The impact of federal policy on Oregon's health care reform efforts:

Opportunities and barriers within Medicaid and the State Children's Health Insurance Program

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Executive summary

Since its inception, Medicaid has been a major force in shaping health care and long-term care services and supports for those who are most vulnerable and needy. It is virtually a lifeline to medical and health-related services for America's poorest people.

Before Medicaid, people who were poor were almost unilaterally uninsured, saw doctors and other health care providers far less often than those who were not poor, and faced serious financial burdens, if and when they were able to obtain care. Medicaid has reshaped the availability and provision of care to the poor, raising access to levels similar to those for people with private coverage.

Medicaid is the 3rd largest health insurance program in the U.S., after employer-based insurance and Medicare.

- It covers nearly 15 percent of the total U.S. population.
- In Oregon, it covers 1 out of every 4 children.
- More than 40 percent of Oregon births are covered by Medicaid.
- About 68,000 Oregon Medicaid beneficiaries have permanent disabilities.
- About 44,000 are aged 65 and over.

By contrast, poor individuals and families who do not have Medicaid coverage continue to face significant barriers to care. There were more than 47 million Americans and more than 600,000 Oregonians who were uninsured in 2006.

Medicaid also provides the only public financing of long-term services and supports for seniors and people with disabilities. It has had an impact on every sector of health and long-term care in America, from hospital care to a broad array of non-medical support services.

The State Children's Health Insurance Program (SCHIP) is a smaller program than Medicaid, also jointly financed by the federal and state governments, targeted at increasing health care coverage among children. While Medicaid provides an open-ended funding stream of federal dollars based on a state-designed Medicaid program and ability to provide the required matching funds, SCHIP funding is capped, with annual formula-based allotments to states.

As a cooperative venture between the federal and state governments, nearly 61 cents of every dollar spent on Medicaid and 72 cents of every dollar spent on SCHIP in Oregon come from the federal government, administered by the U.S.

Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS).

State Plans and waivers

States manage their programs according to federally approved Medicaid State Plans, and exceptions to federal requirements are frequently granted through the "waiver" process. States can often achieve program expansion and/or the implementation of innovative and creative service and delivery approaches through federal approval of waivers.

While Medicaid and SCHIP were designed for a great deal of state discretion in how they are planned and implemented, state programs are always subject to close scrutiny and approval by CMS. In recent years, a major priority of the current Administration, both explicitly and implicitly, has been to limit spending on Medicaid, Medicare, SCHIP, other health care programs and other entitlement programs. Numerous federal actions have been taken to curtail federal spending on these programs, and even more have been proposed and rejected by Congress.

Eligibility

Medicaid eligibility is both financial and categorical. Factors include family income, age and other things, such as being pregnant or having a disability.

The federal government defines a number of "mandatory" eligibility groups that must be provided Medicaid services in every state, and gives each state a choice of adding other populations as "optional" beneficiaries.

Recently, however, limits have been placed on Medicaid state options in order to support the positions of the Bush administration, primarily as expressed in the SCHIP reauthorization process.

For example, the Bush administration holds a position that government-supported medical assistance should be provided only, or at least primarily, to *very low* income people, even though, at any time, low income, lower middle income, and middle income people may also lack access to the health care they need. This has caused CMS to deny states the right to expand their medical assistance programs to serve those outside the very low income demographic, even though the state recognizes the need and is willing to spend the state matching funds.

In this way and in others, such as the rigorous federal requirements for proof of U.S. citizenship, states are severely limited as to whom they may find eligible for medical assistance programs, without regard to need or the state's commitment.

Benefits, delivery and payment systems

The federal government also sets "mandatory" and "optional" benefits, or services, and defines some of the parameters of delivery systems, payment systems, reporting systems and other aspects of the programs.

Oregon remains the only state that has been allowed to provide an extremely unique package of benefits, based on a prioritized list of health care conditions and treatments, and to adjust these benefits over the years. But this has come a at a price: frequently, a protracted process for CMS approval that often lasts more than a year, or even as long as two or three years, as in the case of Oregon's original OHP waiver application.

Recent regulations affecting the "business" side of service delivery provide additional examples of the current federal climate, such as:

- A new rule to take effect in May 2008 that imposes a restrictive new definition of "unit of government" and restricts payments to providers operated by units of government.
- Effective January 2008, there are more stringent requirements on States and more flexibility for CMS regarding the relationship between provider taxes and payments to providers.

Whether this approach at the federal level will continue or not depends to a great extent on the next president's administration, and where presidential and congressional priorities come together in the future.

Still, there are opportunities. In the recent past, Oregon has been able to maximize federal participation with such projects as the Medicaid Transformation Grant, a grant to the state of $5.5 million to develop and implement an electronic health records bank. Oregon has also implemented non-emergency medical transportation brokerages, a new state option under Medicaid.

Waivers and new options for Medicaid State Plan innovations continue to be available, and Oregon continues to seek out possibilities to maximize federal funding and to take advantage of creative alternatives provided by the federal government.

The following "white paper" provides additional information, details and analysis of the impact of federal policy on Oregon's health care reform efforts.[1]

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[1] This paper's focus on Medicaid and SCHIP should not be construed as limiting consideration of other federal policy and funding streams in other program areas; including but not limited to substance abuse treatment or mental health treatment funds from the Substance Abuse and Mental Health Services Administration; additional funding for HIV/AIDS such as the Ryan-White Act; and Title V block grants for maternal and child health. Those options are beyond the scope of this white paper. Additional information can be provided upon request to DHS.

Medicaid – background and overview

Medicaid, the largest source of funding for and a lifeline to medical and health-related services for America's poorest people, became Title XIX of the Social Security Act in 1965 as a cooperative venture between the federal and state governments.

Since its inception, Medicaid has been a major force in shaping health and long-term care services for those who are most vulnerable and needy.

- It is the third largest health insurance program in the U.S., after employer-based insurance and Medicare.
- Medicaid is a major source of federal financial assistance to the states, accounting for as much as 40 percent of all federal grant-in-aid payments to states.
- It covers nearly 15 percent of the total U.S. population.
- Children represent more than half of all Medicaid beneficiaries.
- It covers one out of every four children in the U.S.
- It covers 40 percent of all births.
- Approximately 60 million low-income, elderly and disabled Americans rely on Medicaid for their health care.
- It is the single largest source of public financing for HIV/AIDS care.
- In Oregon, it covers one out of every four children.
- More than 40 percent of Oregon births are covered by Medicaid.
- About 68,000 Oregon Medicaid beneficiaries have permanent disabilities.
- About 44,000 are aged 65 and over.

Medicaid is also the only significant public program providing financing for long-term care, covering 70 percent of nursing home residents and nearly half of nursing home costs nationwide. It has impacted every sector of health care in America, from hospital care to non-medical support services.

More importantly, Medicaid has a significant impact on the individuals it serves. Before Medicaid, people who were poor were almost unilaterally uninsured, saw doctors and other health care providers far less often than those who were not poor, and faced serious financial burdens when they were able to obtain care. Medicaid has reshaped the availability and provision of care to the poor, raising access to levels similar to those for people with private coverage. By contrast, poor

Americans who do not have Medicaid coverage continue to face significant barriers to care. There were more than 47 million Americans and more than 600,000 Oregonians who were uninsured in 2006.

Federal law sets broad parameters and general requirements for the program, and the rest is left to state discretion, subject to approval by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS).

Federal regulations provide a framework for each state to build a unique Medicaid program. Under Section 1902 of the Social Security Act, all states must comply with some basic requirements. States must:

- Serve certain mandatory populations, such as poverty-level children and low-income pregnant women;
- Provide certain mandatory services, such as hospital care and physician services;
- Provide services that are "sufficient in amount, duration, and scope to reasonably achieve (their) purpose"; and
- Provide services throughout the state.

Within these broad national guidelines and additional requirements established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services and (4) administers its own program.

Medicaid policies for eligibility, services, and payment are, therefore, complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, state legislatures may change the state's program, including eligibility, services, and/or reimbursement from year to year.

Financing

Medicaid is a jointly funded state-federal program that provides medical coverage to eligible persons. It is governed by federal laws and regulations that require coverage of certain populations and services and provide flexibility for states to cover additional populations and services.

It is an entitlement program, meaning it guarantees coverage for eligible services to eligible clients, and the federal government provides open-ended funding, or Federal Financial Participation (FFP), depending on available state match, for actual costs to provide services to eligible clients.

The portion of total Medicaid costs paid by the federal government is known as the *Federal Medical Assistance Percentage (FMAP)*, which is based on the average state per capita income compared to the U.S. average. Small decreases or increases in the FMAP rate result in significant changes to our federal funds.

- Maximum FMAP rate is 83 percent of the state's Medicaid costs.
- Minimum FMAP rate is 50 percent of the state's Medicaid costs.
- Oregon's FMAP rate for federal fiscal year (FFY) 2008 is 60.86 percent.
- Oregon's FMAP rate for FFY 2009 is 62.45 percent.

The federal government also provides separate *Administrative Match Rates* for such expenditures as costs related to the development of information technology (IT) systems, operation of claims payment systems, and services performed by skilled medical professionals. Currently, states can receive up to 90 percent match for such costs.

- Most states, including Oregon, receive an Administrative Match Rate in the neighborhood of 50 percent.
- In the Bush administration's 2008 budget proposal, the president proposed cutting the Administrative Match Rate to 50 percent across the board, saving the federal government $5.3 billion over five years.

