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THE ADMINISTRATION'S MEDICAID REGULATIONS: STATE-BY-STATE IMPACTS

PREPARED FOR

CHAIRMAN HENRY A. WAXMAN

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EXECUTIVE SUMMARY

On November 1, 2007, the Committee on Oversight and Government Reform held a hearing on regulations issued by the Centers for Medicare & Medicaid Services (CMS) that would make major, wide-ranging changes in federal Medicaid policy. In general, the seven regulations at issue represent unilateral actions by CMS neither directed nor authorized by Congress. The Committee heard testimony from the principal author of the regulations, Dennis Smith, the Director of the Centers for Medicaid and State Operations within CMS. According to the Administration, the regulations would reduce federal Medicaid payments to states by a total of more than $15 billion over the next five years.

These estimates, like those issued at the time the regulations were published, are national in scope. They do not enable members of Congress or the public to assess the effect of the regulation on their own states. In a program like Medicaid, which is operated by the states on a day-to-day basis and is famous for its variation from state to state, the lack of state-specific estimates represents a major failure of transparency. Mr. Smith, who has lead responsibility for administering the Medicaid program at the federal level, did not present any estimates of the state-specific impact of the regulations, either at the hearing or in response to subsequent Committee requests.

On January 16, 2008, the Committee wrote to each state Medicaid Director requesting a state-specific analysis of the impact of each of the regulations. The Committee received responses from 43 states and the District of Columbia, accounting for approximately 95% of total Medicaid spending. This report analyzes these responses. It is the first state-specific assessment of the impact of the CMS regulations.

The report finds that the state estimates of the fiscal impacts of the regulatory changes are significantly higher than the $15 billion impact projected by the Administration. According to the states who responded to the Committee, the regulations would reduce federal payments to them by $49.7 billion over the next five years, more than three times the Administration's estimate. In the case of one regulation, the state estimates of lost federal funds are more than ten times the Administration's estimate.

The report also finds:

- **The combined effect of the reductions in federal funds from all seven regulations represents a major fiscal blow for many states.** Estimates of the loss of federal funds from all of the regulations range from $7.4 million over five years in Ohio to $10.8 billion over five years in California. The Missouri Medicaid Director explained the cumulative impact: "The combined loss of federal funding for these four regulations for the next five state fiscal years is an average of over $250 million annually. The effects are even more severe when coupled with the corresponding loss of state funding which would result in a total loss of an average of $400 million annually. Such a loss of funding would cause significant cash flow shortages, causing a financial strain on Missouri hospitals which service almost 850,000 MO HealthNet participants plus the

uninsured. This financial strain, in turn, will result in an adverse impact on the health and welfare of MO HealthNet participants and uninsured individuals in need of medical treatment."

- **The regulations will reduce federal spending by shifting costs, not through greater efficiencies.** The Oregon Medicaid Director wrote: "Taken together, the overall effect will reduce federal Medicaid spending within Oregon by approximately $877 million over the next five years. Most of these costs will simply be shifted on the state and local government, at a time when Oregon has less capacity to absorb added costs given the economic slowdown, reduction of timber revenue, weakening fiscal conditions, increased caseloads, and an increase in client demand."

- **The regulations will disrupt existing systems of care for fragile populations.** The Minnesota Medicaid Director reported: "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."

- **The regulations threaten the financial stability of the hospitals, emergency rooms, and clinics that treat Americans without health insurance.** The California Medicaid Director writes that these regulations "have the potential of reducing federal reimbursements to California by several billion dollars annually. … The reductions in federal funding are likely to lead to destabilization of an already fragile health care, safety-net system in California, which bears a heavy burden in rendering needed health care services to Medicaid beneficiaries and the uninsured."

- **The regulations will impose significant administrative burdens and costs on state Medicaid programs.** The Virginia Medicaid Director stated: "One cost that is not quantified is the administrative burden on the State Medicaid agency and many providers to implement these regulations. These costs may be worthwhile if they represent an improvement in policy. In some cases, however, much of the policy embedded in the regulation is dubious or pointless. In other cases, the regulations represent a reversal of long-standing policy, such as Medicaid reimbursement for graduate medical education or school administrative costs. The Department of Medical Assistance Services would also expect unforeseen consequences."

- **The impact of the regulations extends beyond Medicaid beneficiaries.** Some states reported that the number and scope of the policy changes in the regulations would have significant effects beyond their Medicaid

programs. For example, the Georgia Medicaid Director wrote: "The financial impact to the state of Georgia is significant, estimated at $2.6 billion through June 30, 2012. While the short term impact in Georgia most directly impacts the state's ability to finance Medicaid provider reimbursement, I am concerned that the long-term impact will result in decreased access to care, not only for our Medicaid members, but for all citizens."

- **The regulations do not have the support of the State Medicaid Directors.** The Texas Medicaid Director, as just one example of the State Medicaid Director's lack of support, responded: "Texas could lose $3.4 billion in federal Medicaid funds during fiscal years 2008-2012 as a result of these regulations. … 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."

The methodologies used by the states in preparing their estimates for the Committee differ from state to state and from the methodology used by CMS. Nonetheless, the large discrepancy between the state estimates and the CMS estimates is evidence that the regulations are likely to have a much larger fiscal and programmatic impact on state Medicaid programs and state budgets than federal policymakers realize.

I. BACKGROUND

Medicaid is a federal-state program that purchases a broad range of health and long-term care services from hundreds of thousands of providers on behalf of 60 million low-income Americans. States administer the Medicaid program on a day-to-day basis within broad federal requirements. The federal government matches the cost to states of purchasing covered services on behalf of eligible individuals. The federal matching rate varies from a low of 50% to a high of 76%, depending on the state's per capita income. In FY 2008, the federal government is projected to spend $207 billion on Medicaid, making Medicaid by far the largest federal grant program to the states. Under Office of Management and Budget (OMB) projections, Medicaid this year will account for 46% of all federal grants in aid, dwarfing programs like federal aid for education and social services ($57 billion) and federal aid for highways ($38 billion). As a consequence, when the federal government changes Medicaid policy by restricting the state costs that it will match, there is an impact not only on state Medicaid programs but on state budgets generally.[1]

[1] Office of Management and Budget, *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2009*, Table 8-4 (Feb. 2008).

