Submitter : **Jon d'Alessio** **Date: 10/12/2007**

Organization : **Fred Finch Youth Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1132-Attach-1.DOC

#1132

3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

A century of serving children

October 8, 2007

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

To Whom It May Concern:

I am a staff of Fred Finch Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of mental health and social services to California's most vulnerable and troubled youth and families.

Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

PROVISIONS OF THE PROPOSED RULE

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

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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be

custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. 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 developmentally 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.

2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

Recommendation:

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

441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary 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 rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service 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 the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.

2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as 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 and localities should be excluded from this provision.

3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

5. It is especially important that mental health providers be able to work with children with mental health conditions 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.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. 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 these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.

3. Include language 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 and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

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

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule 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. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) 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.

2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation. Please contact me at 510-482-2244 if you have any further questions.

Sincerely,

Submitter : Ms. Penny Wyman **Date:** 10/12/2007

Organization : Ohio Association of Child Caring Agencies

Category : Other Association

Issue Areas/Comments

Background

Background

See Attachment

Collections of Information Requirements

Collections of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Response to Comments

Response to Comments

See Attachment

CMS-2261-P-1133-Attach-1.DOC

#1133

October 12, 2007

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

Re: CMS 2261-P; Comments on Proposed Rule *Medicaid Program; Coverage for Rehabilitative Services*

To Whom It May Concern:

The Ohio Association of Child Caring Agencies (OACCA), represents 70 public and private child- and family-serving member agencies across the state and, on their behalf, respectfully submits these comments on the Proposed Rule for the Medicaid Program's Coverage of Rehabilitative Services (CMS-2261-P) published in the Federal Register on August 13, 2007 (72 Fed. Reg. 45201).

OACCA appreciates that this proposed rule is intended to move the nation to a more accountable system that will promote administrative and managerial integrity and that will be more closely dependent on providers' ability to demonstrate on-going efficacy of treatment. In attempting to do so, however, significant ambiguity remains and OACCA and its member agencies are concerned that various provisions of the proposed regulation—albeit well-intentioned—will seriously impair our ability to provide effective community-based services for children involved with the child welfare, juvenile justice and behavioral health and foster care systems.

We are troubled by the Regulatory Impact Analysis's certification that CMS-2261-P "would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act." Since the proposed regulation significantly changes the scope of rehabilitative services that have been available to children and other individuals with mental and physical disabilities for quite some time and at the same time imposes a large number of new administrative requirements, it is certain that providers will be impacted, but more important will be the number of children who will suffer as a result.

Reducing federal Medicaid spending on rehabilitative services by $2.2 billion between FY 2008 and FY 2012, and not providing other means to serve this population calls into question the statement that "we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule." In fact, our state will not be able to continue to provide the services children in their care need in order to return home and rejoin their communities with current resources.. Meeting the requirements of the Child and Family Service Reviews will be impossible, as a result. We respectfully request CMS to continue to be Ohio's partner so that we can continue to provide health care, including behavioral health care, for eligible and therefore entitled, children and to meet our federal CFSR goals.

According to the Public Children Services Association of Ohio 2007-2008 Fact Book, there were 17,112 Ohio children in custody on January 1, 2006. Eighty-five percent (85%) or 14,545 of these children experienced some kind of mental health needs. Seventy percent (70%) of the children and youth in our juvenile justice have mental health diagnoses. Once they leave state detention, the need for services for these young people is both acute and chronic and prepares them for re-entry to school and community. Ohio depends on our federal partner, CMS/Medicaid, to meet these needs. These mental health services are not intrinsic to the child welfare system – their mission is child protection – nor to the juvenile justice system – their mission is public safety.

Regardless of the reason for removing children from their homes, breaking their familial ties and the instability (temporary, in most cases) that ensues, exacerbate any original mental health issues children may have. Numerous studies document that children in foster care have medical, developmental and mental health needs at a rate that far exceeds those of other children, even those living in extreme poverty.

When children are removed from their homes and placed in custody due to no fault of their own, Medicaid provides many of these children with health care that helps them get on the road to recovery. Medicaid Rehabilitative Services are especially vital, as they offer a realistic opportunity—in the least restrictive setting possible— to reduce the physical and/or mental disabilities that many children in foster care have, thereby restoring the child's functioning level, decreasing lingering and long-term negative impacts of trauma and exposure to violence, abuse or neglect, and ultimately reducing costs. Rehabilitative services are community-based and consumer- and family-driven services, in line with both the President's New Freedom Commission on Mental Health and the U.S. Surgeon

General's recommendations. In 2005, despite states' efforts to provide needed services, the U.S. Department of Health and Human Services Child and Family Services Reviews (CFSRs) found that only one state achieved substantial conformity by ensuring that children in their foster care system physical and mental health needs were met.

The staff and membership of OACCA appreciates this opportunity to comment on the proposed regulation. We look forward to working with you to ensure that federal enhances our ability to meet our children's needs.

PROVISIONS OF PROPOSED RULE:

Section 440.130: Diagnostic, screening, preventative, and rehabilitative services

440.130(d)(1)(iii), Qualified providers of rehabilitative services: We share CMS's desire for providers of rehabilitative services to be appropriately educated, certified and supervised. At the same time, we urge that States be allowed some latitude to ensure that service access is not further restricted as a result of standards set too high. Many areas of Ohio do have enough (or in some cases, any) licensed independent practitioners, but our citizens in these areas of the state remain in need of services.

440.130(d)(1)(v), Rehabilitation plan: The requirement for a written rehabilitation plan will help achieve accountability, but we suggest that children's developmental stages and the often difficult-to-predict phases of restoration, particularly after intense trauma, be taken into account. Children normally progress through developmental stages, to "restore them to functioning" may mean, for children, regression. Similarly, children—as all individuals suffering from physical or mental impairment—can quickly deteriorate, necessitating an adjustment to the rehabilitation plan's enumerated goals. Providers therefore should be granted ample flexibility to adjust children's rehabilitation plans in the form of crisis planning so that prior progress is not sacrificed.

As regards requiring that "the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing," must participate in treatment planning, we applaud the person- and family-centered approach taken. However, we respectfully remind CMS that children involved with the child welfare and foster care systems—though the beneficiary of services—are not always competent to be heavily involved in the process, and that their families may not be, either. Our preliminary research shows that it is the rare county case worker – otherwise known as 'the individual's authorized decision maker" – that is available or credentialed to make clinical decisions.

Similarly, much of this population has limited contact with certain members of their families, so we ask that CMS add language to ensure that "family" is defined broadly to include guardians and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, and group or residential care staff).

440.130(d)(1)(vi), Restorative services: Under the proposed definition, restorative services and covered rehabilitative services are contingent on the individual having a functional loss (i.e.: had the *ability* to perform the function in the past, even if not having actually performed it). This definition may work in the adult context, but does not appropriately incorporate children's developmental stages. A child may not have experienced a "functional loss" per se or have had the ability to perform the function in the past because they had not matured sufficiently to do so. For children, rehabilitative services should restore their ability to grow and develop to adulthood. This definition should be rewritten to include this concept.

OACCA hopes that CMS will continue to allow us to help vulnerable children and youth on the path towards *meaningful* recovery if at the moment s/he reaches the originally stated goal, services and accompanying funds are withdrawn. Were that to happen, the child's progress would be nullified, his/her health would likely rapidly deteriorate—only requiring more intensive and more costly intervention at a later date that could possibly force the child into a more institutional setting. Maintaining functioning should be a permissible goal under the rehabilitation plan if the child/youth's would otherwise deteriorate.

440.130(d)(2), Scope of services: This provision maintains the definition of rehabilitative services as "medical or remedial services," but to more accurately reflect the entire proposed regulation that encompasses certain "restorative services" as covered rehabilitative services (440.130(d)(1)(vi)), the phrase "restorative services" should be added.

440.130(d)(3), Written rehabilitation plan: OACCA supports the written rehabilitation plan's goals. We submit only the following clarification questions and recommendations:

The written rehabilitation plan should incorporate any concurrent health or behavioral health plans that the child has, as well as with any child welfare service plan for the child and family. This will increase coordination of services and lessen administrative burden, resulting in better outcomes and lower costs.

OACCA recognizes the benefits of involving significant individuals to the child in developing, monitoring and modifying treatment plans and services, but asks that CMS add language that acknowledges the sometimes difficulties involved in this for many children involved with the foster care system. These children, especially those whose parents' rights have been terminated, may not have families to involve. We therefore recommend adding to 430.130(d)(3)(ii) and (iii) (or alternatively, to a new subsection) the following language: "For a recipient involved with the child welfare or foster care systems, input or guidance in the development, review, and modification of plan goals and services may be obtained from the child's parents when appropriate, guardians, and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, and group or residential care staff)."

We applaud CMS' desire to have the child involved in their treatment planning, but this should depend on the age and maturity of each child. Language or a new subsection should be inserted stating that "A child under 18 should be as involved in the development, review, and modification of the plan as is deemed appropriate."

If the child is found to be competent to participate in the process, any materials provided to the child to inform him/her should be developmentally and culturally appropriate.

In regards to 440.130(d)(3)(xi), a standardized list of alternate providers should be acceptable as it will provide the relevant information to all children and their families.

Section 440.130(d)(3)(xii) requires the written plan to include the individual's "relevant history, current medical findings, contraindications, and identify the individual's care coordination needs." This is not always available, particularly for children who are placed on an emergency basis. Many children in the foster care system do not have primary care doctors. This subsection should emphasis that the written plan should reference these documents *when available*.

441.45(b), Newly Deemed Non-Covered Services, Intrinsic Element Standard:

Rather than making sweeping changes through rulemaking, OACCA believes that these important decisions that impact vital community-based services should be debated thoroughly and done through the legislative process. It is our understanding that some of this debate already occurred when Congress deliberated over the Deficit Reduction Act of 2005 (DRA, P.L 109-171). During that process, Congress specifically rejected adopting the "intrinsic elements" test for Medicaid rehabilitative services that CMS-2261-P would put in place. This indicates that Congress foresaw the dangers of such language and instead, desires for Medicaid rehabilitative services to remain a strong and viable source of services. The language proposed in 440.145(b) will ultimately burden already struggling programs and further restrict access to services for children in foster care who are eligible for Medicaid.

Denying services to children who come to us because they are victims of abuse, neglect and dependency compounds their injury. It is especially egregious considering their extreme health needs and that the Department of Health and Human Services, in analyzing the Federal Child and Family Services Reviews (CFSRs), found that only one state achieved substantial conformity in ensuring that children involved with the child welfare system's physical and mental health needs were met. In other words, the situation for these children—many of whom have experienced life-altering trauma and have little or no familial support—is already dire and should Medicaid step out of the picture will only worsen.