Eligibility

Medicaid eligibility is both financial and categorical. Low income alone does not constitute eligibility for Medicaid. Eligibility factors for Medicaid include:

- Family income,
- Age, and
- Other factors, such as being pregnant or disabled.

The following are mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Those who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996
- Children under age 6 whose family income is at or below 133 percent of the Federal Poverty Level (FPL)
- Pregnant women whose family income is below 133 percent of the FPL
- Supplemental Security Income (SSI) recipients
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act
- Special protected groups: Typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time
- Children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL, with the exception of non-qualifying non-citizens
- Certain Medicare beneficiaries

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined.

The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their state on July 16, 1996

- Institutionalized individuals eligible under a "special income level" set by each state (up to 300 percent of the SSI federal benefit rate)
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL
- Recipients of state supplementary income payments
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control.
- "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33)
- "Medically needy" persons
- Expansion populations covered under the demonstration waiver[2]

Services/benefit packages

One way the federal government controls state Medicaid programs is through defining “mandatory” and “optional” services.

Mandatory services

Mandatory services are those that federal law requires that all state Medicaid programs pay for:

- Physician services
- Inpatient and outpatient hospital services
- Rural and federally-qualified health center services
- Family planning services and supplies

[2] See Attachment A for information on Oregon’s Medicaid-eligible populations.

- Nurse mid-wife services
- Nurse practitioner services
- Laboratory and x-ray services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21
- Inpatient psychiatric services for individuals under age 21
- Pregnancy-related services
- Medical and surgical services by a dentist
- Nursing facility services for individuals age 21 or over
- Home health services, including medical supplies and equipment
- Medical transportation services

Optional services

Optional services are those that a state may choose to pay for or not, depending on state priorities and availability of state match funding.

There are 34 currently approved optional Medicaid services. Following are some of the most common on a national basis:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Dental services
- Nursing facility services for children under age 21
- Rehabilitation and physical therapy services
- Home and community-based services for seniors and people with disabilities
- Primary Care Case Management services (PCCM)

Optional services provided in Oregon include:

- Prescription drugs
- Case management for women with high-risk pregnancies and infants
- Hospice care

- Intermediate Care Facilities for Persons with mental Retardation (ICF-MR)
- Institutions for mental Disease (IMD) for children
- Rehabilitation services
- Eyeglasses/contact lenses
- Mental health services
- Dental services for adults
- Prosthetic devices
- Occupational, physical and speech therapies
- Diagnostic services
- Primary Care Case Management services (PCCM)

What services are used most by Medicaid beneficiaries (national)?	What services cost the most?
1. Prescription Drugs	1. ICFs/MR and Nursing Homes
2. Physician services	2. Hospital Services
3. Inpatient Hospital	3. Prescription Drugs (fastest growing cost)
4. Outpatient Hospital	4. Home and Community-Based Long Term Care Services
5. Nursing Facilities	5. Physician services

Delivery models

The most common Medicaid service delivery models are Fee for Service (FFS) and Managed Care.

Traditionally, Medicaid services have been delivered on a fee-for-service basis. Beginning in the 1990s, however, many states began to look to managed care as a model of service delivery in an effort to decrease costs and emphasize primary care and care coordination.

Medicaid managed care models range from health maintenance organizations (HMOs) that use prepaid capitated contracts to Primary Care Management (PCM) to loosely structured networks that contract with selected providers for discounted services and control utilization.

Oregon uses the following models to deliver Medicaid services:

- Fee for Service (FFS)
- Primary Care Management (PCM)
- Fully Capitated Health Plans (FCHP)
- Physician Care Organizations (PCO)
- Chemical Dependency Organizations (CDO)
- Mental Health Organizations (MHO)
- Dental Health Organizations (DHO)

How states administer Medicaid

Medicaid State Plan and Amendments

Federal regulations (42 CFR 430.10) require states to develop State Plans as a condition of receiving federal funds. The State Plan outlines how states will administer the programs in accordance with Title XIX and federal regulations. A separate State Plan outlines how the state will administer their SCHIP in accordance with Title XXI and federal regulations.

The Medicaid State Plan constitutes the state's agreement with the federal government on:

- Who will receive Medicaid services – all mandatory and any optional eligibles;

- What services will be provided;
- How the program will be administered;
- Financial administration of the program; and
- Other program requirements the state may wish to employ.

A State Medicaid Plan outlines the design of each state's Medicaid program to CMS, the federal agency that oversees Medicaid. Once CMS approves the original plan, they must also approve all future changes to the plan before any changes become effective.

When a state wants to change any of the Medicaid benefits it offers, or change the way in which services are offered, it must submit a State Plan Amendment (SPA) for CMS approval. The state does not need to submit SPAs for changes to populations made eligible solely through a demonstration project. However, if a population covered through the State Plan is affected by a change to the demonstration, the state must submit a SPA.

Once the CMS Regional Office receives a SPA, it has 90 calendar days to approve or deny the SPA, or to send a formal Request for Additional Information (RAI) letter. Receipt by the state of an RAI stops the 90-day "clock." The clock will not start again until CMS receives the state's written response to the RAI. Throughout this process, CMS has the option of asking informal questions via e-mail or phone.

Once CMS approves a SPA, the changes can take effect retroactive to the first day of the quarter of the federal fiscal year in which the SPA was submitted. These procedures can make the SPA approval process quite lengthy.

Waivers

Another way the state designs and administers its Medicaid program is through Medicaid waivers. A state can request CMS to waive certain federal requirements to allow greater flexibility or expand the Medicaid populations it serves. Waivers provide options for the Medicaid program not available under the Medicaid State Plan and/or standing Medicaid regulations.

Under the waiver program, federal law allows states to apply to CMS for permission to deviate from certain Medicaid requirements through waiver applications. States typically seek waivers to:

- Provide different kinds of services.
- Provide Medicaid services to new groups.
- Target certain services to certain groups.

- Test new service delivery and management models.

Waivers, however, are not unlimited in their scope.[3] For one thing, not all provisions of federal statute and regulation can be waived by CMS. Also, waivers must meet budget neutrality standards and they must be justified to meet a purpose consistent with Medicaid goals.

For example, Oregon must submit to CMS for approval all changes the state wants to make related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost-sharing, evaluation design, sources of non-federal share of funding, budget and allotment neutrality and other comparable program elements. CMS must approve these changes before the state can implement them. Amendments to the demonstration are not retroactive, and federal funds are not available for changes to the demonstration that have not been approved through the amendment process.

Other administrative options

The Medicaid program also allows states flexibility in other administrative areas, such as:

- Cost sharing – premiums, copayments, deductibles (*e.g.*, Oregon's Family Health Insurance Assistance Program (FHIAP)
- Basic benefit package options (*e.g.*, Oregon's Prioritized List of Health Services)
- Employer-sponsored insurance (*e.g.*, FHIAP)
- Variable benefits (*e.g.*, OHP Plus, OHP Standard, FHIAP)

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[3] See page 44 of Attachment B (Oregon Health Plan Special Terms and Conditions) for Oregon's Waiver List and Expenditure Authority.

Oregon's Medicaid waivers

Section 1115 Medicaid waiver

The Oregon Health Plan (OHP) is the state's demonstration project, funded through titles XIX and XXI of the Social Security Act. A demonstration project under Section 1115 of the Social Security Act, the OHP began in phases in February 1994.

- Phase I started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF).
- One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.
- Following the creation of Title XXI of the Social Security Act by Congress in 1997, Oregon's State Children's Health Insurance Program (SCHIP) was incorporated into the Oregon Health Plan. From its inception, SCHIP provided eligible people with essentially the same benefit package available to all OHP-Medicaid clients, as well as a seamless delivery system.
- In October 2002, CMS approved Oregon's application to amend its demonstration project to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration. With this approval, Oregon was able to expand the demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

CMS recently extended Oregon's demonstration project, beginning November 1, 2007, and expiring November 1, 2010. The extension is subject to limitations specified in the Special Terms and Conditions (STCs)[4] and Expenditure Authority.

Under this demonstration, Oregon expects to achieve the following to promote the objectives of Title XIX and Title XXI:

- Health care coverage for uninsured Oregonians
- A basic benefit package of effective services
- Broad participation by health care providers

[4] See Attachment B for the OHP Special Terms and Conditions.

- Decreases in cost-shifting and charity care
- A rational process for making decisions about provision of health care for Oregonians
- Control over health care costs

Two unique features of the Oregon demonstration are:

- It makes Medicaid available to people living in poverty regardless of age, disability or family status.
- It structures benefits (what is covered), using a prioritized list of health care conditions and treatments. This approach enables Oregon to sharply focus its resources towards prevention, and also utilize funding lines as a method of controlling costs.

OHP Standard

OHP Standard is a limited benefit package, covering only a limited number of uninsured adults who are not eligible for traditional Medicaid programs or SCHIP.

- In 2003, due to severe state budget shortfalls, major changes were made to the OHP Standard benefit package, implementing some cuts in services.
- In 2004:
    - Further changes were implemented, making some additional cuts and adding back some services, improving upon the 2003 changes.
    - Due to a court order, copayments were discontinued for OHP Standard clients
    - The OHP Standard benefit package was closed to new enrollment.
- Enrollment in OHP Standard eventually fell to around 24,000, the number targeted under the cuts.
- By 2007, numbers fell to 19,000, providing an opportunity to re-open the program.
- On January 28, 2008, a reservation list from which potential new OHP Standard applicants are randomly selected opened for one month. When the program reaches an average enrollment of 24,000 participants, or a number determined to be within budgetary limits, the program will again close to new enrollees.