In 2003, the Government Accountability Office (GAO) designated Medicaid as a program at high risk of mismanagement, waste, and abuse.[2] This designation was based in part on a GAO finding that some states had used "creative financing arrangements" to increase the effective federal matching rate while reducing the state's own contribution to program costs. Between August 2003 and August 2006, CMS took administrative actions to end inappropriate state financing arrangements in 29 states.[3] In 2005, GAO also examined state use of consultants on contingency fee arrangements to maximize federal Medicaid revenues and made a number of recommendations to CMS designed to better monitor state use of contingency fee consultants in order to reduce inappropriate claims for federal matching funds. GAO also recommended that CMS establish or clarify policies relating to targeted case management, rehabilitation services, supplemental payment arrangements, and administrative costs. The purpose of this recommendation was to "strengthen CMS' overall financial management of state Medicaid activities."[4] GAO did not recommend that CMS make major changes in federal Medicaid policy such as discontinuing federal matching funds for graduate medical education, discontinuing federal payments for outreach and enrollment activities by school employees, or discontinuing federal payments for therapeutic foster care services.[5]

During 2007, CMS issued seven regulations that would make major, wide-ranging changes in federal Medicaid policy. (For a brief description of each regulation and its current status, see Appendix B.) Two of these regulations would reduce Medicaid reimbursements for services furnished by public hospitals and teaching hospitals. Another would restrict how states can raise revenues from the health care sector of their economies in order to fund their share of Medicaid. The remaining regulations would narrow the scope of allowable Medicaid coverage for outpatient hospital services, rehabilitation services, school-based administrative and transportation services, and case management services. With a few exceptions, these regulations are unilateral actions by CMS, not policy changes directed by Congress.[6] As the Kentucky Medicaid Director noted:

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[2] U.S. Government Accountability Office, *Major Management Challenges and Program Risks: Department of Health and Human Services* (Jan. 2003) (GAO/03-101).

[3] Statement of Dr. Marjorie Kanof before the Committee on Oversight and Government Reform, *Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight* (Nov. 1, 2007) (GAO/08-255T).

[4] U.S. Government Accountability Office, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight, 46* (June 28, 2005) (GAO/05-748).

[5] House Committee on Oversight and Government Reform, Testimony of Dr. Marjorie Kanof, *Hearing on the Administration's Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals, and States,* 110th Cong., 100 (Nov. 1, 2007).

[6] Even in the two instances in which the regulations are ostensibly related to Congressional action, the regulations go far beyond any legislative change. These two instances concern provider taxes and targeted case management. In the first case, Congress made relatively small changes enacting a temporary reduction in a rate and a definitional change. (Tax Relief and Health Care Act of 2006, P.L. 109-432, Section 403; Deficit Reduction Act of 2005, P.L. 109-171, Section 6051) The new regulation, however, makes sweeping changes in current provider tax regulations that have nothing to do with these changes. In the second case, Congress altered the statutory definition of "case management services." (Deficit Reduction Act of 2005, P.L. 109-171, Section 6052) The new regulation makes substantial changes not authorized by that provision.

> These regulations represent a continuation of CMS's efforts over the last four to five years to continually eliminate and scale back needed services for Kentucky's Medicaid recipients which had previously been allowable under longstanding federal regulations.[7]

According to the Office of Management and Budget, these regulations would reduce federal Medicaid spending by a total of $15 billion over the five year period FY 2009 - FY 2013.[8] These estimated reductions in federal Medicaid spending are not the result of a drop in the need for the services or a decline in the cost of delivering the services. Instead, these reductions in federal spending would occur because the federal government will no longer match the cost of services or administrative activities for which it is currently making matching payments. State Medicaid programs would then face the choice of no longer paying for the service or activity, or continuing to pay for the service or activity entirely with state funds. In those instances where the state decides to continue to pay for the service or activity, the result of the change in regulatory policy is a shift of costs from the federal government to the states.[9]

II. COMMITTEE'S INVESTIGATION

The number and scope of the policy changes involved, and the fiscal impact of those changes on the states, led the Committee on Oversight and Government Reform to initiate an investigation.

On November 1, 2007, the Committee held a hearing on the Medicaid regulations that had been published as of that date. The Committee heard testimony from Dennis Smith, the official within CMS who is the primary author of the regulations, as well as from a State Medicaid Director, the Government Accountability Office, an emergency care physician, a teaching hospital physician, a public hospital administrator, a school nurse, the manager of a child welfare program, and a former recipient of rehabilitative services.[10]

At the hearing, Mr. Smith testified: "State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. Accordingly, there is variation among the States in eligibility, services, and reimbursement rates to providers and health

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[7] Letter from Elizabeth A. Johnson, Commissioner, Cabinet for Health and Family Services Department for Medicaid Services, to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Feb. 18, 2008).

[8] Office of Management and Budget, *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2009*, Table 25-6 (Feb. 2008). The five-year OMB estimates for each regulation are set forth in Appendix B.

[9] Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Overview and Impact of New Regulations* (Jan. 2008).

[10] House Committee on Oversight and Government Reform, *Hearing on the Administration's Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals, and States,* 110th Cong. (Nov. 1, 2007).

plans."[11] Because of this variation among state programs, it is highly likely that each regulation would have differing impacts on different states — differences that federal and state policymakers alike would want to understand. In order for Medicaid policy changes to be truly transparent, a state-by-state impact analysis of regulatory proposals is essential.

Mr. Smith described his agency's regulatory proposals and the reductions in federal payments to states that these proposals would yield nationwide, but he did not provide the Committee with state-specific information. On November 26, 2007, the Committee requested state-specific analyses of the fiscal and beneficiary impact of each regulation. On February 22, 2008, Mr. Smith responded:

> With respect to your second request concerning state-specific impact analyses, I regret that we are unable to develop and report this information. While we share your interest in having state specific impacts, it is not possible at this time to generate accurate assessments due to a variety of deficiencies in data collection including variation in state reporting, changes in state funding practices, current available data sources, information systems, and resource levels. … While we have taken a number of steps to improve our data collection systems, we continue to be concerned that state-by-state impacts would not be reliable.[12]

III. FINDINGS

On January 16, 2008, the Committee wrote to the Medicaid Directors of each state and the District of Columbia asking for an analysis of the impact on their state of each of the seven Medicaid regulations listed in Appendix B. Responses were requested by February 15, 2008. As of February 29, 2008, the Committee had received written responses from Medicaid Directors of 43 states and the District of Columbia. These jurisdictions account for approximately 95% of total Medicaid spending and represent all regions of the country: Northeast, South, Midwest, and West. This staff report presents the findings from these responses. The seven states that did not respond by February 29 were Alabama, Arkansas, Mississippi, Nebraska, Vermont, West Virginia, and Wyoming.

