



Texas Health and Human Services Commission
4900 N. Lamar, Austin, Texas 78751

FAX Cover Sheet

Schneider
Medicaid

TO: Mr. Andy Schneider		FROM: Chris Traylor/ Mary Dingrando	
FAX # 202-225-4784		Phone 512-424- 1400/512-424- 6663	
Date	February 18, 2008		
Pages including cover page 7			

REMARKS:

Urgent **For your review** **Reply ASAP** **Please Comment**

Mr. Schneider,

There was an error in the Texas beneficiary impact totals on Attachment B as included in the February 15, 2008 analysis of the CMS regulations delivered to Chairman Waxman. Please accept this submission in lieu of the one delivered to on February 15, 2008. The beneficiary impact estimates shown for each rule were and are correct and remain the same but we have corrected an error in the beneficiary impact totals on Attachment B. The header for Attachment B now indicates that it was revised February 17, 2008. We apologize for any inconvenience this may have caused. Please let us know how best to deliver the corrected Attachment B to the minority staff. If you have questions or need anything further, please contact Chris Traylor at 512-424-1400 or Mary Dingrando at 512-424-6663.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

February 15, 2008

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

Dear Chairman Waxman:

As requested in your January 16, 2008 letter, the Texas Health and Human Services Commission submits the enclosed analysis on the impact to Texas of the seven Centers for Medicare and Medicaid Services (CMS) regulations listed below:

- Cost Limits for Public Providers (CMS 2258-FC)
- Payments for Graduate Medical Education (CMS 2279-P)
- Payment for Hospital Outpatient Services (CMS 2213-P)
- Provider Taxes (CMS 2275-P)
- Coverage for Rehabilitation Services (CMS 2261-P)
- Payments for Costs of School Administration and Transportation Services (CMS 2287-P)
- Targeted Case Management Rule (CMS-2237-IFC)

Texas could lose \$3.4 billion in federal Medicaid funds during fiscal years 2008-2012 as a result of these regulations. Attachment A includes details on the program, beneficiary, and fiscal impacts of each rule. Attachment B summarizes the fiscal impact of each rule from fiscal year 2008 through fiscal year 2012. The impact on beneficiaries, while significant, is difficult to quantify, but we have provided estimates on the potential impact when possible. The beneficiary impact estimates shown on Attachment A under "Effect of Reduction on Medicaid Applicants and Beneficiaries" are illustrative calculations based on the estimated amount of federal funds lost divided by the average cost per beneficiary for each program.

In Texas, Medicaid accounts for 26 percent of the state's total budget, provides health care for one out of every three children, pays for more than half of all births, and covers two-thirds of all nursing home residents. We share CMS's goal of achieving greater accountability in the Medicaid budget; however, we urge a different approach that more fully weighs the programmatic as well as the fiscal implications of making changes to the program. Further, states and hospitals must be given enough time to make the system changes necessary to support greater accountability.

Our state is working closely with CMS to implement health care reforms that will achieve better health outcomes and greater accountability for the use of state and federal tax dollars. We believe this approach will lead to transformational changes that reduce the burden of uncompensated care costs on our public

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751

The Honorable Chairman Waxman
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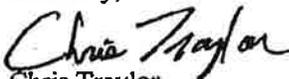
hospitals and support a transparent funding system that is fully accountable and rewards innovative approaches to providing health care for low-income citizens. We believe that transformation must occur before implementation of federal regulations that will reduce funding for safety net hospitals. We are making those changes in Texas, but we must have time to transform our system.

Congress has been successful in enacting moratoriums on the implementation of a number of these provisions. However, the delays are temporary, and without further action Texas and other states will face significant impacts to crucial components of the Medicaid program.

We are working to transform the Texas health care system, but we are concerned that these regulations will put care at risk before we've had adequate time to make the system changes necessary to support a more accountable and effective health care system.

Please let me know if you have questions or need additional information. I can be reached at 512-424-1400 or by e-mail at chris.traylor@hhsc.state.tx.us.