We are further concerned that 440.45(b) provides no guidance on how to determine whether a service is an "intrinsic element" of a program other than Medicaid. The specific mention of child welfare and foster care, we assume in contrast to mental health, makes this population appear likely targets of this language. Please keep in mind that the child welfare system's role is to respond to reports of abuse and neglect, help at risk families, and help secure permanent, safe, and secure homes for children. **Behavioral health care is not intrinsic to that system.** In fact, it is exempt from the requirement for licensed mental health providers because they do not provide mental health services. Child welfare workers may provide social services, but these are not Medicaid billable.

Similarly, Medicaid rehabilitative services are not "intrinsic to" foster care. Title IV-E, Section 475(4) of the Social Security Act and the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20 state that foster care maintenance payments are "to cover the cost of (and the 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 for a child's visitation with family, or other caretakers." Clarifying further that rehabilitative services are not intrinsic to foster care, the Code of Federal Regulations prohibits States from claiming Title IV-E federal financial participation

(FFP) for "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*" (45 CFR, Chapter XIII, Part 1356.60(c)(3)) (emphasis added) States have more discretion under Title IV-B, but because its primary purpose is not to provide medical assistance, rehabilitative services are not "intrinsic to" it, either. Moreover, IV-B is a capped program that does not envision providing and is not able to provide all necessary services.

OACCA urges the Department to allow the child welfare system and Medicaid to complement each other to support the wellbeing and healthy development of each child in care. It is essential that the systems be able to, even encouraged to, work together rather than shifting the full burden onto an already stressed child protection system, as 441.45 permits Medicaid to do. The section also completely defeats the Substance Abuse and Mental Health Services Administration's (SAMHSA) diligent work to promote a system of care that provides a coordinated network of community-based services and supports to meet the challenges of children and youth with serious mental health needs and their families. As such, OACCA strongly urges 441.45(b) to be deleted.

441.45(b)(1)(i) and (ii), Therapeutic Foster Care and Packaged Services Furnished by Foster Care and Child Care Institutions: OACCA urges the exclusion of therapeutic foster care services except for "medically necessary rehabilitative services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers" (441.45(b)(1)(i)) and similar packaged services furnished by foster care or child care institutions (445.45(b)(1)(ii)) from the definition of Medicaid rehabilitative services. As the Surgeon General indicated in his 1999 report on mental health, with care provided in private homes with specially trained foster parents, therapeutic foster care is considered "the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders." It provides evidence-based care for children who otherwise would be placed in more institutional and costly settings—settings which can also reap emotional tolls on children and their families. The Surgeon General recommended therapeutic foster care as a community-based alternative for children's health. This is consistent with the President's New Freedom Commission on Mental Health report.

Unfortunately, the proposed language, while not explicitly prohibiting therapeutic foster care, whittles away at its core so much that access will surely be restricted, if not completely shut off. As a result, because there is a continuum of care in foster care, children who cannot be maintained be in family foster care due to serious emotional or other health issues will be forced into residential or hospital settings..

Only therapeutic foster care services that are "clearly distinct from packaged therapeutic foster care services" could be billed as rehabilitative services, but it is unclear what is meant by "clearly distinct." OACCA strongly advocates that states be afforded the discretion to define therapeutic foster care as a single service and pay through a case, daily, or appropriate mechanism. Packaged services allow the necessary amount of time and attention to be spent on children suffering from intense mental health issues. The alternative imposes significant administrative burden, which ultimately takes time away from the child and reduces services' effectiveness and the child's progress.

441.45(b)(5), Institution of Mental Disease: Summarily excluding services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of community residential treatment facilities with more than 16 beds will send costs soaring. This goes against the best interests of children and again, conflicts with the President's New Freedom Commission on Mental Health's reports urging more community-based care. This subsection must be stricken, at least as it applies to residents under **21**. Alternatively, before changes go into effect, an appropriate and reasonable transition period must be provided for impacted parties to try to find alternative care.

CONCLUSION

On behalf of OACCA, its members, and the children and families we serve, we thank you for the opportunity to comment on this proposed rule. We hope that you will consider our input in the spirit it was given, keeping children and families' needs paramount.

Sincerely,

Penny M. Wyman, MA, MSW, LSW
Executive Director

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

Organization : **Family Service Council of Ohio**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment regarding CMS-2261-P - Section 441.45(b)(1)

CMS-2261-P-1134-Attach-1.DOC

#1134

October 12, 2007

TO: Centers for Medicare and Medicaid Services *(CMS)*

FR: Margaret F. Burns, Executive Director
Family Service Council of Ohio *(FSCO)*

RE: **CMS-2261-P - Section 441.45(b)(1)**

On behalf of the Family Service Council of Ohio *(FSCO)*, I am requesting additional clarification relative to the **definition of the term "intrinsic elements"** and **intent of the phrase "services that are intrinsic elements of programs other than Medicaid"** as used in **Section 441.45 "Rehabilitative Services" under (b)(1)** of the proposed rules entitled "Medicaid Program: Coverage for Rehabilitative Services" as published in Volume 72, Number 155 of the Federal Register on Monday, August 13, 2007.

The Family Service Council understands that the proposed rules apply to medically necessary rehabilitative services provided through the Medicaid Program and that they are not intended to address the comprehensive needs of needs of children, adults or families. The Council, however, is concerned that the proposed rules may be interpreted to minimize the importance of the provision of medically necessary outpatient rehabilitation services to Medicaid eligible children/adults who may also be receiving services through non-medical programs.

The Council respectfully is requesting additional clarification as to the definition of "intrinsic elements" and the intent of Section 441.45(b)(1) and would particularly appreciate it if CMS could provide examples of "intrinsic elements" that relate specifically to behavioral health services.

Thank you for the opportunity to comment and for your consideration.

STRONG FAMILIES MEAN STRONG COMMUNITIES

Family Service Council of Ohio
Margaret F. Burns, Executive Director
50 West Broad Street - #1906 * Columbus, Ohio 43215
Phone: 614-461-1476 * Fax: 614-461-0204 * E-Mail: FSCO@fsco.org

Submitter : **Ms. Kathy Wilhoit** **Date: 10/12/2007**

Organization : **Special Education District of McHenry County**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned about the devastating impact that the proposed CMS regulations for the rehabilitation services option will have on the welfare of children with disabilities. The elimination of these reimbursements would inevitably shift the financial responsibility for rehabilitation claims to individual school districts and early childhood providers across the nation. The Administration estimates that the elimination of the reimbursement for the Medicaid rehabilitation services option will provide a savings of $2.29 billion over the next five years. However, there is no corresponding increase in funding for the federal special education law, the Individuals with Disabilities Education Act (IDEA), that will enable schools and early childhood providers to make up for the reduction in Medicaid reimbursements for rehabilitation services option provided to children with disabilities.

CMS-2261-P-1136

Submitter : Mr. Dean Crocker

Date: 10/12/2007

Organization : Maine Children's Alliance

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1136-Attach-1.DOC

CMS-2261-P-1136-Attach-2.DOC

#1136

October 11, 2007

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

Re: CMS 2261-P

To Whom It May Concern:

The Maine Children's Alliance is gravely concerned by the CMS proposed rules for Medicaid's coverage of rehabilitative services. We ask that CMS reconsider and withdraw these regulations for the following reasons:

Child Welfare – The Child Welfare League of America has done a wonderful analysis of the impact of these regulations on one of this Country's most important programs. We support their analysis. State level reform efforts aimed at better family support and reduced use of expensive out of home options will be crippled.

Education and Corrections – New language denying participation for what are viewed to be "intrinsic elements" of other programs will have a devastating impact on children in those programs. It is also contrary to federal law and intent. Congress amended Medicaid to require cooperation with state educational programs.

Cost of administration – While stating an objective of more efficient and effective administration, these requirements actually increase documentation and service plan requirements contrary to the intent.

Increased hospitalization and residential care – By limiting Medicaid's coverage of preventive or habilitative services, children now supported in their home and community will need to rely on more restrictive, less normalizing and less effective residential and hospital based services.

Fiscal impact – CMS's analysis of fiscal impact is grossly understated. For Maine alone, loss of federal revenue is projected at more than $148,000,000 for both children and adults (Source – Maine Department of Health and Human Services).

We ask that CMS withdraw these regulations and work with Congress and the States to find truly efficient and effective ways to improve the administration of this most critical program.

W can be more specific about our concerns and would welcome the opportunity to discuss them with you. We can suggest better ways to control Medicaid growth.

Yours truly,

Elinor Goldberg
President and CEO

Submitter : **Ms. Mary Ann Bergeron** **Date: 10/12/2007**

Organization : **VA Assn of Community Services Boards**

Category : **Other Association**

Issue Areas/Comments

GENERAL

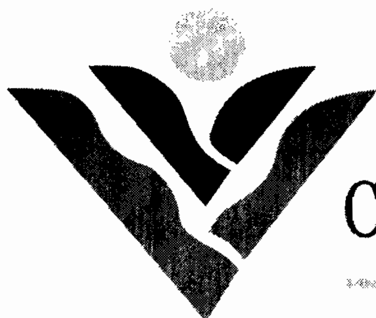
GENERAL

See attachment

CMS-2261-P-1137-Attach-1.DOC

CMS-2261-P-1137-Attach-2.DOC

#1137



Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

TO: Kelly Weems, Acting Administrator, CMS

FROM: Mary Ann Bergeron, Executive Director

DATE: October 12, 2007

SUBJECT: Comments of the VACSB Regarding CMS-2261-P

Thank you for the opportunity to comment upon the recently-published draft regulations for State Rehabilitation Option Services. The Virginia Association of Community Services Boards (VACSB) speaks for the forty (40) Community Services Boards (CSBs) in Virginia, charged by the Code of Virginia to assure community-based services, in all localities of Virginia, for children and adults with mental illness, mental retardation, and substance use disorders. As partners with state agencies and local governments, the CSBs work with those individuals with the most severely disabling conditions, assisting these individuals to remain in the community and avoid the most expensive care, institutionalization.

While the stated goals of the draft regulations seem to be in line with good administrative practices, these regulations, because of the nature of the unique approach each state has taken in this Option, would provide CMS the opportunity to mandate changes to states' plans and, before approval of the changes, insist that states make additional adjustments that may or may not be in keeping with the spirit or intention of Rehabilitation Option Services in a particular state. Since savings is one of the goals, there will be only so many strategies for CMS to utilize to drive the savings. Within a program as lean as Virginia's with its 80% FPL eligibility for its Aged, Blind, and Disabled group and already at a 50% match for FFP, this can mean only restricting services in some way and/or driving fee for service rates lower than current rates.

Neither strategy is acceptable for consumers to be served appropriately. While the President's Freedom Commission emphasized the need for a recovery focus on services for individuals with mental illness, these draft regulations and other dictates accomplished through letter directives to state Medicaid agencies seem to undermine the very tools for consumers to use in their paths to recovery. Taking away or restricting tools that are not expensive in the long term can result in only one thing, the high price of an institutional setting, which may be in Medicaid-reimbursed facilities, defeating the purposes of savings, stabilization and normalcy in communities, and of recovery.

