Medicaid Rehabilitation Services

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July 1, 2008

Congressional Research Service
7-5700
www.crs.gov
RL34432

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

Medicaid rehabilitation includes a full range of treatments that licensed health practitioners may recommend to reduce physical or mental disability or restore eligible beneficiaries to their best possible functional levels. Over the last seven years of available data (1999-2005), reported Medicaid expenditures for rehabilitation increased from $3.6 billion to $6.4 billion, an increase of 77%. In comparison, over the same period, total Medicaid spending increased from approximately $147.4 billion (FY1999) to $275.6 billion (FY2005), an 87% increase.

Both the executive and legislative branches have addressed Medicaid rehabilitation services. For instance, in recent annual budget submissions, the Bush Administration proposed administrative changes to reduce Medicaid rehabilitation expenditures. Congressional and executive branch oversight organizations have documented inconsistent policy guidance and states' practices for claiming federal matching funds that failed to comply with Medicaid rules. The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule on August 13, 2007, for Medicaid rehabilitation services. The proposed rule was intended to more clearly define for states the scope of the rehabilitation benefit and identify services that can be claimed as rehabilitation under Medicaid. CMS estimated that the proposed changes would reduce federal Medicaid expenditures by approximately $180 million in FY2008 and $2.2 billion between FY2008 and FY2012.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) imposed a moratorium until June 30, 2008, on implementation of the rehabilitation proposed rule. On May 22, 2008, the Senate passed the Supplemental Appropriations Act of 2008 (H.R. 2642), which contained a moratorium until April 1, 2009, on implementation of the rehabilitation regulations. H.R. 2642 was amended by the House and passed on June 19, 2008. The House amendments included moratoria until April 1, 2009, for six Medicaid regulations, including rehabilitation services. On June 26, 2008, the Senate passed H.R. 2642 without changes to the House legislation, so that implementation of six Medicaid regulations, including rehabilitation services, would be delayed until April 1, 2009. The President signed P.L. 110-252 into law on June 30, 2008.

Earlier, on June 4 and 5, 2008, the Senate and House, respectively, adopted the final version of the budget resolution (H.Rept. 110-659 accompanying S.Con.Res. 70). The conference agreement established budget-neutral reserve funds that could be used to impose moratoria on Medicaid rules and administrative actions and also includes a sense of the Senate provision on delaying Medicaid administrative regulations including rehabilitation services.

This report describes Medicaid rehabilitation services, discusses major provisions of the Medicaid rehabilitation regulation, and provides various perspectives on the rehabilitation proposed rule. This report will be updated with legislative and regulatory activity.

Contents

Medicaid Rehabilitation 1
Definition 1
Expenditures 2
Guidance to States 3
Rehabilitation Services Proposed Rule 5
Rehabilitation Plans 5
State Plan Amendments and Reimbursement 5
Intrinsic Part/Excluded Services 5
Settings 6
Rehabilitation versus Habilitation Services 6
Financial Impact of Rehabilitation Proposed Rule 6
Various Perspectives on Interim Final Rule 7
Legislative and Other Proposals 9

Tables

Table 1. Estimated Medicaid and Rehabilitation Expenditures and Beneficiaries, FY1999 and FY2005 3

Contacts

Author Contact Information 10

Medicaid Rehabilitation

The Medicaid program covers a range of mandatory and optional health care services for low-income populations, primarily individuals with disabilities, the elderly, members of families with dependent children, and some pregnant women and children.[1] Rehabilitation is an optional Medicaid service, meaning that states are not required to include it in their Medicaid programs. What is included as a rehabilitation service can be particularly difficult to describe, because it may encompass many medical and social service activities. Some have said that the term rehabilitation is so broad that it has become almost meaningless and these services might better be described as a catchall Medicaid service, if an "all other" category did not already exist.[2]

This broad definition of rehabilitation, coupled with limited and contradictory regulations, have had the unintended consequence of creating confusion about what can and cannot be included as Medicaid rehabilitation. States have used the rehabilitation benefit to cover many services, therapies, and treatments, and to even cover services that might be considered benefits of other state and/or federal health and human services programs. There is at least a perception that states are covering an increasing number of services that could be considered habilitative or custodial rather than rehabilitative. To address the confusion surrounding the rehabilitation benefit, clarify definitions, create a more transparent process, and ensure that the services states claim as rehabilitation actually are rehabilitative in nature, CMS issued a proposed rule[3] on August 13, 2007.[4]

Definition

Federal law describes Medicaid rehabilitation services as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."[5] Rehabilitation might once only have been considered physical rehabilitation used mostly for beneficiaries who had strokes or disabling accidents. However, rehabilitation now encompasses a broader range of therapies and treatments.