Sincerely,



Chris Traylor
Medicaid Director

cc: The Honorable Representative Kenny Marchant
Committee on Oversight and Government Reform

Attachment A

**Texas Impact Analysis of Centers for Medicare and Medicaid Services (CMS) Regulations
Submitted by the Texas Health and Human Services Commission
to the Committee on Oversight and Government Reform
February 15, 2008**

Note: Impact to beneficiaries is difficult to quantify, but we have provided estimates when possible. The estimates shown under "Effect of Reduction on Medicaid Applicants and Beneficiaries" are illustrative calculations based on the estimated amount of federal funds lost divided by the average cost per beneficiary for each program.

- **Cost Limits for Public Providers (CMS 2258-FC)** – Imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the financing of the non-federal share of Medicaid payments must meet a restrictive new definition of unit of government.
Loss of Federal Funds: \$2.2 billion during Fiscal Years 2008-2012.
Effect of Reduction on Medicaid Applicants and Beneficiaries: This significant loss of federal funds could jeopardize safety net operations and patient care. We estimate that each year, more than 185,000 Texans would be at risk of not receiving hospital services or experiencing a significant reduction in services.

- **Payments for Graduate Medical Education (CMS 2279-P)** – CMS maintains that Graduate Medical Education (GME) is not within the scope of medical assistance authorized for payment by Medicaid and would no longer allow Medicaid funding to be used for GME. Texas has supported teaching hospitals in the past through the use of Medicaid-funded GME dollars. While the state does not currently have an active GME program, GME has been part of the approved state Medicaid plan since 1997. The Texas Legislature has provided options for hospitals to fund GME, and the state is developing a proposal to implement a GME program.
Loss of Federal Funds: \$348.3 million during Fiscal Years 2008-2012 if Texas implements a GME program in the current year.
Effect of Reduction on Medicaid Applicants and Beneficiaries: This proposed rule would restrict the ability of states to use Medicaid funds to train the next generation of doctors and provide health care for the nation's uninsured and underinsured through teaching hospitals. Teaching hospitals account for approximately 50 percent of all Medicaid hospital claims in Texas.

- **Payment for Hospital Outpatient Services (CMS 2213-P)** – The rule clarifies the requirement that states must complete an aggregate Upper Payment Limit (UPL) cap for the three classes of hospitals that estimate the total Medicaid funds a state can reimburse for outpatient services. This rule would also redefine the scope of services that can be reimbursed as outpatient hospital services to align with Medicare's outpatient scope of service regulations. While states have the option of continuing to reimburse hospitals for services currently approved under the state plan and specific to the populations served in the state, the reimbursement methodology used to reimburse those services would change to reflect the appropriate fee schedule under which these benefits would qualify for federal financial participation (FFP). Routine vision services, annual checkups, vaccinations, school-based services and rehabilitation services which are not typically considered outpatient hospital services would be subject to a different payment methodology to secure FFP.

Loss of Federal Funds: The outpatient aggregate demonstration clarification in the proposed rule would not affect the current amount of federal funds Texas is receiving for outpatient hospital services. Related to the scope of services that can be reimbursed, to the extent that Texas currently covers outpatient hospital services not reimbursable under Medicare, this would result in either a loss of federal funds or a change in payment methodology. The adoption of a change in payment methodology may result in a reduced reimbursement for outpatient hospital facilities currently providing these services.

Effect of Reduction on Medicaid Applicants and Beneficiaries: This rule could impair access to preventive services in hospital outpatient clinics. Restricting access to preventive services leads to poorer health outcomes and ultimately to a higher reliance on more expensive care, such as emergency rooms and inpatient hospital care.

- **Provider Taxes (CMS 2275-P)** – This rule seeks to clarify a number of issues in the original regulation, including more stringent language in applying the hold-harmless test. The new language gives CMS broader flexibility in identifying relationships between provider taxes and payment amounts. The Tax Relief and Health Care Act codified the maximum amount that a state may receive from a health care-related tax at 6 percent. The permissible rate is temporarily reduced to 5.5 percent from January 1, 2008 through 2011. On October 1, 2011, the cap reverts back to 6 percent.

Loss of Federal Funds: \$11.5 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: The health care provider tax has long been a finance mechanism available to states as clarified and approved by Congress since 1991. Texas has used provider taxes to improve the quality of care provided to consumers with mental retardation living in intermediate care facilities.

- **Coverage for Rehabilitation Services (CMS 2261-P)** – CMS seeks to redefine rehabilitative services and to determine the difference between habilitative and rehabilitative services. This rule would no longer allow reimbursement for a number of currently reimbursable Medicaid rehabilitative services including adult day health care services, early childhood intervention services, and certain rehabilitative mental health services.