As shown in Table 1, the impact of each regulation varied from state to state. For example, ten of the responding states indicated that the regulation limiting payments to public providers would have no impact (indicated by "None"). Of the remaining 34 responding states (including the District of Columbia), 22 were able to quantify the fiscal impact, while 12 did not specify what the fiscal impact would be (indicated by "NS," or not specified).

In those cases where a state did not specify the fiscal impact of a regulation — i.e., NS — the reason generally given was lack of clarity in the regulatory purpose or text. For

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[11] *Id.*

[12] Letter from Dennis G. Smith, Director, Center for Medicaid and State Operations, to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Feb. 22, 2008).

example, the Delaware Medicaid Director, in describing the impact of targeted case management services rule, wrote: "Given the uncertainty regarding the scope of the rule and the absence of clear guidance from CMS, it is extremely difficult to develop accurate fiscal impact estimates. However, the apparent intent of CMS to apply these requirements broadly raises concerns that a significant portion of our Medicaid population would be seriously and immediately impacted."

In those cases where a state did specify the fiscal impact of a regulation, the estimate refers only to federal Medicaid matching funds that would be lost to the state.[13] The estimate does not include additional costs that a state would expect to incur in order to comply with a regulation — costs that could result in additional federal spending. These costs could be administrative, as illustrated by the Ohio Medicaid Director's comment that the case management regulation "will result in additional costs as well due to increased staffing needs, increased payments for case management activities, decreased controls, the need to restructure eligibility/service authorization and other gate keeping systems and significant changes to information technology systems to accommodate the newly required fifteen minute billing unit."

These costs could also take the form of more expensive services. This is illustrated by the following comment from the Louisiana Medicaid Director regarding the rehabilitative services regulation: "As of February 6, 2008, 2,599 children are receiving MHR services and we would estimate as many as 90% would no longer qualify for MHR under a strict interpretation of the proposed rule. We cannot quantify the fiscal impact, since we don't know how many of these children would end up in inpatient psychiatric hospitals ($538.80 per day), Office of Youth Development (OYD) detention facilities ($415.48 per day) or Office of Community Services (OCS) congregate care ($138-$169 per day). Therefore, the fiscal impact would be significant and negative, since on average, we currently expend only $12.73 per day or $381.90 per member per month in the MHR program." The estimates set forth in Table 1 do not include such additional state (and federal) costs.

[13] In some cases, states supplied a range of estimates. For example, the Kentucky Medicaid director indicated that the GME regulation "would eliminate an estimated $24 to $27 million in federal funds per year over the next 5 years…" The table reflects the lower bound of the estimate.

Table 1: Summary of State Responses to Committee Request (In Millions)

State	Public Providers Reg.	GME Reg.	Outpatient Hospital Reg.	Provider Taxes Reg.	Rehab. Services Reg.	School Admin. Reg.	Case Management Reg.	Total
Alaska	None	$3.2	NS	None	$45.0	$40.0	NS	**$88.2**
Arizona	NS	$154.7	None	None	NS	$58.5	NS	**$213.2**
California	$4,718.0	$1,240.0	$1,332.0	$2,700.0	NS	$650.0	$119.0	**$10,759.0**
Colorado	$711.0	$60.0	NS	None	NS	$7.0	$9.2	**$787.2**
Connecticut	NS	$20.0	NS	$300.0	$22.5	$25.0	$50.0	**$417.5**
Delaware	None	$14.5	None	NS	$72.1	$6.4	NS	**$93.0**
DC	$8.7	$73.0	None	$2.6	$10.6	$17.5	$80.0	**$192.4**
Florida	None	$220.0	None	None	$160.0	$285.0	NS	**$665.0**
Georgia	$1,478.0	$255.3	NS	$721.8	None	$57.6	$63.9	**$2,576.6**
Hawaii	NS	NS	NS	NS	NS	NS	NS	**NS**
Idaho	$10.8	$0.9	None	None	NS	$0.2	None	**$11.9**
Illinois	$1,300.0	$74.0	$700.0	$9.3	NS	$429.0	$26.0	**$2,538.3**
Indiana	NS	NS	NS	NS	NS	NS	NS	**NS**
Iowa	None	$35.5	None	NS	None	NS	NS	**$35.5**
Kansas	None	$5.9	None	NS	NS	$16.5	NS	**$22.4**
Kentucky	$118.0	$127.0	None	$630.0	$15.0	$65.0	$200.0	**$1,155.0**
Louisiana	$1,209.0	$559.0	$19.0	$92.0	NS	$25.0	NS	**$1,904.0**
Maine	NS	NS	NS	NS	NS	NS	NS	**NS**
Maryland	NS	NS	NS	NS	NS	NS	NS	**NS**
Massachusetts	NS	$115.4	NS	None	$382.2	$246.6	$284.0	**$1,028.2**
Michigan	$1,254.4	$545.8	None	$10.0	$1,729.0	$116.8	$254.0	**$3,910.0**
Minnesota	$275.1	$233.0	None	NS	NS	$40.1	$210.5	**$758.7**
Missouri	$110.7	$532.3	$36.6	$573.2	None	$142.5	NS	**$1,395.3**
Montana	$8.6	$0.8	None	None	NS	$9.0	NS	**$18.4**
Nevada	NS	$2.1	NS	$5.4	$50.4	$4.5	NS	**$62.4**
New Hampshire	NS	NS	NS	NS	NS	NS	NS	**NS**
New Jersey	$96.7	$11.5	NS	$8.4	$55.0	$90.0	$95.7	**$357.3**
New Mexico	$1,444.3	$26.5	None	None	NS	$14.0	$33.4	**$1,518.2**
New York	$2,750.0	$3,375.0	NS	NS	$1,010.0	$220.0	NS	**$7,355.0**
North Carolina	$2,187.0	$420.0	None	NS	NS	$56.0	NS	**$2,663.0**
North Dakota	None	None	NS	None	NS	None	$13.3	**$13.3**
Ohio	$7.4	NS	None	NS	NS	NS	NS	**$7.4**
Oklahoma	None	$250.0	None	None	$42.5	None	$195.0	**$487.5**
Oregon	NS	$110.7	None	$28.3	$378.6	$54.8	$288.0	**$860.4**
Pennsylvania	NS	$235.9	NS	NS	NS	$191.5	NS	**$427.4**
Rhode Island	NS	None	None	$1.6	$628.5	$9.5	$7.0	**$646.6**
South Carolina	None	$310.0	None	None	$90.0	$47.5	NS	**$447.5**
South Dakota	None	$10.6	NS	None	NS	$27.9	NS	**$38.5**
Tennessee	$1,000.0	$160.0	None	$7.5	NS	None	$350.0	**$1,517.5**
Texas	$2,200.0	$348.0	NS	$11.5	$356.3	$49.0	$431.0	**$3,395.8**
Utah	$216.0	$102.7	None	None	$13.0	$13.5	$15.4	**$360.6**
Virginia	$7.7	$85.4	None	None	NS	$138.8	NS	**$231.9**
Washington	None	$38.7	None	$2.3	$166.0	$47.0	$334.0	**$588.0**
Wisconsin	$15.0	$50.0	NS	None	NS	$54.0	$75.0	**$194.0**
Total	**$21,126.4**	**$9,807.4**	**$2,087.6**	**$5,103.9**	**$5,226.7**	**$3,255.7**	**$3,134.4**	**$49,742.1**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