State Medicaid programs followed the development of additional rehabilitation therapies by using Medicaid's flexibility and the broad definition of rehabilitation to extend services to Medicaid-eligible beneficiaries beyond physical rehabilitation. Medicaid rehabilitation, as defined by states, often includes mental health and substance abuse treatment, occupational and speech therapy, and

[1] For more information on optional and required benefits and CMS's approval of state plans, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[2] See Testimony of Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, Before the House Committee on Oversight and Government Reform, on the Administration of Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals, and States, November 1, 2007, at http://oversight.house.gov/documents/20071101163813.pdf.

[3] For a discussion of the federal regulations, see CRS Report RL32240, *The Federal Rulemaking Process: An Overview*, by Curtis W. Copeland.

[4] Medicaid Program; Coverage for Rehabilitative Services, Proposed Rule, *Federal Register*, vol. 72, no. 232, August 13, 2007.

[5] See Section 1905(a)(13) of the Social Security Act and Medicaid regulations at 42 CFR 440.130(d).

other services and treatments. Under Medicaid, rehabilitation services are delivered in a variety of settings, by a range of practitioners, and through diverse treatment models. For example, rehabilitation services are furnished in freestanding outpatient clinics, the offices of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings, as defined by state Medicaid plans. Under the rehabilitation benefit, Medicaid beneficiaries are treated for mental illness, certain disabilities, substance abuse, strokes, diseases (HIV/AIDS, cancer), and other conditions. Medicaid programs cover rehabilitation treatments provided by physicians, nurses, social workers, case managers, speech therapists, recreation therapists, aides, counselors, and other health professionals.

Expenditures[6]

In 2006, 48 states and the District of Columbia covered rehabilitation services.[7] Nationally, estimated Medicaid rehabilitation expenditures have increased. As shown in **Table 1**, total FY2005 federal and state Medicaid expenditures reported to CMS's Medicaid Statistical Information System (MSIS) as rehabilitation services were approximately $6.4 billion. In FY1999, total state and federal rehabilitation expenditures reported by states to MSIS were approximately $3.6 billion. Between FY1999 and FY2005, federal and state Medicaid rehabilitation expenditures increased by 76.7%. In FY1999, 1.2 million beneficiaries received rehabilitation services; in FY2005, the number of beneficiaries receiving rehabilitation had increased by 36.2% to 1.6 million. Per beneficiary rehabilitation expenditures, among those receiving such services, increased by approximately 30% between FY1999 ($3,020) and FY2005 ($3,916).

In comparison, overall Medicaid expenditures increased at an even more rapid rate over the same time period, rising from approximately $147 billion in FY1999 to approximately $276 billion in FY2005, approximately an 86.9% increase. The number of Medicaid beneficiaries also increased during this time period, rising by 43.1% from FY1999 (40.3 million) to FY2005 (57.7 million). During the same time period, spending per Medicaid beneficiary increased by 30.7% from $3,657 in FY1999 to $4,781 in FY2005. Although most states cover rehabilitation services, some do not show rehabilitation expenditures in their MSIS data compiled by CMS from state-reported information.

[6] Rehabilitation expenditures are not reported separately in states' financial reports to CMS, but are included in other financial expenditure categories. Data on rehabilitation expenditures in this report are estimates of overall rehabilitation expenditures based on MSIS data reported by states to CMS. There is considerable variation between states financial reports and MSIS data.

[7] The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits: Online Database (October 2006), http://www.kff.org/medicaid/benefits/service.jsp?gr=off&nt=on&so=0&tg=0&yr=3&%20cat=12&sv=36, accessed March 31, 2008. According to Kaiser, Georgia, Texas, and Pennsylvania did not cover mental health and substance abuse rehabilitation services. In the notes to the online database, Kaiser explains that it counted only mental health and substance abuse services as optional rehabilitation services. Rehabilitation services also can be included in other benefit categories, such as clinic services and physical rehabilitation. If all benefits that could be rehabilitation services are considered, then virtually all states and the District of Columbia cover Medicaid rehabilitation. Nonetheless, for the purpose of this discussion, only 48 states were counted as providing Medicaid rehabilitation services.

