Submitter : **Ms. Katherine Burson** **Date: 10/12/2007**

Organization : **Ms. Katherine Burson**

Category : **Occupational Therapist**

Issue Areas/Comments

Background

Background

I RECOMMEND THE FOLLOWING SPECIFIC NAMI-ENDORSED CHANGES RELATED TO WORK FOR PEOPLE WITH SEVERE MENTAL ILLNESS

I. I do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

2. Delete all references to other systems and pay for rehabilitative services for individuals with serious mental illnesses when they need them and where they need them.

3. I ask that you revise these regulations to make it clear that the federal government encourages any state system to do all they can to provide effective treatments to people with serious mental illnesses.

4. Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

5. Revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning.

GENERAL

GENERAL

I am a consumer, a provider, a state policy maker, an occupational therapist & a certified psychiatric rehabilitation practioner. I am working very hard with others to make evidence based practices available to all. I am confident that the proposed changes will continue to keep persons disabled by mental illness disabled, dysenfrancised, out of the workforce, and most often permanently dependent upon public programs. Recovery should be the expectation for persons with mental illness.

Submitter : **Date: 10/12/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As an individual who works with children and adults with developmental disabilities, I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential services.

Submitter : **Date: 10/12/2007**

Organization : **Hennepin County Human Services and Public Health**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1032-Attach-1.PDF

#1032

Hennepin County Human Services and Public Health Department

Administration
A-2303 Government Center
Minneapolis, MN 55487-0233

612-348-4806
FAX 612-348-8228

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File Code CMS-2261-P, Proposed Rule, Medicaid Program, Coverage of Rehabilitative Services

To Whom It May Concern:

We are writing to express concern about certain elements of the proposed rules governing Medicaid coverage of rehabilitative services. Specifically, we believe that the proposed definition of "qualified providers" and the vague prohibition to pay for services that are an "intrinsic element of another program" will do substantial damage to our efforts to treat children with mental illness in the most cost effective and successful manner. We have learned that children are not best served by an office visit once a week; children respond to a targeted community-based system of care that treats and reinforces treatment for children where they are – at home, in school, and at child care.

We are concerned that the proposed regulation to use only "qualified providers" will restrict or eliminate our ability to use practitioners and behavioral aides. These are people who have specialized skills and certifications and who treat under the supervision of mental health professionals. Eighty to ninety percent of our outpatient, community-based mental health rehabilitative treatment is provided by practitioners who go into the child's home and work with the child and family and into schools or child care facilities to work with the child, the family, and school staff to promote appropriate skills to aid development and learning for children who have a serious mental illness. Even in our urban county, we experience a serious shortage of mental health professionals who will serve children, particularly those who will serve Medicaid children, and who have culturally effective skills. The targeted, coordinated use of practitioners and behavioral aides have proven to be more accessible, less expensive, and more culturally effective for our children with mental illness who more often come from unstable families and many are new residents in our country.

We are gravely concerned that payment for Medicaid rehabilitative services will be prohibited for services "furnished through a non-medical program ... including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship." The very broad, yet very vague prohibition will reinforce "silos" of care, eliminate use of "teams" for service delivery, add administrative costs and undercut best practices of coordinated and integrated care. This language was rejected by Congress and we object to its appearance in this proposed rule.

The proposed limitation assumes that the "other programs" will cover the costs of the rehabilitative services and we have found that is not true. Other programs often have different, more restrictive eligibility. For example, the IVE program that uses a much lower standard of eligibility so many services for children in need of foster care must be paid by a shift to county property tax dollars. The inclusion of rehabilitative services can be essential to achieve the goals of the other program. For example, bringing the rehabilitative service, Children's Therapeutic Support Services, into the school setting provides the child with treatment within a context that improves learning and development. For children it is difficult – and not effective – to separate learning from the treatment experience.

Best practices standards support the use of a comprehensive team and the integration of services across agencies. The vague, broad limitation on Medicaid reimbursement for an "intrinsic element" forces each entity to act separately and the result is additional paperwork, inefficiency, and increased costs for administrative infrastructure. Child protection services, corrections and schools can be involved with a child with mental illness. The greatest barrier to treatment in children's mental health has been lack of identification and the financial pressures on school Special Education budgets which inhibited identification of children with mental health needs because of the financial liability. We believe that the proposed regulations will be a step backwards and will further inhibit identification and early treatment of mental health problems in children in schools, corrections, and child protection.

