Mandated Report to Congress
Independent Study and Report
Contract no: HHSM-500-2005-00024I

Proposed Interview Questions for Regulations Under Review

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Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Partnership

Interview and Data Questions

I. Background

The rule seeks to:

- Clarify that entities involved in financing the non-federal share of Medicaid payment must be Units of Government
- Limit reimbursement to governmentally-operated health care providers to an amount that does not exceed the provider's Medicaid cost
- Establish minimum documentation required to support a certified public expenditure (CPE)
- Require that governmentally operated providers retain the full amount of payment for services covered by the State Plan
- Make conforming changes to SCHIP except for cost limit (i.e., apply changes relating to Unit of Government, CPE and Intergovernmental Transfer (IGT) use, and retention)

II. Interview Questions – Please note that questions will be asked for both Medicaid and SCHIP, if separate programs. For this interview, please identify and include staff that are knowledgeable about public providers, their costs, cost reports, and related financing arrangements, as well as specific aspects of financing such as CPEs, IGTs, and upper payment limits, both within the Medicaid agency as well as other program-specific agencies.

Units of Government – Section 433.50 of the proposed regulation includes the following:

A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority. A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing of the following:

(A) The health care provider has generally applicable taxing authority; or

(B) The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

1. Which "public providers" currently provide services under your Medicaid program? (e.g., inpatient hospital, outpatient hospital, clinic, ICF/MR). What categories of service do they provide? *(also, see data request in Section III)*
2. Which providers will not be considered "Units of Government" under the proposed regulation? *(also, see data request in Section III)*

a. What criteria in the proposed regulation disqualify them?

b. Are there specific providers or types of providers that have been considered public for which it is unclear if they will qualify as "Units of Government"?

c. Are there specific providers or types of providers that have not been considered public that will now qualify as "Units of Government"?

3. What changes in current Medicaid operational processes will be required to comply with determination of government status (e.g. completion of Unit of Government form, process for state determination of status, IT system changes)?

4. To what extent do you anticipate that the loss of public status for some providers will impact the rates, fees, and/or UPLs for Units of Government and non-Units of Government?

    a. Please describe and share any estimates that have been previously been determined regarding, for example, rate changes, increases or decreases in the availability of care, opening or closing of facilities, etc.

Funds from units of government as state-share – Section 433.51 addresses funds from units of government that can used to claim Federal Financial Participation. Specifically these funds must meet the following requirements:

- The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum —

  (1) Identifies the relevant category of expenditures under the State plan;

  (2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;

  (3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and

  (4) Is subject to periodic State audit and review.

- The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

5. Which providers, if any, certify Medicaid spending using CPEs? *(also, see data request in Section III)*

6. Which providers, if any, contribute Medicaid funds through IGTs? *(also, see data request in Section III)*

7. Does the current CPE methodology meet the requirements laid out by CMS in its proposed regulation? If so, please describe. If not, how is the current methodology different from the methodology in the proposed regulation?

8. If the current CPE methodology does not meet the requirements in the regulation, what is the estimated reimbursement impact for Units of Government?

9. What additional State share, grant funds, or other funding, if any, would the State need to provide to support providers that do not qualify as Units of Government at the same level as they would have received had they been allowed to continue to use CPEs?

10. What is the anticipated administrative impact for states and providers of complying with the proposed CPE requirements (e.g. documentation, record keeping, systems changes)?

11. Is the State considering implementing new or additional CPEs based on the proposed regulation? If so, for what providers, and what is the anticipated impact?

Cost Limit for Units of Government – Section 447.206 applies to payments made to providers that are determined to be units of government and includes the following:

(1) All health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients.

(2) Reasonable methods of identifying and allocating costs to Medicaid will be determined by the Secretary in accordance with sections 1902, 1903, and 1905 of the Act, as well as 45 CFR 92.22 and Medicare cost principles when applicable.

(3) For hospital and nursing facility services, Medicaid costs must be supported using information based on the Medicare cost report for hospitals or nursing homes, as applicable.

(4) For non-hospital and non-nursing facility services, Medicaid costs must be supported by auditable documentation in a form approved by the Secretary that is consistent with § 433.51(b)(1) through (b)(4) of this chapter.

12. Which provider types submit Medicaid cost reports and how often? Which provider types do not currently submit cost reports? What other types of cost documentation and/or verification are available? *(also, see data request in Section III, items 3-4)*

13. For those that do not submit cost reports, what other types of cost documentation, verification, and/or benchmarks are available? *(also, see data request in Section III, items 3-4)*

14. Based on your understanding of the proposed regulation, what is the anticipated administrative impact/cost for states and providers of complying with the cost reporting requirements (e.g. developing reports, completing reports, reviewing and reconciling, systems changes)?