The Family Health Insurance Assistance Program

Oregon's demonstration project also includes a premium assistance program, called the Family Health Insurance Assistance Program (FHIAP). The program is administered by the Office of Private Health Partnerships (OPHP) under an interagency agreement with the Department of Human Services.

Under FHIAP, people with incomes under 185 percent FPL can purchase private health insurance plans and receive assistance paying the premium. FHIAP subsidies cover between 50 and 95 percent of the premium cost, based on the member's family income. Health insurance plans must be actuarially equivalent to federally mandated Medicaid benefits in order to be subsidized.

FHIAP covers Oregon families, including children, parents and childless adults. As part of the 2007 1115 waiver renewal, CMS ruled that the program can no longer use SCHIP matching funds to serve adults; instead, CMS is allowing the use of Medicaid matching funds for the adult population.

Because of this ruling, FHIAP has stopped accepting applications for both individual and group health insurance subsidies, and may be closed to all new enrollments (including in the group market) until the end of the 2009-11 biennium. People wanting to access the program will be put on a first-come, first-served reservation list, which FHIAP has used since its inception to manage enrollment into the program.

State Children's Health Insurance Program

The Balanced Budget Act of 1997 created Title XXI of the Social Security Act, a new children's health insurance program called the State Children's Health Insurance Program (SCHIP) administered by CMS. Program funding became available October 1, 1997, and provided $24 billion in federal matching funds over 10 years to help states expand health care coverage to uninsured children. In 2007, the 110th Congress extended the SCHIP program at current annual funding levels through March of 2009, rather than reauthorizing the program.

SCHIP is also jointly financed by the federal and state governments and administered by the states. Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage and administrative and operating procedures. This program gives each state the option of offering health insurance to children up to age 19 who are not already insured. SCHIP has an "enhanced" federal match rate which is as much as 10 percent to 15 percent higher than Medicaid's match rate.

Unlike Medicaid's open-ended entitlement, however, SCHIP provides a capped amount of funds to States on a matching basis. SCHIP provides limited authority for states to cover families (*i.e.*, uninsured parents as well as their uninsured children). However, the opportunities to cover parents with SCHIP funds are quite limited under the law and are becoming more limited by CMS policy decisions.

SCHIP represented the first federal legislative attempt to more closely align public health insurance coverage standards for low income children with private health insurance principles. Not only is SCHIP *not* a legal entitlement for children; in addition, SCHIP coverage rules are expressed as an insurance premium "benchmark" bounded by actuarial value rather than by defined benefits. Although SCHIP permits coverage of services and benefits that are virtually as broad as those found in Medicaid, its minimum coverage requirements are quite limited; and coverage standards are expressed as broad categories rather than defined benefits. Furthermore, coverage adequacy is tied to the value of a premium rather than to specific coverage rules.

In this regard, SCHIP moved public financing for low income families closer to the concept of "premium support," under which a group health insurance sponsor offers competing insurers a defined contribution toward the cost of enrollee coverage, with the concept of coverage itself broadly defined.

Oregon's SCHIP

In July of 1998, Oregon implemented an SCHIP State Plan[5] to expand health insurance coverage to infants and children through a separate program to provide coverage to the following groups:

- Children from birth to age 6 with family incomes between 133 percent and 170 percent of the FPL
- Children from age 6 to age 19 with incomes between 100 percent and 170 percent of the FPL

In 2000, the state increased the number of children permitted under the state's enrollment cap, then increased the assets limit for determining SCHIP eligibility from $5,000 to $10,000 in 2004. In 2006, Oregon amended the SCHIP State Plan to extend continuous eligibility for SCHIP from 6 months to 12 months.

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[5] See Attachment C for Oregon's SCHIP State Plan. **Note**: Amendments #7 and #9 are not yet approved. CMS has asked the state to remove most of the material in amendment #9 pertaining to the FHIAP program. Amendment #7, when approved, will allow Oregon to provide prenatal care to pregnant immigrant women.

- *Delivery system:* The state uses the same delivery system for SCHIP as the OHP, comprised primarily of Prepaid Health Plans (PHP) and Primary Care Managers (PCM).
- *Benefit package:* Oregon's SCHIP program offers coverage that is essentially the same as coverage offered under the OHP, based on the Prioritized List of Health Services.

During federal fiscal year 2006, there were (unduplicated) 59,039 children and 13,750 adults enrolled in Oregon's SCHIP program.[6]

Other Oregon Medicaid waivers

In addition to health care waivers, Oregon has a number of Medicaid Home and Community Based Services (HCBS) waivers, known as 1915(c) waivers, including:

- *Comprehensive ICF/MR:* Allowing people with MR/DD (mental retardation/developmental disabilities) who meet the ICF/MR (institutional) level of care to remain living at home and in the community. Services include: habilitation, non-medical transportation, nursing home diversion, in-home service, and respite.
- *Support Services:* Allowing people with MR/DD who meet the ICF/MR level of care to remain living at home and in the community. Services include in-home services, adult foster care, assisted living facilities, transportation, and residential care facilities.
- *Model:* Allowing people with MR/DD who meet the ICF/MR level of care to remain living at home and in the community. Services include behavioral consultation, specialized medical equipment and supplies, and environmental access adaptation.
- *Aged and Disabled:* Allowing people with physical disabilities and those aged 65+ who meet the nursing facility level of care to remain living at home and in the community. Services include support services brokerage, community living and inclusion, and non-medical transportation.
- *Hospital Model:* Allowing children with special care needs who meet the hospital level of care to remain living at home and in the community. Services include specialized medical equipment and supplies, environmental access adaptation, and homemaker services.

[6] See Attachment A for SCHIP populations and eligibility.

- *Family Planning Demonstration*: to extend eligibility for family planning services to uninsured men and women, with income at or below 185 percent of the Federal poverty level who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, or Medicare. This waiver covers more than 100,000 Oregonians.
- *Non-emergency Medical Transportation*: Provided by medical transportation brokerages for clients with no other means of transportation available to them to get to and from locations where they receive medical services.

The Medicare-Medicaid relationship

Medicare beneficiaries who have low incomes and limited resources may also receive assistance from the Medicaid program. For these people, services available under Medicaid supplement their Medicare health care coverage, according to their eligibility category.

- Examples of additional services available to people enrolled in both Medicare and Medicaid include nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs not covered by Medicare, eyeglasses, and hearing aids.
- For persons enrolled in both programs, any services covered by Medicare are paid for by the Medicare program before any payments are made by Medicaid, since Medicaid is always considered the "payer of last resort."

CMS estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

Supplemental insurance programs

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through Medicaid. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers.

- QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates.
- SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes less than 133 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums.

A third category of Medicare beneficiaries who may receive help consists of "disabled-and-working" individuals who lost Medicare eligibility because of their return to work, but are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

Medicare prescription drug benefits

Since January 2006, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA -- Public Law 108-173), the Medicare prescription drug benefit provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for both Medicare and Medicaid receive the low-income subsidy for both the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid no longer provides most drug benefits for Medicare beneficiaries.

Since the Medicare drug benefit and low-income subsidy replaces a portion of state Medicaid expenditures for drugs, the MMA requires each state to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006, this payment was 90 percent of the projected 2006 reduction in state spending. In subsequent years the percentage decreases by 1-2/3 percent per year, to 75 percent for 2014 and later.

Program of All-Inclusive Care for the Elderly

Program of All-Inclusive Care for the Elderly (PACE) is a unique optional benefit under both Medicare and Medicaid that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities.

For most people, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan. PACE is available only in states which have chosen to offer PACE under Medicaid.

Oregon currently utilizes the PACE option at five centers in the Portland area through Providence ElderPlace, a comprehensive program that offers health, housing, social service and care coordination for seniors.

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Federally Qualified Health Centers

FQHCs are community-based and consumer-run organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.

Grant-supported FQHCs are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). These include:

- *Community Health Centers*, which serve a variety of underserved populations and areas.
- *Migrant Health Centers,* which serve migrant and seasonal agricultural workers.
- *Healthcare for the Homeless Programs,* which reach out to homeless individuals and families and provide primary care and substance abuse services.
- *Public Housing Primary Care Programs,* which serve residents of public housing and are located in or adjacent to the communities they serve.

FQHC "look-alikes" are health centers that have been identified by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) and certified by CMS as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.

Outpatient health programs/facilities are operated by tribal organizations (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

Universal healthcare is fully supported by the stated goal of the HRSA's FQHC program (http://bphc.hrsa.gov/policy/pin0321.htm):

> The goal of the FQHC program is to maintain, expand and improve the availability and accessibility of essential primary and preventive health care services and related "enabling" services provided to low income, medically underserved and vulnerable populations that

> traditionally have limited access to affordable services and face the greatest barriers to care. As fundamental components of the health care "safety net," FQHCs provide a comprehensive system of care reflective of the community's needs and available to all persons residing in their service area(s), regardless of the person's or family's ability to pay for such services. The FQHCs further ensure access to care by establishing a schedule of discounts for persons unable to pay a full fee, including nominal or no fees for services provided to the poorest of the populations served, persons whose incomes are below 200 percent of the federal poverty guidelines.