The prohibition on payment for an "intrinsic element" is based on an assumption that the funding is being used to offset a local or state funded program cost. This is not true, especially in children's mental health services. We have used the flexibility of the rehabilitative services to expand services to a population that has historically been underserved. The use of behavioral aides and practitioners has allowed us to build a targeted, community-based system of coordinated and integrated services for children that assures greater success by keeping the child connected to their family, child care setting and their school. This is a cost effective model to ensure that children served in their communities and families reduces the need for more expensive, intensive and restrictive services, such as residential treatment.

Sincerely,

Suzanne Zuidema, Area Director
Human Services & Public Health Department

Submitter : Ms. Connie Hughes **Date:** 10/12/2007

Organization : Delaware Association of Rehabilitation Facilities

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1033-Attach-1.DOC

#1033

DELAWARE ASSOCIATION OF REHABILITATION FACILITIES
100 W. 10th St., Suite 103 ✸ Wilmington, Delaware ✸ 302-622-9177 ✸ Fax: 302-777-5386

October 12, 2007

Acting Administrator Kerry Weems
Centers for Medicare & Medicaid Services
Dept of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Comments on CMS-2261-P from DELARF

Dear Acting Administrator Weems:

These comments are submitted on behalf of DelARF, the Delaware Association of Rehabilitation Facilities and the voice of disability service providers in Delaware. The mission of DelARF is "to support members working to improve the quality of life for people with disabilities." DelARF members currently provide services to people with a broad range of disabling condition under the rehabilitative services option.

The Centers for Medicare and Medicaid (CMS) issued a Notice of Proposed Rule Making (NPRM) on August 13, 2007. The primary purpose of this rule is to save $2.3 billion over five years by restricting services provided under the Medicaid rehabilitative services option

While DelARF understands and shares CMS' commitment to reducing Medicaid fraud and abuse, we are concerned that the agency's proposals regarding the Medicaid Rehabilitative Services option could have a negative impact on Medicaid recipients. DelARF strongly opposes final promulgation of this rule in current form because implementation would severely restrict access to vital rehabilitative services on which many individuals with mental illness and developmental disabilities depend to remain in their homes and communities. Improving access to rehabilitative services should be a critical component of the federal government's efforts to implement the New Freedom Initiative, the Americans with Disabilities Act (ADA), and the Olmstead Supreme Court decision.

We note that a similar proposal was first seen in 2005 as a legislative proposal sent from the Secretary of the Department of Health and Human Services (HHS) to a Republican-led Congress. HHS offered this legislative proposal as a potential means of achieving savings in the Deficit Reduction Act of 2006 (DRA); however, the proposal was ultimately rejected due to serious concerns regarding its impact on access to community living for individuals with disabilities and the financial strains it would place on state and local governments. DelARF remains unclear as to why HHS once believed these highly

controversial changes had to be accomplished legislatively, but now is attempting to implement them via the regulatory process.

The following are DELARF' comments pertaining to the section (I) titled "Provisions of the Proposed Regulations."

I. Definitions and Requirements for Rehabilitative Services *{(440.130 (d)(1)(iii); 440.130(d)(3)(xi); and 441.45 (a)(5)(i)}*

This section of the proposed rule relates to 1) the required description of discrete rehabilitation services; 2) the provider qualifications required for each discrete service; 3) required indication of alternate providers of each discrete service; and, 4) recipient choice from among all qualified providers of each discrete service. When taken together, these requirements seem to disregard and, in fact, discourage if not preclude the use of, evidence-based and best practices [e.g.: Assertive Community Treatment (Act)] for the most effective and efficient delivery of rehabilitation services to individuals with serious and persistent mental illness. ACT, and its variants, rely on a highly organized and cohesive team-based delivery of individual service components to be effective. The delivery of the same rehabilitative service components by independently practicing providers, even with consultation, creates a highly fragmented delivery of service that is ineffective in treating the individual with serious and persistent mental illness. It is not clear that CMS intends to discourage the use of evidence-based service delivery models, but at the very least, CMS should clearly acknowledge that such models are appropriate for the delivery of rehabilitation services and provide for flexibility allowing states to determine when rehabilitation services should be delivered by qualified ACT provider organizations while maintaining free individual choice of qualified ACT provider organization.

II. Written Rehabilitation Plan (C) *((§440.130 (d)(3))*

The proposed rule would create a new requirement that a written rehabilitation plan be developed for each individual receiving services under the Rehabilitative Services option. This section states that the rehabilitation plan would establish a basis for evaluating the effectiveness of care offered in meeting the stated goals, provide a process to involve the beneficiary and other stakeholders in the management of the rehabilitation care, and document that the services are allowable under the regulations. The rehabilitation plan would include a timeline based on anticipated rehabilitative "progress" to be revaluated yearly and if no progress is determined upon evaluation, it appears that a new plan would have to be drafted.