Loss of Federal Funds: \$356.3 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: Adult day health care services enable elderly Texans to remain in their homes. If adult day care services are no longer reimbursable, many consumers would be adversely impacted and nursing facility utilization may increase. Each year, an estimated 21,000 elderly beneficiaries receiving adult day care services could be affected if the program becomes ineligible for Medicaid funding. Although CMS cites the elimination of the Day Activity and Health Services (DAHS) program as a “cost savings,” the state and federal governments most assuredly will experience an increase in costs, as these persons matriculate into more costly settings.

Additionally, it is estimated that annually, 4,000 to 5,000 children ages birth through 3 years, who are receiving rehabilitation services could be affected if developmental rehabilitation services can no longer be provided by certified Early Childhood Intervention Specialists (EISs). About 50 percent of the developmental rehabilitation services are delivered by the certified EISs as approved in the Texas Medicaid state plan. There is no provision to recognize these EIS providers as Medicaid providers under the new rehabilitation rules.

- **Payments for Costs of School Administration and Transportation Services (CMS 2287-P)** – CMS is proposing to eliminate funding for school-based administration and transportation activities covered by Medicaid. CMS currently allows states to claim federal financial participation (FFP) for school-based administrative activities, such as Medicaid

outreach, information and referral, and coordination of health services. States also will no longer be able to receive federal funding for School Health and Related Services (SHARS) specialized transportation when transporting school-age children to and from school, even on days when they are receiving a SHARS service. Specialized transportation is the third largest claim total of all school-based medical services in Texas.

Loss of Federal Funds: \$48.8 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: The proposed rule will place a significant financial burden on local school districts to either identify funds to preserve existing programs currently funded by Medicaid or to eliminate those programs. Schools play a vital role as a partner with the Medicaid program to provide health care services to children. Schools have a unique ability to enroll hard-to-reach or at-risk youth that would otherwise go without benefits. Eliminating this school-based Medicaid outreach, information and referral program would potentially increase the number of uninsured children in Texas schools and across the state. Each year, more than 14,500 students would have received SHARS specialized transportation services. These services would no longer be eligible for federal matching funds under this rule.

- **Targeted Case Management Rule (CMS-2237-IFC)** – CMS published an interim final rule on December 4, 2007, that clarifies the definition of targeted case management services (TCM) as required by Section 6052 of the Deficit Reduction Act (DRA). The rule requires significant changes to case management programs that could diminish quality and access to a service used by vulnerable populations in the Texas Medicaid program. The CMS interpretation of the regulations goes beyond the language and intent of the DRA and presents significant obstacles to the state's ability to continue to provide the same level of Medicaid case management services. CMS' interpretation of the DRA provision would apply this regulation to all forms of Medicaid case management, including targeted case management, administrative case management, and case management provided by home and community based waiver programs. Further, rule requirements related to individuals transitioning from institutions to the community could reduce the ability of states to assist people who are elderly or have disabilities in successfully transitioning from institutional to community-based services. Texas continues to assess the potential impact of the rule on other Medicaid case management programs, and it is likely that the state will need to make substantial program and reimbursement changes in order to continue providing case management services to many other vulnerable Texans.

Loss of Federal Funds: \$430.9 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: This loss of federal funds would result in fewer dollars for direct delivery staff in both the Child Protective Services program and Adult Protective Services program. In addition, case management services provided to children who are blind or visually impaired will not meet the new TCM rule criteria.