In CMS efforts to use a more medical approach for rehabilitation services, equating the services to more of a joint replacement approach for example, there is a lack of recognition of the nature of mental illness and that each person progresses toward recovery at a different rate, on a

different path, and may have setbacks along the way because of the complexity of the illness and any corresponding medical conditions.

From a state and provider perspective, these regulations could doom the innovative services and service modalities that have been developed and demonstrate effectiveness for consumers, who may, in Virginia, be service recipients and service providers through peer support vehicles. Additionally, administrative changes that may be forced by the draft regulations can result in more severe administrative burdens for providers.

Virginia DMAS is already developing a system for additional management of the Rehabilitation Option Services with prior authorization and utilization review. No state and no Virginia agency, state or local, is in the business of providing more services than consumers need. In Virginia, these draft regulations are not needed as it is a well-managed and lean program, evidenced by the relatively few providers of Rehabilitation Option Services.

It is the recommendation of the VACSB that CMS note the stringent eligibility for Rehab Option Medicaid services in Virginia, the work in assisting consumers in the development of and adherence to Wellness, Action, and Recovery Plans (WRAP), and consumer employment in the field of mental health. That done, CMS should recognize that there is no need for further change in Virginia's State Plan.

Thank you again for this opportunity. For additional information or questions, please contact me at 804.330.3141 or via email at mabergeron@vacsb.org.

Submitter : **Ms. Deborah Becker** **Date: 10/12/2007**

Organization : **Dartmouth Psychiatric Research Center**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am responding to your invitation to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am a former rehabiltation counselor and director of a community support program serving people with severe mental illness in a community mental health center. Currently I am an assistant professor at Dartmouh Medical School. I am part of the Dartmouth Psychiatric Research Center. My comments are based upon my experience in each of these positions. Evidence-based supported employment is the best mental health treatment for people with severe mental illness. Employment is the only service that decreases medicaid and SSA costs. Any decrease in employment supports would be tragic.

1. 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. Please remove 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. Please 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.

Sincerely,

Deborah R. Becker
Dartmouth Psychiatric research Center

Submitter : **Ms. Debra Deater** **Date: 10/12/2007**

Organization : **Ottawa County Mental Health**

Category : **Local Government**

Issue Areas/Comments

Background

Background

I would just like to say that by allowing these cuts to go through you would be hurting so many lives. Thousands of michigan residents would be effected by these appalling changes. Persons with Developmental disabilities need these services to maintain a healthy fulfilled quality of life. In passing these cuts the last 40 years in gains for people with disabilities would be completely erased. My hope is that you will please hear our comments and question your actions before making such drastic cuts. Not only would people with Developmental Disabilities be effected, but the thousands of people that work with them daily would no longer have full-time jobs. If you think Michigan has a high unemployment rate now, just think about what it would be after such cuts. Please consider the consquences of your actions before passing such cuts. Thank You

CMS-2261-P-1145

Submitter : **Mr. Neill Horton** **Date: 10/12/2007**

Organization : **Mr. Neill Horton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1145-Attach-1.TXT

#1145

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

To Whom It May Concern:

Reference: File Code CMS-2261-P
Comments on 42 CFR Parts 440 and 441: Medicaid Program: Coverage for Rehabilitative Services

I am writing as an interested community member of Montgomery County, Maryland. I concur with the comments submitted by St. Luke's House, Inc.

St. Luke's House, Inc. is a private, non-profit, non-sectarian organization that helps people live, learn and work successfully in their communities by offering integrated mental health services and resources. St. Luke's House serves adults who have serious and persistent mental illness and youth who have been identified as seriously emotionally disturbed through a wide array of community based services, such as psychiatric and residential rehabilitation, supported employment, supported living, case management, outpatient mental health clinics and crisis residential services. St. Luke's House is certified to provide two of the SAMHSA Evidence Based Practice models, Supported Employment and Family Psychoeducation, as well as integrates other evidence based models, like DBT into its programs. St. Luke's House has provided services for 36 years and serves more than 1,000 individuals each year. Our primary focus is on individuals needing services through the public mental health system, and as such, most of our funding comes from Medicaid, Medicare and state and local government.

It is critical that the proposed regulations support the people we serve in maximizing their functioning in the community. We are seriously concerned that the proposed regulations, as written, may create significant obstacles to the recovery process for adults and children. Therefore, we respectfully submit these comments in hopes of eliminating these potential barriers and promoting the well being of these individuals. We ask that you consider changing the following specific areas:

440.130(d)(1)(vi) Definition of Restorative Services and 3(xiv) Measurable Reduction of Disability

It is critical that these regulations fully recognize the nature of mental illnesses and the recovery process. The regulatory language must reflect the flexibility needed to help children grow and develop and to support adults in dealing with relapse and the challenges in sustaining levels of functioning. Therefore the following changes to language are recommended:

Section 440.130 (d)(1)(vi) Definition of "restorative services"

Recommendations:

- Include language that states 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.

- Add the following language to the end of section:

  "Examples of acceptable rehabilitation goals in this context would include: living in the community without long-term or intermittent hospitalization; reduction or control of symptoms to avoid further deterioration or hospitalization."

440.130 (d)(3) (xiv) Requirement of "Measurable Reduction of Disability"

Recommendation: Add the following language to the end of the section:

"For some individuals, particularly those with serious mental illness, 'reduction of disability' and 'restoration of functional level' may be measured by comparing the effect of continuing rehabilitation versus discontinuing it. Where there is reasonable expectation that if rehabilitation services had been withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion is met."

440.130 (3) preamble, (3)(xi), (xv), (xvi) Written Rehabilitation Plan

There are four specific areas we would like this section to address. First, the preamble of this section refers to a written rehabilitation plan. While it does not prohibit an integrated treatment and rehabilitation plan, it also does not specifically allow for one. Since integrated planning and service delivery is in the consumer's best interest, we feel that the regulations should support an integrated plan. Second, (re: 3xi) while there is great value in consumers knowing their options for alternate providers, we think that information should be shared earlier in the process than during rehabilitation planning, at any time the consumer expresses a desire to consider other options or at specific progress review periods. The rehabilitation planning process is an important time of partnership. The routine inclusion of information about alternate providers during this process may disrupt the therapeutic bond, may cause confusion and anxiety for the consumer and also places an unnecessary burden on the provider. Third, (re: 3 xv) due to the episodic nature of serious mental illness and sometimes due to specific symptoms, some consumers may not be able or willing to sign the treatment/rehabilitation plan at a given time.

The need for the services is still likely to be critical. The individual may not have appointed a representative who could sign on behalf of him/her. Therefore, CMS should allow for documentation of efforts of the provider to secure the signature and the reasons that the consumer or his/her representative is not able to sign the plan. Finally, (re: 3xvi) since the provider is already bound by Medicaid requirements, the inclusion of the statement in the last bullet below seems unnecessary and inappropriate for inclusion in the service plan and seems to add no real value. In the interest of time and clarity, we recommend it be deleted from this section.

Recommendations:

- Specifically clarify that a single integrated treatment and rehabilitation plan is acceptable (3 preamble)
- Delete the section that reads "Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." (3xi)
- Allow providers to document attempts to involve consumers in the development of their treatment/rehabilitation plans and to secure their signatures. (3xv)
- Delete the section that reads "Document that the services have been determined to be rehabilitative services consistent with the regulatory definition." (3xvi)

441.45 (a) (2) : Rehabilitative Services

This recommendation serves to reinforce what has been said regarding restorative services and "measurable reduction of disability."

Recommendation: Reiterate here when services may be provided to retain or maintain functioning.

441.45 (b) (1) Non-Covered Services

In order to strongly support the concept of integrated and coordinated services and to ensure that consumers have access to covered rehabilitation services, the following clarifications are recommended.

Recommendations:

- Add the following to the end of the first paragraph in Section 441.45(b) (1):

  "...except for medically necessary rehabilitation services for an eligible individual that are clearly distinct from these non-covered program services and are provided by qualified Medicaid providers. One way to demonstrate this distinction is by clearly and reasonably distinguishing the funding stream for the rehabilitation services as being distinct from that of non-covered services.'

- Clarify that pre-vocational services are allowable services when appropriately tied to a rehabilitation goal.

Thank you for this opportunity for commenting and for your consideration of these recommendations.

Sincerely.

Neill Horton
Bethesda, MD
hortonn7@yahoo.com

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

Organization : **Arizona Health Care Cost Containment System AHCCCS**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

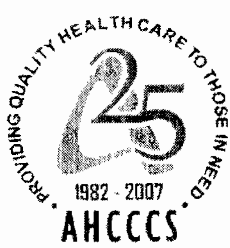
See Attachment.

CMS-2261-P-1146-Attach-1.DOC

CMS-2261-P-1146-Attach-2.DOC

#1146

Janet Napolitano, Governor
Anthony D. Rodgers, Director



801 E. Jefferson, Phoenix, AZ 85034
P.O. Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

October 12, 2007

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

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS) I am pleased to submit comments on the proposed regulations regarding Medicaid Coverage for Rehabilitative Services, published at 72 Fed. Reg. 45201 (August 13, 2007). AHCCCS is the state agency that administers Arizona's Medicaid program, which covers over one million members.

The rehabilitative services option is the primary basis of Arizona's outpatient behavioral health services program. Some of the behavioral health services AHCCCS provides under the rehabilitation services option include screening, assessment, and evaluation; counseling, including individual, group, and family therapy; behavior management services. including peer support; psychosocial rehabilitation, including living skills training; and medication management. AHCCCS has elected to provide most physical, occupational, and speech and hearing services under the separate state plan option related to those services; therefore, these comments relate specifically to the coverage of behavioral health services.

Rehabilitative services are essential to help people with mental illness improve or maintain their functioning, allowing people with mental illness to reduce their dependence on inpatient services.

42 C.F.R. § 440.130(d)(1)(iii)
The proposed rule defines the term "qualified providers of rehabilitative services." It is unclear if this definition includes peer support services, which, as provided in State Medicaid Director Letter #07-011 "are an evidence-based mental health model of care" that "can be an important component in a State's delivery of effective treatment." AHCCCS recommends clarifying in the preamble to the final rule that peer support specialists can be qualified providers of behavioral health rehabilitative services.

42 C.F.R. § 440.130(d)(1)(iv)
The definition of "under the direction of" in the proposed rule requires that a licensed practitioner supervise the provision of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. While the proposed rule states that this definition applies specifically to providers of those services, the last sentence of the definition states that the "language is not meant to exclude appropriate supervision arrangements for other rehabilitative services." AHCCCS is concerned that this language will be construed as requiring comparable levels of supervision for behavioral health services. Arizona is experiencing a shortage of licensed behavioral health providers, and requiring a comparable level of supervision for behavioral health services would severely jeopardize the availability of behavioral health services; therefore, AHCCCS recommends that the last sentence of the definition be removed.