15. What is the estimated reimbursement impact of the cost-limit? If possible, please share methodology, calculations, etc.

16. If you currently reimburse some "public" providers above cost, what is the rationale of doing so?

Retention of Payments – Section 447.207 of the proposed regulation requires that providers that are units of government retain payments for Medicaid services, specifically:

All providers are required to receive and retain the full amount of the total computable payment provided to them for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable). The Secretary will determine compliance with this provision by examining any associated transactions that are related to the provider's total computable payment to ensure that the State's claimed expenditure, which serves as the basis for Federal Financial Participation, is equal to the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied.

17. What providers currently considered public do not retain all the funds they receive from Medicaid/SCHIP? (note that ALL providers are required to retain the full amount of funds, not just public providers)

    a. How much is not retained?

    b. How do you know if the funds are retained?

    c. If funds are not retained, what are they used for?

18. What methods are (or could be) used to track that Medicaid reimbursements are fully retained by providers?

19. What changes in current Medicaid operational processes will be required to comply with verifying retention of Medicaid reimbursements?

Additional information to be collected – The following questions will help with the determination of the overall impact of the proposed regulation, including potential data sources, as well as alternative methods of addressing the problems that the proposed regulation seeks to address.

20. What data sources, analytic methods, and impact assumptions were used to develop previous estimates of the impact of this regulation, including your State's response to the Waxman request?

21. Can the State assess the overall impact of the proposed regulation on the State's safety net and other programs including potential financial, public health, and other impacts (e.g. change in availability of programs to various populations, change in the number of providers, changes in charges to the uninsured, etc.)?

22. Which programs (if any) in your State were previously cited as problematic by CMS, GAO, OIG, etc.? What modifications were made to bring them into compliance?

23. What other approaches could be taken to accomplish the goals of the proposed regulation?

24. Of the funding streams involved (e.g. rates, fees, and other Medicaid payments), which are currently handled outside of the MMIS and are they "total computable payments"?

III. Data Requests

1. List of governmentally-operated providers including provider ID number (NPI) and provider type

2. List of services provided by the previously identified providers

3. Total Medicaid/SCHIP reimbursement to governmentally operated providers, by provider ID (NPI) and type of service. Indicate whether reimbursement is "total computable" or federal-share only

4. Total cost of care provided to Medicaid eligibles by governmentally operated providers, by provider ID (NPI) and type of service

5. List of providers that would (or possibly would) no longer be considered public including provider ID (NPI), type, and reason for exclusion

6. Total CPE expenditures by provider, by provider ID (NPI) and type of service

7. Total funds transferred via IGTs, by provider, by provider ID (NPI) and type of service

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Graduate Medical Education

Interview and Data Questions

I. Background

The proposed rule asserts that costs and payments associated with GME programs are not authorized medical assistance expenditures, thereby eliminating all federal payments for Direct Graduate Medical Education (DME) and Indirect Graduate Medical Education (IME). In addition, the Medicare Direct GME payments would be removed from the Medicaid Upper Payment Limit (UPL) calculations.

II. Interview Questions

Questions 1 through 8 request information about State program administration, payment methods, and policy issues pertaining to Medicaid GME. Responses to these questions will provide a foundation for understanding the current structure of the State's GME program and how it is financed to better assess the impact that implementation of this regulation could have on the State in this area.

1. Which agencies and departments are responsible for administering the Medicaid GME program in your State? What are their respective roles and responsibilities?

2. Which types of providers and/or other organizations are eligible to receive GME payments in your State and what specific criteria are used to determine eligibility for Medicaid GME payments?

3. Are payments specifically designated as Medicaid GME identified within the States Medicaid reimbursement methodology?

4. How are Medicaid GME payments determined in your State, and on what basis (per-diem, per-case, other) are they distributed? To what extent are methods similar to Medicare used?

5. Does your State place explicit limits on Medicaid GME payments to eligible providers? If yes, how is the maximum limit for GME payments determined?

6. Does your State currently link Medicaid GME payments to State work force or other policy goals (such as addressing shortages of primary care physicians, or shortages of health care providers in medically underserved communities)? If yes, please elaborate.

7. Has your states Medicaid GME program ever been cited as problematic by CMS, GAO, OIG or other federal organizations? If yes, what modifications to the program were made to bring it into compliance?