The regulations estimated to have the greatest impact, measured in terms of number of responding states affected, were those relating to case management (only one state reported that the regulation would have no impact); graduate medical education (two states reported no impact); rehabilitative services (three states reported no impact); and school administrative and transportation (three states reported no impact). In the case of each of the remaining regulations, a majority of the responding states reported an impact.

The responding states estimated that the regulations as a whole would result in a loss of $49.7 billion in federal Medicaid funds over the next five years. The regulation that the responding states estimated would cause the greatest loss in federal funds is the cost limit on public providers ($21.1 billion over five years), followed by GME ($9.8 billion), rehabilitative services ($5.2 billion), provider taxes ($5.1 billion), school administration and transportation ($3.2 billion), case management ($3.1 billion), and outpatient hospital services ($2.1 billion).

Among the responding states, the state projecting the highest loss of federal funds over the next five years from all seven regulations was California ($10.8 billion), followed by New York ($7.3 billion), Michigan ($3.9 billion), Texas ($3.4 billion), North Carolina ($2.7 billion), Georgia ($2.6 billion), and Illinois ($2.5 billion). In short, these seven states alone estimate a five-year fiscal impact of $33.2 billion — twice as large as that estimated by the Office of Management and Budget (OMB).

These estimates should be viewed with caution, for several reasons. First, not all states responded. Second, the states that did respond may have used different estimation methods, which could lead to differences in five-year estimates. For example, state fiscal years do not generally track federal fiscal years. Third, some of the states that provided estimates sometimes qualified those estimates by indicating that they had not had an opportunity to conduct a full analysis, so that their estimate might understate the actual impact. Finally, as noted above, in many cases states indicated that one or more regulations would have an impact but were not able to specify that impact. The fact that a regulation is drafted so vaguely that many states are unable to specify the loss in federal funds that would result does not mean that the regulation will not cost them federal funds.

The remainder of this report summarizes the findings specific to each regulation.

A. Cost Limits for Public Providers (CMS 2258-FC)

As shown in Appendix C, ten states indicated that this regulation would have no impact on them. 21 states and the District of Columbia provided estimates of the amount of federal funds they would lose as the result of this regulation. 12 states reported that this regulation would have a fiscal impact but were not able to quantify that impact. The loss in federal funds over five years, as estimated by the states, totals $21.1 billion. The OMB estimate of the reduction in federal funds over the five years FY 2009 - FY 2013 is $5.7 billion. [14]

[14] Office of Management and Budget, *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2009*, Table 25-6 (Feb. 2008).

The Illinois Medicaid Director explained the implications of this rule for his state:

> We estimate the reduction in [federal Medicaid matching funds] to Illinois over the next five years to be over $1.3 billion. The vast majority of this reduction will be due to reduced payments to public hospitals. As the providers of last resort, public hospitals play a vital role in serving not only Medicaid beneficiaries, but also the uninsured. Because Illinois has, relative to the size of the State, a low ($202.5 million) federal allocation for disproportionate share hospital adjustment (DSH) payments, we have used Medicaid payments in excess of Medicaid costs to maintain access to needed care by uninsured individuals who are not Medicaid-eligible … . Enforcement of the rule will create a serious funding problem for relatively low DSH states, like Illinois, that have relied on basic Medicaid reimbursement to make up the shortcomings in their DSH allotment.

B. Graduate Medical Education (GME) (CMS 2279-P)

Appendix D summarizes the state responses relating to the regulation that would prohibit federal Medicaid funding for the costs of medical interns and residents. Only two states indicated that the regulation would have no impact. Most of the remaining states (36, including the District of Columbia) provided estimates of the loss of federal funds over five years; these estimates total $9.8 billion. The OMB estimate of the reduction in federal funds over the five years FY 2009 – FY 2013 is $1.8 billion.[15]

Colorado provides one example of the impact of this regulation:

> This proposed regulation 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 fellows 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.

[15] *Id.*

C. Outpatient Hospital Services (CMS 2213-P)

As shown in Appendix E, 21 states and the District of Columbia report that this regulation will have no impact on them. Another 18 states report that there may be a financial impact but they are not able to quantify it. Four states, California, Illinois, Louisiana, and Missouri, supplied estimates of federal funds that they would lose ($1.3 billion, $700 million, $19 million, and $37 million, respectively). CMS states in its proposed rule that "[d]ue to the lack of available data, we cannot determine the fiscal impact of the proposed rule."[16]

The implications of this regulation were described by the Nevada Medicaid director:

> The more restricted definition of "outpatient services" may not only reduce hospital revenues by limiting/eliminating reimbursable services such as early, periodic screening, diagnosis and treatment for children; dental services for children; physician emergency department services; physical, occupational and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services but create <u>major access problems as well</u> (emphasis in original). CMS seems to be taking the unsupported position that services no longer reimbursed through hospital outpatient departments will be provided by and paid for through other parts of the Medicaid program. In large swaths of rural Nevada, it is unclear that such services are available anywhere but from small, "safety net" hospital outpatient departments.

D. Provider Taxes (CMS 2275-P)

Appendix F summarizes the responses relating to the provider tax regulation. 15 states indicated that the regulation would have no impact on them. 16 states, including the District of Columbia, furnished estimates, while 13 states were not able to specify the impact. The states that supplied estimates projected a total loss of $5.1 billion in federal Medicaid matching funds from this regulation. The CMS estimate is $430 million over the five-year period FY 2008 – FY 2012.[17]

The Kansas Medicaid Director described the potential implications of this regulation:

> The Kansas Medicaid Provider Tax is a relatively new program that began in SFY2005 with CMS approval of the methodology. CMS conducted an audit of the KS Provider Tax fund and payouts during SFY2007. Due to the recent approval and review, the Kansas program is in compliance with

[16] Centers for Medicare & Medicaid Services, *Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit*, 72 Fed. Reg. 55164 (Sept. 28, 2007) (proposed rule).