42 C.F.R. § 440.130(d)(1)(v)
The proposed rules define "rehabilitation plan" and introduce requirements for the written rehabilitation plan. The regulation is silent on the relationship between the rehabilitation plan and the treatment plan, and AHCCCS is

concerned that the proposed rules will require two plans and two planning processes for the written rehabilitation plan and a separate treatment plan. AHCCCS recommends that the rules clarify that the treatment plan can be the written rehabilitation plan (as long as the treatment plan includes all requirements for the rehabilitation plan) rather than require two separate planning processes and plans.

42 C.F.R. § 440.130(d)(1)(vi)
The proposed regulation defines "restorative services"; however, it is unclear how the term will be used in the final rule because the term is not used in the proposed rule or the statute. The definition states that the "emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past." AHCCCS is concerned that this definition may be used to exclude services for young children because the child's capacity to perform the function may not be known. AHCCCS is recommending that the proposed rules or the preamble clarify the application of this rule to young children who had not yet reached developmental milestones.

The proposed definition also states that "services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services." It is unclear if this sentence allows the rehabilitation goal to be maintenance of function; however, maintenance of function is often an appropriate goal for individuals with behavioral health conditions. AHCCCS recommends that the regulations are written or applied in a manner consistent with the Medicare Hospital Manual § 230.5(B)(3) which provides: "For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement."

42 C.F.R. § 440.130(d)(3)(xi)
The proposed rule requires that the written rehabilitation plan "indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." This is apparently included to ensure patients have a choice of providers; yet there are already several processes in place to ensure patient choice, including informed consent and the grievance and appeal process. Further, in the managed care setting, individuals are provided a comprehensive directory of network providers. Listing all providers in the rehabilitation plan is onerous and makes the rehabilitation plan unwieldy and can lead to a delay in accessing services.

42 C.F.R. § 440.130(d)(3)(xiv)
The proposed rule provides, "If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods." Consistent with the above comment regarding the definition of "restorative services," AHCCCS recommends that the regulation be written or applied in a manner consistent with Medicare.
The Medicare Hospital Manual § 230.5(B)(3) provides:

> "The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.
>
> "It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
>
> "Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the

evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment."

42 C.F.R. § 440.130(d)(3)(xv)
The proposed rules require the rehabilitation plan to "document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan." This requirement can become a barrier to services for individuals who refuse to sign the form for reasons related to their disease or disability. For example, individuals who have been court-ordered to receive treatment may refuse to sign the form. Individuals with paranoid disorders or cognitive disabilities such as dementia, may refuse to sign because they do not understand. AHCCCS recommends that there be a means of opting out, if the reason for failing to obtain the individual's signature is included in the rehabilitation plan.

42 C.F.R. § 440.130(d)(3)(xvi)
The proposed regulation requires that the rehabilitation plan "document that the services have been determined to be rehabilitative services consistent with the regulatory definition." It seems unreasonable to require a clinician to document compliance with the proposed regulation, and including this makes the document more complex for both clinicians and individuals and their families. As required by 42 C.F.R. § 440.130(d)(3)(x), the document has already been signed by the individual responsible for developing the plan. Individuals may be even more uncomfortable signing the document. AHCCCS recommends deleting this provision.

42 C.F.R. § 440.130(d)(3)(xvii)
Under 42 C.F.R. § 440.130(d)(3)(i), the rehabilitation plan must "be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living." The requirement that the rehabilitation plan must "include the individual's relevant history, current medical findings, contraindications" essentially forces the rehabilitation plan to rewrite or duplicate the comprehensive assessment required by 42 C.F.R. § 440.130(d)(3)(i). This requirement contains unnecessary work and makes the document even larger and more confusing for the individual or their family. AHCCCS recommends deleting this provision.

42 C.F.R. § 441.45(a)(5)
The proposed rule requires the state to "ensure the State plan rehabilitative services . . . specifies the methodology under which rehabilitation providers are paid." In the past year, several states have been forced by CMS to abandon case rate or the bundled approach which is paying for services and pay for billing of services in 15 minute increments. This approach significantly increases the amount of time that clinicians must spend completing paperwork and thus reduces the amount of time available to spend with clients. AHCCCS recommends that CMS provide states with necessary flexibility in reimbursement.

42 C.F.R. § 441.45(b)(1)
This section prohibits federal financial participation (FFP) for services that are "intrinsic elements of programs other than Medicaid." While the rule provides a few examples of services that are believed to be intrinsic elements of other non-Medicaid programs, it fails to identify the criteria used to determine whether a service is an intrinsic element of another program. This vague standard provides no guidance to states trying to implement the proposed regulations. At the same time, it appears to provide great latitude to CMS and the Office of Inspector General in interpreting this standard. Further, this appears to run counter to the goals developed by the President's New Freedom Commission on Mental Health. The report establishes goal 2.3, "align relevant Federal programs to improve access and accountability for mental health services" and states that "States will have the flexibility to combine Federal, State, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between health care, employment supports, housing, and the criminal justice systems." The "intrinsic element" standard establishes a new bureaucratic boundary that will have a chilling effect on state's efforts. AHCCCS recommends deleting this entire portion of the proposed rule.

Thank you for this opportunity to comment on the proposed regulation.

Sincerely,

Anthony D. Rodgers,
Director

CMS-2261-P-1147

Submitter : Dr. Simcha Goldman **Date:** 10/12/2007

Organization : Pacific Clinics

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

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

Organization : **New York State Department of Health**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attached letter re proposed CMS regulation No. 2261-P

CMS-2261-P-1148-Attach-1.PDF

#1148

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

October 11, 2007

Ms. Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8018
Baltimore, MD 21244-8018

Dear Ms. Norwalk:

We have reviewed the proposed CMS regulations regarding Coverage for Rehabilitative Services. It is our belief that these regulations are both complex and far-reaching, and may drastically reduce the availability of important medically necessary services currently provided under this option. New York State cannot support these regulations as written. These comments reflect the concerns of not only the New York State Medicaid Program, but those of our Offices of Mental Health and Mental Retardation & Developmental Disabilities, as well. We further believe that there are a number of issues which need to be addressed and modified. It is important to remember that rehabilitative services are provided to the most vulnerable populations, and as such, an adequate level of service must be maintained. In order to do so, we recommend changes to the proposed regulation in the following areas.

<u>Nexus of rehabilitation services and EPSDT:</u>

Because of the complexity of these regulations, and the fact that their interactions with EPSDT rules are not addressed, we are concerned that they may interact with the EPSDT program in a way that unintentionally reduces services. They may adversely affect access to needed services for children with disabilities. We are specifically concerned that these regulations may reduce access to services under programs such as those authorized under the Individuals with Disabilities with Education Act (IDEA) to provide early intervention services to infants and toddlers with disabilities. These services authorized under Part C of IDEA are provided to address developmental needs of children rather than educational needs. IDEA specifically provides that [20 U.S.C.A. § 1440(c)] States maintain medical assistance for children as a supplemental source of funding to be combined with IDEA funds. Further, we believe that CMS needs to positively state that these rules do not interfere with the Federal requirement that all Medicaid eligible services are available to children under the EPSDT program, whether or not they are currently covered in the New York's State Plan.

Exclusion of habilitation services:

As the State reads the proposed regulation, it would not prohibit habilitation services from being provided under the clinic option. Existing regulations define "clinic services" at 42 C.F.R. §440.90, and "rehabilitation services" at §440.130(d). The State requests clarification that CMS also reads the proposed regulation to allow habilitation services to be claimed under the clinic option. If CMS reads the proposed regulation as prohibiting states from providing habilitation services under the clinic option, the State takes the position that the regulation is clearly not what Congress intended and would not lift the moratorium in OBRA '89.

The State also objects to any restriction on habilitation services being provided as clinic or rehabilitation services. Any such restriction will be impossible for healthcare practitioners to follow, will have the effect of discriminating against persons with developmental disabilities, and will reduce cost-effective preventive services to children.

The distinction CMS makes between "rehabilitation" and "habilitation" is simplistic and unworkable. Clinicians are not trained to distinguish between habilitation and rehabilitation services provided to children and persons with developmental disabilities. It is not realistic to expect that they could be trained to make such a distinction. It is difficult if not impossible for clinicians to always know enough about the etiology of a particular sign or symptom to discern if it is based on the loss of a skill or relates to a skill that was never acquired, or in the case of children, have not yet had the opportunity to acquire.

By reducing services needed by children with disabilities, including those with developmental disabilities, the proposed rule will create the need for more expensive and less desirable services later in life. If a child's needs in areas of occupational therapy, physical therapy, speech and language, behavioral, and socialization are not comprehensively addressed, he or she is at risk for a lifelong disability and the need for more intensive and costly services later in life. These more intensive and costly services may well include institutionalization. This is especially true for children with Autism Spectrum Disorders (ASD), for whom it has been demonstrated that early diagnosis followed by appropriate, intensive interventions as early as possible prior to age eight can significantly ameliorate symptoms and reduce the functional deficits common to ASD.

Limiting habilitation services to ICFs/MR, the 1915(c) HCBS waiver or the 1915(i) HCBS state plan option is bad fiscally and programmatically. Many individuals with developmental disabilities do not now meet ICF/MR level of care, but need habilitation services to maintain function and prevent loss of function. Under the proposed regulation, these individuals would have to be placed in more costly residential care. Other individuals would be eligible for 1915 (c) HCBS waiver services if they applied, but can successfully remain in the community with a limited amount of habilitation services. If these people enrolled in a waiver, they would be eligible for the full array of waiver services at a much higher cost to the state and federal governments.

Provider Qualification:

The proposed regulations require that rehabilitation services are provided by a "qualified provider". Qualified providers are defined as individuals rather than agencies. This is a departure from the State's current approach, which views a "qualified provider" from the perspective of the licensed agency, rather than the perspective of individual staff members.

The requirement that qualified providers be specified for each service could result in limitations on the scope and amount of reimbursable services that could be delivered by non-professionals, necessitating increased levels of professional staffing in programs that currently rely heavily on paraprofessionals and peer staff. This in turn would increase program costs, exacerbate professional staff and recruitment problems, and decrease provider agencies' willingness to employ peers.

Eligible Services:

In order to be eligible for Medicaid reimbursement, rehabilitation services must be specifically related to an identified rehabilitative goal, of time-limited duration, and designed to result in the maximum reduction of mental disability and restoration to the best functional level. Services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a specific rehabilitation goal.

While most individuals served in rehabilitation programs are actively engaged in pursuit of recovery goals, there are also numerous individuals who rely on long-term services to retain current levels of functioning and to avoid hospitalization. Individuals who continue to need critical support services from their rehabilitation programs beyond the point where continuous progress toward specific recovery goals can be demonstrated will require non-Medicaid financial support from the State.

The need to show measurable reduction of disability and restoration of functional level will be particularly difficult for the most vulnerable recipients, particularly long-term residents of community residence programs.

Coverage Restrictions for "Intrinsic Elements"

The State is concerned about the provision that Medicaid coverage for rehabilitation services is prohibited for services that are furnished through a non-medical program as either a benefit or administrative activity. The actual impact on various State programs and recipients will depend on how broadly this provision is interpreted by CMS. Specifically, would this type of restriction include situations where there is theoretical coverage by another program, but where funding is unavailable?