DELARF does not oppose the implementation of a written rehabilitation plan requirement if it will improve accountability and quality of services. Additionally, we support the NPRM's requirement that virtually all stakeholders be involved in the process of establishing the written rehab plan including the individual receiving services and their family/guardians.

However, we fear that the written plan could be used as a basis for termination of services when "progress" is not achieved according to the plan. Given the unpredictability of mental illness and the variability of developmental disabilities, it would be difficult for many

providers, clinicians, consumers and other stakeholders to develop written rehabilitation plans that accurately predict the functional progress to be made by most individuals with these disabilities. We encourage CMS to allow a significant level of flexibility when it comes to evaluating individuals' progress based on their rehabilitation plans. Determination of appropriate rehabilitative "progress" and any termination of services should be made on a case-by-case basis by clinicians and other rehabilitation experts.

Additionally, DELARF has significant concerns with this section's use of the term "recovery goals," in the written rehabilitation plan. While it may be reasonable for federal Medicaid to look for documented progress in rehabilitative services provided to some individuals, recovery often implies that an individual is "cured" of a condition. Such a concept may apply to physical rehabilitation after an individual breaks their hip or other such injuries. However, in terms of psychosocial rehabilitation, such a concept generally does not apply as few individuals with mental illness or developmental disabilities will ever "recover" from their disabilities. Instead the majority of such individuals, with the help of consistent, quality rehabilitative services, may attain and then maintain their optimal level of independent function. We urge CMS to recognize that, in this context, recovery should imply attainment of functionality, independent living and/or participation in the community.

Finally, we encourage CMS to closely monitor the administrative burden of compiling such plans on rehabilitation providers and agencies.

III. Settings (E) *(§440.130 (d)(5))*

This subsection states that States have the authority to determine in which settings a particular service may be provided, as long as the rehabilitative services option is not utilized as an inpatient benefit. We applaud CMS' flexibility in terms of settings, as the types of rehabilitative services currently provided in many states under this option are most effective in settings other than clinical or medical facilities, such as a person's home, workplace, school, or other setting.

IV. Requirements and Limitations for Rehabilitative Services (F) (Limitations for Rehabilitation Services (2))

The Intrinsic Element Standard (§441.45 (b)(1)):

This subsection proposes that Medicaid cease from covering services that are "intrinsic elements" of other programs. DELARF believes this to be the most damaging provision of this NPRM in terms of access to services. While at face value this may seem a reasonable provision, its implementation would be a significant and dangerous departure from the current standard, restricting the ability of disability services providers to provide necessary rehabilitation services.

This provision essentially removes the Medicaid safety net, a defining characteristics of this entitlement program. While Medicaid coverage is always subject to third party liability and considered the "payor of last resort," this new policy appears to exempt federal Medicaid

from covering its share of the cost of rehabilitative services that are allowed under - but may not be provided or are denied by - vocational, prevocational, educational, substance-abuse, mental health, and assisted living programs. More clarity is needed regarding implementation of this new standard; however, it appears to establish a very alarming precedent.

In *Section V "Regulatory Impact Analysis," Subsection A "Overall Impact,"* the NPRM states that the rule would not impose any costs on State or local governments. Then, in *Subsection C "Alternatives Considered,"* CMS states that, in drafting this regulation, the agency considered "not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs." However, the rule continues, the absence of this provision would result in a "less efficient use of Medicaid funding because.... increased Medicaid funding would have simply replaced other sources of funding." DELARF strongly disagrees with these assumptions.

Denial of FFP does not simply render important Medicaid rehabilitative services unnecessary. Some state and local governments will likely attempt to help ensure that individuals maintain access to these services at substantial costs to their governments. However, state and local governments have budgetary constrains and are often financially strained, and as these governments' abilities to shoulder this cost-shifting is challenged, significant access problems will result. While there indeed may be discretionary federal, state, and local programs that allow similar rehabilitative services to those currently being provided under Medicaid, there is no indication that these other programs will be able to provide such services to a large influx of Medicaid recipients.

