

Testimony on H.R.5613, "Protecting the Medicaid Safety Net Act of 2008"  
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Subcommittee on Health of the Committee on Energy and Commerce

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Good morning Mr. Chairman and members of the Subcommittee, and thank you for the opportunity to testify at this important hearing. My name is John Folkemer. I have worked in Medicaid for the State of Maryland for more than 25 years, and have been Maryland's Medicaid Director for the past year.

The mission of the Medicaid program, which is a state and federal partnership, is to provide health care to the neediest and most vulnerable populations in our country. Medicaid currently provides comprehensive coverage to well over 50 million Americans. It is the single largest payer for the long-term care costs that are perhaps the greatest economic and health care challenge that we face as baby-boomers approach retirement. Medicaid provides support and services for millions of Americans with a wide range of disabilities that enables them to live independent lives in the community. It is the single largest payer of mental health services; the largest purchaser in the nation of pharmaceuticals; and the source of health insurance coverage for most of the nation's working poor. Medicaid is the largest source of care for children in low-income families and is the largest payer in most states for maternity and prenatal care.

In recent years there has been a significant increase in the number of Americans without health insurance as employer-sponsored coverage has steadily deteriorated. States have responded by covering many of these uninsured families and individuals in their Medicaid and State Children's Health Insurance (SCHIP) programs. In Maryland, approximately 200,000 individuals have been added to our Medicaid and SCHIP rolls over a 10-year period, with current enrollment at about 650,000. Spending on Medicaid and SCHIP now account for 20 – 25% of most states' budgets. However, many states are again facing huge budget shortfalls, creating incredible pressure to figure out how to provide quality Medicaid services to ever expanding populations while operating under increasingly tighter budget constraints.

States have long had flexibility to structure their Medicaid programs to best serve the needs of their beneficiaries in a streamlined, cost-effective manner. Over the past year, the Centers for Medicare and Medicaid Services (CMS) has issued a series of Medicaid regulations that significantly shift costs to states and restrict services, leaving states unable to effectively provide access to quality services for the most vulnerable of our citizens: low-income uninsured children and families; the elderly; and persons with disabilities. The series of regulations aims to restrict states' flexibility and impose harsh cuts in federal matching funds under the guise of reducing fraud and abuse. While it is true that there have been instances of abuses in claiming federal Medicaid matching funds, CMS's response of overarching regulations is excessive, inappropriate and harmful. Cases of fraud and abuse should be dealt with on a state-specific basis, rather than restricting services and cutting funds from all states. The cut in federal funds comes at a time when the need for services continues to increase, leaving already financially strapped states with additional cost burdens. Maryland feels that it is critical to delay these regulations to allow for consideration of their full impact.

## **Impact in Maryland**

While all seven regulations addressed in this legislation have adverse impacts on the states and their citizens, I would like to focus on the regulations that are of greatest concern to Maryland.

### **Case Management:**

The case management regulations, which took effect on March 3, 2008, are probably the most harmful of these regulations. CMS followed guidance in the Deficit Reduction Act (DRA) of 2005 to issue regulations defining case management services more clearly in order to reduce potential abuses of such services. The resulting interim final rule, however, harmfully overreaches the original language and intent of Congress. Nearly 200,000 people in Maryland receive some type of Medicaid case management services or components of those services, and all of these programs will be affected, potentially putting more than \$60 million in federal funds at risk for the State.

To come into compliance with the provisions of the rule, Maryland may be forced to leave many vulnerable populations without any access to needed case management services, or create disruptions and confusion in how they receive them. Recipients may have to change case managers as program structures are changed. Transitions from institutions to community living will be more difficult, resulting in individuals being forced to remain in institutions. Recipients may receive less case management if billing limits are set. The quality of case management provided to recipients will likely be lowered as it becomes more difficult for the State to adequately monitor an expanded array of case managers. Administrative costs for both providers and the State will increase dramatically.

Maryland has long-established case management programs that have been approved by CMS, including targeted case management, case management provided to home and community-based services (HCBS) waiver participants, and administrative case management. The new rule will require restructuring of all of these programs, causing major administrative disruptions and significant additional costs. Medicaid can no longer reimburse for Individualized Education Plan (IEP) services, which are care planning and coordination activities for children aged 3 to 21 performed by schools. This will result in a \$20 million cut in funds to school systems. Programs that provide important services to Medicaid recipients but do not meet the complete definition of case management or all of the administrative requirements will lose funding, resulting in cost-shifting to states or termination of programs.