Certain federal requirements governing Federally Qualified Health Centers (FQHCs) as providers under the Medicaid program create both barriers and opportunities to Oregon's reform goals, including reducing the number of uninsured in Oregon. [7]

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[7] See Attachment D for federal policy opportunities and barriers experienced by FQHCs.

Ways the federal government makes Medicaid policy

Social Security Act

Medicaid policy was originally set by Congress when it passed the Social Security Act in 1965. Title XIX of this law entitles each state with an approved Medicaid plan to payment of federal matching funds at a state-specific rate for all allowable expenditures. Section 1902(a) of the Social Security Act sets forth approximately 70 requirements (some mandatory and some optional) for State Medicaid Plans.

SCHIP

In 1997, Congress passed the State Children's Health Insurance Program (SCHIP), a smaller companion program to Medicaid, also in the Social Security Act. SCHIP lacks Medicaid's "entitlement" to federal funds contingent on state matching funds, but policy to direct the program is enacted in the same manner as Medicaid policy.

Medicaid State Plan

Congress sets Medicaid policy through legislation establishing and modifying State Plan requirements. Over the last 40 years, Congress has made numerous changes in federal Medicaid policy, by modifying existing State Plan requirements or adding new ones.

Internal oversight

Congress also oversees Medicaid policy by monitoring the executive branch agencies that carry out legislative changes, primarily CMS. Congress conducts this oversight through its own staff, or it may direct the Government Accountability Office (GAO) or the Office of Inspector General (OIG) to do so.

Federal budget setting

The federal administration and Congress set Medicaid policy through the passage of an annual budget. Administration recommendations and/or congressional actions in passing the annual budget have the same effect as laws and regulations in their effect on health policy.

- For example, though it was not ultimately in the final budget, the Bush administration's 2007 proposed budget contained significant cuts in Medicaid, as well as proposals for legislative changes that would have

reduced federal Medicaid funding by $5.1 billion over 10 years, and regulatory changes that would have reduced federal funding by an additional $12.2 billion over five years. These changes would have been achieved by shifting costs to states, virtually ensuring the need for modification of state Medicaid programs and policies.

- The administration's 2008 budget also included a proposal to tax employer-provided health care benefits. This policy change would have meant significant cuts in SCHIP and Medicare as well as major reductions in payments to doctors, hospitals, nursing homes, and home health agencies.

State Plan approval

Medicaid policy is set by the Secretary of HHS, through CMS, via statutory authority to approve State Medicaid Plans and support them with federal funds. Congress delegated the statutory responsibility for approving a state's Medicaid plan and for paying federal matching funds to the Secretary of HHS, who has delegated it to the CMS administrator. In approving State Plans and approving payment, CMS relies upon its own interpretation of the statute.

Waiver approval

Medicaid policy is set by the Secretary of HHS, through CMS, via statutory authority to waive certain federal Medicaid requirements. While the Medicaid statute sets the ground rules for administering the Medicaid program, Congress has given the Secretary of HHS various statutory authorities to waive State Medicaid Plan requirements so that states do not have to meet them but can still receive federal Medicaid matching funds for allowable expenditures. These waivers effectively constitute Medicaid policy at the state level, and often lead to national Medicaid policy changes.

CMS regulations

CMS sets Medicaid policy through the issuing of regulations. Medicaid regulations are found in Title 42 of the Code of Federal Regulations, Parts 430 to 456. Regulations, or "rules," are one of the means by which federal agencies like HHS implement statute. Importantly, however, HHS can make changes in regulations without formal congressional action. For example, the president may propose a budget that includes proposals to reduce federal Medicaid spending by issuing regulations to change certain policies.

CMS traditionally uses the "notice and comment" procedure or Notice of Proposed Rulemaking (NPRM). The agency, however, often publishes an "interim final"

rule. The rule is actually a final rule, effective immediately, and the public is given an opportunity to comment only after its publication. Without an NPRM to review, states and the public are not able to comment on CMS policy decisions before they take effect. This de-emphasis of formal rulemaking, with a notice and comment period, has led to less transparency in the federal Medicaid policy process.

Other CMS written guidance

Medicaid policy is set by CMS in other written guidance. Many CMS policy interpretations are found not in regulations, but in other written guidance, including:

- The State Medical Manual (SMM), which contains "instructions" for implementing provisions of Title XIX;
- Letters to State Medicaid Directors (SMD Letters); and
- Memoranda from the CMS Central Office to CMS Regional Offices.

Unlike regulations, which require public comment opportunities and laws, which require Congressional passage, CMS is not required to give advance notice of State Medical Manual changes, State Medicaid Director Letters or Regional Office memoranda.

CMS review of state policy changes

CMS sets Medicaid policy when it determines if state policy changes are in compliance with federal law. Among other tasks, CMS reviews state requests for approval of waivers, waiver extensions, State Plan Amendments or other program policy changes to determine whether they comply with the federal Medicaid statute.

In determining whether a state's proposed policy change complies with requirements set forth in Title XIX of the Social Security Act, CMS often relies upon its own written interpretation of those requirements, establishing de facto Medicaid policy in the process.

Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the Deficit Reduction Act (DRA) of 2005 into law. The most significant set of changes to Medicaid since its 1965 enactment, the DRA refashioned some of the program's most basic rules in ways that have long term implications for beneficiaries, health care providers, and states. The DRA presented both opportunities and barriers to state health reform efforts.

Opportunities for state Medicaid reform under the DRA

The Family Opportunity Act

The DRA created a new state option, the Family Opportunity Act (FOA), which allows families to purchase Medicaid coverage for their children with disabilities. The option extends to Medicaid coverage of children under age 19 who meet the SSI disability standards and whose income and/or assets exceed SSI limits, but are less than 300 percent of the Federal Poverty Level. States taking up this option must require parents eligible for family coverage under a group health plan to apply for, enroll in, and pay premiums for the family coverage as a condition of FOA eligibility for the child. However, this requirement applies only if the employer contributes at least 50 percent of the total cost of the annual premium.

Family to Family Centers

Within the Medicaid and SCHIP title of the DRA, the Title V Maternal and Child Health Services Block Grant was amended to appropriate funds for a special project of regional and national significance grant programs to develop and support family-to-family health information centers. These centers would assist families of children with disabilities or special health care needs to make informed choices; provide information; identify successful health delivery models; provide training and guidance regarding the provision of care; and conduct outreach activities to families, children, health professionals, schools and other appropriate entities and individuals.

Medicaid Transformation Grants:

The DRA adds subsection (z) to 42 U.S.C. § 1396b, setting aside $75 million a year for fiscal years 2007 and 2008 for Medicaid transformation grants. The grants were awarded to states (including Oregon) without the normal requirement for state matching funds to be used "for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance ..."

Health Opportunity Accounts

The DRA adds 42 U.S.C. § 1396x to the Medicaid Act, creating state demonstration programs for Health Opportunity Accounts (HOAs). HOAs allow states to condition the receipt of Medicaid services on the payment of a deductible (and other applicable cost sharing) and use the health savings account concept.

Non-emergency medical transportation brokerages

The DRA included a new state option to establish a non-emergency medical transportation brokerage program. The purpose of this program is to more cost-effectively provide transportation for individuals who need access to medical care or services and have no other means of transportation.

Extension of transitional Medicaid

The DRA continued transitional Medicaid until December 31, 2006. It has since been continued by Congress with temporary extensions. The extended coverage applies for up to one year for employed Medicaid beneficiaries and their families, who would otherwise be losing their Medicaid coverage because of an increase in the countable income of the wage earner.

Enhancement of third party identification and payments

Medical child support payments must now be included in child support orders. "Medical support" may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, copayments, and deductibles) and payment for medical expenses incurred on behalf of a child. Over a period of time, this should result in more children being covered by medical support orders, requiring a non-custodial parent to provide medical support.

State high-risk health insurance pool

A majority of states have established high-risk health insurance pool programs as one approach to reducing the number of uninsured persons. The DRA appropriated for FY 2006 $75 million for the losses incurred by a state from the operation of a qualified high-risk pool. The DRA also included $15 million in FY 2006 to fund seed grants for states to create, and initially fund, a high-risk pool. This provision provided the funding for the State High Risk Pool Funding Extension Act of 2005, which was enacted on February 10, 2006, as Public Law 109-172.

Oregon's high-risk pool, the Oregon Medical Insurance Pool (OMIP) received an Operational Losses Grant of nearly $2.4 million to cover losses that OMIP incurred from July to December 2006 (out of $50 million available nationally). OMIP also

received a Bonus Grant of $1.5 million that funds a reduction in the generic drug copayment from $20 to $10 from January 2007 through 2008 (out of $25 million available nationally.)

Long-term care

The DRA also opened some opportunities on the long-term care side of Medicaid, such as:

- Home and Community Waivers for Children
- Money Follows the Person
- Expanded Home and Community-Based Services for the Elderly and Disabled
- Cash and Counseling

Barriers to state Medicaid reform under the DRA

Limiting definitions of "case management"

The DRA rewrote the Medicaid case management definition to more specifically define services and to clarify the difference between "case management" and "targeted case management."