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Rule	Loss of federal dollars (millions)						Effect of Reduction on Medicaid Applicants and Beneficiaries*NOTE				
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Total FY 2008-2012	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Cost Limits for Public Providers (CMS 2258-FC)¹	\$ 127.4	\$ 511.8	\$ 523.0	\$ 534.5	\$ 546.3	\$ 2,243.0	46,957	184,951	185,336	185,663	186,064
Payments for Graduate Medical Education (CMS 2279-P)	\$ 70.7	\$ 69.4	\$ 69.4	\$ 69.4	\$ 69.4	\$ 348.3	This proposed rule would restrict the ability of states to use Medicaid funds to train the next generation of doctors and provide health care for the nation's uninsured and underinsured through teaching hospitals. Teaching hospitals account for approximately 50 percent of all Medicaid hospital claims in Texas.				
Payment for Hospital Outpatient Services (CMS 2213-P)	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	This rule could impair access to preventive services in hospital outpatient clinics. Restricting access to preventive services leads to poorer health outcomes and ultimately to a higher reliance on more expensive care, such as emergency rooms and inpatient hospital care.				
Provider Taxes (CMS 2275-P)	\$ 2.1	\$ 3.1	\$ 3.0	\$ 3.0	\$ 0.3	\$ 11.5	Texas has used provider taxes to improve the quality of care provided to consumers with mental retardation living in intermediate care facilities.				
Coverage for Rehabilitation Services (CMS 2261-P)²	\$ 14.2	\$ 85.0	\$ 84.9	\$ 85.7	\$ 86.5	\$ 356.3	4,165	25,154	25,519	25,864	26,225
Payments for Costs of School Administration and Transportation Services (CMS 2287-P)	\$ -	\$ 12.2	\$ 12.2	\$ 12.2	\$ 12.2	\$ 48.8	0	14,507	14,507	14,507	14,507
Targeted Case Management Rule (CMS-2237-IFC)	\$ 37.5	\$ 97.0	\$ 98.8	\$ 98.8	\$ 98.8	\$ 430.9	This loss of federal funds would result in fewer dollars for direct delivery staff in both the Child Protective Services program and Adult Protective Services program. In addition, case management services provided to children who are blind or visually impaired will not meet the new TCM rule criteria.				
GRAND TOTAL, ALL RULES	\$ 251.9	\$ 778.5	\$ 791.3	\$ 803.6	\$ 813.4	\$ 3,438.7	51,121	224,612	225,362	226,034	226,796

*Note: Impact to beneficiaries is difficult to quantify, but we have provided estimates when possible. The estimates shown under "Effect of Reduction on Medicaid Applicants and Beneficiaries" are illustrative calculations based on the estimated amount of federal funds lost divided by the average cost per beneficiary for each program.

¹ Beneficiary impact is based on an average claim amount per year and assumes one claim per beneficiary.

² The estimated numbers shown for impact to beneficiaries reflects the impact if the entire adult day health services program becomes ineligible for Medicaid funding and the impact if rehabilitation services to children ages birth to three years can no longer be provided by certified Early Childhood Intervention Specialists.



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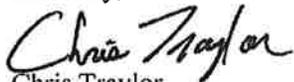
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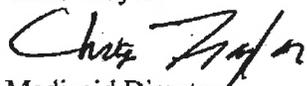
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Chris Traylor



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Washington, DC 20515-6143

Dear Chairman Waxman:

As requested in your January 16, 2008 letter, the Texas Health and Human Services Commission submits the enclosed analysis on the impact to Texas of the seven Centers for Medicare and Medicaid Services (CMS) regulations listed below:

- Cost Limits for Public Providers (CMS 2258-FC)
- Payments for Graduate Medical Education (CMS 2279-P)
- Payment for Hospital Outpatient Services (CMS 2213-P)
- Provider Taxes (CMS 2275-P)
- Coverage for Rehabilitation Services (CMS 2261-P)
- Payments for Costs of School Administration and Transportation Services (CMS 2287-P)
- Targeted Case Management Rule (CMS-2237-IFC)

Texas could lose \$3.4 billion in federal Medicaid funds during fiscal years 2008-2012 as a result of these regulations. Attachment A includes details on the program, beneficiary, and fiscal impacts of each rule. Attachment B summarizes the fiscal impact of each rule from fiscal year 2008 through fiscal year 2012. The impact on beneficiaries, while significant, is difficult to quantify, but we have provided estimates on the potential impact when possible. The beneficiary impact estimates shown on Attachment A under "Effect of Reduction on Medicaid Applicants and Beneficiaries" are illustrative calculations based on the estimated amount of federal funds lost divided by the average cost per beneficiary for each program.

In Texas, Medicaid accounts for 26 percent of the state's total budget, provides health care for one out of every three children, pays for more than half of all births, and covers two-thirds of all nursing home residents. We share CMS's goal of achieving greater accountability in the Medicaid budget; however, we urge a different approach that more fully weighs the programmatic as well as the fiscal implications of making changes to the program. Further, states and hospitals must be given enough time to make the system changes necessary to support greater accountability.