[17] Centers for Medicaid & Medicare Services, *Medicaid Program; Health Care-Related Taxes*, 73 Fed. Reg. 9697 (Feb. 22, 2008).

> the current regulations. In regards to the proposed CMS rule, we do not know how the clarifications may impact this program. However, it is clear that loss of this program has the potential to severely restrict KS Medicaid beneficiaries' access to hospital and physician providers. KS would anticipate a reduction of 25% in KS Medicaid claims payment rates due to the loss of federal matching funds as well as an elimination of direct access payments to hospital providers.

E. Rehabilitative Services (CMS 2261-P)

As shown in Appendix G, all but three of the responding states reported that this regulation would have an impact. 23 states were not able to quantify the fiscal impact. The 18 states that were able to do so estimate that, in total, the regulation would result in a loss of $5.2 billion in federal Medicaid funds over the next five years. The OMB estimate of the reduction in federal payments to states attributable to this regulation is $2.7 billion over the five-year period FY2009 – FY2013.[18]

The Utah Medicaid Director made the following observation about the impact of this regulation on his state:

> Public mental health providers have a significant share of seriously and persistently mentally ill (SPMI) consumers for whom medication management may be the primary, if the not exclusive rehabilitative service modality. Through effective symptom management many such consumers who previously spent years in State hospitals or cycled repeatedly through acute inpatient settings have been able to maintain institutional independence … . If the Medicaid rehabilitation rule is finalized as proposed, there is concern that exclusive medication management services could be interpreted as a maintenance or custodial benefit and could therefore become vulnerable to a denial of coverage … . Such an outcome, we predict, would result in higher rates of inpatient care and institutional utilization, with untold costs to both consumer and system alike.

F. School Administration and Transportation Services (CMS 2287-P)

Appendix H sets forth the state responses regarding the regulation denying federal matching payments for school administration and transportation costs. Only three states reported that this regulation would have no impact on them. 34 states, including the District of Columbia, provided estimates of the fiscal impact of this regulation, while seven states did not specify the impact. In total, the states supplying estimates projected a loss of federal funds of $3.2 billion over the next five years. The OMB estimate of the

[18] Office of Management and Budget, *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2009*, Table 25-6 (Feb. 2008).

reduction in federal spending produced by this regulation is $3.6 billion over the five-year period FY 2009 – FY 2013.[19]

The Connecticut Medicaid Director points out the contradiction between this regulation and the policy objective of enrolling more eligible but unenrolled children in Medicaid and SCHIP:

> The proposed regulations would eliminate Medicaid funding for administrative activities at the schools. The impact on our rates would approximate $10 million ($5 million in federal financial participation, or FFP). But more important than the initial fiscal impact would be the effect that these regulations would have on school outreach. The Administration intends to hold Connecticut and other states that cover children above 200% of the federal poverty level to an assurance that 95% of the Medicaid eligible children below 200% FPL are already covered. One of the best places to conduct outreach to these children is through the schools, and Governor Rell has dedicated funds in a new initiative to do exactly that. But this rule would disallow FFP for eligibility determinations at the schools unless they were performed by staff of the Department of Social Services. DSS cannot afford to state-fund an outreach effort in 3,000 schools in 169 towns without the benefit of the federal match.

G. Case Management Services (CMS 2237-IFC)

As shown in Appendix I, only one of the responding states (Idaho) reported that this regulation would have no impact on it. 21 of the remaining states were able to estimate a fiscal impact, while the other 22 did not specify. The 21 states (including the District of Columbia) estimate that the regulation will reduce federal Medicaid matching payments to them by a total of $3.1 billion. CMS estimates that the regulation will reduce federal spending by $1.3 billion over the five-year period FY 2008 – FY 2012.[20]

The following observation was offered by the Tennessee Medicaid director:

> The recipients of case management services in Tennessee are, by and large, among the most vulnerable persons in our program — children in state custody, persons who are mentally ill, persons with mental retardation, persons who are aged and/or disabled enough to require nursing facility care, and adults who require protective services to prevent abuse, neglect, or financial exploitation. It is unfair to make these persons bear the brunt of CMS's 'sledgehammer' approach to cutting costs, as exemplified in this rule.

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[19] *Id.*

[20] Centers for Medicare & Medicaid Services, *Medicaid Program: Optional State Plan Case Management Services* 72 Fed. Reg. 68091 (Dec. 4, 2007) (Interim final rule with comment period).

IV. CONCLUSION

The findings presented in this report should be of concern to members of Congress as well as officials at CMS. They indicate that the CMS Medicaid regulations, taken as a whole, have fiscal and programmatic impacts that are far more extensive and far more harmful than has commonly been understood. This lack of policy transparency in a program that affects the health of 60 million low-income Americans is as regrettable as it was avoidable.

Appendix A: Medicaid Directors Responding to January 16, 2008 Request

Alaska: Jerry Fuller, Medicaid Director, Department of Health and Social Services, (907) 465-3030
Arizona: Anthony D. Rodgers, Director, Health Care Cost Containment System, (602) 471-4000
California: Stan Rosenstein, Chief Deputy Director, Health Care Programs, Department of Health Care Services, (916) 440-7400
Colorado: Joan Henneberry, Executive Director, Department of Health Care Policy and Financing, (303) 866-2993
Connecticut: David Parrella, Director, Medical Care Administration, Department of Social Services, (860) 424-5583
Delaware: Harry Hill, Director, Department of Health and Social Services, (302) 255-9627
DC: Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, (202) 442-5988
Florida: Carlton D. Snipes, Acting Deputy Secretary for Medicaid, Florida Medicaid, (850) 488-3560
Georgia: Mark Trail, Chief, Medical Assistance Plans, Department of Community Health, (404) 657-1502
Hawaii: Lois Lee, Acting Med-QUEST Division Administrator, Department of Human Services, (808) 692-8050
Idaho: Leslie M. Clement, Administrator, Division of Medicaid, Department of Health and Welfare, (208) 334-5747
Illinois: Theresa A. Eagleson, Administrator, Division of Medical Programs, Department of Healthcare and Family Services, (217) 782-1200
Indiana: Jeffrey M. Wells, Director of Medicaid, Family and Social Services Administration, (317) 233-4690
Iowa: Eugene I. Gessow, Medicaid Director, Department of Human Services, (515) 725-1123
Kansas: Andy Allison, Medicaid Director, Health Policy Authority, (785) 296-3981
Kentucky: Elizabeth A. Johnson, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, (502) 564-4321
Louisiana: Jerry Phillips, Medicaid Director, Department of Health and Hospitals, (225) 342-3891
Maine: Tony Marple, Director, Office of MaineCare Services, Department of Health and Human Services, (207) 287-2674
Maryland: John G. Folkemer, Deputy Secretary of Health Care Financing, Department of Health and Mental Hygiene, (410) 767-4073
Massachusetts: Tom Dehner, Medicaid Director, Office of Medicaid, Executive Office of Health and Human Services, (617) 573-1770
Minnesota: Christine Bronson, Medicaid Director, Department of Human Services, (615) 431-2914
Michigan: Paul Reinhart, Director, Medical Services Administration, Department of Community Health, (517) 241-7882