Under the DRA, the term "case management service" includes:

- Assessment of a Medicaid-eligible individual to determine service needs (*e.g.*, taking client history, gathering information from other sources such as family, providers, and educators)
- Development of a specific care plan
- Referral and related activities to help the individual obtain needed services
- Monitoring and follow up activities, including those to insure that the service plan is effectively implemented

Under the law, case management does not include the direct delivery of medical, education, social or other services to which the individual has been referred.

The term "targeted case management services" means case management services that are provided to targeted populations without regard to statewideness and comparability requirements. The DRA adds 42 U.S.C. § 1396n(g)(3) providing that contacts with individuals who are not eligible for Medicaid (or not in the target population) do not count as case management unless the purpose of the contact is directly related to managing the eligible individual's care.

Also, federal financial participation is only available for case management if there are no other third parties liable for the care, such as another medical, social, or educational program. Moreover, a state is required to allocate the cost of case management services between Medicaid and any other relevant federal program and only bill Medicaid for its portion.

Prohibition against covering adults

The DRA limits the Secretary of HHS from approving a waiver, experimental, pilot or demonstration project that would use SCHIP funds to provide child health assistance or other health care coverage to nonpregnant, childless adults. Caretaker relatives are not considered childless adults in this context.

This section was not intended to apply to any project approved before the enactment of the DRA or to any extension of such project made after the enactment of the DRA. This intent was restated in the March 31, 2006, letter from CMS. The letter also explained that states submitting a demonstration application on or after October 1, 2005, may not obtain SCHIP funds to provide coverage to nonpregnant, childless adults. However, they can use Medicaid funds for such health benefits coverage. CMS has modified its Health Insurance Flexibility and Accountability (HIFA) application template to reflect implementation of this provision.

In the 2007 renewal process for Oregon's 1115 waiver, the SCHIP portion of the FHIAP program fell victim to this provision of the DRA, even though the state could have been "grandfathered," severely affecting the program and limiting the services that are available to Oregonians who cannot afford health insurance.

Mixed DRA provisions

The DRA also enacted a number of provisions, primarily related to drugs, which have posed mixed results for states. While beneficial in many cases, the changes and the technology of the changes required can also slow state operations, cause confusion among providers and beneficiaries and present barriers to services. These provisions include:

Multiple-source drugs

The DRA categorizes more drugs as multiple source drugs subject to the upper payment limits found in 42 CFR § 447.332(b). Previously, in order to be considered a multiple source drug, there had to be three or more therapeutically and pharmaceutically equivalent drugs in any given class of drugs. The DRA amends 42 U.S.C. § 1396r-8(e)(4) so that it now requires only two such drugs in

any class for all the drugs in that class to be considered multiple source drugs. It also adds § 1396r-8(e)(5), which redefines how upper payment limits are to be calculated. Instead of setting that limit at 150 percent of the lowest AWP for any drug in a multiple source class, the law now instructs the Secretary of HHS to set the limit at 250 percent of the average manufacturer price (AMP, as newly defined by the DRA, see below) for the particular drug.

Public disclosure of price information

Prior to the DRA, drug manufacturers were required to report their AMP and best price for single source (*i.e.*, brand name) drugs to HHS at the end of each rebate period where the information was kept confidential, except for very limited purposes.

The DRA amended § 1396r-8(b)(3)(A) to require manufacturers to report AMP and best price data to HHS on a monthly basis. The new subsections also require HHS to provide the AMP information for both brand name and multiple source drugs to the states on a monthly basis, and instruct the Secretary to make that information available to the public by means of a Web site.

Definition of average manufacturer price

Prior to the DRA, AMP for a covered outpatient drug was defined as "the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts." The DRA, § 6001(c), amended 42 U.S.C. § 1396r-8(k)(1) to require drug companies to disregard prompt pay discounts when computing their AMP but to report their prompt payment discounts to HHS on a monthly basis along with their AMPs and best prices.

In 2006, a lawsuit was brought by the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association NCPA against CMS claiming that the provisions related to public disclosure of price information and the new definition of AMP would represent a significant loss of revenues to independent and chain retail pharmacies, and could create severe financial hardships for many Medicaid pharmacy providers.

In December of 2007, the U.S. district court for the District of Columbia granted an injunction to prevent CMS from adopting the AMP-based reimbursement formula for generic prescriptions in Medicaid until the agency "had an opportunity to fully review the new payment plan." The injunction also prohibited CMS from posting AMP data on the Internet.

Determination of best price

Previously, in reporting to HHS what constitutes its best price for a drug, the manufacturer was not required to count so-called nominal prices that it affords to customers in certain circumstances (*e.g.*, less than 10 percent of the AMP). The DRA amended 42 U.S.C. § 1396r-8(c)(1) to limit the nominal price exception to a short list of types of purchasers.

Beneficiary education

Previously, 42 U.S.C. § 1396r-8(g)(2) required states to have a drug review program that, among other things, required a pharmacist to discuss with a Medicaid beneficiary information relevant to the use and storage of the drug being dispensed. Effective upon the DRA's passage, this section of the Medicaid Act was amended to clarify that pharmacists do not have to verify either that they offered the required consultation or whether the beneficiary accepted or refused it.

Congressionally recognized drug compendia

Congress designated three drug compendia that states are to use to determine whether a drug has been prescribed for a medically accepted indication.

Authorized generics

Manufacturers of a single source drug sometimes allow another manufacturer, or one their subsidiaries, to produce and sell limited quantities of the drug under another name, and generally at a lower price than the manufacturer sells the same drug. The drugs so produced and sold are usually referred to as "authorized generics."

Previously, in computing both the best price for single source drugs, and the AMP for all its outpatient drugs, a manufacturer was not required to include the prices charged for authorized generics. The DRA amended 42 U.S.C. § 1396r-8(b)(3)(A), to require manufacturers to include the price of authorized generics when reporting both their best price for single source drugs and their AMP for all outpatient drugs.

Participation of children's hospitals

The DRA added children's hospitals as "covered entities" entitled to purchase drugs at the same prices as do community health centers and DSH hospitals. To qualify for these discounted prices, a children's hospital must be owned or have been given governmental powers by a state or local government, or be a private hospital that has a contract to provide care to low-income individuals who are not eligible for Medicare or Medicaid. (42 U.S.C. § 256b(4)(L)(i))

Emergency room services

The DRA permits the use of higher client copayments for non-emergency care obtained in an emergency room.

Medicaid integrity initiatives

The DRA provides for a number of Medicaid integrity initiatives, including False Claims Recovery and a national Medicaid Integrity Program administered by CMS.

Other program integrity requirements

Other statutes and regulations also address issues of program integrity, such as:

- *Improper Payments Act of 2002:* This led to the development of a process by CMS to measure improper payments in Medicaid and SCHIP. This is known as the Payment Error Rate Measurement (PERM)
- *Balanced Budget Act of 1997:* Managed care fraud and abuse requirements were first introduced in the Balanced Budget Act of 1997 and the federal rules are now found in 42 CFR Part 438.

Administrative barriers

Over the past several years, administrative actions taken by CMS have shifted billions of dollars in federal costs to states, local governments and school districts. Historically a strong federal-state partnership was the centerpiece of the program. While states are committed to upholding their responsibility to Medicaid, they have significant concerns that recent actions taken by CMS[8] will effectively end the federal government's participation in many crucial components of the Medicaid program and shift those costs to states, counties, hospitals, schools and other providers throughout the country.

Recent administrative actions have presented a substantial departure from past practices and reflect new and unsupported interpretations in Medicaid law. Almost all of the statutory provisions that CMS seeks to "clarify" have been in place for at least 15 years and some since the inception of Medicaid (Title XIX) in 1965. Many of the rule changes were rejected by Congress when the Deficit Reduction Act of 2005 (DRA) was considered. In fact, it is commonly believed that CMS is currently mandating policy changes outside their scope and outside Congressional intent.

While CMS has continued to ask states to accept increased responsibility for health care delivery and access, the agency is simultaneously proposing to decrease state flexibility and authority to respond to this mandate through these rule changes. The end result will be reduced access, lower quality of care and fewer people with health coverage.

Congress has long rejected changes to the Medicaid program that simply shift costs from the federal government to states, as would be the case for nearly every one of the recently proposed, or adopted, CMS administrative actions.

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[8] See Attachment E (CMS Regulatory and Waiver Approval Actions) for an analysis of several of the changes CMS has proposed or implemented.

See Attachment F for the National Association of State Medicaid Directors (NASMD)'s analysis of CMS regulations proposed in 2007.

See Attachment G for an analysis of federal regulations affecting Senate Bill 329.

OHP budget neutrality limitations

Budget neutrality is the mechanism prescribed by Section 1115 of the Social Security Act to limit the amount of federal Medicaid funding a state receives for its Medicaid demonstration project.

- The federal match for expenditures under a demonstration project is limited to no more than the funding would be (allowable) under a traditional Medicaid health plan.
- Budget neutrality only covers program expenditures matched with Medicaid (Title XIX) funds. Expenditures for overhead and the SCHIP allowed under Title XXI funds are not included in the calculation.

Under budget neutrality, as revised by the federal government when it recently approved a three-year extension of the Oregon Health Plan demonstration project, Oregon is only at risk for the per member per month (PMPM) cost of client populations eligible to be covered by Medicaid, and parents enrolled in the OHP Standard (Allowable Population). For these populations, Medicaid takes the risk for the number of clients covered.

