



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4688 FAX: 603-271-4912 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

February 15, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
United States House of Representatives
Room 2157
Rayburn House Office Building
Washington, D.C. 20515-6143

Schneider

Medicaid

45 pp

Re: Analysis of Proposed CMS Regulations

Dear Chairman Waxman:

Thank you for your January 16, 2008, request that the New Hampshire Department of Health and Human Services (Department) comment on the regulatory changes proposed by the Centers for Medicare and Medicaid Services (CMS). The changes proposed by CMS will have a significant impact on New Hampshire's Medicaid program and the citizens of the State. The following analysis should assist the Committee in understanding the effect of these proposed regulatory changes.

The speed with which the proposed regulations are being pushed is of great concern to the Department. The regulations impose significant policy changes that will substantially impact New Hampshire's Medicaid operations. The Department has not been given sufficient time to truly evaluate the impacts of some of these sweeping changes. The Department has also not been given sufficient time to adapt its program in order to come into compliance with the new regulations.

Cost Limits for Public Providers (CMS 2258-FC)

New Hampshire is one of seventeen states commenting on these proposed rules, filing initial comments on March 20, 2007 and supplementary comments on July 13, 2007. The proposed regulation seeks to limit New Hampshire's ability to utilize several types of Medicaid financing mechanisms by adding new language to define a "unit of government" and by establishing minimum requirements for documenting Medicaid costs when using a Certified Public Expenditure (CPE). The regulation also limits New Hampshire's ability to utilize the intergovernmental transfer process and limits health care providers operated by units of government to Medicaid reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients. Further, the regulation explicitly requires that all health care providers receive and retain the total computable amount of their Medicaid payments. Finally, with the exception of the cost limits on reimbursement, the regulation makes the above requirements applicable to the State Children's Health Insurance Program (SCHIP).

The proposed regulation could prevent New Hampshire Medicaid from accepting sources of funding that have traditionally been used to support the state match required in SCHIP and impact the State's ability to provide insurance coverage for 3,000 children already enrolled in the SCHIP program. Further, the regulation may also prohibit the coverage of certain administrative costs associated with state Medicaid contracts. Such restrictions would have a significant impact on the State's budget.

The proposed rules create a significant administrative burden on both government providers and state Medicaid agencies. The proposed rules require that municipal, county and school districts supported with public tax monies submit annual certifications of their tax-supported status, along with lengthy, detailed annual financial reports to prove they are not being reimbursed more than one hundred percent of cost. Additionally, state Medicaid agencies are expected to review and audit these reports annually. New Hampshire has eleven county nursing homes and more than two hundred twenty-five schools that are supported with public tax money; all of these enrolled Medicaid providers would be subject to the new certification and reporting regulations.

The proposed rule also requires that the non-federal share of matching funds derived from local, county and school districts must be under the administrative control of the state Medicaid agency prior to the expenditure of those funds for allowable Medicaid services.

Payment for Graduate Medical Education (CMS 2279-P)

The proposed regulation states that graduate medical education (GME) payments are not an allowable cost or payment for medical assistance eligible for federal financial participation (FFP) under Medicaid State Plans. In other words, CMS will not consider funding for GME as expenditures for a covered Medicaid service. CMS proposes to amend 42 CFR § 447.201 by adding a new section (c) to indicate that GME cannot be included as part of any payment methodology in Medicaid State Plans. CMS also proposes to amend 42 CFR § 447.257 and 42 CFR § 447.304 to state that FFP is no longer available for any reimbursement that includes or specifically pays for GME.

On May 25, 2007, a one-year legislative moratorium was enacted prohibiting CMS from taking "any action to... promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program" (P.L. 110-28, Sec. 7002(a)(1)(C)). Thus, the proposed regulation prohibiting GME payments appears to be contrary to legislative intent. The American Public Human Services Association (APHSA) raised this issue in an October 29, 2007, letter sent to Kerry Weems, Acting Administrator for CMS.