8. Has your State considered or implemented any strategies designed to address CMS issues of concern regarding Medicaid GME payments? If yes, please elaborate on strategies and their anticipated impacts.

Additional information to be collected – Questions 9 through 14 will help with the determination of the overall impact of the proposed regulation, including potential data sources, as well as identifying possible alternative methods of addressing the problems that the proposed regulation seeks to address.

Currently the general instructions regarding Medicaid State Plan requirements for payment methods for all Medicaid services are provided at § 447.201. We propose to add a new § 447.201(c) to indicate that GME cannot be included as part of any payment methodology in the Medicaid State Plan.

We propose also to modify §§ 447.257 and 447.304 to address that FFP is no longer available for any reimbursement that includes or specifically pays for GME.

We propose to modify § 447.272(b)(1) and 447.321(b)(1) to indicate that the term ''Medicare payment principles'' must exclude any Medicare payments associated with direct GME when calculating the Medicaid UPL.

We propose to modify § 438.6(c)(5) by removing paragraph (v) that addresses the coordination of GME payments under the State plan with capitated rates paid to a Medicaid MCO.

We propose to modify § 438.60 to provide that the limit on payment to other providers would not include an exception related to GME payments made to providers outside the capitation rate and under the Medicaid State Plan.

9. What are the current methods of allocating Medicaid GME payments to eligible providers in your State?

    a. Fee-for-service (per case, per resident, other)

    b. Managed Care (bundled payment, separate payment, other)

    c. Both fee-for-service and Managed Care

    d. Other-please specify

10. To what extent is your State able to clearly identify all Medicaid GME payments to eligible providers under FFS and managed care payment systems?

11. Do you anticipate that any new and significant administrative costs will be incurred by your State Medicaid agency and/or other State entities in complying with federal requirements as a result of this proposed rule? If yes, please describe the nature of these costs and estimate their key impacts on State agencies.

12. Has your State performed an independent analysis of the financial impact of the proposed Medicaid GME rule, including any analyses conducted at Representative Waxman's request? If yes, please share with us:

    a. Data sources used to perform the financial impact analysis

b. Analytic methods, time periods, and impact assumptions used to develop the analysis

c. Any analysis results, including those shared with any federal agencies or other interested organizations

13. As you know, the proposed CMS rule would eliminate the federal share of State Medicaid GME payments.

    a. How much Medicaid GME funding has your State received through federal matching payments during the most recent State Fiscal Year for which this information is available?

    b. Do you believe that your State would consider addressing lost federal matching payments from other State revenue sources? If yes, to what extent and from which State sources of revenue?

    c. How would your State's likely response impact State Medicaid GME payments to eligible providers and other organizations?

14. The proposed CMS rule would also remove federal Medicare DME payments from the calculation of your State's Medicaid UPLs.

    a. Would this component of the proposed rule, if enacted, have a significant financial impact on your State Medicaid program? If so, in what ways?

    b. Would it likely have a significant impact on hospital Medicaid payment rates? If yes, which provider types would likely be most impacted (State, city/county, or private providers)?

Questions 15 and 16 focus on data sources and the transparency, completeness, and accuracy of data for capturing State Medicaid GME payments.

15. Are all Medicaid GME payments currently captured in your State's MMIS?

    a. Yes, both total DME and IME payments are captured

    b. DME only

    c. IME only

    d. Other

16. Are there any Medicaid GME payments to eligible providers that are currently processed outside of the MMIS in your State? If yes:

    a. What provider types are involved and what is the magnitude of these payments for the most recently available fiscal year?

b. What method, if any, is used for claiming federal matching dollars for Medicaid GME payments processed outside of the MMIS?

c. What strategies are in place to ensure the fiscal integrity of the Medicaid GME payments that are processed outside of the MMIS in your State?

III. Data Requests

1. List of eligible providers and Medicaid GME payments by provider type

2. Aggregated and hospital-specific payments under fee-for-service and managed care

3. Aggregated and total Medicaid GME payments, by component, to non-teaching hospital providers

4. Aggregated and facility group specific Medicaid UPLs

5. Medicare DME payments to teaching hospitals in total and by facility group for the most recent State Fiscal Year

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Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School

Interview and Data Questions

I. Background

The rule clarifies that Federal Financial Participation (FFP) is no longer available for: (1) all Medicaid administrative activities performed by school employees, school contractors, and anyone under the control of a public or private educational institution, and (2) transporting school-age children between school and home.