Table 1. Estimated Medicaid and Rehabilitation Expenditures and Beneficiaries, FY1999 and FY2005

Expenditures/Beneficiaries	FY1999	FY2005	FY1999-2005 % Change
Medicaid Expenditures (federal & state) for Rehabilitation ($ billions)	$3.64	$6.44	76.7%
Beneficiaries Receiving Rehabilitation Services	1,207,543	1,645,095	36.2%
Medicaid Expenditures per beneficiary for Rehabilitation	$3,020	$3,916	29.7%
Total Medicaid (federal & state) Expenditures for all Services ($ billions)	$147.37	$275.57	86.9%
Total Medicaid Beneficiaries	40,300,394	57,652,988	43.1%
Medicaid Expenditures (federal & state) per Beneficiary for all states	$3,657	$4,781	30.7%

Sources: Congressional Research Service, based on Medicaid Statistical Information System (MSIS) data from CMS (downloaded January 24, 2008). FY2004 data were used for Maine as an estimate of FY2005 data.

Notes: Medicaid expenditures include both federal and state shares as well as Medicaid-expansions spending under the State Children's Health Insurance Program (M-SCHIP). Spending for the territories and amounts not directly tied to service use by individuals (e.g., administrative costs) are excluded. Rehabilitation service expenditures are not reported separately in financial reports submitted by states to CMS. Data on rehabilitation expenditures in this report are estimates of overall rehabilitation expenditures based on MSIS data reported by states to CMS. There is considerable variation in rehabilitation services data across states, because states use different expenditure categories to report these data.

Guidance to States

There have been several attempts to clarify in statute and regulation what activities states may cover as rehabilitation services. These administrative and legislative activities strived to define how rehabilitation service benefits should be used, as well as to control or reduce states' rehabilitation service expenditures. For example, in the 1970s and 1980s, the Secretary of Health and Human Services approved 17 state plans[8] to cover *habilitative* services for mentally retarded (a statutory term) individuals under the rehabilitation option. Habilitative, in contrast to rehabilitative services, are intended to help individuals acquire, retain, and improve self-help and adaptive skills, but are not intended to remove or reduce individuals' disabilities. The Secretary later withdrew approval for habilitative services, because the services were determined to not meet conditions to qualify for the rehabilitation benefit. In 1989, with passage of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239),[9] Congress intervened and permitted states that had received the Secretary's approval to continue to cover these services. Congress prohibited other states from gaining approval to cover habilitative services for mentally retarded individuals.

[8] Based on a conversation with CMS staff, the 17 states approved to provide habilitative services under the rehabilitation benefit were Arkansas, California, Colorado, Delaware, Idaho, Iowa, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, New York, Ohio, Oregon, Rhode Island, and Wyoming.

[9] See Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA, P.L. 101-239).

CMS issued a state Medicaid director letter (SMDL)[10] in June 1992 (FME-42) that provided guidance to states on using the rehabilitation option as a vehicle for providing services to mentally ill beneficiaries. This letter reiterated regulatory guidance that rehabilitation services were intended to be "medical and remedial in nature for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." The letter offered examples of services that states could cover under the rehabilitation option, including basic living skills, social skills, counseling, and therapy. The SMDL also described examples of services CMS believed to fall outside of the definition of rehabilitation, including vocational training, direct personal care services, and case management (case management is covered under a separate Medicaid benefit option).