Missouri: Ian McCaslin, Director, Division of Medical Services, Department of Social Services, (573) 751-6922
Montana: John Chappuis, State Medicaid Director, Department of Public Health and Human Services, (406) 444-4084
Nevada: Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, (775) 684-3600
New Hampshire: Nicholas A. Toumpas, Commissioner, Department of Health and Human Services, (603) 271-4912
New Jersey: Clyde H. Henderson, III, Director, Washington Office, State of New Jersey, (202) 638-0631
New Mexico: Carolyn Ingram, Medical Assistance Division Director, Human Services Department, (505) 827-3106
New York: Deborah Bachrach, Medicaid Director, Deputy Commissioner, Office of Health Insurance Programs, Department of Health (518) 474-3018
North Carolina: William W. Lawrence, Jr., Acting Director, Division of Medical Assistance, Department of Health and Human Services, (919) 855-4100
North Dakota: Maggie D. Anderson, Director, Medical Services Division, Department of Human Services, (701) 328-2321
Ohio: John R. Corlett, Medicaid Director, Job and Family Services, (614) 752-3739
Oklahoma: Mike Fogarty, Chief Executive Officer, Health Care Authority, (405) 522-7300
Oregon: Jim Edge, Interim State Medicaid Director, Office of Medical Assistance Programs, Department of Human Services, (503) 945-5772
Pennsylvania: Michael Nardone, Deputy Secretary, Office of Medical Assistance Programs, Department of Public Welfare, (717) 787-1870
Rhode Island: Gary D. Alexander, Director, Department of Human Services, (401) 462-2121
South Carolina: Emma Forkner, Director, Department of Health and Human Services, (803) 898-2504
South Dakota: Larry Iversen, Medicaid Director, Department of Social Services, (605) 773-3495
Tennessee: Darin J. Gordon, Director, Bureau of TennCare, Department of Finance and Administration, (615) 507-6000
Texas: Chris Traylor, Medicaid Director, Health and Human Services Commission, (512) 424-1400
Utah: Michael Hales, Director, Health Care Financing, Department of Health, (801) 538-6689
Virginia: Patrick W. Finnerty, Director, Department of Medical Assistance Services, (804) 786-7933
Washington: Kathy Leitch, Assistant Secretary, Aging and Disability Services Administration, Department of Social and Health Services (360) 902-7797; Doug Porter, Assistant Secretary, Health Recovery Services Administration, Department of Social and Health Services (360) 725-1867
Wisconsin: Jason A. Helgerson, Medicaid Director, Department of Health and Family Services, (608) 266-8922

Appendix B: CMS Medicaid Regulations

Rule	Description	Effective Date	Estimated Reduction Federal Funds (OMB) (5 yr.)	Moratorium Status
Cost Limit for Public Providers (CMS 2258-FC) Final Rule 72 Fed. Reg. 29748 (May 29, 2007)	Narrows definition of a public provider, limits payments to public providers to cost of treating Medicaid patients	July 30, 2007	-$5.71 billion (FY 2009-FY 2013)	Enacted (sec. 7002 of P.L. 110-28); expires May 25, 2008
Payments for Graduate Medical Education (GME) (CMS 2279-P) Proposed Rule 72 Fed. Reg. 28930 (May 23, 2007)	Prohibits federal matching funds for costs of GME programs as part of Medicaid reimbursement for inpatient or outpatient hospital services	First full State FY following effective date of final rule	-$1.82 billion (FY 2009-FY 2013)	Enacted (sec. 7002 of P.L. 110-28); expires May 25, 2008
Redefine Outpatient Hospital Services (CMS 2213-P) Proposed Rule 72 Fed. Reg. 55158 (September 28, 2007)	Narrows scope of Medicaid outpatient hospital services to Medicare outpatient hospital services paid on a prospective basis; excludes other Medicaid services (e.g., rehabilitative services) from coverage as outpatient hospital services	Not specified	"Due to lack of available data, we cannot determine the fiscal impact of this proposed rule."	None
Allowable Provider Taxes (CMS 2275-P) Final Rule 73 Fed. Reg. 9685 (February 22, 2008)	Implements Tax Relief and Health Care Act of 2006 (P.L. 109-432) reduction of threshold from 6% to 5.5% of revenues; substantially tightens "hold harmless" test	April 22, 2008	-$430 million (FY 2008-FY 2012)	None
Rehabilitative Services (CMS 2261-P) Proposed Rule 72 Fed. Reg. 45201 (August 13, 2007)	Prohibits federal matching funds for rehabilitative services furnished through a non-medical program (e.g., foster care, adoption services, education, juvenile justice	"We will work with States to implement this rule in a timely fashion…."	-$2.72 billion (FY 2009-FY 2013)	Enacted (sec. 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. 110-173); expires June 30, 2008
Payments for Costs of School Administration, Transportation; (CMS 2287-P) Final Rule 72 Fed. Reg. 73635 (December 28, 2007)	Prohibits federal matching funds for (1) administrative activities by school employees or contractors and for (2) transportation of school-aged children from home to school and back	2008-2009 school year	-$3.62 billion (FY 2009-FY 2013)	Enacted (sec. 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. 110-173); expires June 30, 2008
Case Management Services (CMS 2237-IFC) Interim Final Rule 72 Fed. Reg. 68077 (December 4, 2007)	Limits period of coverage for case management services for individuals transitioning from institutions to the community; specifies a 15-minute unit of service for all case management services; bars coverage of case management activities as administrative costs	March 3, 2008	- $1.28 billion (FY 2008-FY 2012)	None