Final Rule:

"Federal financial participation under Medicaid is not available for expenditures for administrative activities by school personnel, school contractors, or anyone under the control of a public or private educational institution." ***(42 CFR §433.20)***

"Necessary transportation does not include transportation of school-age children between home and school." ***(42 CFR §431.53)***

"Transportation includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient. Such transportation does not include transportation of school-age children from home to school and back." ***(42 CFR 440.170)***

CMS Rationale:

"Administrative activities performed by schools, and transportation of school-age children from home to school and back, are not necessary for the proper and efficient administration of the State Medicaid plan, and are not within the scope of transportation services recognized by the Secretary under 42 CFR 440.170(a) for the following reasons:

(1) The activities or services support the educational program and do not specifically benefit the Medicaid program;

(2) The activities or services are performed by school systems to further their educational mission and/or to meet requirements under the IDEA, even in the absence of any Medicaid payment;

(3) The types of school-based administrative activities for which claims are submitted to Medicaid largely overlap with educational activities that do not directly benefit the Medicaid program; and

(4) Transportation from home to school and back is not properly characterized as transportation to or from a medical provider."

(Federal Register, Vol. 72, No. 248, pages 73635-73651 (See II. Provisions of the Proposed Regulation.)

II. Interview Questions

1. Does your State Medicaid agency participate in school-based Medicaid administrative claiming for activities performed by any/all of the following:

a. School employees (yes/no)?

b. School contractors (yes/no)?

c. Other individuals under the control of a public or private educational institution (yes/no and, if yes, please specify)?

For a-c, describe their roles and responsibilities with respect to school-based Medicaid administrative activities performed.

2. *While states are not required to submit school-based administrative claiming plans to CMS for approval prior to claiming school-based Medicaid administration, some states have opted to do so. In addition to assessing the impact of the rule, Lewin is required to recommend actions by federal agencies and states to make claims more accurate, complete, and consistent with statute. We are requesting the information below to gain a better understanding of approval processes for school-based Medicaid administrative claiming plans and to recommend actions for CMS or states.*

    a. Did your State submit a Medicaid school-based administrative claiming plan to CMS for approval? If so, when was the plan approved?

    b. If your State submitted a Medicaid school-based administrative claiming plan and received approval before May 2003 from CMS, did your State revise its approved plan following issuance of the May 2003 CMS Medicaid School-Based Administrative Claiming Guide to be in compliance by October 1, 2003? If so when was the revision submitted and approved?

3. How does your State report school-based administrative claiming expenditures?

    a. Does the State report them on the CMS-64? If not, what is the rationale and how is school-based administrative claiming expenditure data otherwise reported?

    b. How does the State report Medicaid school-based administrative claiming expenditure data?

4. Which (and to what extent) do entities other than the State Medicaid agency [e.g., State Department of Education, Local Education Agencies, (LEAs)] perform school-based Medicaid administrative activities to school age children?

    a. Please list each claiming agency/entity and describe its roles/responsibilities related to school-based Medicaid administrative claiming (e.g., education, local health departments, MR/DD, etc.).

    b. How do the various agencies/entities involved assure no duplicative claiming?

    c. Describe how these agencies'/entities' roles/responsibilities to perform school-based administration will change as a result of this rule.

5. To what extent does your State Medicaid agency, Education department, or LEA use the services of independent consultants and/or private contractors/entities for purposes of

administering the school-based Medicaid administrative claiming program or developing the claims?

   a. Please describe their roles and responsibilities for administrative claiming in schools.
   b. Describe how their roles/responsibilities may change if the rule goes into effect.
   c. Will your State continue to provide administrative claiming in the school setting if the rule goes into effect?

6. What is the total Medicaid school-based administrative expenditure (total computable amount) in the most recently completed State Fiscal Year that would be disallowed/eliminated under the regulation?

   a. How would the State otherwise finance these services?
   b. Please identify whether the non-Medicaid funding source(s) would be State, local, or Federal funding, and in what proportions, if known.

7. How are federal funds for school-based Medicaid administrative activities distributed?

   a. To which entities (e.g., State education departments, schools/LEAs, billing agents/independent contractors, Medicaid agency) and in what proportion(s)?
   b. Does your State dictate how funds claimed for school-based Medicaid administrative activities must be used? If so, what are the requirements for the use of funds and how is compliance assured (e.g., do LEAs report on how they use funds and to whom)?

8. Which State or local agencies provide the required State matching funds for school-based Medicaid administrative claiming?

   a. What is the funding mechanism for the non-federal share [e.g., Certified Public Expenditures (CPEs), IGTs, other]?
   b. What is the source of funds for the non-federal match (e.g., State general fund appropriations, local taxes, other)?