For all remaining client populations, including Childless Adults/Couples enrolled in OHP Standard and those FHIAP clients not Medicaid eligible, Oregon is responsible for both the PMPM cost and number of enrollees. This is a change from Oregon's prior demonstration project agreement, where these groups were also included in the Allowable Population.[9]

In order to maintain budget neutrality, expenditures for these remaining populations must be paid for by savings generated in covering the Medicaid eligible client populations.

A potential concern with the budget neutrality calculation is how CMS has chosen to "trend" (inflate) each population groups' allowed annual PMPM. In the most recent OHP demonstration project extension negotiations, CMS informed Oregon they will now trend PMPMs by the lesser of the rates used in the prior year or the rates used in the president's Medicaid budget. This ensures the trend rate can at best remain steady, and at worst decrease, regardless of actual expected medical inflation.

[9] See Section XII of Attachment B (OHP Special Terms and Conditions) for additional budget neutrality detail.

SCHIP allotment limitation

Each year, Oregon is allotted a limited amount of federal funds to match against Title XXI (SCHIP) expenditures, both program and administrative. The advantage of using these funds is that they are matched against state funds at a higher rate than Medicaid funds. For Oregon, the difference is currently 11.74 percentage points.

Two of the disadvantages of SCHIP funding are that it is limited in both amount and in the time a state has to use it. Once funds are allotted to a state, it has three years to spend them.

- If after three years the funds are not spent, the remaining balance reverts back to CMS to allocate to states that have run short of their allotment.
- If a state runs out of their allotment, the state must notify CMS of the expected shortfall and may potentially submit a plan to move (revert) a portion of its SCHIP caseload to Medicaid. CMS will review the plan and approve, negotiate changes or disallow the plan submitted.

Attachment A

OREGON ELIGIBILITY CHART

I. Mandatory Medicaid Populations

Description	Funding FMAP*	Authority	Income Limits	Resource Limits	Benefit Package
Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0 to 133% FPL	No Asset Test	OHP Plus
Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0 to 133% FPL*	No Asset Test	OHP Plus
Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0 to 100% FPL	No Asset Test	OHP Plus
Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus
AFDC low-income families	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus
Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus

*Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages – Effective October 1, 2007 – September 30, 2008 (Fiscal Year 2008) Title XIX funds 60.86% and Title XXI funds 72.60%

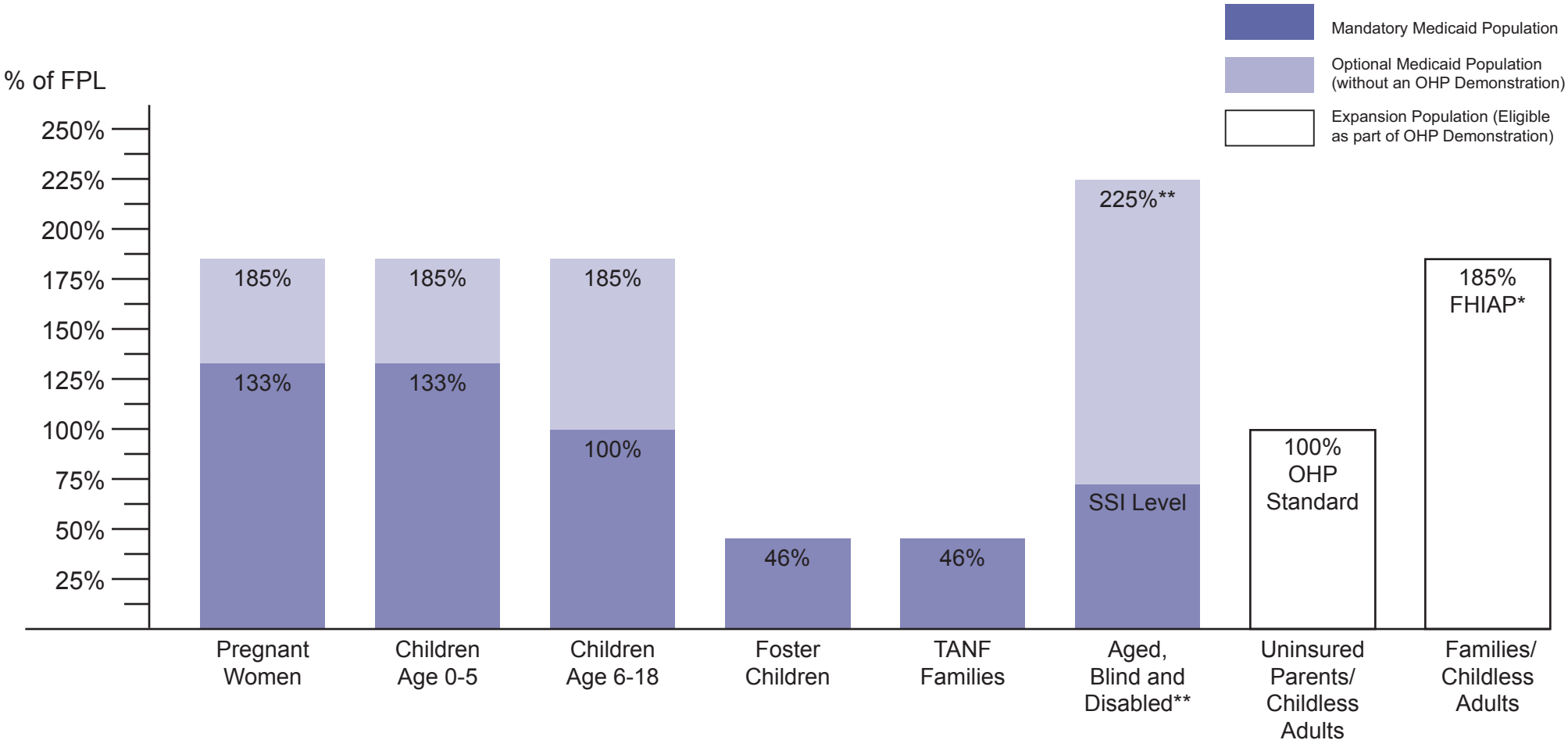
II. Optional Medicaid/SCHIP Populations

Description	Funding FMAP	Authority	Income Limits	Resource Limits	Benefit Package
Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	133 to 170% FPL	No Asset Test	OHP Plus
Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus
Pregnant Women not eligible for Medicaid or Medicare	Title XIX	Title XIX State Plan and Section 1115	170 to 185% FPL	None	OHP Plus
Uninsured children ages 0 through 5 and Uninsured children ages 6 through 18 meeting title XXI definition of targeted low-income child and who choose voluntary enrollment in FHIAP	Title XXI	Section 1115 and SCHIP State Plan	133 to 185% FPL 100 to 185% FPL	$10,000	FHIAP

III. Expansion Populations

Description	Funding FMAP	Authority	Income Limits	Resource Limits	Benefit Package
General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus
Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard
Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard
Participants in FHIAP as of 9/30/02; prior state-funded FHIAP parents and childless adults who already have insurance and the FHIAP children	Title XIX	Section 1115	Up to 170% FPL	$10,000	FHIAP
Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	0 to 185% FPL	$10,000	FHIAP
Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	Up to 185% FPL	$10,000	FHIAP
Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	Up to 185% FPL	$10,000	FHIAP

Approximate Federal Poverty Levels (FPL) for Medical Assistance Eligibility Groups



* The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the FPL must enroll in FHIAP if they have employer-sponsored insurance. Parents and childless adults over 100% of the FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

** Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.

Attachment D

Federal policy barriers experienced by FQHCs

FQHCs	Opportunities	Barriers
Ability to utilize FQHCs to provide services	FQHCs that receive federal funding under section 330 of the Public Health Services Act, and operate under this categorical grant program, furnish a wide array of services. FQHCs deliver primary medical, dental, behavioral, and preventive health services in federally designated medically underserved areas and/or to medically underserved populations. Grant funds subsidize the provision of care to the uninsured.	If Federal matching funds are to be received under the States' Medicaid plan, the state is required to include Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings. FQHC services are a mandatory Medicaid benefit. This is not the State's decision, and is a federal requirement under Title XIX, Social Security Act. Oregon's 1115 waiver, however, allows the use of the Prioritized List of Health Services and a managed care delivery system.
Population Served	FQHCs that receive HRSA funding or those that meet all the requirements of HRSA funded health centers but do not receive funding ("FQHC Look-Alikes") are required to provide access to services without regard for a person's ability to pay.	None – FQHCs are required to serve the uninsured population
Ability to Pay Ability to pay is determined by a patient's annual income and family size according to the most recent U.S. Department of Health & Human Services	FQHCs must meet certain requirements regarding schedules of fees and discounts (often called a sliding fee scale) for the services they provide to ensure that the cost of services not covered by insurance are	

Federal Poverty Guidelines	discounted on the basis of the patient's ability to pay. They must:
	
	• Prepare a schedule of fees or payments for the provision of services that is:
	  o consistent with locally prevailing rates or charges and
	  o designed to cover the reasonable costs of operation.
	• Make all reasonable effort to obtain reimbursement from third party payors — either public (Medicaid, SCHIP, Medicare and any other public assistance program) or private health insurance (for patients who are eligible for coverage). These third party payors should be billed on the basis of the full amount of fees and payments for such services without application of any discount.
	• Prepare a corresponding schedule of discounts (or sliding fee scale) to be applied to the payment of such fees, in which discounts are adjusted on the basis of the patient's ability to pay.
	
