's ability to continue to offer Intergovernmental Transfer (IGT) programs as a vehicle to provide additional reimbursement to nursing facility providers. In addition to jeopardizing the IGT program, this regulation redefines a public entity and limits payments to cost for those providers that meet this unit of government definition. This means that nursing facilities, like hospitals, are now subject to an upper limit applied to the facility individually. Current rules allow nursing homes to be tested against an aggregate upper limit for the class of provider. This would mean that a particular nursing home that meets this definition will not be able to accept any rate higher than their costs, whether the rate comes in the form of the routine payment rate, the IGT or any other special payment. This sets the state up to have a two pronged reimbursement methodology; a cost based methodology for units of government and a prospective methodology for all other facilities. In addition, it changes the aggregate calculation for the Upper Payment Limit (UPL) for classes of providers where a portion are subject to the cost limit and the balance of facilities are subject to the Medicare UPL calculation for that class of provider.

In Montana, twenty-eight facilities continue to participate in IGT's. Of these, fifteen facilities meet the unit of government definition and are subject to the new definition and cost limits. Of the fifteen, six facilities will not be able to participate at any level in IGT as they have costs below their currently calculated 2008 Medicaid rate. Four facilities will be able to participate up to their projected cost, which is higher than their current 2008 rate but lower than the UPL calculation for the class. Five of the remaining facilities will be able to participate up to the established UPL for the class as their current cost is above the UPL.

As a result of this change for units of governments now being limited to their costs, six facilities will see a decrease in revenue of approximately \$1,000,000 total funds (annually) based on the comparison of their Medicaid calculated rate to their indexed cost. In addition, the lost opportunity to participate in the IGT funding pool will be approximately \$700,000 total funds (annually) for these six facilities. Four facilities who meet the unit of government definition will not be limited by their computed Medicaid rate, but do have indexed cost that is below the calculated UPL for the class of government providers. Their total lost opportunity due to the cost limitation is \$360,000 total funds (annually). The remaining thirteen facilities do not meet the unit of government definition as defined by these regulations and will continue to participate in the program as they have in the past. Additionally, increased State cost will be incurred as retrospective reviews and cost settlements must be completed for any facility that meets the unit of government definition to insure that they are not paid in excess of their actual cost.

In regards to this regulation and its impact on school-based services, the financial impact to the Department is unknown because schools match the non-federal share of the cost through a certified public expenditure. This regulation also impacts our schools and requires that each participating school must file a cost report that the Department must audit and settle with the school. This additional administrative cost will fall on schools who want to continue to bill for Medicaid services.

Montana also reimburses twenty seven government ambulance providers who have IGT agreements set up with the Department. The IGT agreements are based on Medicare allowable amounts. The regulation states "The proposed cost limit applies to all governmentally operated Medicaid health care providers, including ambulance providers." Because there is no statutory or regulatory basis to require Medicaid reimbursement policy for the provision of ambulance services to follow Medicare reimbursement policy for such services, this program will be eliminated as it currently exists and the providers will be reimbursed no more than cost.

There are also six Critical Access Hospitals (CAH) that are owned and operated by units of government. Under provisions of the state plan, critical access hospitals are reimbursed 101 percent of costs related to services provided to Medicaid recipients. While the impact of reducing reimbursement to 100 percent for these six very small facilities would be minimal to the State, the reduction could have a significant impact on the operating budget of the facilities themselves.

**Payment for Graduate Medical Education (CMS 2279-P)
Federal Medicaid Fiscal Impact: \$850,018**

This proposed regulation would exclude any reimbursement for graduate medical education under Medicaid. Montana currently pays direct medical education to Prospective Payment System (PPS) facilities (Montana has 14 of these facilities) as a cost settled add-on payment in addition to their DRG reimbursement. Medical Education, if applicable, is paid to CAHs as part of their overall cost. Under the provisions of the regulation, these programs would no longer be eligible for Federal Funding reimbursement. The State is unsure of the impact this regulation will have on Montana Medicaid clients.