Our state is working closely with CMS to implement health care reforms that will achieve better health outcomes and greater accountability for the use of state and federal tax dollars. We believe this approach will lead to transformational changes that reduce the burden of uncompensated care costs on our public

The Honorable Chairman Waxman
February 15, 2008
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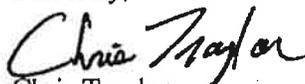
hospitals and support a transparent funding system that is fully accountable and rewards innovative approaches to providing health care for low-income citizens. We believe that transformation must occur before implementation of federal regulations that will reduce funding for safety net hospitals. We are making those changes in Texas, but we must have time to transform our system.

Congress has been successful in enacting moratoriums on the implementation of a number of these provisions. However, the delays are temporary, and without further action Texas and other states will face significant impacts to crucial components of the Medicaid program.

We are working to transform the Texas health care system, but we are concerned that these regulations will put care at risk before we've had adequate time to make the system changes necessary to support a more accountable and effective health care system.

Please let me know if you have questions or need additional information. I can be reached at 512-424-1400 or by e-mail at chris.traylor@hhsc.state.tx.us.

Sincerely,


Chris Traylor
Medicaid Director

cc: The Honorable Representative Kenny Marchant
Committee on Oversight and Government Reform

**Texas Impact Analysis of Centers for Medicare and Medicaid Services (CMS) Regulations
Submitted by the Texas Health and Human Services Commission
to the Committee on Oversight and Government Reform
February 15, 2008**

Note: Impact to beneficiaries is difficult to quantify, but we have provided estimates when possible. The estimates shown under “Effect of Reduction on Medicaid Applicants and Beneficiaries” are illustrative calculations based on the estimated amount of federal funds lost divided by the average cost per beneficiary for each program.

- **Cost Limits for Public Providers (CMS 2258-FC)** – Imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the financing of the non-federal share of Medicaid payments must meet a restrictive new definition of unit of government.
Loss of Federal Funds: \$2.2 billion during Fiscal Years 2008-2012.
Effect of Reduction on Medicaid Applicants and Beneficiaries: This significant loss of federal funds could jeopardize safety net operations and patient care. We estimate that each year, more than 185,000 Texans would be at risk of not receiving hospital services or experiencing a significant reduction in services.
- **Payments for Graduate Medical Education (CMS 2279-P)** – CMS maintains that Graduate Medical Education (GME) is not within the scope of medical assistance authorized for payment by Medicaid and would no longer allow Medicaid funding to be used for GME. Texas has supported teaching hospitals in the past through the use of Medicaid-funded GME dollars. While the state does not currently have an active GME program, GME has been part of the approved state Medicaid plan since 1997. The Texas Legislature has provided options for hospitals to fund GME, and the state is developing a proposal to implement a GME program.
Loss of Federal Funds: \$348.3 million during Fiscal Years 2008-2012 if Texas implements a GME program in the current year.
Effect of Reduction on Medicaid Applicants and Beneficiaries: This proposed rule would restrict the ability of states to use Medicaid funds to train the next generation of doctors and provide health care for the nation’s uninsured and underinsured through teaching hospitals. Teaching hospitals account for approximately 50 percent of all Medicaid hospital claims in Texas.
- **Payment for Hospital Outpatient Services (CMS 2213-P)** – The rule clarifies the requirement that states must complete an aggregate Upper Payment Limit (UPL) cap for the three classes of hospitals that estimate the total Medicaid funds a state can reimburse for outpatient services. This rule would also redefine the scope of services that can be reimbursed as outpatient hospital services to align with Medicare’s outpatient scope of service regulations. While states have the option of continuing to reimburse hospitals for services currently approved under the state plan and specific to the populations served in the state, the reimbursement methodology used to reimburse those services would change to reflect the appropriate fee schedule under which these benefits would qualify for federal financial participation (FFP). Routine vision services, annual checkups, vaccinations, school-based services and rehabilitation services which are not typically considered outpatient hospital services would be subject to a different payment methodology to secure FFP.