	The schedule of discounts must:
	
	• Be made available for all	

	individuals and families with an annual income below 200 percent of the poverty guidelines. • Provide for a full (100 percent) discount for all individuals and families with an annual income below 100 percent of the poverty guidelines. • Nominal fees may be collected from individual or families with an annual income at or below 100 percent of the poverty guidelines when imposition of such fees is consistent with project goals.	
Benefits for FQHC (and possible cost-savings passed to state)	• Section 330 grant funds offset the costs of uncompensated care and other key enabling services. (New starts can request up to $650,000 in funding) • Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (FQHC Look-Alikes are not eligible for this benefit.) • Enhanced Medicare and Medicaid reimbursement under the Prospective Payment System • PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program • Federal loan guarantees for capital improvements (FQHC Look-Alikes are not eligible for this	

	benefit.) • Access to on-site eligibility workers to provide Medicaid and State Child Health Insurance Program (SCHIP) enrollment services • Reimbursement by Medicare for "first dollar" of services because deductible is waived if FQHC is providing services • Access to Vaccines for Children Program for uninsured children • Access to National Health Service Corps (NHSC) medical, dental, and mental health providers • National network of similar organizations committed to improving the mission • Less costly care for Medicare patients, whose Medicare deductible costs are waived for FQHC-provided services	
Federal Payment Policy FQHCs receive a set dollar amount in grant funds through the federal Bureau of Primary Health Care (BPHC) [330 grant funds]. This dollar amount is based on the need demonstrated in the grant proposal and is determined by the BPHC. FQHCs are not	330 grant funding is intended to support care for the uninsured and to prevent and FQHC becoming insolvent.	Congress established the Prospective Payment System (PPS) methodology, a cost-based rate of reimbursement for both Medicaid and Medicare, to ensure 330 grant funds did not subsidize what were at one time low Medicaid payment rates. 330 grant fund dollars are

reimbursed on a per patient basis; the amount they are given in their federal grant is a set amount that does not change even if the number of uninsured patients increases. The only exception to this is if Congress appropriates funding for "base adjustments" for FQHCs. HCFA 15-1, 6l2.l PHS Grants--General.--Public Health Service grants are authorized under the Public Health Service Act on a fiscal year basis. In general, the purpose for which the grant was authorized will determine if any of the funds received are applied as a reduction of allowable costs. If for example, the grant were authorized for a provider of health services to be used as the provider deems proper and necessary, the grant would be considered unrestricted and would not be used to reduce allowable costs. Public Health Service grants awarded to a comprehensive health center under § 330(d) (formerly § 3l4(e)) of the Public Health Service Act are to be treated as unrestricted grants and therefore are not to be deducted from operating		given to FQHCs based on their percentage of uninsured, but are capped for every FQHC based on the appropriated amount, not on the FQHC's need. – UNCLEAR what effect universal healthcare would have on a ***new*** FQHC seeking 330 grant funding.

costs in computing the center's allowable costs for Medicare reimbursement purposes.		
Payment by States to FQHCs Prospective Payment System (PPS)	FQHCs have proven to reduce more costly emergency room-based care. *"DELIVERING MEDICAID SAVINGS THROUGH QUALITY CARE* FQHCs control costs by providing primary care and prevention services, thereby reducing the need for more costly hospital care down the road. Several studies found that FQHCs save Medicaid programs as much as 33% in annual spending for FQHC Medicaid patients due to reduced specialty care referrals and fewer hospital admissions and emergency room visits. In addition, their management of patients with chronic conditions has improved patient outcomes, generating, for example, significantly lower costs per Medicaid diabetes patient compared to other providers." **National Association of Community Health Centers, Inc**. /Fact Sheet #0306 Sources: NACHC 2006, based on 2005 Uniform Data System, BPHC, HRSA, DHHS. Kasier Family Foundation (2003), *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role*, www.kff.org. NACHC (2004), Nation's Health at Risk II: A Front Row Seat in a Changing Health Care System, www.nachc.com/research. NACHC studies on health center cost effectiveness, www.nachc.com/research. For more information, email research@nachc.com.	Not a Federal regulation barrier, but a barrier… An FQHC's PPS rate is generally viewed as a higher rate of reimbursement when compared to rates of reimbursement to non-FQHC/RHCs. However, Federal Law requires State Medicaid programs to set a PPS rate compliant with full-cost reimbursement and thereby ensuring a FQHCs sustainability and the uninsured access to healthcare. It is difficult for individuals to see the benefit of PPS reimbursement to FQHCs in the short-term. Or, if a health center becomes insolvent and therefore cannot care for Medicaid or uninsured patients, causing patients to revert to emergency room–based care over the long-term the state may pay a larger cost.

Attachment E

CMS REGULATORY AND WAIVER APPROVAL ACTIONS

CMS REGULATORY ACTION	CONCERN
Government Provider Cost Limit Regulation – 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. Congress acted to delay the effective date of this regulation to May 25, 2008. Additional Congressional action is needed to withdraw these regulations or extend the moratorium.	This regulation would adversely impact safety net hospitals. Additionally, the proposed rule oversteps statutory authority by redefining what constitutes a unit of government that may permissibly fund the non-federal share of Medicaid payments. This rule is estimated to result in $120 million in savings during FY 2007 and $3.87 billion in savings over five years according to CMS. No specific impact as been calculated for Oregon. What is known however is that administrative costs will increase with the implementation of this proposed rule.
Eliminating Medicaid Reimbursement for Graduate Medical Education (GME) – The CMS proposal would no longer allow Medicaid funding to be used for GME. Congress acted to delay the effective date of the regulations to May 25, 2008. Additional Congressional action is needed to withdraw these regulations or extend	It is of critical importance for Medicaid to continue its commitment to help train our future doctors and to pay for Medicaid services provided by residents. Today, Medicaid provides financial support to facilities that train medical residents. These teaching hospitals are essential to maintain our supply of new physicians. The proposed CMS regulation would simply allow the

the moratorium.	federal government to walk away from this important commitment to the crucial services provided by teaching hospitals across the country. This rule is estimated to reduce Federal Medicaid outlays by $140 million in FY 2008, and $1.8 billion over five years according to CMS. The impact to Oregon would be the elimination of roughly $16 million dollars to Oregon Health Sciences University and other hospitals. Effective July 1, 2008, Oregon is planning to re-establish the state's basic GME program.
Health Care Provider Tax – The proposed CMS rule would redefine permissible provider taxes and it would give CMS broad new authority to approve or disapprove health care provider taxes. The rule would allow CMS to find a violation in virtually any situation in which it subjectively believes that linkages exist between provider tax revenues and Medicaid payments, grants, or other monetary benefits to taxed providers.	The health care provider tax has long been a finance mechanism available to states as clarified and approved by Congress since 1991. States have used provider taxes to significantly improve the quality of, and access to, care in hospitals, nursing homes and centers for the developmentally disabled. The President's Budget did not assume any reduction in Medicaid outlays from redefining health care provider taxes and it is not clear if this proposed rule represents what was intended in the Budget.

CMS REGULATORY ACTION	**CONCERN**
Outpatient Hospital and Clinic – CMS seeks to reduce the amount of funding that states can pay outpatient hospitals and clinics by restricting costs that can be counted in the upper payment limit, which is the maximum a state can pay for these services.	This rule would redefine what Medicaid can reimburse under the hospital outpatient benefit to only include those services Medicare reimburses through its more restrictive definition of outpatient hospital services. It should be highlighted that Medicaid and Medicare serve hugely different populations and procedures necessary for good health for both populations are not at all interchangeable. Hospitals would not be reimbursed under the hospital Medicaid benefit for such things as: hospital based physician services; routine vision services; annual check-ups; vaccinations; school-based services; and rehabilitation services. This rule could impair access to preventive services in hospital outpatient departments and clinics and, as a consequence, result in an increased need for treatment of acute conditions in more expensive inpatient hospital settings. CMS states that, due to a lack of available data, it cannot estimate the fiscal impact of this rule, but does "not believe the proposed rule would have significant economic effects."
School Based Medicaid Services – Administration and Transportation – CMS is proposing to eliminate funding	This rule change would end federal reimbursement for all administrative and most transportation services

for 1) administrative activities performed by school employees or contractors or anyone under the control of a public or private educational institution, and 2) transportation from home to school and back for school-age children with an individualized education or family plan.	provided by school employees in the provision of Medicaid eligible services for children with disabilities. The provision of these services is required under federal law through the Individuals with Disabilities Education Act (IDEA). CMS estimates that this provision would reduce Medicaid expenditures by $3.6 billion over 5 years. Statewide, MAC reimbursement is approximately $20 million a year. The rules also eliminate funding for transportation between home and school. The department is currently determining the fiscal impact on transportation reimbursement. Taken together, Oregon schools will no longer have at least $20 million in Medicaid funding for the next school year. The bill passed SCHIP extension in December of 2007contained a moratorium on CMS's implementation for the proposed school-based transportation and rehabilitative services rules through June 2008.
Rehabilitation Services – CMS seeks to clarify the definition of rehabilitative services and to determine the difference between habilitative and rehabilitative services.	The rule would redefine a lengthy list of currently eligible Medicaid rehabilitative services as no longer reimbursable and could end federal Medicaid funding for: prenatal services, rehabilitative mental health services, specialty mental health services, drug and alcohol treatments, adult day health care and even dialysis services in some states. CMS estimates that these changes would reduce Medicaid outlays by $2.3 billion over 5 years. The specific impact to Oregon has

	yet to be determined.
Regulations governing the Deficit Reduction Act of 2005 were promulgated in 2007, requiring, for the first time Proof of Citizenship. Medicaid law requires citizenship or legal status of a minimum duration for all but emergency care. Prior to the DRA, however, federal law required no written proof of citizenship at the time of application or re-determination, although legal residents were required to submit written proof of legal status. Citizenship was dealt with on the basis of oral affirmation.	Requiring this tangible proof serves as a barrier to providing services to potentially eligible individuals who simply lack documentation.