Payment for Hospital Outpatient Services (CMS 2213-P)

Federal Medicaid Fiscal Impact: \$0

This proposed regulation would amend the regulatory definition of outpatient hospital services for the Medicaid program to align the definition more closely to the Medicare definition and improve the functionality of the applicable upper payment limits while clarifying the scope of services for which FFP is available. Montana Medicaid covers outpatient services as outlined in 42 CFR 440. Medicaid does not allow for reimbursement of practitioner (including Method II billing for CAHs), adult mental health day rehabilitative or school based services under its outpatient program. Montana follows the Medicare OPPTS (Outpatient Prospective Payment System) for reimbursement in PPS facilities using a single statewide conversion factor that is approximately \$20 less than that used by Medicare. Medicaid allows reimbursement for providers meeting the Medicare definition of provider based status, however Medicaid does not allow for self declared status. For those outpatient services reimbursed using the Medicare fee schedule, Medicaid reimburses 60 percent of Medicare for non-sole community and 62 percent for sole community facilities. CAHs are reimbursed on interim at a hospital specific cost to charge ratio and then cost settled at a later date. Because we have been following the Medicare reimbursement system policy, this regulation does not negatively impact Montana.]

Provider Taxes (CMS 2275-P)

Federal Medicaid Fiscal Impact: \$0

This regulation limits the allowable amount that can be collected from a health care-related tax from 6 to 5.5 percent of net patient revenues received by the taxpayers. For nursing facility providers, Montana is at or below the current 5.5 percent limit. The provider tax rate for nursing facilities was last increased in July 2006. Because we are close to the maximum level of funding that can be raised from this source of revenue Montana will not be able to increase their provider taxes any time in the near future.

For hospital providers, Montana Medicaid does not exempt any inpatient hospital facility from their obligation to pay the hospital utilization fee. Hospitals are also under the maximum requirement of 6 percent for provider taxes. A retrospective review of the revenue produced by the provider tax and the regular Medicaid reimbursement is performed annually to insure that on the aggregate it does not exceed the Medicaid UPL. Therefore, Medicaid meets the requirements of the hold harmless provisions of the federal regulations and does not believe this regulation will impact Montana hospitals.

Coverage for Rehabilitation Services (CMS 2261-P)

Federal Medicaid Fiscal Impact: Unknown

This regulation seeks to clarify the definition of rehabilitative services and outlines the difference between habilitation services and rehabilitative (rehab) services as well as defining that rehabilitation services do not include and FFP is not available for expenditures when the services are furnished through a non-medical program including services that are intrinsic elements of programs other than Medicaid. Montana has significant concerns with the proposed regulations and the impact for the clients that receive services in Montana. Due to our many questions and concerns regarding this regulation, the financial impact is not known. The activity of setting fee for service rates to unbundle currently established service rates cannot be accomplished by the proposed effective date of June 30, 2008.

As proposed under this regulation, Medicaid will only be able to pay for rehab services (as defined in the regulation) and not for habilitative services. Because of this change in definition, providers will need to review the current services they provide, determine if the services are habilitative or rehabilitative and discontinue billing Medicaid for services that the proposed rule considers to be habilitation services. The impact to the providers may be an interpretation that the services provided were rehabilitative. A post-payment review may result in overpayments to providers and recoupments of Medicaid funds. This process

will jeopardize the provider network established to service clients on Montana Medicaid. Without an adequate provider network, for example, youth with serious emotional disturbance may need to be served in inpatient psychiatric residential treatment facilities at an increased cost to Montana and CMS. It will be difficult to qualify and quantify if rehabilitation services are beneficial as a client may make progress, then regress slightly and then makes progress again.

Another component of this regulation is the unbundling of rates paid to Therapeutic Group Home (TGH) providers. Currently, Montana reimburses TGH at daily per diem rate that covers all therapeutic services provided to the client. With the implementation of this regulation, providers will be required to bill each service provided to the client individually. We anticipate that this change will increase the cost to the Medicaid program without any added benefit to the client.