Put simply, DELARF members and other clinicians and providers will not have the necessary funding to provide vital rehabilitation services to individuals currently in need and will have to cease such care if this "intrinsic element standard" is implemented. This disruption in the continuum of care for some of that nation's most vulnerable individuals will ultimately lead to greater institutionalization. Removing the safety net which ensures continued access to these services clearly contradicts the intent of the Olmstead Supreme Court Decision, the New Freedom Initiative, and Americans with Disabilities Act (ADA), all aimed at increasing community living for individuals with disabilities. Therefore, we **strongly recommend that CMS reconsider implementation of a harmful intrinsic element standard for the Medicaid rehabilitative services option.**

Exclusion of Habilitative Services (§441.45 (b) (2)):

This subsection also proposes to exclude FFP for all rehabilitative services that assist individuals in attaining and/or maintaining function (as opposed to regaining function) under section 1905(a)(9) or 1905(a)(13) of the Social Security Act. CMS refers to such services as "habilitative" and proposes to include services provided to individuals with "mental retardation or related conditions" in this habilitation exclusion. **DELARF strongly opposes implementation of this provision.**

Several states currently provide important day habilitation services to Medicaid recipients with disabilities. Section 6411(g) of the Omnibus Budget and Reconciliation Act of 1989 (OBRA 89) put a moratorium on elimination of coverage of day habilitation services for

people with mental retardation for states who included such services in their state Medicaid plan prior to enactment. The statute states that CMS may issue an NPRM outlining the specific types of day habilitation and related services that a state may cover under the rehabilitative services option. CMS contends that the NPRM issued on August 13, 2007 serves as the NPRM allowed by OBRA 89. However, DELARF argues that the terms put forth in the August 13th NPRM would completely eliminate day habilitation services from coverage under the Medicaid rehabilitative services option and, thus, are inconsistent with the terms set out in OBRA 89 which permit CMS to specify the *types* of day habilitation and related services covered under this option.

Additionally, we are concerned that in this provision, CMS is trying to force a medical model onto a benefit clearly designed to provide psychosocial rehabilitation services to individuals with extremely complex disabilities and chronic conditions. Medical rehabilitation, which one might complete following an injury or accident, is not a concept often applicable to individuals with cognitive disabilities, mental illness, and substance abuse issues. For such individuals, maintenance of function is as important as attainment and/or regaining of function and must be achieved through continuous access to rehabilitative/habilitative care.

Additionally, we believe it is discriminatory for CMS to provide services under this option to those who have once had skills associated with independent living, but deny similar services to those who have never attained such skills. In a medical context, would it be reasonable to provide hip replacement surgery to someone who fell and shattered their hip, but deny the same surgery to someone born without hip sockets? No, it would not be reasonable at all. DELARF finds denial of services based on whether an individual is 'attaining' versus 'regaining' a skill wholly unjust and contrary to statutory Medicaid requirements (e.g. comparability).

The regulation states that Medicaid currently covers habilitation services in two ways - in an ICF/MR or under the HCBS waiver/HCBS option – and seems to imply that this provision would not deny access but result simply in transitioning services from one benefit to another. However, we do not believe that solely providing habilitation services under these alternatives will reach all of the individuals in need of such care. Clearly, if this were the case, there would be no savings associated with this provision.

For example, an ICF/MR would not be an appropriate setting for many individuals to receive habilitative services, specifically when such habilitative services may help them from reaching the institutional level of care required by the ICF/MR benefit. Additionally, the HCBS waiver has much stricter eligibility requirements, as does the new HCBS option, although regulations implementing this option have yet to be published.

We urge CMS to refrain from pushing states to use waivers to provide appropriate rehabilitation services when, for many years, states have been successful in using the flexibility currently allowed by the rehabilitative services option to best serve the needs of their population.

V. Conclusion

DELARF recognizes that growth in the Medicaid rehabilitation benefit is clearly a result of increased access to community living for individuals with disabilities who might otherwise be institutionalized. We think increased utilization of community rehabilitative services represents a much delayed shift in the Medicaid program away from outdated, institutional living to independent, community living for people with disabilities, and we strongly oppose any action by CMS to restrict the ability of states and providers to provide the services that essentially allow this shift to take place.

We appreciate your consideration of these recommendations and comments. Please feel free to contact Connie Hughes, Executive Director at chughes@delarf.org or by phone at 302-622-9177 if you need clarification or have any additional questions regarding our position on this issue.

Thank you.

Sincerely,

Connie Hughes
Executive Director
The Delaware Association of Rehabilitation Facilities (DelARF)

Submitter : Mr. Joseph Mineo **Date:** 10/12/2007

Organization : Niagara Cerebral Palsy

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached Document

CMS-2261-P-1034-Attach-1.PDF

#1034

Niagara Cerebral Palsy
9812 Lockport Road
Niagara Falls, NY 14304

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–2261–P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: File Code CMS–2261–P

To Whom It May Concern:

On behalf of the thousands of children and adults who receive our services, I voice their opposition to the provision related to excluding federal financial participation for habilitation services. I urge you on their behalf to withdraw the proposal rule.

I also believe that CMS' elimination of FFP for habilitation and clinic options is ill conceived.