Loss of Federal Funds: The outpatient aggregate demonstration clarification in the proposed rule would not affect the current amount of federal funds Texas is receiving for outpatient hospital services. Related to the scope of services that can be reimbursed, to the extent that Texas currently covers outpatient hospital services not reimbursable under Medicare, this would result in either a loss of federal funds or a change in payment methodology. The adoption of a change in payment methodology may result in a reduced reimbursement for outpatient hospital facilities currently providing these services.

Effect of Reduction on Medicaid Applicants and Beneficiaries: This rule could impair access to preventive services in hospital outpatient clinics. Restricting access to preventive services leads to poorer health outcomes and ultimately to a higher reliance on more expensive care, such as emergency rooms and inpatient hospital care.

- **Provider Taxes (CMS 2275-P)** – This rule seeks to clarify a number of issues in the original regulation, including more stringent language in applying the hold-harmless test. The new language gives CMS broader flexibility in identifying relationships between provider taxes and payment amounts. The Tax Relief and Health Care Act codified the maximum amount that a state may receive from a health care-related tax at 6 percent. The permissible rate is temporarily reduced to 5.5 percent from January 1, 2008 through 2011. On October 1, 2011, the cap reverts back to 6 percent.

Loss of Federal Funds: \$11.5 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: The health care provider tax has long been a finance mechanism available to states as clarified and approved by Congress since 1991. Texas has used provider taxes to improve the quality of care provided to consumers with mental retardation living in intermediate care facilities.

- **Coverage for Rehabilitation Services (CMS 2261-P)** – CMS seeks to redefine rehabilitative services and to determine the difference between habilitative and rehabilitative services. This rule would no longer allow reimbursement for a number of currently reimbursable Medicaid rehabilitative services including adult day health care services, early childhood intervention services, and certain rehabilitative mental health services.

Loss of Federal Funds: \$356.3 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: Adult day health care services enable elderly Texans to remain in their homes. If adult day care services are no longer reimbursable, many consumers would be adversely impacted and nursing facility utilization may increase. Each year, an estimated 21,000 elderly beneficiaries receiving adult day care services could be affected if the program becomes ineligible for Medicaid funding. Although CMS cites the elimination of the Day Activity and Health Services (DAHS) program as a “cost savings,” the state and federal governments most assuredly will experience an increase in costs, as these persons matriculate into more costly settings.

Additionally, it is estimated that annually, 4,000 to 5,000 children ages birth through 3 years, who are receiving rehabilitation services could be affected if developmental rehabilitation services can no longer be provided by certified Early Childhood Intervention Specialists (EISs). About 50 percent of the developmental rehabilitation services are delivered by the certified EISs as approved in the Texas Medicaid state plan. There is no provision to recognize these EIS providers as Medicaid providers under the new rehabilitation rules.

- **Payments for Costs of School Administration and Transportation Services (CMS 2287-P)** – CMS is proposing to eliminate funding for school-based administration and transportation activities covered by Medicaid. CMS currently allows states to claim federal financial participation (FFP) for school-based administrative activities, such as Medicaid

outreach, information and referral, and coordination of health services. States also will no longer be able to receive federal funding for School Health and Related Services (SHARS) specialized transportation when transporting school-age children to and from school, even on days when they are receiving a SHARS service. Specialized transportation is the third largest claim total of all school-based medical services in Texas.

Loss of Federal Funds: \$48.8 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: The proposed rule will place a significant financial burden on local school districts to either identify funds to preserve existing programs currently funded by Medicaid or to eliminate those programs. Schools play a vital role as a partner with the Medicaid program to provide health care services to children. Schools have a unique ability to enroll hard-to-reach or at-risk youth that would otherwise go without benefits. Eliminating this school-based Medicaid outreach, information and referral program would potentially increase the number of uninsured children in Texas schools and across the state. Each year, more than 14,500 students would have received SHARS specialized transportation services. These services would no longer be eligible for federal matching funds under this rule.