9. Under the regulation, FFP will remain available for school-based Medicaid administrative activities if performed by a Medicaid State agency or local health department staff.

   a. Does the State intend to transition school-based Medicaid administrative activities to Medicaid State agency or other local health department personnel?
   b. If so, how will this occur [e.g., by placing Medicaid State agency staff in schools, (as outstationed employees), or some other arrangement]?

10. Based on the regulation, which school-based Medicaid administrative activities performed by school employees, school contractors, or anyone under the control of a public or private institution (for which you currently claim FFP) may no longer be provided? Which will continue to be performed by schools as a result of IDEA or other educational missions/mandates (e.g., "child find")?

11. *The rule would prohibit Medicaid administrative claiming for activities performed by school employees, school contractors, or anyone under the control of a public or private educational institution. To help identify how elimination of funding for these activities will impact services for school-age children, we wish to identify if the State already has a mechanism in place to assess the status of programs and funding for children's services*.

    Does your State prepare a "state children's budget" or otherwise conduct an overall assessment of spending on children's programs? If so, to what extent does that budget address whether/how elimination of funding for school-based Medicaid administrative activities could affect (directly or indirectly):

    a. Medicaid enrollment rates among school-age children?

    b. Provision of Medicaid-covered direct medical services for school-age children (e.g., EPSDT services)?

Related questions if the State claims for school-based transportation as an optional medical service

Final Rule:

"Necessary transportation does not include transportation of school-age children between home and school." ***(42 CFR §431.53)***

CMS' response to proposed rule comments states:

"CMS will continue to reimburse States for school-based Medicaid service costs authorized in their approved Medicaid State plans, including transportation of school-aged children from school or home to a non school-based direct medical service provider that bills under the Medicaid program, and from the non-school-based provider to school or home. CMS will also continue to reimburse States for transportation costs related to children who are not yet school-age and are being transported from home to another location, including a school, and back to receive direct medical services, as long as the transportation is not primarily for purposes other than gaining access to a Medicaid provider for covered services (such as when it is regularly scheduled transportation to a day care program)."
Federal Register, Vol.72., No. 248, page 73638.

12. Does the State Medicaid agency claim FFP for school-based transportation services? States are generally required to provide transportation to and from Medicaid covered medical services for certain eligible individuals. States may provide such transportation under the Medicaid State plan as either a required administrative activity (42 CFR 431.53) or as an optional medical service (recognized by the Secretary under section 1905(a)(28) of the Act and implemented at 42 CFR 440.170(a)). Which of these two options does the state use to provide transportation to school-age children? (administrative activity/optional medical services)

    a. If your State claims for school-based transportation for Medicaid students with an IEP/IFSP as an optional medical service, are these claims submitted through the MMIS?[1]

        - If not, what is the rational for not submitting claims through MMIS?
        - How are they submitted (e.g., paper claims, other electronic system)?
        - Does the claiming system interface with MMIS and if so how?
        - Which provider type/entity is responsible for submitting the claim (e.g., LEA, State education agency, transportation provider, etc.?)

    b. If your State uses the administrative claiming option for transportation for covered services for Medicaid, describe the following:

        - Does the state claim for the administrative activities related to transportation (e.g., arranging for/scheduling transportation)?
        - Does the state claim for the actual transportation services and under what circumstances?
        - How does the State track these claims that roll up into the CMS-64 or other reporting mechanism?

13. Does your State maintain trip logs, attendance records, or other documentation to determine what proportion is for

    a. Transportation between home and school? and

    b. Transportation between school and a covered medical service location?

14. What changes will the State have to make to come into compliance, should the regulations be implemented? Please respond separately for each agency affected (e.g., Medicaid State agency, education department, LEAs, school districts, etc.).

[1] It is our understanding that if a state claims school-based transportation as an administrative service, it is not captured in the state's MMIS.

a. Changes in State administrative rules or statutes.

b. Changes in CMS-64, MBES/CBES, and other claiming mechanism.

c. Development or changes to reimbursement policy or fee schedule (e.g., restructure rates to include school-based administrative costs in the payment for school-based optional medical services).

d. Staffing changes or organizational restructuring (to provide Medicaid administrative activities permitted only if performed by Medicaid agency or other local health department personnel).

15. Whether or not this regulation is implemented, what recommendations does your State have for CMS to better monitor the program and provide improved guidance to States and schools?