Montana utilizes a variety of medical models of care in serving the varied needs of the population. The proposed regulation would reduce our flexibility in packaging rehabilitative services with other community-based service networks and limit our ability to design effective systems of care.]

Payments for Costs of School Administration and Transportation Services (CMS 2287-F)
Federal Medicaid Fiscal Impact: \$9,000,000

This regulation eliminates Federal Medicaid payment for the cost of school-based administrative activities. Beginning July 2008, the Medicaid Administrative Claiming (MAC) program administered by Medicaid will no longer be available to Montana's Public or Private Schools. With this provision, payments will no longer be available for administrative activities performed by school district employees or contractors. There are currently 72 Montana school districts and co-ops that participate in the MAC program.]

In addition, this regulation also impacts school-based transportation. Medicaid will no longer be able to provide payment of home to school and back transportation for school-age children. However, the regulation does allow medically necessary travel from a home or school to a non-school based medical appointment. While school-based transportation is a covered service in Montana, it was rarely utilized and this portion of the proposed change will have a minimal impact.

Medicaid Reimbursement for Targeted Case Management (CMS 2237-IFC)
Federal Medicaid Fiscal Impact: Unknown

This regulation is meant to clarify the design and delivery of Targeted Case Management (TCM) services delivered by Medicaid programs. It will require a major restructuring of the TCM services that are provided to Montana clients. One of the main clarifications in the regulation requires that clients may only have one case manager. Due to complex medical situations of clients, for example, high risk pregnancy who meets criteria for another TCM group and Developmentally Delayed (DD) or mentally ill clients, there may be a need for more than one case manager. It is unreasonable to expect other case managers participate in the care of a client without payment. In these circumstances, this regulation placed the individual at risk if we limit payment to one case manager.

The regulation also requires freedom of choice for clients to choose to not have a case manager. The 1915c waiver requires the function of a case manager to oversee cost plans and plans of care. This requirement must have the allowance to require the function of a case manager for approved 1915c waivers, without states having to apply for a 1915(b) waiver. Under the 1915(c) waiver, the case manager acts in the client's best interest to assist the client in accessing the necessary services. While the freedom of choice of a case manager is an ideal concept, due to Montana's frontier status there are often times where there is only one qualified provider for multiple counties.

The regulation also limits the transition activity from institutions to a community setting to sixty days for individuals who have been in an institution for more than six months. Because of the great deal of work that must be done to transition clients to the community setting, we are concerned that sixty days of planning is insufficient. The lack of time for adequate transition planning has the potential to increase the average length of stay in the institution as well as an increase in the recidivism rate. In addition, the regulation states that providers are not able to bill for their TCM services until the client has been discharged from the facility. This payment delay could discourage Medicaid providers and contribute to the provider shortage issue that Montana is currently facing.

Due to the complexity of completing changes in administrative rules, state plans, billing methodologies, provider methods, and instituting computer system changes, it is unreasonable to expect states to be compliant by March 3, 2008. Montana assumes that CMS will allow states to work towards compliance, but there is nothing in writing to support additional time for compliance. It would be extremely beneficial to have CMS address compliance in writing.

Montana is dedicated to providing affordable healthcare to Medicaid individuals. We appreciate your interest and oversight of these new federal regulations and the effects on our Medicaid population. As more information becomes available, we will gladly provide you additional details. If you have any questions regarding the information above, please contact Duane Preshinger, Senior Medicaid Policy Manager at (406) 444-4145 or by email at dpreshinger@mt.gov.

Sincerely,



John Chappuis, State Medicaid Director
Montana Department of Public Health and Human Services

cc: Joan Miles, Director, Department of Public Health and Human Services
Mary Dalton, Administrator, Health Resources Division
Joyce DeCunzo, Administrator, Addictive and Mental Disorders Division
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