- **Targeted Case Management Rule (CMS-2237-IFC)** – CMS published an interim final rule on December 4, 2007, that clarifies the definition of targeted case management services (TCM) as required by Section 6052 of the Deficit Reduction Act (DRA). The rule requires significant changes to case management programs that could diminish quality and access to a service used by vulnerable populations in the Texas Medicaid program. The CMS interpretation of the regulations goes beyond the language and intent of the DRA and presents significant obstacles to the state's ability to continue to provide the same level of Medicaid case management services. CMS' interpretation of the DRA provision would apply this regulation to all forms of Medicaid case management, including targeted case management, administrative case management, and case management provided by home and community based waiver programs. Further, rule requirements related to individuals transitioning from institutions to the community could reduce the ability of states to assist people who are elderly or have disabilities in successfully transitioning from institutional to community-based services. Texas continues to assess the potential impact of the rule on other Medicaid case management programs, and it is likely that the state will need to make substantial program and reimbursement changes in order to continue providing case management services to many other vulnerable Texans.

Loss of Federal Funds: \$430.9 million during Fiscal Years 2008-2012.

Effect of Reduction on Medicaid Applicants and Beneficiaries: This loss of federal funds would result in fewer dollars for direct delivery staff in both the Child Protective Services program and Adult Protective Services program. In addition, case management services provided to children who are blind or visually impaired will not meet the new TCM rule criteria.

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Rule	Loss of federal dollars (millions)						Effect of Reduction on Medicaid Applicants and Beneficiaries*NOTE				
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Total FY 2008-2012	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Cost Limits for Public Providers (CMS 2258-FC) ¹	\$ 127.4	\$ 511.8	\$ 523.0	\$ 534.5	\$ 546.3	\$ 2,243.0	46,957	184,951	185,336	185,663	186,064
Payments for Graduate Medical Education (CMS 2279-P)	\$ 70.7	\$ 69.4	\$ 69.4	\$ 69.4	\$ 69.4	\$ 348.3	This proposed rule would restrict the ability of states to use Medicaid funds to train the next generation of doctors and provide health care for the nation's uninsured and underinsured through teaching hospitals. Teaching hospitals account for approximately 50 percent of all Medicaid hospital claims in Texas.				
Payment for Hospital Outpatient Services (CMS 2213-P)	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	This rule could impair access to preventive services in hospital outpatient clinics. Restricting access to preventive services leads to poorer health outcomes and ultimately to a higher reliance on more expensive care, such as emergency rooms and inpatient hospital care.				
Provider Taxes (CMS 2275-P)	\$ 2.1	\$ 3.1	\$ 3.0	\$ 3.0	\$ 0.3	\$ 11.5	Texas has used provider taxes to improve the quality of care provided to consumers with mental retardation living in intermediate care facilities.				
Coverage for Rehabilitation Services (CMS 2261-P) ²	\$ 14.2	\$ 85.0	\$ 84.9	\$ 85.7	\$ 86.5	\$ 356.3	4,165	25,154	25,519	25,864	26,225
Payments for Costs of School Administration and Transportation Services (CMS 2287-P)	\$ -	\$ 12.2	\$ 12.2	\$ 12.2	\$ 12.2	\$ 48.8	0	14,507	14,507	14,507	14,507
Targeted Case Management Rule (CMS-2237-IFC)	\$ 37.5	\$ 97.0	\$ 98.8	\$ 98.8	\$ 98.8	\$ 430.9	This loss of federal funds would result in fewer dollars for direct delivery staff in both the Child Protective Services program and Adult Protective Services program. In addition, case management services provided to children who are blind or visually impaired will not meet the new TCM rule criteria.				
GRAND TOTAL, ALL RULES	\$ 251.9	\$ 778.5	\$ 791.3	\$ 803.6	\$ 813.4	\$ 3,438.7	34,396	161,104	164,140	167,216	170,367

*Note: Impact to beneficiaries is difficult to quantify, but we have provided estimates when possible. The estimates shown under "Effect of Reduction on Medicaid Applicants and Beneficiaries" are illustrative calculations based on the estimated amount of federal funds lost divided by the average cost per beneficiary for each program.

¹ Beneficiary impact is based on an average claim amount per year and assumes one claim per beneficiary.

² The estimated numbers shown for impact to beneficiaries reflects the impact if the entire adult day health services program becomes ineligible for Medicaid funding and the impact if rehabilitation services to children ages birth to three years can no longer be provided by certified Early Childhood Intervention Specialists.

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GRAND TOTAL, ALL RULES	\$ 251.9	\$ 778.5	\$ 791.3	\$ 803.6	\$ 813.4	\$ 3,438.7	51,121	224,612	225,362	226,034	226,796

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