16. Has your state school-based administrative claiming program or school based optional medical transportation services been subject to review or audit by CMS, GAO or OIG?

    a. If so what (if any) activities, practices or policies in your State were previously cited as problematic by CMS, GAO, OIG?

    b. What modifications were made to bring them into compliance?

III. Data Requests

A. School-Based Administrative Claims

1. The total amount claimed as school-based Medicaid administrative expenditures, for the most recent completed year for which data is available.

    a. What proportion of this total amount is attributable to transportation-related activities?

    b. If your State's administrative claim includes both administrative activities (e.g., arranging/scheduling transportation) and actual transportation services, please provide the proportion claimed for each of these two components.

2. Total and source of non-federal expenditures in support of claims for Medicaid school-based administrative activities, broken down by:

    a. Total amount provided through an IGT

    b. Total amount provided through certification of public expenditures.

B. School-Based Transportation

1. Total number of Medicaid school-age children with IEPs/IFSPs for whom school-based transportation was claimed for the most recently completed State Fiscal Year, and if possible, break down the total by:

    a. Transportation between school and home

    b. Transportation between school/home to a covered medical examination or treatment

2. For the students identified, the average number of trips per month for which school-based transportation was claimed during the most recent State Fiscal Year. If possible, break down the average monthly trips by:

    a. Trips between school and home

    b. Trips between school/home to a covered medical examination or treatment

3. The Medicaid reimbursement rate(s) for Medicaid covered transportation services.

C. Impact Analyses Conducted to Date

Has your State conducted any impact analyses on this regulation to date (e.g., at the request of Senator Waxman)? If so, please describe the methodology and the data your State used to estimate the impact of this regulation.

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Coverage for Rehabilitative Services

Interview and Data Questions

I. Background

The proposed rule would restrict the scope of rehabilitation services that are eligible for federal Medicaid matching payments. The rule:

- Defines key terms used to set parameters for coverage of rehabilitation services under the Medicaid Rehabilitation Option
- Specifies State Plan requirements
- Specifies the scope of services, with a key focus on all services being directed toward a specific rehabilitation goal in a written rehabilitation plan
- Defines rehabilitation services, excluding habilitative services and those that are "intrinsic elements" of programs other than Medicaid
- Requires maintenance of case records for rehabilitation services

II. Interview Questions

A. Background

1. Do you cover the optional Medicaid rehabilitation services benefit under Section 1905(a)(13) of the Social Security Act (i.e., the rehabilitation option) through your Medicaid State Plan?

2. Which agencies are responsible for administering services covered through the Medicaid rehabilitation option?

    a. Who pays the State share of the Medicaid expenditures?

    b. What formal arrangements outline roles and responsibilities (e.g., interagency agreements, contracts)?

3. Please describe the types of services covered through the rehabilitation option.

    a. What are the target populations for those rehabilitation services? (e.g., people with mental illness, people with substance abuse problems, people with MR/DD, children with special needs, etc.)

    b. Are there different distinct models of care covered through the rehabilitation option (e.g., assertive community treatment), other than those already described above? If yes, please describe.

4. Does the State have any documents that are useful for understanding the rehabilitation option services other than those described in the State Plan? (if so, please share)

5. Are the rehabilitation option services also available to children enrolled in CHIP?

6. Are the services covered through the rehabilitation option also covered under an 1115 demonstration or any other waiver authority? Are the target populations the same as described above? If not, please describe.

7. Are the services covered through the rehabilitation option primarily covered on a fee-for-service basis? Are any covered through capitation payments to managed care plans? If yes, please describe.

8. Have any of your services under the rehabilitation option been previously cited as problematic by CMS, GAO, OIG, etc.? If so, which ones? What modifications (if any) have you made to bring them into compliance?

9. Have you made any significant changes in recent years (or are you planning to make any changes) to services covered through the rehabilitation option? If so, what was the nature of those changes? Have you taken any actions to address the types of issues CMS is attempting to address through the proposed regulations? If so, please describe the changes and the expected outcomes.

10. How much Medicaid funding is dedicated to services covered under the rehabilitation option (see the data request in section III below)? In the absence of the proposed regulations, are you expecting any major changes in rehabilitation-related expenditures in the near future?