Recommendations for Specific Regulatory Revisions:

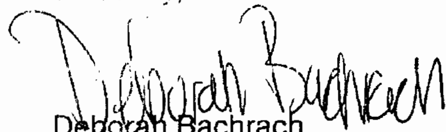
- Rehabilitation services by a licensed program should be treated in the same manner as services provided under the clinic option of the State Plan, where the "qualified provider" is the program and not the practitioner.
- Existing programs operating pursuant to approved State Plan Amendments should be "grandfathered" and further Plan amendments should not be necessary as long as changes are made in State regulations to conform to the new federal requirements.
- While Medicaid is the payer of last resort, payment will not be denied for otherwise reimbursable services unless it can be demonstrated that another program was mandated to pay for them.

Requests for Additional Clarification:

- Can employment be the recovery goal, itself, as long as Medicaid only reimburses for medically necessary services to improve functional impairments that are a barrier to achievement of the goal?
- In an integrated program, can treatment and rehabilitation goals and services be addressed within the same plan, or are separate plans required?
- Will CMS provide more substantive guidance on such issues as:
  - Timeframes for determining that progress is insufficient and that rehabilitation goals/plans need to be revised?
  - Criteria for determining whether a service is an "intrinsic element" of another program?
  - The kinds of documentation that would satisfy the new standards?

We thank you for the opportunity to comment on these proposed regulations, and look forward to working with CMS to ensure that recipients continue to receive the necessary medical services in a timely manner.

Sincerely,



Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Submitter : **Mr. Fernando Serrano** **Date: 10/12/2007**

Organization : **State of NV Division of Child and Family Services**

Category : **Individual**

Issue Areas/Comments

Background

Background

See Attachment

Collections of Information Requirements

Collections of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Response to Comments

Response to Comments

See Attachment

CMS-2261-P-1149-Attach-1.DOC

#1149

JIM GIBBONS
Governor

STATE OF NEVADA

MICHAEL J. WILLDEN
Director

FERNANDO SERRANO
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD AND FAMILY SERVICES
4126 Technology Way – 3rd Floor
Carson City, Nevada 89706
(775) 684-4400

MEMORANDUM

DATE: October 12, 2007

TO: Centers for Medicaid & Medicaid Services
Department of Health and Human Services

FROM: Fernando Serrano, Administrator
Nevada Division of Child and Family Services

RE: CMS – 2261 - P

Comments Regarding the Proposed Rule for Coverage for Rehabilitative Services
Written Rehabilitative Plan: 440.130 (d) (3)

- The requirement for a Written Rehabilitative Plan adds another plan required for recipients of mental health services. Potentially a single recipient could have a treatment plan, a targeted case management plan and a rehabilitative plan.

  Recommendation: Allow for a rehabilitative plan as either a stand-alone plan or as part of a treatment or targeted case management plan to support single coordinated behavioral health plans for a recipient. This would support stronger care coordination and integration of behavioral health services for the recipient.

- The expectation for the involvement of the beneficiary child's family in the re-evaluation of the rehabilitative plan is a positive addition to the regulations.

  Recommendation: Strengthen the family involvement further by requiring the involvement of the beneficiary, family or other responsible individuals in the development and re-evaluations of plans.

Requirements for Rehabilitative Services

- **Requirement that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for maximum reduction of physical or mental**

disability and restoration of the individual to the best possible functional level: 441.45 (a) (2)

Recommendation: Add language describing when rehabilitative services may be used to retain or maintain functioning.

Limitations for Rehabilitative Services

- **Exclusion of coverage of rehabilitative services that are furnished through a non-medical program...such as foster care, child welfare, education, child care, vocational and pre-vocational training, parole and probation, juvenile justice, or public guardianship...intrinsic elements: 441.45 (b) (1)**
  There is no clear definition of "intrinsic elements." This section would deny covered Medicaid services for a covered Medicaid recipient if that recipient is involved in other public programs. This proposed rule would deny medically necessary services to a Medicaid recipient, in direct contradiction of federal statute 42 U.S.C. 1396.
  The provision of services to non-Medicaid eligible recipients through other federal and/or state funding sources should not deny Medicaid participation by a Medicaid recipient. Per the proposed language in this section, "enrollment in these non-medical programs does not affect eligibility for Title XIX services."

  In addition, Rehabilitative Services are community-based and in a facility, home, or other setting per 440.130 (d) (5). They need to be provided in the community-settings that best meet the rehabilitative needs of the recipient. For children with serious emotional disturbances, they may need rehabilitative services in their family home or their foster home; in their child care center or school classroom, etc. Rehabilitative services address the child's functional impairment rehabilitative needs, not their caretaking or education, and therefore are not duplicative of other services.

  Recommendation: Delete this entire section

- **Therapeutic Foster Care is denied reimbursement as a single service type: 441.45 (b) (1)**
  Therapeutic foster care is the least restrictive level of residential treatment care for a child with a serious emotional disturbance. It has been established as an evidence-based practice over multiple research studies. Therapeutic foster care is not and should not be a treatment service type that is limited to children in the child welfare system. In Nevada, children in parent/family custody and children in public custody are eligible for therapeutic foster care if they meet medical necessity criteria. Many of these children meet medical necessity criteria for residential treatment center care and are treated in therapeutic foster care as the least restrictive level of care that can meet their needs. This regulation would require that each component of therapeutic foster care be billed separately. This will greatly increase administrative work – from direct treatment providers through support functions such as billing and a resultant increase in costs for this service.

Recommendation: Therapeutic foster care/treatment homes should be listed as a Rehabilitative Option service type and paid through a single rate. It should be listed as a covered service for children with serious emotional disturbances whose least restrictive level of treatment is residential treatment.

Regulatory Impact Analysis

Only the impact to Federal Medicaid spending on Rehabilitative Services was analyzed. It appears that because Fee for Service will be excluded from rehabilitative services that are included in other federal, state and local programs these costs are being shifted to other federal streams as well as state and local funding streams.

Recommendation: CMS in collaboration with other federal agencies such as the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, Department of Education, Office of Juvenile Justice and Delinquency Prevention should analyze the impact of the proposed regulation changes on other federal programs as well as the impact on state and local funding streams.

Concerns regarding Medicaid coverage of services that are intrinsic elements of other programs are raised in CMS 2261-P and are disallowed in 441.45 (b) (1) while it is affirmed that enrollment in these non-medical programs does not affect eligibility for Title XIX services:

Recommendation: CMS in collaboration with other federal agencies that fund or oversee the program cited under intrinsic elements map out how services can be coordinated and how funding streams can be utilized to develop rate methodologies.

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

The inclusion in this definition on covering rehabilitative services for an individual who may not have had the ability in the past is important for children and adolescents who may never have achieved a functional ability that is an age-appropriate functional ability. This definition also recognizes that services which provide assistance in maintaining functioning may be considered rehabilitative when necessary to help attain a rehabilitative goal. This language is not included in the Requirements and Limitations for Rehabilitative Services, section 441.45.

Recommendation:

- Include the above cited language in section 441.45.
- Clarify the language further that a child does not have to have achieved a functional ability in the past, as may not have been age or developmentally appropriate
- Clarify when services which provide assistance in maintaining functioning may be considered rehabilitative and add an example for both children and adults

Other Issues Related to CMS – 2261 – P

Covered Services

Services that have been established and recognized nationally as evidence-based practices are not covered.

Recommendation: Add evidence-based practices with the most appropriate rate methodology to the particular practice (e.g. daily) such as therapeutic foster care, multi-dimensional treatment foster care, multi-system therapy, day treatment, etc.

Rate Methodology

The proposed regulation does not specifically address rate methodology. It does however, support rates in 15 minute increments as CMS has begun to require. A change to 15 minute increment billing for many of these services will increase administrative functions and costs which will increase rates and/or decrease direct services to recipients.

Recommendation: CMS work with other federal agencies, states and providers to develop efficient and appropriate rate methodologies for Rehabilitative Services types.

Submitter : **Ms. Olga Golik** **Date: 10/12/2007**

Organization : **Citrus Health Network, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We support the new requirement for a written rehabilitation plan consistent with recovery goals. We also support the emphasis on the New Freedom Commission on Mental Health.

Consistent with the New Freedom Commission on Mental Health is the concept of services being consumer driven and integrated systems of care. We are not in support of proposed changes that are inconsistent with these goals of the New Freedom Commission on Mental Health.

We are opposed to the changes which would exclude the option of paying for therapeutic foster care (or similar programs, such as ACT) through a single daily rate, case rate or similar payment to the provider. Having to instead bill each service separately discourages making services consumer driven since it encourages services to be reimbursement driven.

We are also opposed to proposed changes that would prohibit federal payment for services that CMS deems intrinsic elements of other programs. The list of programs included under this rule includes foster care, child welfare, education, child care, vocational and prevocational training programs, housing, parole and probation, juvenile justice and public guardianship. This is completely inconsistent with encouraging integrated systems of care and would result in our programs for foster care children being closed since Medicaid reimbursement for services is a critical component.

We are hopeful that these comments will be taken into consideration prior to finalizing the rule, and thank you for this opportunity to comment.

Submitter : **Ms. Carmen Schulze** **Date: 10/12/2007**

Organization : **Missouri Coalition of Children's Agencies**

Category : **Other**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1151-Attach-1.DOC

#1151

Missouri Coalition of Children's Agencies (MCCA)
Carmen Schulze, Executive Director
213 E Capitol Suite 101
Jefferson City, MO 65101

October 11, 2007
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 21244-8018

Re: CMS 2261-P; Comments on Proposed Rule *Medicaid Program; Coverage for Rehabilitative Services*

To Whom It May Concern:

The Missouri Coalition of Children's Agencies (MCCA) is a membership association whose mission and purpose is it to strengthen and support its member organizations' efforts to foster healthy families and children. MCCA respectfully submits these comments on the Proposed Rule for the Medicaid Program's Coverage of Rehabilitative Services (CMS-2261-P) that was published in the Federal Register on August 13, 2007 (72 Fed Reg. 45201).

MCCA recognizes and appreciates that this proposed rule attempts to move towards a more transparent system that will promote administrative and managerial integrity, while also making rehabilitative services more person-centered and focused on positive, effective outcomes. In attempting to do so, however, significant ambiguity remains and MCCA is highly concerned that various provisions of the proposed regulation—albeit well-intentioned—will greatly restrict access to vital community-based services for many vulnerable populations, including children involved with the child welfare system and in Missouri's foster care system.

In addition, MCCA is concerned by the Regulatory Impact Analysis's certification that CMS-2261-P "would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act." As the proposed regulation significantly changes the scope of rehabilitative services that have been made available to children and other individuals with mental and physical disabilities for quite some time and imposes new administrative requirements, it is hard to imagine that providers would not be impacted.