In 2005, the Government Accountability Office (GAO) and Health and Human Services Office of Inspector General (HHS/OIG) issued reports that were critical of states' and CMS's practices on rehabilitation. Congressional testimony presented by CMS officials also was critical of state practices to maximize federal matching payments for rehabilitation and other Medicaid expenses.[11] GAO's reports were critical of CMS for not issuing guidance that would clarify rules for states to follow in claiming federal financial participation (FFP) for Medicaid services, such as rehabilitation.[12] These same GAO reports and testimony found that states increased federal matching payments for rehabilitation and other services by increasing Medicaid payments to other state government agencies—non-Medicaid human services agencies that serve Medicaid beneficiaries. In addition, HHS/OIG audits showed that states did not meet federal and state reimbursement requirements for rehabilitation services or comply with state and/or federal Medicaid rules.[13]

Even though statutory and regulatory guidance for states on claiming Medicaid rehabilitation expenditures have been inconsistent, states often receive explicit guidance on specific services that can be covered under the rehabilitation benefit when preparing and submitting state plan amendments (SPAs) to CMS's Regional and Central Offices. These CMS staff must review and approve all SPAs before a state may add or change services. Through the SPA approval process, states can receive considerable direction. SPA approvals, however, are dependent on states making changes to their Medicaid service offerings, and as long as the programs remain static, it is not necessary to seek CMS's approval. Further, CMS contends that new rehabilitation rules are needed to guide states in making changes to their rehabilitation benefit offerings; to provide states with clear, transparent, and consistent guidance; and to clarify definitions. Moreover, CMS states, a new rule is necessary to protect beneficiaries and to maintain the fiscal integrity of the Medicaid program.

[10] CMS issues periodic policy guidance and clarification through correspondence with states' Medicaid directors—state Medicaid director letters, or SMDLs. These letters generally are available on CMS website at http://www.cms.hhs.gov/SMDL/. However, this letter is unavailable on CMS's SMDL website.

[11] Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, testimony to Senate Committee on Finance hearing on Medicaid Fraud and Abuse, June 28, 2005, at http://finance.senate.gov/hearings/testimony/2005test/DStest062805.pdf.

[12] See *Medicaid Financing, States Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, Report to the Chairman, Committee on Finance, U.S. Senate, U.S. Government Accountability Office, June 2005, at http://www.gao.gov/new.items/d05748.pdf.

[13] See Department of Health and Human Services, Office of Inspector General, *Audit of Iowa's Adult Rehabilitation Services Program*, (A-07-03-03041), March 23, 2005, and *Review of Medicaid Community Mental Health Center Provider Services in Indiana*, (A-05-05-00057), April 5, 2007, at http://oig.hhs.gov/oas/oas/cms.html.

Rehabilitation Services Proposed Rule

In August 2007, CMS issued a proposed rehabilitation services rule to more clearly define the scope of the rehabilitation benefit for states.[14] CMS officials testified that the changes embodied in the proposed new rule were intended to clearly define allowable services that may be claimed as rehabilitative services under Medicaid.[15] The major changes addressed in the proposed rule are outlined below.

Rehabilitation Plans

States would need to require written treatment plans from providers that describe therapeutic goals (and identify specific outcome objectives for each patient), treatments to achieve those goals, a specific time-line for treatment, and the health care provider responsible for developing the plan. Rehabilitation plans would need to provide for a process to engage the beneficiary as well as families and other responsible parties in the management of rehabilitation care. This "person-centered" approach is intended to improve transparency, help to speed recovery, and facilitate coordination with other non-Medicaid, human services programs. Rehabilitation services would need to be delivered under the direction of qualified providers who assume professional responsibility for ensuring all services are provided and are medically necessary.

State Plan Amendments and Reimbursement

States that intend to continue to provide rehabilitation services would need to amend their state Medicaid plans. States also would need to include in their Medicaid plans, a description of the services offered as rehabilitation, providers delivering rehabilitation services and their qualifications (education, training, and credentials), and the reimbursement methodologies states would use to pay providers. States would need to specifically describe services that are reimbursable and their individual payment methodologies.

Intrinsic Part/Excluded Services

The rule proposes to exclude FFP for services that are intrinsic elements of programs other than Medicaid. However, the rule stipulates that beneficiaries of other non-Medicaid programs may still be covered for Medicaid rehabilitation services if all Medicaid program requirements are met and the services are not the responsibility of the other, non-Medicaid, programs. For example, therapeutic foster care (TFC)[16] is cited in the proposed rule as an example of a non-covered

[14] Medicaid Program; Coverage for Rehabilitative Services, Proposed Rule, *Federal Register*, vol. 72, no. 232, August 13, 2007.