The Department recognizes the importance of having qualified and well-trained physicians deliver patient care. The proposed rule prohibiting GME payments to such hospitals will impact four of New Hampshire's largest hospital providers in the areas of both primary care and emergency services. These hospitals served a total of 29,862 Medicaid recipients providing over 109,000 visits in fiscal year 2007 (July 1, 2006 – June 30, 2007). The proposed regulation will result in a total loss of \$1,639,000 in funds per year to these hospitals. The Department submitted its own separate comments on these proposed rules on June 21, 2007.

Payment for Hospital Outpatient Services (CMS 2213-P)

The proposed regulation seeks to clarify and restrict the amount Medicaid can pay for hospital outpatient services. The regulation accomplishes this by requiring Medicaid to follow Medicare rules for service definitions and enforcing the Medicare upper payment limit (UPL) based on those definitions. Under the proposal, the definitions of outpatient hospital services and the UPL requirements for those services would undergo significant revision to determine the reasonable estimate of what Medicare would pay for equivalent Medicaid services in a privately operated outpatient facility

In order to avoid confusion, the regulation must be able to be applied consistently to all types of providers; hospitals, physician groups, clinics, and ambulatory surgical care centers are all providers whose payments would be included under the regulation. If the regulation is unclear, it will be extremely difficult to determine the allowable Medicaid payment rate and create an administrative burden on the State and providers. Presently, New Hampshire is working on developing an Outpatient Prospective Payment System (OPPS).

Provider Taxes (CMS 2275-P)

This regulation codifies the maximum amount that a state may receive from a health care-related tax and temporarily reduces the permissible tax rate to 5.5 percent from January 1, 2008, through September 30, 2011. This regulation became effective on January 1, 2008. This regulation did not allow New Hampshire sufficient time to properly plan for this reduction in the permissible tax rate and will result in a net reduction in New Hampshire general funds of \$1,400,000. While the Department missed the comment submission deadline, it had intended to join with eighteen other states in commenting on these proposed rules. These proposed rules allow the CMS "negotiate" tax rates lower than 5.5 percent if it so chooses. There are no criteria identified as to how CMS would determine a lower tax rate would be determined or approved.

Coverage of Rehabilitative Services (CMS 2261-P)

On October 8, 2007, and October 11, 2007, the Department sent letters with its analysis of this proposed regulation to CMS. In its letter, the Department made several recommendations to CMS regarding the proposed changes to coverage for rehabilitative services. Rather than restate the contents of the letter, a copy of the letter is attached for the Committee's review. The Department also jointly submitted additional comments as one of fifteen states on October 12, 2007. (Attachment A, letter dated October 8, 2007, and letter dated October 11, 2007).

Payments for Costs of School Administrative and Transportation Services (CMS 2287-P)

On October 25, 2007, the Department sent a letter with its analysis of this proposed regulation to CMS. In its letter the Department requested that CMS reconsider the proposed revisions to the coverage of transportation and administrative costs under the Medicaid to Schools Program. Rather than restate the contents of the letter, a copy of the letter has been attached for the Committee's review. (Attachment B, letter dated October 25, 2007). The Department also jointly submitted comments as one of fourteen states on November 5, 2007.

Revisions to Procedures for the Departmental Appeals Board (45 CFR 16; NPRM 72 FR 73708)

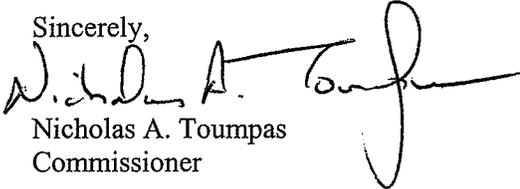
Congress commissioned the Departmental Appeals Board (DAB) to allow states the ability to seek reconsideration of decisions of the Secretary of the Department of Health and Human Services. The Appellate Division provides an impartial tribunal that adjudicates disputes between the states and the federal government. The regulation proposes significant changes to the current process.

On January 28, 2008, New Hampshire, along with sixteen other states, filed joint comments with the United States Department of Health and Human Services in opposition to the proposed rule. It is the Department's understanding that a number of other states also filed comments in opposition to the proposed regulation. A copy of those joint comments is attached for the Committee's review. (Attachment C).