B. Impacts

11. Has the State estimated the impacts of complying with the proposed rule? If yes, please provide a listing/description of the data sources, analytic methods, and impact assumptions used to develop these estimates:

    a. General impact

    b. Administrative impacts on the Medicaid agency and other agencies

    c. Financial impacts

    d. Impacts on Medicaid beneficiaries; Access to care

    e. Impacts on providers. Please describe which types of providers would be affected.

    f. Impact by key provision (see questions below)

Intrinsic Elements – Section 441.45 (b)(1) of the proposed regulation includes the following:

"Rehabilitation does not include, and FFP is not available in expenditures for, services defined in §440.130(d) of this chapter if the following conditions exist:

(1) The services are furnished through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship."

12. The regulations would preclude the rehabilitation option from covering services that are an "intrinsic element" of programs outside of Medicaid (441.45(b)(1-8)), such as foster care, child welfare, education, child care, vocational and pre-vocational training, housing, parole and probation, juvenile justice, or public guardianship.
    a. Do you believe that CMS would consider any of your current rehabilitation option services to be "intrinsic elements" of other non-Medicaid programs?
    b. If so, which ones?
    c. What impacts?
    d. What steps would your agency need to take to come into compliance?
    e. Would you be able to shift coverage to other types of Medicaid programs?

Habilitation Services – In describing Section 441.45 (b)(2) of the proposed regulation, CMS proposes to exclude FFP for expenditures for habilitation services including those provided to individuals with mental retardation or "related conditions" as defined in the State Medicaid Manual §4398.

"As a matter of general usage in the medical community, there is a distinction between the terms "habilitation" and "rehabilitation". Rehabilitation refers to the measures used to restore individuals to their best functional levels. The emphasis in covering rehabilitation services is the restoration of a functional ability."

"Habilitation typically refers to services that are for the purpose of helping persons acquire new functional abilities."

13. The regulations clarify that the rehabilitation option would not include habilitation services (441.45(b)(2)).
    a. Do you believe that CMS would consider any of your current rehabilitation option services to be habilitation services?
    b. If so, how does the State anticipate that the elimination of habilitative services from the Medicaid rehabilitation option would impact service delivery and access?
    c. What steps would you need to take to come into compliance?
    d. Would you be able to shift coverage to other types of Medicaid programs (e.g., transitioning habilitative services to HCB waiver services).
    e. What ancillary issues would this raise (e.g., impact on waiting lists for waivers)?

Restorative Services – Section 440.130 (d)(1)(vi) of the proposed regulation includes the following:

"Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past."

"Rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services."

14. The regulations clarify that the definition of restorative services would not include those that provide assistance in maintaining functioning, unless when helping an individual achieve a rehabilitation goal defined in the rehabilitation plan(440.130(d)(1)(vi)).
    a. Do you believe that CMS would consider any of your current rehabilitation option services to be inconsistent with this provision?
    b. If so, how does the State anticipate that the elimination of maintenance services from the Medicaid rehabilitation option would impact service delivery and access?
    c. What steps would you need to take to come into compliance?
    d. Would you be able to shift coverage to other types of Medicaid programs?

Provider Qualification Requirements – Section 440.130 (d)(1)(iii) of the proposed regulation includes the following: "Qualified providers of rehabilitative services means individuals who meet any applicable provider qualifications under Federal law that would be applicable to the same service when it is furnished under other benefit categories, qualifications under applicable State scope of practice laws, and any additional qualifications set forth in the Medicaid State plan. These qualifications may include minimum age requirements, education, work experience, training, credentialing, supervision, and licensing requirements that are applied uniformly."

15. The regulations would require providers of rehabilitative services to meet the qualification requirements applicable to the same service when it is furnished under another benefit category (440.130(d)(1)(iii)). This may include education, work experience, training, credentialing, supervision, and licensing. Furthermore, the regulations would require uniform application of these qualifications.
    a. What qualification requirements does your State currently apply to providers of rehabilitative services?
    b. What steps would you need to take to adopt the provider qualification requirements applicable to each service covered under the rehabilitation option?

***Written Rehabilitation Plan* – Section 440.130 (d)(3) of the proposed regulation includes the following:**

"The written rehabilitation plan shall be reasonable and based on the individual's condition(s) and on the standards of practice for provision of rehabilitative services to an individual with the individual's condition(s). In addition, the written rehabilitation plan must meet the following requirements:

(i) Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing.

(iii) Follow guidance obtained through the active participation of the individual, and/or persons of the individual's choosing (which may include the individual's family and the individual's authorized health care decision maker), in the development, review, and modification of plan goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce identified physical impairment, mental health and/or substance related disorder.

(vii) Identify the methods that will be used to deliver services.

(viii) Specify the anticipated outcomes.

(ix) Indicate the frequency, amount and duration of the services.