Similarly, while it is sometimes necessary to change the contours of a service or program, the evolution here seems to be one-sided, reducing Federal Medicaid spending on rehabilitative services by $2.2 billion between FY 2008 and FY 2012 and although acknowledging that States will be affected, merely stating that "we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule." As a federal-state partnership, Medicaid has a responsibility to provide health care for those deemed eligible, including children in foster care, and we fear the result if such a substantial amount of Federal funding is withdrawn.

In Missouri there are over 9,000 children in foster care today. 25% of those cases are managed by private agencies under contract with the state's child welfare agency. Many children that enter the foster care system are at an extremely high risk for both physical and mental health issues as a result of biological factors and/or the maltreatment they were exposed to at home. Some children are in out-of-home care for other reasons, such as their parent(s) voluntarily placing them or feeling compelled to do so. Child Welfare League of American has given the example that, the Government Accounting Office estimates that in 2001, due to limits on public and private health insurance, inadequate supply of services, and difficulty meeting eligibility requirements, parents placed over 12,700 children into the nationwide child welfare or juvenile justice systems solely so that these children would be more likely to receive necessary mental health services.

Regardless of why the child has come into the child welfare or foster care systems, removing the child from his/her home, breaking familial ties and the continued instability that often ensues greatly exacerbate any original vulnerability. Numerous studies have documented that children in foster care have medical, developmental and mental health needs that far surpass those of other children, even those living in poverty.

And regardless of why the child comes into the child welfare or foster care system, there is one entitlement and that is medical coverage through the Medicaid program in Missouri. An assumption has been made in the regulations that other programs could or does pay for the rehabilitative services that Missouri provides through this option. The assumption that this is improper reliance on a benefit furnished by other social or educational development programs is inaccurate. Children in foster care experience trauma that we cannot even imagine. The family support team in Missouri must focus on a permanency plan for the children, using all resources available. Why?

When children are removed from their home base and placed in state custody due to no fault of their own, Medicaid steps in to provide many of these children with health care that helps them get on the road to permanency. Medicaid Rehabilitative Services are especially vital, as they offer a realistic opportunity to—in the least restrictive setting possible—reduce the physical and/or mental disabilities that many children in foster care have thereby restoring the child's functioning level, decreasing lingering and long-term negative impacts, and ultimately reducing costs. And we cannot forget to include that permanency for a child may occur sooner than for foster children than those who do not receive these services. Rehabilitative services are also community-based and consumer- and family-driven services, in line with both the President's New Freedom Commission on Mental Health and the U.S. Surgeon General's recommendations. As the status quo stands, despite concerted efforts, when evaluating the Federal Child and Family Services Reviews (CFSR's), the U.S. Department of Health and Human Services in 2005 found that only one state achieved substantial conformity in ensuring that children involved with the child welfare system's physical and mental health needs were met.

It is the government's responsibility to care for the foster child, they are the parents of the child because custody has been removed from their caregiver. It is incumbent that all foster children receive the services that they need to expedite their quest for a permanent, life long connection called home.

PROVISIONS OF PROPOSED RULE:

Section 440.130: Diagnostic, screening, preventative, and rehabilitative services

440.130(d)(1)(iii), Qualified providers of rehabilitative services: We appreciate that CMS holds with us the joint desire for providers of rehabilitative services to be aptly prepared, but we urge that States be granted the latitude necessary to ensure that services would not be restricted as a result. For instance, States' recognition of and threshold for therapeutic foster parents as qualified providers should remain untouched.

440.130(d)(1)(v), Rehabilitation plan: The requirement for a written rehabilitation plan will help ensure accountability, but we suggest that children's developmental stages and the often difficult-to-predict phases of restoration be taken into account. With children consistently progressing through developmental stages, even upon the most informed initial assessment of needs, it is complicated to pinpoint anticipated progress. Similarly, children—as all individuals suffering from physical or mental impairment—can quickly deteriorate, necessitating an adjustment to the rehabilitation plan's enumerated goals. Providers therefore should be granted ample flexibility to adjust children's rehabilitation plans in the form of crisis planning so that prior steps forward are not negated.

In regards to the plan needing to be developed with input from "the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing," we applaud the person- and family-centered approach taken. However, we remind CMS that children involved with the child welfare and foster care systems—though the beneficiary of services—are not always competent to be heavily

involved in the process or in the case of strained familial relations, to be the ones determining who is involved. Similarly, much of this population has limited contact with certain members of their family, so we urge language be added to ensure that "family" is broadly interpreted to include guardians and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, and group or residential care staff).

MCCA urges that the federal government allow Missouri's family support team plan to be used as the rehabilitation plan blueprint, rather than establishing yet another plan. This would reduce the duplication of paperwork and allow more resources to go to the children and families by the private agencies who serve them.

440.130(d)(1)(vi), Restorative services: Restorative services and thus covered rehabilitative services, under the proposed definition, are contingent upon the individual having experienced a functional loss and having had the *ability* to perform the function in the past (and not necessarily having actually performed it). This definition affords fair latitude in the adult context, but does not properly consider children and their special circumstances. A child may not have experienced a "functional loss" per se and/or have had the ability to perform the function in the past because simply, it was not age appropriate for him/her to have had the ability. In that situation, it is the very point of rehabilitative services to fill that deficiency and seek to bring the child to an age- or developmentally-appropriate level. This definition should be more child-aware such that even if a child did not have the ability to perform the function in the past, restorative services and thus rehabilitative services include services to enable that child to achieve age-appropriate growth and development.

MCCA agrees that rehabilitative services' goal is not just to maintain functioning, but to move the individual toward recovery and towards permanency for a youth. It is difficult, however, to continue the individual—in our case a vulnerable child or youth—on the path towards *meaningful* recovery if at the moment s/he reaches the originally stated goal, services and accompanying funds are withdrawn. Were that to happen, the child's progress would be nullified, his/her health would likely rapidly deteriorate—only requiring more intensive and more costly intervention at a later date that could possibly force the child into a more institutional setting. Maintaining functioning should be a permissible goal as long as they continue to move towards their goals of permanency under the rehabilitation plan if the child/youth's would otherwise deteriorate.

440.130(d)(2), Scope of services: This provision maintains the definition of rehabilitative services as "medical or remedial services," but to more accurately reflect the entire proposed regulation that encompasses certain "restorative services" as covered rehabilitative services (440.130(d)(1)(vi)), the phrase 'restorative services' should be added.

440.130(d)(3), Written rehabilitation plan: MCCA supports the written rehabilitation plan's goals of transparency and ensuring that "services are designed and coordinated to lead the goals set forth in the statute and regulation" and the general avenues taken to achieve those goals. We submit only the following clarification questions and recommendations:

The written rehabilitation plan should be able to be integrated with any concurrent family support/health plans that the child has. We urge CMS to consider allowing the Family Support Plan to be used as the rehabilitation plan. This will lessen administrative burden and by crossing system lines, work towards a more integrated, effective structure for the child.

MCCA appreciates the desire to have surrounding parties involved in the development, review, and modification of the plan goals and services, but hopes to have language added that acknowledges the very different situation held by children involved with the child welfare and foster care systems. These children, especially those who have had parental rights terminated and are in the custody of the state, may not have familial support or input to turn to. We therefore recommend adding to 430.130(d)(3)(ii) and (iii) (or alternatively, to a new subsection) the following language: "For a recipient involved with the child welfare or foster care systems, input or guidance in the development, review, and modification of plan goals and services may be obtained from the child's parents when appropriate, guardians, and/or

caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, and group or residential care staff)."

Along similar lines, while CMS is properly hoping for a person-centered process by requiring the involvement of the individual in the development, review, and modification of the plan, a child may not always be competent to participate. Language or a new subsection should be inserted stating that "A child under 18 should be actively involved in the development, review, and modification of the plan if deemed developmentally ready and appropriate."

If the child is deemed competent to participate in the process, any materials provided to the child to inform him/her should be age- and developmentally appropriate and the plan should be thoroughly explained to the child. The plan, on a more general note, should be culturally appropriate and plainly understandable by those who are involved.

In regards to 440.130(d)(3)(xi) that requires the written plan to indicate the extent to which services may be available from alternate providers, a standardized list of alternate providers should be acceptable (to lessen administrative burden of repeating this process)

440.130(d)(3)(xii) requires the written plan to include the individual's "relevant history, current medical findings, contraindications, and identify the individual's care coordination needs." This is important, but is not always possible. Because the children who MCCA and its members serve are often moved frequently through the system and between placements and because of other uncontrollable factors such as lapses in health care, relevant history and current medical findings may not be accessible. The child may not have even had a primary care doctor. This subsection should emphasis that the written plan should reference these documents *when possible*

441.45(b) Newly Deemed Non-Covered Services, Intrinsic Element Standard:

MCCA wholeheartedly desires for providers to properly and accurately bill various, distinct programs, including Medicaid, and appreciates CMS's attempts to draw more recognizable lines. However, we feel that 441.45(b), which would put in place an "intrinsic element" standard, is a disproportionately large reaction to the situation and any existing concerns. Gradual changes are occasionally needed to better programs and services, but we do not view 441.45(b) as an improvement and instead see it as an enormous step backwards with a devastating real world impact.

Rather than making such sweeping changes through rulemaking, MCCA believes that these important decisions that impact vital community-based services should be debated thoroughly and done through the legislative process. It is our understanding that some of this debate already occurred when Congress deliberated over the Deficit Reduction Act of 2005 (DRA, P.L 109-171). During that process, Congress specifically rejected adopting the "intrinsic elements" test for Medicaid rehabilitative services that CMS-2261-P would put in place. This indicates that Congress foresaw the dangers of such language and instead, allows for Medicaid rehabilitative services to remain a strong and viable stream of care. This language proposed in 440.145(b) seems to do the exact opposite, as it will ultimately burden already struggling systems and restrict access to services for some of the most vulnerable segments of the Medicaid beneficiary population, including children in foster care.

We are further concerned that 440 45(b) provides no guidance on how to determine whether a service is an "intrinsic element" of a program other than Medicaid and rather, seems to charge ahead, listing certain public programs such as child welfare and foster care as likely targets. It does recognize that these public programs are broad and to sweep them all into one general classification does not describe the full picture. The child welfare system's role is to respond to reports of abuse and neglect, help at risk families, and find safe, permanent, safe and secure homes for children. Part of this equation is to assist children who have suffered trauma in the recovery process and to help locate adequate services when the child has been removed from his/her family. Child welfare, however, is not qualified to provide certain services and because the system instead merely acts as a go-between, Medicaid rehabilitative services are not "intrinsic to" child welfare.

Similarly, medicaid rehabilitative services are not "intrinsic to" foster care. Title IV-E, Section 475(4) of the Social Security Act and the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20 state that foster care maintenance payments are "to cover the cost of (and the 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 for a child's visitation with family, or other caretakers." Clarifying further that rehabilitative services are not intrinsic to foster care, the Code of Federal Regulations prohibits States from claiming Title IV-E federal financial participation (FFP) for "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*" (45 CFR, Chapter XIII, Part 1356.60(c)(3)) (emphasis added). States have more discretion under Title IV-B, but because its primary purpose is not to provide medical assistance, rehabilitative services are not "intrinsic to" it either. Moreover, IV-B is a capped program that does not envision providing and is not able to provide all necessary services.