Targeted Case Management (CMS-2237-IFC)

New Hampshire, along with twenty-two other states and state Medicaid agencies, filed joint comments with the United States Department of Health and Human Services in opposition to the proposed rule on February 4, 2008. The Commenting states requested that CMS suspend the interim final rule pending modification. A copy of those joint comments is attached for the Committee's review. (Attachment D).

These comments should provide some insight into the specific issues facing New Hampshire should the proposed regulations become law. Once again, the Department extends its thanks to you and the Committee for your request for our response. If you have any further questions, please do not hesitate to contact me.

Sincerely,

Nicholas A. Toumpas
Commissioner

cc: His Excellency, Governor John H. Lynch
The Honorable Tom Davis
Kathleen A. Dunn, Acting Medicaid Director

Enclosures



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES

129 PLEASANT STREET, CONCORD, NH 03301
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Nicholas A. Toumpas
Acting Commissioner

Nancy L. Rollins
Director

October 8, 2007

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

To Whom It May Concern:

State of New Hampshire
Comments on Coverage for Rehabilitative Services Proposed Rules
42 CFR Parts 440 and 441
CMS-2261-P

Non-covered services: 441.45(b)

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There is little clarity in the regulation on how this provision would be applied, as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

There appear to be only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service B, in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or CMS is concerned that non-medical programs are furnishing Medicaid-covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the

other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

New Hampshire is concerned that children in foster care, child welfare, and juvenile justice (juveniles that are not placed in secure detention or wilderness facilities) may be unfairly restricted from receiving medically necessary rehabilitative services for the sole reason that these children are involved with foster care, child welfare or juvenile justice systems. The proposed rule does not define "intrinsic elements of programs other than Medicaid." The Code of Federal Regulations at 1356.60 Fiscal Requirements (Title IV-E) specifically prohibit States from claiming Title IV-E federal financial participation (FFP) for medical or rehabilitative services as "Allowable administrative costs do not include the costs of social services provided to the child, the child's family or foster family which provide counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions." In addition, the Child Welfare Policy Manual at 8.1B Title IV-E Administrative Functions/Costs, Allowable Costs – Foster Care Maintenance Payments Program in the answer under Question #1 further clarifies by stating "Examples of non-reimbursable services include counseling, homemaker or housing services and assisting in reuniting families. These services are not reimbursable regardless of the credentials or training of the provider, e.g. these services provided by a caseworker are unallowable. Further, they are not reimbursable regardless of whether they are provided on a single occasion or as part of a series." Further in the same section of the Child Welfare Policy Manual under Question #4 it is stated "In accordance with sections 474(a)(3) and 475 (4) of the Social Security Act and 45 CFR 1356.60 (c), administrative costs for the processing and management of health care services for foster children under Title IV-E are not allowable." Section 475(4) of the Social Security Act defines the term "foster care maintenance payments" as "payments to cover the cost of (and cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child and reasonable travel to the child's home for visitation." Clearly the major funding source for child welfare outside of Medicaid is Title IV-E, which strictly prohibits payment for medical, or social services provided to children in foster care, child welfare or juvenile justice.

Recommendation:

New Hampshire strongly recommends that this entire section be dropped, because it conflicts with the Medicaid statute.

Alternatively, the section should be clarified and narrowed so as to focus on situations where an entity (e.g. an insurer) has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded from this provision.

The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

Similarly, a child with a serious mental disorder being reunified with its family may have specific issues directly stemming from the mental disorder. Mental health rehabilitation services to address these problems (as distinct from generic reunification services) should be covered.

New Hampshire recommends that the Final Rule clearly state that children in foster care, child welfare or juvenile justice are entitled to receive medically necessary rehabilitative services and that such children are not prohibited from receiving rehabilitative services based on the sole fact that they are involved in the foster care, child welfare or juvenile justice systems.

Therapeutic Foster Care: 441.45(b)(1)(i)-

The regulation denies payment for therapeutic foster care as a single program, requiring instead that each component part be separately billed.

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

If states are not able to create a package of covered services such as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs.