[15] See Testimony of Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, Before the House Committee on Oversight and Government Reform, on the Administration of Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals, and States, November 1, 2007, at http://oversight.house.gov/documents/20071101163813.pdf.

[16] Therapeutic foster care (TFC) programs place troubled youth (serious emotional and behavioral issues) with trained foster families. Although TFC programs vary, children/adolescents are placed for six to seven months in a structured environment where they are rewarded for positive social behavior and penalized for disruptive and aggressive behavior. TFC also separates repeat juvenile offenders from their delinquent peers and provides close supervision at school, as well as at home.

rehabilitation service. TFC, the rule contends, is a "model of care," not a medically necessary service. The proposed rule states that TFC is an intrinsic part of states' foster care service offerings and should be reimbursed through foster care, not Medicaid. States could receive FFP, the rule acknowledges, for other rehabilitation services delivered to Medicaid-eligible beneficiaries placed in TFC as long as the services were deemed medically necessary and described in a rehabilitation treatment plan supervised by a qualified provider. In addition, the proposed rule describes services that would not be considered rehabilitative. Services furnished through non-medical programs as benefits or administrative activities would not be considered rehabilitation under the proposed rule. The rule identifies non-Medicaid programs such as foster care, child welfare, education, child care, vocational and pre-vocational training, housing, parole and probation, juvenile justice, and public guardianship. Also, Medicaid rehabilitation would exclude room and board coverage for residents of community, home, or institutional settings, including beneficiaries residing in institutions for mental disease, such as community residential treatment facilities.

Settings

Although rehabilitative services may be provided in a facility, home, or other setting, the proposed rule specifies that such care does not include room and board in an institution, community, or home setting, and thus is not an inpatient benefit. When rehabilitative services are provided in a residential setting and delivered by qualified providers, only the costs of the specific rehabilitative services would be covered under the rehabilitation benefit.

Rehabilitation versus Habilitation Services

The proposed rule seeks to clarify distinctions between rehabilitative and habilitative services, where rehabilitation focuses on restoration of functional level and habilitation services help people to acquire new functional abilities. Habilitation services, particularly in states approved prior to OBRA 1989, are associated with day treatment services for mentally retarded individuals (or individuals with related conditions). The proposed rule would prohibit habilitative services for states grandfathered under OBRA 1989. These states that were approved for habilitative services coverage under the clinic or rehabilitation benefits would need to transition those programs to other Medicaid authorities, such as (1) home and community-based service (HCBS) 1915(c) waiver programs or (2) the HCBS state plan option, 1915(i), established under the Deficit Reduction Act of 2005 (DRA; P.L. 109-171). CMS was forbidden from taking adverse action against the 19 states that were approved to cover habilitation services until such time as the agency issued regulations that specify types of day habilitation services states may cover. CMS stipulates that with the proposed rehabilitation rule the agency has met OBRA 1989 conditions so that states that were permitted to cover habilitation under rehabilitation benefits would need to phase out those services.

Financial Impact of Rehabilitation Proposed Rule

Estimates of the financial impact of the proposed rule vary. Some claim that CMS underestimated the impact of the rehabilitation proposed rule and other Medicaid regulations and that CMS is

attempting to shift Medicaid costs to states.[17] CMS estimated that the proposed rule would reduce federal Medicaid spending by approximately $180 million in FY2008 and $2.24 billion for the period FY2008-FY2012. In a recent estimate for the period FY2008-FY2012, the Congressional Budget Office (CBO) forecasted that federal Medicaid outlays would decrease by $1.4 billion for the five-year period. A survey of state Medicaid directors by the Majority Staff of the House Committee on Oversight and Government Reform estimated the financial impact of the rehabilitation proposed rule to be approximately $5.2 billion over five years from FY2009-FY2013.[18]

Various Perspectives on Interim Final Rule

There are at least three distinct perspectives on rehabilitation policy issues: (1) the viewpoint of the federal regulatory agency, CMS, responsible for monitoring and enforcing states' compliance with federal Medicaid statutes; (2) the perspective of advocates representing children and adults who could receive Medicaid rehabilitation services; and (3) the stance of state governments and state Medicaid agencies.