(x) Be signed by the individual responsible for developing the rehabilitation plan.

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the individual, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

(xvii) Include the individual's relevant history, current medical findings, contraindications and identify the individual's care coordination needs, if any, as needed to achieve the rehabilitation goals."

16. The regulations would require covered rehabilitative services for each individual to be identified under a written rehabilitation plan (440.130(d)(3)). The rehabilitation plan would be based on a qualified provider's assessment of an individual's rehabilitation needs and would require the active participation of the individual.

    a. Does your State currently require written rehabilitation plans for each recipient of rehabilitative services?

    b. If so, do you believe that your current requirements are compliant with those outlined in the regulations?

    c. What steps would you need to take to come into compliance?

17. The regulations would explicitly exclude expenditures for room and board from payment under the rehabilitation option (441.45(b)(6)). Do your payment methodologies for residential rehabilitation services clearly exclude costs related to room and board? If not, do you anticipate that this provision would impact service delivery?

18. CMS has expressed concern about states bundling reimbursement for services to include both rehabilitation and non-rehabilitation services. Does your State "bundle" these? What steps would you need to take to "unbundle" the reimbursement of services?

19. Are there any other aspects of the proposed regulations that you feel would have an impact on the rehabilitation option in your State?

20. What would be the overall <u>administrative</u> impact of the proposed regulations?

    a. Short term vs. long term

    b. Level of effort – e.g., significant reduction in administrative work, no significant change, significant increase

    c. Have you estimated administrative costs?

21. What impact might this regulation have on the number of providers who serve Medicaid beneficiaries in the State?

C. MMIS

22. To what extent are services under the rehabilitation option processed through the claims/financial and provider subsystems of MMIS? If applicable, please provide a list of services, codes, and descriptions used for billing rehabilitation services and identify whether these services are captured in the State's MMIS. For codes and/or services that are <u>not</u> captured in the MMIS:

    a. Describe how the claims are processed

    b. Explain why they are captured outside of the MMIS

c. Describe which types of providers use the billing codes that are not processed through MMIS

d. Explain whether the State has intends to capture such claims in the MMIS and the timeframe

23. Are care plans developed electronically, and to what extent are they linked to the State's MMIS system to assure that only services authorized in care plans are reimbursed? How does the State assure that claims are only paid for items and services identified in an individual's care plan?

D. Implementation

24. Are there any other thoughts you have about different ways these proposals could be implemented?

III. Data Requests

1. Please provide the following data on expenditures, by types of rehabilitation option services:

a. The total Medicaid expenditures for services covered through the rehabilitation option in the most recent Fiscal Year for which data are complete. How many individuals received rehabilitation option services during that time period?

b. The total CHIP expenditures for services covered through the rehabilitation option in the most recent Fiscal Year for which data are complete. How many individuals received rehabilitation option services during that time period?

c. If any of the data is unknown or unavailable, please indicate it and describe the reasons (e.g., data may not be available for some services covered through capitation payments to managed care plans)

Please use a format similar to the sample table below:

Type/model of rehabilitation service	**TFC**	**TFC**	**ACT**
Target population	Children in foster care	Children in foster care	Children and adults with SPMI
Admin agency	Department of Human Resources	Department of Human Resources	Mental Hygiene Administration
Available to CHIP enrollees?	X	X	X
Covered under the State Plan?	X	X	X
Covered through an 1115 demo?			X
Covered through other authority?			
Paid on a fee-for-service basis?	X	X	
Paid through capitation to MCO?			X
Billing codes	code #1	code #2	code #1

Type/model of rehabilitation service	**TFC**	**TFC**	**ACT**
Description of billing code	Basic service	Intensive service	ACT
Medicaid expenditures, most recent complete fiscal year, total funds (state and federal)	$1,000,000	$500,000	$20,000,000
Medicaid expenditures claimed through MMIS	$0	$0	$20,000,000
Unduplicated Medicaid recipients of the service	200	57	1,800
Applicable Medicaid FMAP rate	50%	50%	50%
CHIP expenditures, most recent complete fiscal year, total funds (state and federal)	$100,000	$20,000	$5,000,000
CHIP expenditures claimed through MMIS	$0	$0	$5,000,000
Unduplicated CHIP recipients of the service	45	12	4,051
Applicable federal CHIP matching rate	65%	65%	65%
Fiscal Year for data above	FY 2006	FY 2006	FY 2006

2. Data supporting estimated impacts conducted to date (e.g., listing/description of the data sources, analytic methods, and impact assumptions used to develop these estimates)