Appendix C: Estimated Loss of Federal Funds from CMS Regulation on Cost Limits for Public Providers (CMS 2258-FC) (In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**None**	**None**
Arizona	**NS**	**NS**
California	**943.6**	**4,718.0**
Colorado	**142.2**	**711.0**
Connecticut	**NS**	**NS**
Delaware	**None**	**None**
District of Columbia	**NS**	**8.7**
Florida	**None**	**None**
Georgia	**30.2**	**1,478.0**
Hawaii	**NS**	**NS**
Idaho	**2.0**	**10.8**
Illinois	**255.0**	**1,300.0**
Indiana	**NS**	**NS**
Iowa	**None**	**None**
Kansas	**None**	**None**
Kentucky	**21.0**	**118.0**
Louisiana	**222.0**	**1,209.0**
Maine	**36.0**	**NS**
Maryland	**NS**	**NS**
Massachusetts	**NS**	**NS**
Michigan	**225.9**	**1,254.4**
Minnesota	**50.5**	**275.1**
Missouri	**22.1**	**110.7**
Montana	**NS**	**8.6**
Nevada	**NS**	**NS**
New Hampshire	**NS**	**NS**
New Jersey	**3.0**	**96.7**
New Mexico	**168.7**	**1,444.3**
New York	**550.0**	**2,750.0**
North Carolina	**430.6**	**2,187.0**
North Dakota	**None**	**None**
Ohio	**1.4**	**7.4**
Oklahoma	**None**	**None**
Oregon	**NS**	**NS**
Pennsylvania	**NS**	**NS**
Rhode Island	**NS**	**NS**
South Carolina	**None**	**None**
South Dakota	**None**	**None**
Tennessee	**200.0**	**1,000.0**
Texas	**127.0**	**2,200.0**
Utah	**40.7**	**216.0**
Virginia	**1.4**	**7.7**
Washington	**None**	**None**
Wisconsin	**3.0**	**15.0**
Total	**3,476.3**	**21,126.4**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

Appendix D: Estimated Loss of Federal Funds from CMS Regulation on Graduate Medical Education (GME) (CMS 2279-P)
(In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**0.4**	**3.2**
Arizona	**30.1**	**154.7**
California	**248.2**	**1,240.0**
Colorado	**12.0**	**60.0**
Connecticut	**4.0**	**20.0**
Delaware	**2.7**	**14.5**
District of Columbia	**NS**	**73.0**
Florida	**44.0**	**220.0**
Georgia	**5.2**	**255.3**
Hawaii	**NS**	**NS**
Idaho	**0.2**	**0.9**
Illinois	**14.0**	**74.0**
Indiana	**NS**	**NS**
Iowa	**7.1**	**35.5**
Kansas	**1.2**	**5.9**
Kentucky	**24.0**	**127.0**
Louisiana	**103.0**	**559.0**
Maine	**NS**	**NS**
Maryland	**NS**	**NS**
Massachusetts	**21.1**	**115.4**
Michigan	**104.4**	**545.8**
Minnesota	**42.0**	**233.0**
Missouri	**91.0**	**532.3**
Montana	**NS**	**0.8**
Nevada	**0.4**	**2.1**
New Hampshire	**NS**	**NS**
New Jersey	**3.5**	**11.5**
New Mexico	**5.3**	**26.5**
New York	**675.0**	**3,375.0**
North Carolina	**84.0**	**420.0**
North Dakota	**None**	**None**
Ohio	**33.4**	**NS**
Oklahoma	**NS**	**250.0**
Oregon	**21.1**	**110.7**
Pennsylvania	**45.4**	**235.9**
Rhode Island	**None**	**None**
South Carolina	**62.0**	**310.0**
South Dakota	**2.0**	**10.6**
Tennessee	**32.0**	**160.0**
Texas	**71.0**	**348.0**
Utah	**19.3**	**102.7**
Virginia	**15.4**	**85.4**
Washington	**7.3**	**38.7**
Wisconsin	**10.0**	**50.0**
Total	**1,841.7**	**9,807.4**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

Appendix E: Estimated Loss of Federal Funds from CMS Regulation on Outpatient Hospital Services (CMS 2213-P)
(In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**NS**	**NS**
Arizona	**None**	**None**
California	**266.4**	**1,332.0**
Colorado	**NS**	**NS**
Connecticut	**NS**	**NS**
Delaware	**None**	**None**
District of Columbia	**None**	**None**
Florida	**None**	**None**
Georgia	**NS**	**NS**
Hawaii	**NS**	**NS**
Idaho	**None**	**None**
Illinois	**130.0**	**700.0**
Indiana	**NS**	**NS**
Iowa	**None**	**None**
Kansas	**None**	**None**
Kentucky	**None**	**None**
Louisiana	**3.0**	**19.0**
Maine	**NS**	**NS**
Maryland	**NS**	**NS**
Massachusetts	**NS**	**NS**
Michigan	**None**	**None**
Minnesota	**None**	**None**
Missouri	**5.9**	**36.6**
Montana	**None**	**None**
Nevada	**NS**	**NS**
New Hampshire	**NS**	**NS**
New Jersey	**NS**	**NS**
New Mexico	**None**	**None**
New York	**NS**	**NS**
North Carolina	**None**	**None**
North Dakota	**NS**	**NS**
Ohio	**None**	**None**
Oklahoma	**None**	**None**
Oregon	**None**	**None**
Pennsylvania	**NS**	**NS**
Rhode Island	**None**	**None**
South Carolina	**None**	**None**
South Dakota	**NS**	**NS**
Tennessee	**None**	**None**
Texas	**NS**	**NS**
Utah	**None**	**None**
Virginia	**None**	**None**
Washington	**None**	**None**
Wisconsin	**NS**	**NS**
Total	**405.3**	**2,087.6**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

Appendix F: Estimated Loss of Federal Funds from CMS Regulation on Provider Taxes (CMS 2275-P) (In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**None**	**None**
Arizona	**None**	**None**
California	**540.0**	**2,700.0**
Colorado	**None**	**None**
Connecticut	**60.0**	**300.0**
Delaware	**None**	**NS**
District of Columbia	**NS**	**2.6**
Florida	**None**	**None**
Georgia	**None**	**721.8**
Hawaii	**NS**	**NS**
Idaho	**None**	**None**
Illinois	**1.7**	**9.3**
Indiana	**NS**	**NS**
Iowa	**1.0**	**NS**
Kansas	**NS**	**NS**
Kentucky	**126.0**	**630.0**
Louisiana	**17.0**	**92.0**
Maine	**NS**	**NS**
Maryland	**0.2**	**NS**
Massachusetts	**None**	**None**
Michigan	**10.0**	**10.0**
Minnesota	**NS**	**NS**
Missouri	**92.9**	**573.2**
Montana	**None**	**None**
Nevada	**1.1**	**5.4**
New Hampshire	**NS**	**NS**
New Jersey	**2.1**	**8.4**
New Mexico	**None**	**None**
New York	**NS**	**NS**
North Carolina	**NS**	**NS**
North Dakota	**None**	**None**
Ohio	**NS**	**NS**
Oklahoma	**None**	**None**
Oregon	**8.5**	**28.3**
Pennsylvania	**NS**	**NS**
Rhode Island	**0.3**	**1.6**
South Carolina	**None**	**None**
South Dakota	**None**	**None**
Tennessee	**1.5**	**7.5**
Texas	**2.1**	**11.5**
Utah	**None**	**None**
Virginia	**None**	**None**
Washington	**None**	**2.3**
Wisconsin	**None**	**None**
Total	**864.4**	**5,103.9**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