Recommendation:

Therapeutic foster care should be listed as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. States should be given the discretion to define therapeutic foster care as a single service and pay through a case rate, daily rate or other appropriate mechanism.

Language should also be included in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care.

Rehabilitative Services: 441.45(a)(2)-

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level, as defined in the law. However, it would be helpful to reiterate here when services may be furnished to retain or maintain functioning.

It would also be valuable to include the language now in the preamble (page 45204) regarding how to determine whether a particular service is a rehabilitation service, based on its purpose.

Recommendation:

Insert additional language into 441.45(a)(2). to describe when services may be furnished with the goal of retaining or maintaining functioning.

Insert additional language into this section (from the preamble) to state that it is helpful to scrutinize

the purpose of the service as defined in the care plan in order to determine whether a specific service is a covered rehabilitative benefit.

Definition of Restorative Services: 440.130(d)(1)(vi)-

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services is at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services. There is concern that states and providers will interpret the current proposed regulation as prohibiting coverage of services necessary for retention of improved functioning and for maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

Section 1901 of the statute specifically authorizes funds for "rehabilitation and other services" to help individuals "retain" capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain an individual's functional level.

New Hampshire has concern with the above language, as children's developmental issues must be considered when determining whether a service is "habilitation" or "rehabilitation." It is well documented in various studies that children in placement suffer from developmental delays in much greater numbers than children who are not in the foster care system as a result of the neglect or abuse that brought them into the foster care system. These same children, had they not experienced the neglect or abuses, may never have experienced such developmental delays. Insisting that there be a black and white distinguishing of medically necessary services as either "habilitation" or "rehabilitation" based on whether or not the medical services will restore a child to their best functional level or help a child to acquire new functional abilities will increase an already extensive administrative burden in providing children with rehabilitation services as a result of the requirements contained in this proposed rule.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR 438.210(a)(4)(ii)(B)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

Second, revise the definition of when services may be furnished to maintain functioning to include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

Related Medicaid Rehabilitation Issues:

1) Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services through 15-minute increments and denying payment through daily rates, case rates and similar arrangements is supported by language in the regulation, at least by inference.

These new shifts in rate-setting methodology are not efficient and, moreover, are extremely detrimental to the provision of the evidence-based mental health services that are increasingly being offered as a package of intertwined interventions delivered flexibly. These services include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

There are alternative ways to hold states accountable for ensuring that non-covered activities are not reimbursed. For example, it is possible to devise rate structures that do not pay providers for time spent on non-covered activities, but that remove the currently imposed extreme administrative burden.

The requirements in this regulation regarding service planning and documentation are relevant here. The new rules should negate the need for overly prescriptive micro-management of Medicaid providers.

Recommendation:

It is strongly urged that CMS work with other federal agencies, states and the field to devise payment methodologies that support the best practice and the most successful outcomes for children and adults with mental disorders. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

2) EPSDT Mandate

The regulation appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. In several places, the regulation needs to be amended to reflect the EPSDT provision.

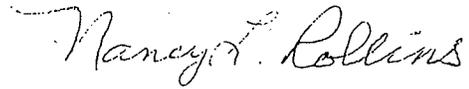
Recommendation:

Section 441.45(a), insert a new paragraph clearly stating that states must ensure that children receive all federally covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

Section 441.45(b) (4), which refers to services having to be targeted under the state's plan, should be amended to reference EPSDT for children.

Section 441.45(a)(5) should clarify that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically necessary.

Sincerely,



Nancy L. Rollins
Director, Division of Community
Based Care Services

Cc: The Honorable John H. Lynch, Governor of New Hampshire
The Honorable Judd Gregg, U.S. Senate
The Honorable John E. Sununu, U.S. Senate
The Honorable Carol Shea-Porter, U.S. House of Representatives
The Honorable Paul W. Hodes, U.S. House of Representatives
The Honorable Sylvia Larsen, President of the N.H. Senate
The Honorable Terie Norelli, Speaker of the N.H. House of Representatives
The Honorable Lou D'Allesandro, Chair, N.H. Senate Finance Committee
The Honorable Marjorie Smith, Chair, N.H. House of Representatives Finance Committee
The Honorable Iris W. Estabrook, Chair, N.H. Senate Health and Human Services Committee
and, N.H. Senate Education Committee
The Honorable Cindy Rosenwald, Chair, N.H. House of Representatives, Health and Human
Services Committee
The Honorable Emma Rous, Chair, N.H. House of Representatives Education Committee