MCCA envisions and has long advocated for the child welfare system and Medicaid to work collaboratively towards the wellbeing and healthy development of each child in its care. It is essential that the systems work together rather than one stepping completely out of the picture, as 441.45 permits Medicaid to do in certain vital circumstances. The section also completely defeats the Substance Abuse and Mental Health Services Administration's (SAMHSA) diligent work to promote a system of care that provides a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. *As such, MCCA strongly urges 441.45(b) to be wholly dropped.*

441.45(b)(1)(i) and (ii), Therapeutic Foster Care and Packaged Services Furnished by Foster Care and Child Care Institutions: MCCA wishes to specifically address the exclusion of therapeutic foster care services except for 'medically necessary rehabilitative services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers' (441.45(b)(1)(i)) and similar packaged services furnished by foster care or child care institutions (445.45(b)(1)(ii)) from the definition of Medicaid rehabilitative services. As the Surgeon General indicated in his 1999 report on mental health, with care provided in private homes with specially trained foster parents, therapeutic foster care is considered "the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders." It provides evidence-based care for children who otherwise would be placed in more institutional and costly settings—settings which can also reap emotional tolls on children and their families. The Surgeon General recommended therapeutic foster care as a community-based avenue forward for children's health and it also seems very in line with the report issued by the President's New Freedom Commission on Mental Health.

Unfortunately, the proposed language, while not explicitly prohibiting therapeutic foster care, whittles away at its core so much that access will surely be restricted, if not completely shut off. As a result, because there is a continuum of care in foster care, children who cannot be maintained be in regular foster care due to serious emotional or other health issues will be forced into more restrictive and more costly settings.

Only therapeutic foster care services that are 'clearly distinct from packaged therapeutic foster care services' could be billed as rehabilitative services, but it is unclear what is meant by 'clearly distinct." MCCA strongly advocates that states be afforded the discretion to define therapeutic foster care as a single service and pay through a case, daily, or appropriate mechanism. Packaged services allow the necessary amount of time and attention to be spent on children suffering from intense mental issues. The alternative imposes the significant administrative burden of relegating activities into somewhat arbitrary time blocks, which ultimately takes time away from the child and reduces services' effectiveness and the child's progress.

CONCLUSION

On behalf of MCCA, its members, and the children and families we serve, we thank you for the opportunity to comment on this proposed rule. We hope that as we move forward with this process, we

will wo[illegible] only then can we ensure that children and the[illegible] mental health needs are made a national priority.

MCCA would like to thank the Child Welfare League of America for their assistance in helping MCCA put together these comments.

In summary, MCCA recommends:

- Supports transparency of the Medicaid Rehabilitative Option which promotes a higher degree of administrative and managerial integrity while simultaneously focusing on a positive, effective outcome through person-centered practice;
- Re[illegible] that there is a direct impact on providers by changing the scope of services and [illegible] responsibility government has towards foster children by withdrawing significant federal resources is completed;
- Develop an understanding that foster children have unique needs and need more than room, board and [illegible] supervision as they move towards a successful permanency plan and home;
- [illegible] latitude in the definition of a qualified provider of rehabilitative services;
- Accept a child welfare treatment plan, also known as a family support team plan in Missouri, for the Rehabilitation plan decreasing need for duplication of paper work and directing those [illegible] to treatment;
- [illegible] services" in the definition of rehabilitative services;
- [illegible] section 44[illegible].45(6), "intrinsic" element from the proposed regulations;
- Revise section 441.45(b) (1, (i) and (ii) to include therapeutic foster care as a medically [illegible] services and to allow packaged services to be provided by a foster care [illegible] residential treatment center because of the distinct needs of foster children. Further to clarify what "clearly distinct packaged therapeutic foster care" is. Ambiguity exists allowing for individual discretion interpretation.

Again, thank you for the opportunity to comment.

Sincerely
The Board [illegible] Missouri Coalition of Children's Agencies (MCCA)

Mike Bren[illegible], St. [illegible] - Chair
Evangelic[illegible]

Kevin [illegible] - Chair [illegible]
Good Samaritan Boys Ranch

Mike Fitzg[illegible] Treasurer
Catholic Charities of St. Louis

Jim Bra[illegible]
Youth [illegible]

John Can[illegible]
Butterfie[illegible]

Dr. Stephen [illegible]
Crittenton [illegible]

Wayne [illegible] St. Louis
Edgew[illegible]

Kevin Dre[illegible]nger, St. Louis
Epworth

Paul Gemeinhardt, Kansas City
Cornerstones of Care

Randi Howard, St. Louis
Bringing Families Together

Vince Hillyer, St. James
Boys and Girls Town of Missouri

Scott Hummel, St. Louis
Bringing Families Together

Laurie Jackson, Kansas City
Synergy Services

Russel Martin, St. Louis
Missouri Baptist Children's Home

Lee Ann Taylor, St Louis
Father Dunne's/Good Shepard

Jim Thurman, St. Louis
Presbyterian Children's Services

CMS-2261-P-1152

Submitter : Ms. Eve Becker-Doyle **Date:** 10/12/2007

Organization : National Athletic Trainers' Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment for comments on CMS 2261-P from the National Athletic Trainers' Association.

CMS-2261-P-1152-Attach-1.DOC

CMS-2261-P-1152-Attach-2.DOC

#1152

October 12, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8050

Submitted electronically

Re: Medicaid Program: Coverage for Rehabilitative Services Proposed Rule

Dear Mr. Weems:

These comments are submitted on behalf of the National Athletic Trainers' Association (NATA) and the 30,000 licensed and certified athletic trainers we represent. Thank you for the opportunity to comment.

Athletic trainers are fully qualified to perform rehabilitative services, and are part of the physical medicine and rehabilitation medical team. Our review of the proposed changes appears to give states broad latitude to recognize those health professionals authorized by state law or state regulatory mechanism to provide physical medicine and rehabilitation services, as long as those health professionals are acting within the scope of their practice as defined by the state.

Athletic trainers work in collaboration with physicians and, in most cases, practice under the referral or direction of physicians. In almost all cases, there is a physician who is responsible for the care provided by the Athletic Trainer to the patient although the physician is not typically on-site supervising the work of the athletic trainer. The physician/athletic trainer relationship is similar to that of other mid-level health care providers.

Athletic trainers are licensed or regulated and authorized in 46 states to provide physical medicine and rehabilitation services to individuals in a variety of settings, including secondary schools and outpatient clinics.

Our comments are directed at the MEDICAID PROGRAM COVERAGE FOR REHABILITATIVE SERVICES PROPOSED RULE.

In General

Athletic trainers (AT) are a vital part of the public health care system. As you might imagine, many athletic trainers work in high schools throughout the United States and as such, come into contact with many children and young adults whose health care is paid for by the Medicaid program.

Athletic trainers are historically known for providing injury prevention, assessment, treatment and rehabilitation to active individuals. It would not be uncommon for an athletic trainer to see and provide rehabilitation services to individuals covered by a state's Medicaid program.

Also, because of their specialized skills in treating musculoskeletal injuries and illnesses, ATs often work in hospital and other outpatient therapy clinics for which Medicaid reimbursement might be sought by the hospital or clinic that employs the athletic trainer.

Overview

The current definition of rehabilitation services is rather broad and could cover a wide variety of services for which coverage may not have been intended. CMS is proposing to clarify coverage requirements by establishing formal definitions for words that previously were left up to the state to define. Current Medicaid requirements for coverage of a "Rehabilitative Service" are:

> *"...any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."*

In lieu of this brief description, CMS now proposes to insert the following new language:

1. Proposed Change to 440.130

(d) Rehabilitative Services - 1

Definitions. For purposes of this subpart, the following definitions apply:

> ***(i) Recommended by a physician or other licensed practitioner of the healing arts means that a physician or other licensed practitioner of the healing arts, based on a comprehensive assessment of the individual, has—***
>
> > ***(A) Determined that receipt of rehabilitative services would result in reduction of the individual's physical or mental disability and restoration to the best possible functional level of the individual; and***
> >
> > ***(B) Recommended the rehabilitative services to achieve specific individualized goals.***

Discussion of proposed change to 440.130(1)(d)(i)

NATA believes this is an appropriate clarification of policy as it establishes the need for a comprehensive assessment, retains the states flexibility to base coverage on the authority of the physician or other licensed practitioner of the healing arts to determine the appropriateness of care and assess the outcome of that care in terms of restoration of the individuals best functional level.

We recommend adoption of proposed 440.130(1)(d)(i)

2. **Proposed Change to 440.130(1)(d)(ii)**

> ***(ii) Other licensed practitioner of the healing arts means any health practitioner or practitioner of the healing arts who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.***

We recommend adoption of proposed 440.130(1)(d)(ii)

3. **Proposed Change to 440.130(1)(d)(iii)**

> ***(iii) Qualified providers of rehabilitative services means individuals who meet any applicable provider qualifications under Federal law that would be applicable to the same service when it is furnished under other Medicaid benefit categories, qualifications under applicable State scope of practice laws, and any additional qualifications set forth in the Medicaid State plan. These qualifications may include minimum age requirements, education, work experience, training, credentialing, supervision and licensing requirements that are applied uniformly. Provider qualifications must be documented in the State plan and be reasonable given the nature of the service provided and the population served. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.***

Discussion of proposed change to 440.130(1)(d)(iii)

Our interpretation of this modification is that as long as an individual is otherwise qualified to provide the service under state law or state regulatory mechanism and not otherwise prohibited from providing the service under some other Medicaid provision, the individual would be considered a "qualified provider of rehabilitative services".

We are concerned about specific references in the introductory comments describing the intent behind these changes. Specific references to physical therapy, occupational therapy and speech language and hearing pathology services is confusing. As you have

noted. The term rehabilitative services covers a broad spectrum of services, which can be provided by a wide variety of providers.

Athletic trainers provide many of the same services that might be generically referred to as "physical therapy" but which are more accurately described as physical medicine or rehabilitation. **We strongly recommend that you delete any reference to "physical therapy" or other specific therapy providers as these are not the same as rehabilitative services and could cause some to believe that only physical therapists are eligible to provide certain rehabilitative services to Medicaid recipients.**

<u>We recommend adoption of proposed 440.130(1)(d)(iii)</u>

4. Proposed change to 440.130(1)(d)(iv)

> ***(iv) Under the direction of means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see § 440.110, "Inpatient hospital services, other than services in an institution for mental diseases") the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the supervision of services and ongoing involvement in the treatment. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.***

<u>Discussion of proposed change to 440.130(1)(d)(iv)</u>

As previously noted, athletic trainers are state licensed and certified to provide a wide range of physical medicine and rehabilitation services. The references in this revision to CFR 440.110 and the parenthetical mention of "Inpatient hospital services, other than services in an institution for mental diseases" are confusing. Section 440.110 of the CFR deals with standards for "Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders." Not inpatient hospital services as the reference implies. It is also not clear **whether this language refers to only those**

services that would be considered "physical therapy" versus physical medicine and rehabilitation?