Appendix G: Estimated Loss of Federal Funds from CMS Regulation on Rehabilitation Services (CMS 2261-P)
(In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**9.0**	**45.0**
Arizona	**NS**	**NS**
California	**NS**	**NS**
Colorado	**NS**	**NS**
Connecticut	**4.5**	**22.5**
Delaware	**13.4**	**72.1**
District of Columbia	**NS**	**10.6**
Florida	**32.0**	**160.0**
Georgia	**None**	**None**
Hawaii	**NS**	**NS**
Idaho	**NS**	**NS**
Illinois	**NS**	**NS**
Indiana	**NS**	**NS**
Iowa	**None**	**None**
Kansas	**NS**	**NS**
Kentucky	**3.0**	**15.0**
Louisiana	**NS**	**NS**
Maine	**17.4**	**NS**
Maryland	**NS**	**NS**
Massachusetts	**64.6**	**382.2**
Michigan	**321.6**	**1,729.0**
Minnesota	**NS**	**NS**
Missouri	**None**	**None**
Montana	**NS**	**NS**
Nevada	**9.5**	**50.4**
New Hampshire	**NS**	**NS**
New Jersey	**4.5**	**55.0**
New Mexico	**NS**	**NS**
New York	**202.0**	**1,010.0**
North Carolina	**NS**	**NS**
North Dakota	**NS**	**NS**
Ohio	**NS**	**NS**
Oklahoma	**NS**	**42.5**
Oregon	**72.9**	**378.6**
Pennsylvania	**NS**	**NS**
Rhode Island	**125.7**	**628.5**
South Carolina	**18.0**	**90.0**
South Dakota	**NS**	**NS**
Tennessee	**NS**	**NS**
Texas	**14.2**	**356.3**
Utah	**2.4**	**13.0**
Virginia	**NS**	**NS**
Washington	**33.2**	**166.0**
Wisconsin	**NS**	**NS**
Total	**947.9**	**5,226.7**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

Appendix H: Estimated Loss of Federal Funds from CMS Regulation on School Administration and Transportation Costs (CMS 2287-P)
(In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**8.0**	**40.0**
Arizona	**11.7**	**58.5**
California	**130.0**	**650.0**
Colorado	**1.4**	**7.0**
Connecticut	**5.0**	**25.0**
Delaware	**1.2**	**6.4**
District of Columbia	**NS**	**17.5**
Florida	**57.0**	**285.0**
Georgia	**None**	**57.6**
Hawaii	**NS**	**NS**
Idaho	**0.0**	**0.2**
Illinois	**82.0**	**429.0**
Indiana	**NS**	**NS**
Iowa	**NS**	**NS**
Kansas	**3.2**	**16.5**
Kentucky	**13.0**	**65.0**
Louisiana	**5.0**	**25.0**
Maine	**NS**	**NS**
Maryland	**1.0**	**NS**
Massachusetts	**47.3**	**246.6**
Michigan	**22.0**	**116.8**
Minnesota	**None**	**40.1**
Missouri	**28.5**	**142.5**
Montana	**NS**	**9.0**
Nevada	**0.8**	**4.5**
New Hampshire	**NS**	**NS**
New Jersey	**15.8**	**90.0**
New Mexico	**2.8**	**14.0**
New York	**44.0**	**220.0**
North Carolina	**NS**	**56.0**
North Dakota	**None**	**None**
Ohio	**NS**	**NS**
Oklahoma	**None**	**None**
Oregon	**10.3**	**54.8**
Pennsylvania	**35.0**	**191.5**
Rhode Island	**1.9**	**9.5**
South Carolina	**9.5**	**47.5**
South Dakota	**5.4**	**27.9**
Tennessee	**None**	**None**
Texas	**None**	**49.0**
Utah	**2.5**	**13.5**
Virginia	**25.1**	**138.8**
Washington	**9.4**	**47.0**
Wisconsin	**10.8**	**54.0**
Total	**589.6**	**3,255.7**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.

Appendix I: Estimated Loss of Federal Funds from CMS Regulation on Case Management Services (CMS 2237-IFC) (In Millions)

STATE	FIRST YEAR	5-YEAR TOTAL
Alaska	**NS**	**NS**
Arizona	**NS**	**NS**
California	**24.0**	**119.0**
Colorado	**1.8**	**9.2**
Connecticut	**10.0**	**50.0**
Delaware	**NS**	**NS**
District of Columbia	**NS**	**80.0**
Florida	**NS**	**NS**
Georgia	**None**	**63.9**
Hawaii	**NS**	**NS**
Idaho	**None**	**None**
Illinois	**5.0**	**26.0**
Indiana	**NS**	**NS**
Iowa	**NS**	**NS**
Kansas	**NS**	**NS**
Kentucky	**37.0**	**200.0**
Louisiana	**NS**	**NS**
Maine	**17.5**	**NS**
Maryland	**66.2**	**NS**
Massachusetts	**54.6**	**284.0**
Michigan	**48.3**	**254.0**
Minnesota	**8.7**	**210.5**
Missouri	**NS**	**NS**
Montana	**NS**	**NS**
Nevada	**NS**	**NS**
New Hampshire	**NS**	**NS**
New Jersey	**NS**	**95.7**
New Mexico	**6.4**	**33.4**
New York	**NS**	**NS**
North Carolina	**NS**	**NS**
North Dakota	**NS**	**13.3**
Ohio	**NS**	**NS**
Oklahoma	**NS**	**195.0**
Oregon	**52.0**	**288.0**
Pennsylvania	**NS**	**NS**
Rhode Island	**1.4**	**7.0**
South Carolina	**NS**	**NS**
South Dakota	**NS**	**NS**
Tennessee	**70.0**	**350.0**
Texas	**37.5**	**431.0**
Utah	**2.8**	**15.4**
Virginia	**NS**	**NS**
Washington	**61.0**	**334.0**
Wisconsin	**15.0**	**75.0**
Total	**519.2**	**3,134.4**

None = State indicated that the regulation would have no impact.
NS = State indicated that the regulation may have an impact but impact not specified.