CMS believes there is evidence that additional guidance is needed to clarify what can and can not be claimed as rehabilitation services. CMS cites criticism from GAO and HHS/OIG. The agency also notes that through the SPA process it has discerned confusion among states about what is rehabilitation and habilitation and other issues related to rehabilitation. Further CMS claims, and as GAO also has recommended, without clarifying guidance, states could inappropriately claim excess FFP by paying for services and administrative components of other non-Medicaid state agencies that service Medicaid beneficiaries.

Organizations representing individuals living with mental illness and their families, as well as child welfare and disability groups, have expressed concerns that "person-centered" care approaches, while well-intentioned, may be problematic with rehabilitation beneficiaries.[19] These groups argue that rehabilitation therapy is often provided to individuals with serious mental health issues and these populations may be unable to be actively involved in their therapy decisions. These groups state that requirements for "person-centered" rehabilitation plans need to be more flexible when dealing with non-compliant beneficiaries, as opposed to a one-size-fits-all requirement for "person-centered" rehabilitation plans. Similarly, child welfare groups contend that requirements to engage parents in decisions about therapy for children in foster care may compound, delay, or undo therapy by returning an abused or neglected child to influences that are detrimental to the child's treatment.

Organizations representing children, particularly special-needs children, are concerned that the rehabilitation proposed rule would make it more difficult for children to receive rehabilitation and related services by creating administrative barriers and restricting access by tightening the

[17] See *The Administration's Medicaid Regulations: State-by-State Impacts*, United States House of Representatives, Committee on Oversight and Government Reform, Majority Staff, March 2008, at http://oversight.house.gov/features/medicaid08/.

[18] Ibid.

[19] See, for example, The National Alliance on Mental Illness (NAMI), *Comments on Proposed Regulations on Coverage for Medicaid Rehabilitative Services*, October 10, 2007 (p. 2), http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Medicaid/comments_on_rehab_regs_for_consumersfamilies10.10.doc.

definition of rehabilitation. Advocates for special-needs children[20] argue that the distinction between rehabilitation and habilitation is not a relevant factor in addressing children's needs for health services. Advocates say that because of early and periodic screening diagnostic and treatment (EPSDT) provisions in Medicaid, children should receive rehabilitation treatment whether it can be considered habilitation or rehabilitation. Medicaid's children's health benefits, known as the EPSDT benefits,[21] ensure that children receive comprehensive coverage for at least categorically needy beneficiaries. According to special-needs children advocates, EPSDT coverage ensures that children receive treatment to ameliorate physical or mental conditions whether children were born with the conditions or developed them later.[22]

Similarly, other child welfare advocates indicate that it can be a much more complex judgment with children to determine when a beneficiary has lost functioning or when the child may not yet have developed certain skills or abilities in the first place. Children acquire and master skills at different times and may not be at age appropriate levels because of physical, emotional, social, or many other problems. These judgments are further compounded among special-needs children, which would include most children in foster care.[23]

Advocates for mentally retarded and developmentally disabled (MR/DD) individuals are concerned that the proposed rehabilitation regulations could reduce a key funding stream for community-based mental health services resulting in reductions in services for needy individuals, and incentives to treat MR/DD individuals in institutional settings.[24] If MR/DD individuals and their families were unable to find suitable community-based care, the result might be increased Medicaid expenditures where the costs for institutional care might exceed community-based services. They argue that if the goal is to save money, the proposed rule could be counter-productive. Further, mental health advocates are concerned that the proposed Medicaid rehabilitation regulations requiring treatment plans to document skill recovery and lost functionality will diminish Medicaid-reimbursed services for individuals who are developing skills to cope with mental and emotional disabilities, but are not considered to have lost previously acquired skills.

States are concerned that CMS's proposed rehabilitation service regulations would entail substantial new administrative and procedural burdens on states in bringing their Medicaid state plans into compliance. In addition, states claim that reductions in rehabilitation expenditures might be more costly in the long run as individuals, particularly children, would benefit from earlier interventions that might avert future, more costly care. Further, states note that Medicaid expenditures run counter to business cycles, so that when states' economic conditions deteriorate, Medicaid expenditures rise. Thus, state governors argue, as the economy contracts, federal

[20] Special-needs children are defined by their health care needs or diminished health status, not by family income. See First Focus, *CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs*, Sara Rosenbaum, J.D., March 2008, http://firstfocus.net/Download/CMS.pdf.

