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Rules Changes are Different, but Both Would Hurt Ohio

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Recent discussions about changes to the Medicaid program, both on the state and federal level, have lead to a fair amount of confusion. In the last year, the Centers for Medicare and Medicaid Services (CMS) has made a number of rulings that could profoundly limit Medicaid's reach. These changes break down into two categories: the August 17 CMS SCHIP (State Children's Health Insurance Program) Directive and a collection of seven Medicaid changes that are being addressed together. Some efforts to change these rules have included both the directive and the collection of Medicaid regulations, while others have taken them as two separate items for legislation. In order to effectively communicate with legislators in the coming weeks and months, it is essential that advocates understand the difference between the two.

The Infamous August 17 CMS Directive

On August 17, 2007, CMS released a directive limiting the ability of states to expand their SCHIP programs. According to the letter, states that wanted to expand eligibility for the program beyond 250 percent of the federal poverty level (FPL) -$44,000 for a family of three- would first have to prove that they were covering at least 95 percent of those children at 200 percent FPL ($35,200) and below. No state in the country meets that standard.

Last year, a bipartisan effort to expand Ohio's SCHIP program succeeded. If the plan was approved by CMS, Ohio would go from covering children at 200 percent of FPL to

300% of FPL. Unfortunately, citing the August 17 directive, CMS rejected Ohio's state plan amendment; a plan that would have covered an additional 35,000 children.

Efforts are currently underway to reverse the CMS directive. Both the Government Accountability Office and the Congressional Research Service have issued rulings finding that the CMS action was illegal. The GAO report, released April 17, 2008, stated, "The August 17 letter from CMS to state health officials….is a rule under the Congressional Review Act. Therefore, before it can take effect, it must be submitted to Congress and the Comptroller General."[1]

Reversing the CMS directive must be a priority for those eager to see Ohio's original SCHIP expansion succeed, but it is not the only issue facing Ohio's public health care system.

Medicaid Regulations

Efforts to delay the implementation of a group of Medicaid regulations issued over the last year and included in the President's FY 2009 budget are often confused with efforts to repeal the August 17 directive. The proposed regulations would force states to make significant changes to Medicaid and would shift billions in costs to states and local government.

Taken together, the regulations would disrupt access to rehabilitation services and case management services for children in foster care, people with physical and developmental disabilities, and people with mental illnesses, and to Medicaid services provided to children in schools. The regulations would eliminate federal Medicaid reimbursement for the costs of graduate medical education (GME) provided by teaching hospitals, which many state Medicaid programs have used to help offset the additional costs these facilities incur as a result of their special missions of educating physicians and caring for patients who require more intense, complex care. The regulations also put new limits on Medicaid payments for safety-net hospitals that would cause cutbacks in essential services used by the entire community, such as care for the uninsured, trauma care, and neonatal intensive care.

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[1] United States Government Accountability Office, April 17, 2008, "Applicability of the Congressional Review Act to Letter on State Children's Health Insurance Program," p.6.

These changes would result in a total reduction in federal Medicaid funding nationally of between $15 and $21 billion over five years.[2] Shifting such costs to states would result in cuts to the program, revenue increases, or both.

On April 23, the U.S. House of Representatives passed H.R. 5613, which extends an earlier moratorium on the regulations at issue. The bill, which passed with overwhelming bipartisan support, now moves on to the Senate for consideration.

Like the August 17 directive, supporting legislation to delay implementation of these damaging regulations is critical, not only for Ohio's families but for Ohio's budget. Changing the rules while so many struggle with the downturn in the economy and skyrocketing health care costs places greater pressure on state budgets, and as a result, greater pressure on people.

Going forward, there will be increasing discussion and debate on both of these issues. Some versions of legislation even group both together. What is clear is that both sets of changes are damaging to Ohioans who currently rely on SCHIP and Medicaid, and those who would benefit from Ohio's planned expansion.

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[2] Based on estimates from the Office of Management and Budget, these regulatory changes, taken together, would reduce federal Medicaid spending by more than $15 billion over the next five years. New estimates from the Congressional Budget Office indicate the reductions would be larger and could equal $21 billion over five year (see: http://www.cbo.gov/budget/factsheets/2008b/medicaremedicaid.pdf)