The broad interpretation CMS has taken of the rule to include all case management provided in HCBS waivers is inappropriate and harmful. The strict requirements of the regulations will mean that Maryland Medicaid will lose the ability to effectively monitor and control programs. For example, because case management cannot be required in order to receive other Medicaid services, the State will not be able to ensure proper and cost-effective plans of care for waiver participants. With any willing provider able to enroll as a waiver case manager, the State will have little control over quality of services provided to the most vulnerable populations. Maryland's seven HCBS waivers serve medically fragile adults and children, individuals with developmental disabilities, the elderly, and autistic children.

#### Rehabilitative Services:

Many states use the rehabilitative services option to allow individuals with developmental disabilities, severe mental illness, or other special needs the ability to live independently in

community-based settings, avoiding costly institutional placements. Although Maryland has not been able to quantify the fiscal impact, it is clear that this rule would have a significant impact on certain mental health services and programs. It could also have a negative impact on reimbursement for services provided to children in out-of-home placement. Losses in federal funds for these services will result in the need to implement further cost containment, which generally results in decreases in services, or could force individuals who could live successfully in the community to be institutionalized. Approximately 30,650 Medicaid recipients currently receive rehabilitative services that could be affected.

Intergovernmental Transfer (IGT):

Medicaid programs do not function alone—it takes collaboration with other governmental agencies and providers such as teaching hospitals, local health departments, school systems, public health agencies, and child welfare agencies to provide a continuum of care to recipients. These collaborations have been encouraged and sometimes mandated by Congress. 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 certified public expenditures and other reporting requirements. This rule will require significant increases in administrative burdens for state and local agencies. All government providers will be required to cost settle payments on an annual basis. This mainly affects schools and local health departments throughout Maryland. Small safety net providers, especially in rural areas, who serve vulnerable populations, may have to discontinue services or reduce the scope and quality of services. For some small public community clinics and services, the cost of an annual cost settlement may be greater than their total Medicaid reimbursement.

### Graduate Medical Education (GME):

Historically, payers have shared in the cost of providing training of medical professionals in hospitals. Medicare law specifically requires these costs to be recognized in establishing reimbursement rates. State Medicaid programs have always recognized their obligation to pay for their fair share of these costs, a practice which has always been approved by CMS.

Nonetheless, because there is no specific language in Title XIX that requires states to pay their fair share of GME costs, CMS is now prohibiting state Medicaid programs from doing so. Providing funding for GME is essential to help ensure an adequate number of trained medical providers, especially as our country faces a massive physician shortage in the next decade. Maryland Medicaid could lose about \$7 million in federal matching funds as a result of this regulation.

### Conclusion

CMS maintains that the elimination of \$20 billion in federal Medicaid funding for Medicaid administrative activities in the schools, or rehabilitation services for children with developmental delays, or graduate medical education, or the numerous other affected services and programs is appropriate because these activities were never intended to be part of Medicaid, despite decades of approved State Plan provisions across the nation. There are no appropriations on the horizon to replace this loss of revenue—Medicaid is simply supposed to reduce the scope of its activities. It is particularly ironic that this philosophy should come at a time when most experts in the field would say that the nation's health care system is in a state of crisis. The emergency rooms of our teaching hospitals are bursting at the seams as they try to provide both emergency and non-emergency care to the 47 million Americans who have no health insurance. A greater awareness of autism spectrum

disorders and mental illness among very young children has placed a strain on the entire mental health system. Persons with disabilities are struggling to find more creative alternatives to live independent and productive lives. A retrenchment by Medicaid will only make those struggles more difficult for millions of Americans.

Maryland, like many other states, has been forced to impose new taxes and cost containment initiatives to deal with huge budget deficits. During these difficult fiscal times, it is even more critical that we continue to provide health care to our most vulnerable populations. Implementation of CMS's excessive and damaging regulations will only serve to reduce such critical care. I urge Congress to enact this legislation placing a moratorium on these regulations. CMS created the regulations without sufficient consideration of their impact on Medicaid beneficiaries, providers and states. I encourage an open discussion that is focused on outcomes as well as costs, and that is mindful of the needs of our most vulnerable citizens.

Thank you. I would be happy to try to answer any questions.