CMS Waiver Approval Actions	
CMS has rejected recent proposals by states expand their Medicaid programs to cover more people by restricting the upper income levels it will approve for eligibility. In his budget request last February, the President said he wanted to return the SCHIP program to its "original objective" of covering children with family incomes less than twice the poverty level. He asked Congress to cut payments and increase requirements on states that covered children at higher income levels. Congress did	States will no longer have the flexibility to determine income eligibility levels appropriate to their population

not do so. The policy was originally set forth, therefore, in a letter to State SCHIP officials, applying to SCHIP only. CMS, however, has now chosen to apply it to Medicaid waiver requests as well.	
The DRA limits the Secretary of HHS from approving a waiver, experimental, pilot or demonstration project that would use SCHIP funds to provide child health assistance or other health care coverage to nonpregnant, childless adults. This section was not intended to apply to any project approved before the enactment of the DRA or to any extension of such project made after the enactment of the DRA (2005). This intent was restated in the March 31, 2006, Dear State Health Official letter from CMS. The letter also explains that states submitting a demonstration application on or after October 1, 2005 may not obtain SCHIP funds to provide coverage to nonpregnant, childless adults. In the 2007 renewal process for Oregon's 1115 Waiver, the SCHIP portion of the FHIAP program fell victim to this provision of the DRA, even though Oregon should have been "grandfathered" as a program that started prior to October 1, 2005.	This has severely affected the program and limited the services that are available to Oregonians who cannot afford health insurance.

NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

NPRM	Comments Due	Effective Date	What the Rule Proposes to Do	Cost estimate	Congressional Action
Provider Tax					
3/23/07	5/22/07	1/1/08	The proposed 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 affords CMS borader flexibility in identifying relationship between provider taxes and payment amounts.	$85 million in FY 2008, $115 million in FYs 2009-2011	P.L. 109-432 (Tax Relief and Health Care Act) - Codifies that the maximum amount that a state may receive from a health care-related tax is 6 percent. Temporarily reduces the permissible rate from Jan. 1, 2008 through 2011 to 5.5 percent. On Oct. 1, 2011, the cap reverts back to 6 percent.
GME					
5/23/07	6/22/07	**Delayed Until: 5/25/2008**	CMS indicates that GME isn't in the statute and therefore isn't allowable.	$140 million in FY 2008, $460 million over five years.	P.L. 110-28 includes a one-year moratorium that prohibits CMS from taking further action on the proposal until May 25, 2008.
Public Provider Cost Limit Regulation					
Final Rule May 29, 2007	7/13/07	**Delayed Until: 5/25/2008**	The rule 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 be a unit of government. In addition, the rule formalizes policies for CPEs and other reporting requirements. The regulation also applies to SCHIP, except for the cost limit on other reporting requirements.	$120 million in FY 2008, $3.87 billion over five years	Congress acted to delay the effective date to May 25, 2008.
Medicaid Pharmacy Pricing					
Final Rule July 17, 2007	1/2/2008--comments are due on AMP and FUL sections	**delayed**	The regulation implements pharmacy-related requirements of the DRA	$4.9 billion over 5 years	The D.C. U.S. District Court placed an injunction on the implementation until the case can be reviewed.

NPRM	Comments Due	Effective Date	What the Rule Proposes to Do	Cost estimate	Congressional Action
Rehabilitation Services Option					
8/13/07	10/12/07	**Delayed Until: 6/30/2008**	NPRM seeks to clarify the definition of rehabilitative services. Seeks to determine difference between habilitative services and rehab services.	$180 million in FY 08 and $2.2 billion over five years	The Medicare Medicaid SCHIP Extension Act includes a moratorium until June 30, 2008. In addition, the manager's amendment to the Indian Health Care Improvement Act Amendments of 2007 (H.R. 1328) Includes a new definition of "Rehabilitation" ‘‘(8) REHABILITATION.—The term ‘rehabilitation’ means medical and health care services that—(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law; (B) are furnished in a facility, home, or other setting in accordance with applicable standards; and (C) have as their purpose any of the following: (i) The maximum attainment of physical, mental, and developmental functioning. (ii) Averting deterioration in physical or mental functional status. (iii) The maintenance of physical or mental health functional status."
Tamper-Resistant Prescription Pads					
8/17/07		**Delayed Until: 3/31/2008**	The new mandate was enacted in the Iraq War Supplemental. Requires that prescriptions for Medicaid patients must be on tamper-resistant prescription paper, unless they meet an exception that is indicated in the regulation. If these standards are not met, there will be no FFP.	$133 million	P.L. 110-90 (TMA, Abstinence Education, and QI Programs Extension Act of 2007)-Provided for a 6 month extension until March 31, 2008.
School-Based Administration and Transportation					
8/31/07	11/7/07	**Delayed Until: 6/30/2008**	Proposed rule eliminates funding for administrative activities performed by school employees or contractors or anyone under the control of a public or private educational insitatution, and transportation from home to school and back for school-age children with an IEP or IFSP.	$635 million in FY 2009 and $3.6 billion over five years.	The Medicare Medicaid SCHIP Extension Act includes a moratorium until June 30, 2008.

NPRM	Comments Due	Effective Date	What the Rule Proposes to Do	Cost estimate	Congressional Action
Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit					
9/28/2007	10/29/2007		The propsed rule implements cost limits on payments to governmental providers and restrictions on Medicaid Graduate Medical Education payments. The rule would also limit the definition of outpatient hospital services and put a restriction for upper payment limit methodologies for private outpatient hospitals and clinics.	CMS declined to estimate the fiscal impact of this proposed rule because of "lack of available data"	
Targeted Case Management					
12/4/2007	2/4/2008	3/3/2008	The interim final rule(ifr) implements restrictions so that states would no longer receive Medicaid reimbursement for case management services that could be paid for by third parties or other federal programs. Among the activities excluded from the definition of Targeted Case Management are transportation services, day care services and administrative activities for foster care or other non-medical programs.	$1.28 billion between FY 2008 and FY 2012	

Attachment G

Division of Medical Assistance Programs (DMAP)
Analysis of
Federal regulations affecting S.B. 329

SB 329 Section	Medicaid or SCHIP regulation	Comments
Section 9(A)-eligibility Section 9 (d)-eligibility requirements	Title XIX Medicaid 42 CFR 435 subpart A thru L- mandatory & optional categories. Title XXI SCHIP 42 CFR 457 subpart C	Includes income limits
Section 9 (2)(a)(F)- requesting federal waivers. 9(2)(b)(G)-combining or eliminating agencies	Title XIX Medicaid 42 CFR 431 Title XXI SCHIP 42 CFR 457 Subpart J	Single state agency designated to administer the Medicaid agency. State Plan change is needed if changing from DMAP as administrator of Medicaid program. Medicaid requirements for MAC
Section 2 (3)- Define set of services	Title XIX -Medicaid Mandatory: 42 CFR 440.10 through 440.40, 440.70, 440.160 through 440.166, 440.210, 431.53,435.406 Optional: See attachment for full list of benefits Or Title XIX 1937 SSA	Medicaid regulation defines mandatory and optional services which are approved in a Medicaid state plan. Or Option of providing 'benchmark benefits' under state plan (new

SB 329 Section	Medicaid or SCHIP regulation	Comments
		DRA flexibility).
Section 2 (3)- Define set of services	Title XIX -SCHIP 42 CFR 457.402	Similar to Medicaid mandatory & optional svcs (not as comprehensive as Medicaid) An have "secretary approved benefit plan
Section 3(2)- Same set of essential benefits	Title XIX -SCHIP 42 CFR 457 Subpart D	Currently waiver allows SCHIP & OHP to the same benefits. FHIAP has similar but not identical benefits
Section 2 (8)- Safety net clinics (FQHC)	Title XIX 42 USC 1396	Requires specific payment methodology for Medicaid & Medicare
Section 9(2)(d)(iii)- provider enrollment	Title XIX 42 CFR 431.108	Medicaid regulation already provide for this type of retro enrollment
Section 9(2)(d)(iv)- waiting period & pre x conditions	Title XIX Title XXI-42 CFR 457.320, 457.480	 Not allowed, except as specified in law
Section 9(2)(d)(C)- grievance and appeals	Title XIX 42 CFR 431 Subpart E	Medicaid regulations
Training of Sub professionals & agency staff	Title XIX 42 CFR 432 subpart B & C	
Section 9(2)(D)-accountable health plan	Title XIX Medicaid 42 CFR 438 subpart A thru I	Managed Care requirements
Section 9(2)(B)(iv)-pre existing	Title XIX SCHIP	SCHIP allows, Medicaid does not

SB 329 Section	Medicaid or SCHIP regulation	Comments
conditions	42 CFR 457.380	