It is also my belief that this proposal runs counter to the Congressional intent to protect access to day habilitation services for individuals with developmental disabilities when Congress enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 (OBRA '89).

We strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. We urge you to withdraw this proposed rule.

The proposed rule would severely harm people with intellectual and other developmental disabilities in two major ways: (1) it eliminates longstanding programs for providing habilitation services to people with developmental disabilities; and (2) it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with intellectual disabilities/mental retardation and related conditions.

(1) Elimination of FFP for habilitation services provided under the rehabilitative and clinic options – We believe that this proposed restriction violates the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 (OBRA '89). This section reads:

> (g) DAY HABILITATION AND RELATED SERVICES-
>
> (1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS - Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not –
>
> (A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or
>
> (B) withdraw Federal approval of any such State plan provision.
>
> (2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--
>
> (A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and
>
> (B) any requirements respecting such coverage.
>
> (3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with intellectual disabilities/mental retardation and related conditions. It establishes that the Secretary may not deny federal financial participation (FFP) for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

In contradiction to the plain language of Section 6411(g) of OBRA '89, the proposed rule **does not** specify which day habilitation services that a state may cover. Instead, the proposed regulation would prohibit provision of *any* habilitation services under paragraphs (9) and (13) of section 1905(a) of the Social Security Act. We believe that this NPRM exceeds the regulatory authority granted by the Congress and must be withdrawn. At a minimum, since the regulation does not comply with the OBRA '89 language, the Secretary would not have authority to deny FFP for habilitation services provided in those states with approved state plan coverage prior to June 30, 1989.

We also oppose the prohibition of habilitation services on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that individuals receive the highest quality habilitative and rehabilitative services according to current standards of treatment. The preamble of the proposed rule states that the rehabilitative option is not a "custodial" benefit. We agree with the Secretary that state programs operated under the rehabilitative and clinic options should set high standards for delivering active treatment and for innovating to develop programs for people with intellectual and other developmental disabilities that enhances their ability to attain, maintain, and retain their maximum ability to function, consistent with the original conception of rehabilitation, as found in section 1901 of the Social Security Act.

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under their state plans to transition to appropriate Medicaid coverage authorities, such as Section 1915(c) waivers or the Home and Community-Based Services State plan option under Section 1915(i)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under the state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding state plan options. Further, Section 1915(c) waivers and Section 1915(i) are not equivalent to the rehabilitative or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something which is not required for rehabilitative or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed the aspects of section 1915(i), established in the Deficit Reduction Act of 2005, that permit enrollment caps and that do not extend an entitlement to services. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehabilitative and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006).
We strongly recommend that the proposed exclusion of FFP for habilitative services under the clinic and rehabilitative options not be implemented.

(2) Discriminatory and arbitrary exclusion from receiving rehabilitative services for people with mental retardation and related conditions - We strongly oppose the proposed rule's definition of habilitation services [see Section 441.45(b) (2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary

shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see Section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehabilitative option services for people with intellectual and other related disabilities. Additionally, it exposes a false premise that people with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehabilitative option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

On behalf of the thousands of children and adults with developmental disabilities, I urge you to withdraw this regulation. As always, I am available to discuss this matter of such great importance to our mutual constituents with you or your representatives.

Sincerely,

Joseph O. Mineo
Executive Director of Niagara Cerebral Palsy

Submitter : Mr. Craig Bass **Date:** 10/12/2007

Organization : Mr. Craig Bass

Category : Social Worker

Issue Areas/Comments

Background

Background

Therapeutic Foster Care: 441.45(b)(1)(i)-
The regulation denies payment for therapeutic foster care as a single program.

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. It is a widely covered evidence-based practice that falls in line with the President s New Freedom Commission Report and was specifically recommended in the Surgeon General s report on mental health. The alternative for most such children would be immediate placement in an institutional setting at significantly higher expense. Even worse, families may turn to relinquishing custody of their mentally ill children to the state in order to access foster care services. This is clearly unacceptable.

I recommend that therapeutic foster care 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.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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 provided 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 there is no guidance on how to determine whether a service is an "intrinsic element" of another program. Congress explicitly rejected adopting an intrinsic to test in regards to Medicaid rehabilitative services when debating and finalizing the Deficit Reduction Act. In addition, the results of the CFSR s of the 50 states recognized child welfare agencies struggle to meet the mental health needs of children. The proposed intrinisic to test will only worsen the situation.

Under this new rule, Medicaid-eligible individuals will be denied services, both by Medicaid and by the other eited program (due to lack of resources in the other program). I strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute and the intrinsic elements has already been rejected by Congress.