Overview of Recent Medicaid and SCHIP Regulatory and Administrative Actions

Regulation	Description	Savings[3]	Status
School-based Services 72 Fed. Reg. 73635 (Dec. 28, 2007)	Eliminates federal funds for outreach, enrollment assistance, coordination of health care services, and related activities by school personnel to enroll more eligible poor children in Medicaid. The rule also would reverse current policy that allows federal funds to be used to transport children to school if the children have special health needs and receive health care services at school.	$635 million FY 2009 $3.6 billion FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 in the December 2007 Medicare, Medicaid, and SCHIP Extension Act
Rehabilitation Services 72 Fed. Reg. 45201 (Aug. 13, 2007)	Limits the types of rehabilitative services that states can cover with federal funds, including special instruction and therapy for children and other beneficiaries who have mental illness or developmental disabilities.	$360 million FY 2009 $2.5 billion FY 2009-2013	Delayed by Congressional action 6/30/08 in the December 2007 Medicare, Medicaid, and SCHIP Extension Act
Targeted Case Management 72 Fed. Reg. 68077 (Dec. 4, 2007)	Significantly limits federal Medicaid matching funds for case management services, going beyond changes to the Medicaid case management benefit that Congress enacted in the Deficit Reduction Act. The regulation will have a detrimental impact on beneficiaries, especially children in foster care and people with physical or mental disabilities or other chronic health conditions.	$230 million FY 2009 $1.3 billion FY 2008-2012	Interim final rule becomes effective 3/3/08
Hospital Cost-Limits 72 Fed. Reg. 29748 (May 29, 2007)	Limits payments to hospitals and other institutions operated by state or local governments to the cost of providing services to Medicaid beneficiaries. Also revises the definition of "providers" for purposes of Medicaid financing.	$790 million FY 2009 $5.7 billion FY 2009-2013	Final rule issued; implementation delayed in the 2007 supplemental appropriations bill until 5/25/08

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[3] Estimated federal Medicaid savings from all regulations, other than targeted case management and provider tax, taken from the President's Fiscal Year 2009 Budget, Analytical Perspectives, Table 25-6, "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008. Estimated federal Medicaid savings from targeted case management and provider tax regulations are based on Administration estimates of regulations issued in 2007.

The February 29th updated CBO budget baseline assumes different estimated five year federal Medicaid savings from these regulations (discounting some estimates based on CBO's assumption that there is a 50% probability that the not-yet-final rules will be implemented): School-based Services: $4.2 billion; Rehab Services: $1.4 billion; TCM: $2 billion; Hospital Cost-limit: $9 billion; GME: $800 million; Outpatient Hospital Services: $300 million; Provider Tax: $600 million. If finalized, however, savings from the Rehab Services, GME and Outpatient Hospital Services rules would double because savings from these regulations would no longer be discounted by half. CBO has not yet provided year-by-year estimates of federal savings from the regulations. The CBO budget baseline also estimates five year savings of $100 million from the SCHIP Directive. Congressional Budget Office, Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO's Baseline, February 29, 2008, at: http://www.cbo.gov/budget/factsheets/2008b/medicaremedicaid.pdf.

Graduate Medical Education 72 Fed. Reg. 28930 (May 23, 2007)	Eliminates federal Medicaid funding for the costs of graduate medical education (GME) provided by teaching hospitals.	$150 million FY 2009 $1.8 billion FY 2009-2013	Delayed in the 2007 supplemental appropriations bill until 5/25/08
Outpatient Clinic and Hospital Facility Services 72 Fed. Reg. 55158 (Sep. 28, 2007)	Changes the definition of outpatient hospital services to significantly narrow the types of services states can cover under this benefit category, severely restricting reimbursement rates for such services as hospital-based physician services, routine vision services, annual check-ups, and vaccinations.	CMS declined to estimate the impact of this proposed rule due to lack of available data.	Expected to be finalized in early 2008
Provider Tax 73 Fed. Reg. 9685 (Feb 22, 2008)	Makes technical changes to provider tax rules that will limit states' ability to raise federal Medicaid matching funds.	$115 million FY 2009 $115 million in each of FYs 2010 and 2011	Final rule issued; effective 4/22/08
Departmental Appeal Board Procedures 72 Fed. Reg. 73708 (Dec. 28, 2007)	Require the HHS Departmental Appeals Board (DAB) to apply all Department interpretations — including those that have not been published — and subjects DAB rulings to Secretarial review.	CMS determined that this was not a major rule and therefore was not required to provide a cost analysis.	
SCHIP Directive (Aug 17, 2007)	The directive imposes a gross income cap in SCHIP equal to 250%of the federal poverty level. Twenty-six states are affected by this new restriction on the SCHIP match.	OMB baseline does not show savings; see note re: CBO estimate.	Takes full effect Aug 17, 2008

Taken from Orris and Solomon, "Administration's Medicaid Regulations Will Weaken Coverage, Harm States, and Strain Health Care System." http://www.cbpp.org/2-13-08health.pdf.