[21] Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid children under age 21 in CN groups receive comprehensive screening services and preventive care, and are guaranteed access to all federally coverable services necessary to treat a problem or condition. EPSDT may be offered to MN children.

[22] See First Focus, *CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs*, Sara Rosenbaum, J.D., March 2008 (pp. 15-17), http://firstfocus.net/Download/CMS.pdf.

[23] See Child Welfare League of America (CWLA) Comments to CMS on Proposed Rule CMS-2261-P: Coverage for Rehabilitative Services, October 12, 2007, http://www.cwla.org/advocacy/medicaid071012.htm.

[24] See, for example, Consortium for Citizens with Disabilities, comment letter on Proposed Medicaid Rehabilitation Rule, October 10, 2007 (p. 3), http://www.c-c-d.org/task_forces/health/CCD%20Comments%20final%20final.pdf.

Medicaid expenditures should not be reduced.[25] Moreover, some states already report shortages of qualified mental health care professionals willing to participate in Medicaid. Additional administrative burdens, as well as requirements that mental health and other professionals assume responsibility for rehabilitation plans, might further reduce the supply of rehabilitation service providers.[26]

Legislative and Other Proposals

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) imposed a moratorium until June 30, 2008, on implementation of the rehabilitation proposed rule and other Medicaid program changes. In March 2008, the Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613) was introduced, which would extend until April 1, 2009, moratoria on regulations affecting Medicaid, including rehabilitation services. The House Energy and Commerce Committee sent H.R. 5613 to the full House on April 16, 2008. H.R. 5613 would require the Secretary to submit a report by July 1, 2008, to the House Energy and Commerce and the Senate Finance Committees. The Secretary's report would be required to cover three topics: (1) an outline of specific problems the rehabilitation and other Medicaid regulations were intended to correct, (2) an explanation of how the regulations would address these problems, and (3) the legal authority for the regulations.

In addition, H.R. 5613 would require the Secretary to retain an independent contractor to prepare a comprehensive report by March 1, 2009, which also would be submitted to the House Energy and Commerce and the Senate Finance Committees. The independent contractor's report would describe the prevalence of the specific problems identified in the Secretary's report, identify existing strategies to address these problems, and assess the impact of the regulations on each state and the District of Columbia. In the Senate, a similar measure to H.R. 5613, the Economic Recovery in Health Care Act of 2008 (S. 2819), was introduced in April. Like H.R. 5613, S. 2819 would impose a one-year moratorium on rehabilitation and other Medicaid regulations until April 1, 2009.

On May 22, 2008, the Senate passed the Supplemental Appropriations Act of 2008 (H.R. 2642), which contained a moratorium until April 1, 2009, on implementation of the rehabilitation regulation. H.R. 2642 was amended by the House and passed on June 19, 2008. The House amendments included moratoria for six Medicaid regulations, including rehabilitation services. In addition, H.R. 2642 retained requirements from H.R. 5613 for the Secretary to report to the House Energy and Commerce and Senate Finance Committees, and to hire an independent contractor to report on Medicaid regulation issues. On June 26, 2008, the Senate passed H.R. 2642 without changes to the House legislation, so that implementation of six Medicaid regulations, including rehabilitation services, would be delayed until April 1, 2009. H.R. 2642 also retains the requirements for the Secretary and an independent contractor to submit reports on the Medicaid regulations to the House Energy and Commerce and Senate Finance Committees. The President signed P.L. 110-252 into law on June 30, 2008.

[25] See New York Times, *Governors of Both Parties Oppose Medicaid Rules*, Robert Pear, February 24, 2008.

[26] See, for example, Arizona Health Care Cost Containment System (AHCCCS) Comments on Medicaid Rehabilitation proposed rule, October 12, 2007, at http://www.ahcccs.state.az.us/Regulations/LawsRegulations/CMSRulesSummary/0938-AL81_Comments.pdf.

Earlier, on June 4 and 5, 2008, the Senate and House, respectively, adopted the final version of the budget resolution (H.Rept. 110-659 accompanying S.Con.Res. 70). Among other provisions, the conference agreement establishes a number of deficit-neutral reserve funds and a sense of the Senate provision that would delay Medicaid administrative regulations, including Medicaid rehabilitation services.

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