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Nicholas A. Toumpas
Acting Commissioner
NH DHHS

and

DEPARTMENT OF EDUCATION

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Lyonel B. Tracy
Commissioner
NH DOE

October 11, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-2261P
PO Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

The New Hampshire Department of Health and Human Services and Department of Education are writing to provide their comments in response to the proposed changes to Section 1905 (a)(13), the Rehabilitation Option published in Federal Register dated August 13, 2007, Volume 72, Number 155, pages 45201 – 45213.

The State of New Hampshire's Medicaid to Schools program is filed in the State Medicaid Plan under the "Rehabilitation Option." The current arrangement has enabled New Hampshire to meet the needs of children receiving covered Medicaid Services as part of an individualized educational program as defined under the Individuals with Disabilities Education Improvement Act (IDEA). The NH Medicaid to Schools program generates approximately \$18 million in federal funds annually to provide the health related supports necessary for children with disabilities to access a free and appropriate education, as mandated under IDEA. This program has been successfully implemented in NH since 1990 and currently benefits over 9,000 children with disabilities on an annual basis. The rule as proposed by CMS would severely restrict the flexibility of the current program, impose substantial new record keeping requirements on providers, and more importantly specifically exclude health services provided within educational settings.

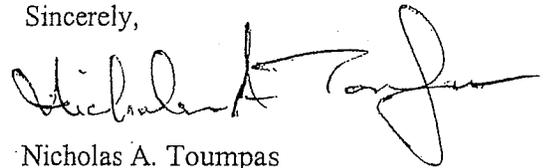
Relative to limitation of rehabilitation services, the proposed rule states:

In section 441.45 (b)(1)-(b)(8) we set forth limitations on coverage of rehabilitation services in this proposed rule. We proposed in section 441.45 (b)(1) that coverage of rehabilitation services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and pre-vocational training, housing, parole and probation, juvenile justice or public guardianship.

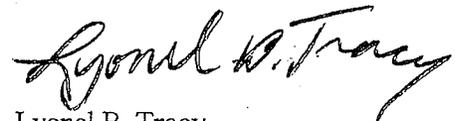
This language would eliminate NH's Medicaid to Schools Program. We believe that the proposed limitation of educational settings is not consistent with the Medicare Catastrophic Aid regulations which state that Medicaid covered reimbursable services cannot be denied reimbursement simply because they are part of an educational plan. Further, this change would shift the costs of the unfunded mandate under federal IDEA to the state and local levels.

We respectfully request that CMS reconsider the proposed revisions to the "rehabilitation option" or specifically exempt Medicaid to Schools programs that are currently regulated by both IDEA and Medicaid requirements.

Sincerely,



Nicholas A. Toumpas
Acting Commissioner
DHHS



Lyonel B. Tracy
Commissioner
DOE

cc: The Honorable Governor John H. Lynch
The Honorable Judd Gregg, U.S. Senator
The Honorable John E. Sununu, U.S. Senator
The Honorable Carol Shea-Porter, U.S. Representative
The Honorable Paul W. Hodes, U.S. Representative
The Honorable Sylvia B. Larsen, Senate President
The Honorable Terie Norelli, Speaker of the House
The Honorable Lou D'Allesando, Chair, Senate Finance
The Honorable Marjorie Smith, Chair, House Finance
The Honorable Emma L. Rous, Chair, House Education Committee
The Honorable Iris W. Estabrook, Chair, Senate Health and Human Services Committee
The Honorable Cindy Rosenwald, Chair, House Health, Human Services and Elderly Affairs Committee



STATE OF NEW HAMPSHIRE

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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and

DEPARTMENT OF EDUCATION

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Nicholas A. Toumpas
Acting Commissioner
NH DHHS

Lyonel B. Tracy
Commissioner
NH DOE

October 25, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-2287-P, Mail Stop S3-14-22
7500 Security Blvd
Baltimore, MD 21244

Dear Sir or Madam:

The New Hampshire Department of Health and Human Services and Department of Education are writing to provide their comments in response to the proposed changes to 42 CFR Parts 431, 433, and 440, Medicaid Program: Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School, published in the Federal Register dated September 7, 2007, Volume 72, Number 173, pages 51397 – 51403.

Transportation

Historically, CMS has allowed Medicaid reimbursement for specially modified vehicles used to transport children with disabilities to receive covered services in their Individualized Education Plan (IEP), as described under the Individuals with Disabilities Education Improvement Act (IDEA). The proposed rule would restrict reimbursement to transportation of school age children from school to a non-school based provider that bills under the Medicaid Program. Elimination of reimbursement for vehicles specially modified due to a child's disability as a coverable transportation service would result in a loss to local NH school districts of approximately \$3.5 million annually.

It is our belief that vehicle modifications are, in fact, a coverable service under the Medicaid Program as demonstrated by Vehicle Modifications included under Home and Community Based Care Waivers (HCBC). Although the Medicaid to Schools Program is not a HCBC, it is our position that Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) would allow coverage of this medically necessary service. In addition, this proposed change would shift the costs of the unfunded mandate under federal IDEA to State and local levels.

Administrative Costs

There are two methods for receiving Federal Financial Participation (FFP) for costs related to administration of the Medicaid to Schools Program. The first method involves administrative claiming as a distinct set of activities reimbursable to entities implementing the Medicaid to Schools Program. The second method is the inclusion of an administrative cost allowed as part of a rate structure. The State of NH's Medicaid to Schools Program utilizes a fee for service model, and when rates were established for

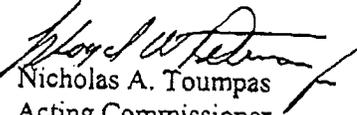
October 25, 2007

covered services in a child's IEP, an administrative percentage was built into the cost formula. Participating NH school districts bill their actual covered costs and are reimbursed fifty percent (50%) of their actual costs or 50% of the rate as established by the state, whichever is less. In calculating their actual billable costs, districts are allowed to include up to ten percent as an administrative cost when appropriately documented in their actual cost calculating methodologies. This is similar to other Medicaid providers who include administrative costs as part of their program expenditures. The proposed rule would eliminate coverage for administrative functions. Given that NH's local school districts receive approximately \$18 million in reimbursement annually, the State would anticipate school districts losing up to \$1.8 million on a yearly basis.

The Medicaid to Schools Program has been successfully implemented in NH since 1990 and currently benefits over 9,000 children with disabilities on an annual basis. As indicated previously, it is our position that the proposed changes would shift the costs of the unfunded federal mandates under IDEA to the state and local levels. Additionally, we believe that the proposed changes are not consistent with the Medicare Catastrophic Coverage Act of 1988 which states that Medicaid covered services cannot be denied reimbursement simply because they are part of an education plan. Vehicle modifications and administrative costs are recognized reimbursable Medicaid services.

We respectfully request that CMS reconsider the proposed revisions to the coverage of Transportation and Administrative costs under the Medicaid to Schools Program.

Sincerely,


Nicholas A. Toumpas
Acting Commissioner
NH DHHS


Lyonel B. Tracy
Commissioner
NH DOE

cc: His Excellency, Governor John H. Lynch
The Honorable US Senator Judd Gregg
The Honorable US Senator John E. Sununu
The Honorable US Representative Carol Shea-Porter
The Honorable US Representative Paul W. Hodes
The Honorable Sylvia B. Larsen, Senate President
The Honorable Terie Norelli, Speaker of the House
The Honorable Lou D'Allesando, Chair, Senate Finance
The Honorable Marjorie Smith, Chair, House Finance
The Honorable Emma L. Rous, Chair, House Education Committee
The Honorable Iris W. Estabrook, Chair, Senate Health and Human Services Committee
The Honorable Cindy Rosenwald, Chair, House Health, Human Services and Elderly Affairs Committee