The rest of the revised language appears to give states broad latitude in deciding what type of health professional can be covered to provide rehabilitation services and we support that language.

<u>We recommend revising the proposed change to 440.130(1)(d)(iv)</u>

We propose that that the words

> "that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see § 440.110, "Inpatient hospital services, other than services in an institution for mental diseases")"

be stricken and the new language read as follows:

> *(iv) Under the direction of means that the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the provision of services and ongoing involvement in the treatment. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.*

5. Proposed Change to 440.130(1)(d)(v)

> ***(v) Rehabilitation plan means a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals. The plan is developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing and also ensures the active participation of the individual, individual's family, individual's authorized decision maker and/or of the***

individual's choosing in the development, review, and modification of the goals and services. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition. The plan must have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. The plan must be reasonable and based on the individual's condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individual's condition(s).

<u>We recommend adoption of proposed 440.130(1)(d)(v)</u>

6. Proposed change to 440.130(1)(d)(vi)

(vi) Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past. For example, a person may not have needed to take public transportation in the past, but may have had the ability to do so prior to having the disability. Rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services.

<u>Discussion of proposed change to 440.130(1)(d)(vi)</u>

We appreciate the broad interpretation of the term restorative services. The language provides states with guidance on what is meant by restorative services without being overly constraining or restrictive on the types of personnel who can be utilized to provide these services. As we have noted in earlier comments, **the use of broad terms such as "restorative" or "rehabilitation" rather than more restrictive terms such as "physical therapy" when it comes to physical medicine and rehabilitation services is appropriate and avoids unnecessary confusion.**

<u>We recommend adoption of proposed 440.130(1)(d)(vi)</u>

7. Proposed change to 440.130(1)(d)(vii)

(vii) Medical services means services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care of a physical or mental disorder and are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Medical

> ***services may include physical therapy, occupational therapy, speech therapy, and mental health and substance-related disorder rehabilitative services.***

<u>Discussion of proposed change to 440.130(1)(d)(vii)</u>

Rehabilitative services provided by athletic trainers working under physician supervision are considered physical medicine. Therefore these services would be covered under the definition you propose. Giving states the ability to recognize or pay for therapy as a subset of medicine is appropriate.

What is not clear is what would constitute "physical therapy"? To the extent physical therapy is a service provided by a physical therapist, then we would not object to the proposed inclusion of this terms within the definition of "medical service". However some may seek to broadly define "physical therapy" as any rehabilitative service that is provided to a patient in need of physical medicine and then **seek to restrict the delivery** of physical medicine and rehabilitation therapy to individuals meeting the state definition of physical therapist.

Just as medical services can be provided by a broad range of health professionals (physicians, physician assistants, nurse practitioners, nurse midwives, etc.) so too can rehabilitation services be provided by a broad range of health professionals. Your language acknowledges that states permit many health professionals to provide medical services by inclusion of the language "other licensed practitioner of the healing arts within the scope of his or her practice under State law".

As the language is permissive (i.e. states "may") rather than mandatory, we do not believe this language will cause any confusion regarding the ability of the full range of health professionals to provide medical rehabilitation services.

<u>We recommend adoption of 440.130(1)(d)(vii)</u>

8. Proposed change to 440.130(1)(d)(viii)

(viii) Remedial services means services that are intended to correct a physical or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.

<u>We recommend adoption of 440.130(1)(d)(viii)</u>

9. Proposed Change to 440.130(2)

> ***(2) Scope of services. Except as otherwise provided under this subpart, rehabilitative services include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a individual to the best possible functional level.***

Rehabilitative services may include assistive devices, medical equipment and supplies, not otherwise covered under the plan, which are determined necessary to the achievement of the individual's rehabilitation goals. Rehabilitative services do not include room and board in an institution or community setting.

<u>We recommend adoption of the proposed change to 440.130(2)</u>

<u>10. Proposed change to 440.130(3)</u>

(3) Written rehabilitation plan.

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

<u>Discussion of proposed changes to 440.130(3)</u>

The practice of medicine is both and art as well as a science. Each patient is different and the way a patient will respond to treatment will be different. While development of a rehabilitation plan of care is reasonable and appropriate, it is often difficult to predict the way the patient will respond to that treatment plan. It is often necessary to adjust a plan during the course of treatment. This could mean longer duration of treatment or shorter duration of treatment. Athletic trainers find shorter total duration of therapy to be particularly true when working with younger patients. In other words, many patients recover from injuries faster.

We are concerned that the proscriptive nature of this section could be disruptive to the rehabilitation of individuals. In the worst case situation, the language could force a provider to prematurely reduce the level of care to individuals in need of physical rehabilitation, which could reduce the accelerated return to activity that is the specialty of athletic trainers.

It is common that, within a plan of care, student-athletes are treated more frequently but for a shorter duration of time. This allows for quick recovery at less cost to the health care system. Otherwise, the proposed requirements for a written rehabilitation plan are acceptable.

<u>We encourage CMS to reexamine this language to ensure that health professionals have sufficient flexibility to adjust a plan of care and carry out the adjusted plan of care in a way that best suits the rehabilitation needs of the patient.</u>

11. Proposed change to 440.130(5)

(5) Settings. Rehabilitative services may be provided in a facility, home, or other setting.

Discussion of proposed change

42 percent of secondary schools have access to an athletic trainer and on-site athletic training facilities are very common in secondary and middle schools. These athletic training facilities—sometimes called sports medicine facilities—are where rehabilitation services are delivered. It is important for patient continuity of care that rehabilitation started in these facilities be completed in these facilities, whenever possible.

We appreciate the recognition by CMS that rehabilitative services can be delivered in a variety of settings and that no limitations have been placed on where these services can be delivered.

We recommend adoption of the proposed change to 440.130(5)

12. Proposed creation of a new 441.45 Rehabilitative services.

Discussion of the creation of a new 441.45 Rehabilitative Services.

It is essential that Medicaid beneficiaries have the freedom of choice of qualified providers as determined by the State. As more and more athletic trainers provide physical medicine and rehabilitation services to high school students, many of whom may be covered by the Medicaid program, it is critical that the states have the authority to cover these rehabilitative services if provided by a state licensed and physician supervised athletic trainer. The athletic training room in the high school may be the least restrictive and most accessible location for the delivery of physical medicine and rehabilitation services to these high school students.

13. Proposed limitations on covered services 441.45(b)(3)

> ***(3) Recreational or social activities that are not focused on rehabilitation and not provided by a Medicaid qualified provider…***

NATA points out that athletic training services provided by athletic trainers are typically defined as physical medicine or rehabilitation services. However, there are some elements of athletic training services that are non-medical in nature. It is noted that Medicaid would not reimburse for non-medical services. Only those services that are medical, rehabilitative or, depending on individual State Medicaid rules, performed in order to prevent the worsening of an injury would be subject to reimbursement.

The services performed by athletic trainers, as described in this paper, are not intrinsic elements of program other than Medicaid. In other words, these services are not reimbursable by any other federal or state government health care programs. If a service was determined to be recreational in nature, it would not be subject to reimbursement by Medicaid.

CMS is encouraged to allow states, through the Medicaid program, to explore the beneficial patient outcomes and cost effectiveness of early intervention of injury and illness provided by athletic trainers. Athletic trainers have found that preventing an injury from worsening often means a reduction of physical disability, faster recovery from injury and an improved quality of life over a lifetime. We would be pleased to consider a Medicaid demonstration or similar project with states and CMS.

14. Regulatory Impact Analysis: Overall Impact

> *The Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule.*

Discussion of the impact

NATA and its 30,000 athletic trainer members have serious concerns that the Secretary may not have considered the role of athletic trainers in providing physical medicine and rehabilitation medical care to Medicaid beneficiaries. Despite the use of what appears to be broad, inclusive language, we are concerned about possible "unintended consequences."

Athletic trainers have a 55 year history of working with student athletes and other individuals benefiting from the public health system. Because of our history of working under the direction of a physician and not commonly billing directly for services, the positive impact and benefits have not been widely known. It is our desire to make CMS aware of the vital role of athletic trainers as qualified providers.

Consequently, we are taking this opportunity to share with you information about Athletic trainer education and credentialing so you can be better informed about the role and responsibilities of athletic trainers in our health care delivery system.

Increasingly, physicians are turning to other health care professionals to provide therapy services to their patients for quality, access and cost reasons. One approach has been to hire certified athletic trainers to provide these services in the physician's office under the direct supervision of the physician.

Education and Training of Certified Athletic Trainers

Certified athletic trainers have national academic and certification standards. ATs are highly educated allied health care professionals who specialize in the prevention, assessment, treatment and rehabilitation of injuries and illnesses that occur to both the physically active and athletes of all ages. All ATs have a bachelor's degree, and almost 70 percent have a master's degree. Medically related continuing education is required to

maintain certification. The athletic training profession has recognized as allied health care profession since 1990. It should be noted that athletic trainers and personal trainers are different: personal trainers are concerned with fitness and aesthetics not health care.

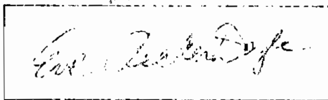
Athletic trainers work in a wide array of settings, including clinics, hospitals, physicians' offices, corporate health programs, secondary schools, colleges and universities, and professional athletics. ATs satisfy stringent educational and experiential requirements, and are required to pass an extensive competency examination administered by the Board of Certification Inc. (BOC). The BOC is reviewed and re-accredited every five years by the National Commission for Certifying Agencies.

The coursework for ATs includes therapeutic modalities and exercise, risk management and injury prevention, pathology of injury and illnesses, pharmacology, nutritional aspects of injury and illness, and health care administration. Further, ATs practice in collaboration with physicians, generally under referral or direction.

Conclusion

Thank you for the opportunity to voice NATA's concerns. We look forward to receiving information on the CMS decision after the comment period. If you need any additional information or would like clarification of any of NATA's points, please contact Patty Ellis at (1-800-879-6282) or our Washington Representative, Bill Finerfrock (202-544-1880).

Sincerely,



Eve Becker-Doyle, CAE
Executive Director
National Athletic Trainers' Association
2952 Stemmons Free Way, Ste. 200
Dallas, Texas 75247
www.NATA.org

Cbl/regulatory/Medicaid_Coverage for RehabilitativeServices_2261-P_final_101207

Submitter : Ms. Leah Keyes **Date:** 10/12/2007

Organization : AR Chapter of Foster Family Based Treatment Assoc.

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

On behalf of the Arkansas Chapter of the Foster Family-Based Treatment Association, our chapter is in total support of the recommendations/comments made by the Foster Family-Based Treatment Association Policy Committee, located at 294 Union Street, Hackensack, New Jersey 07601.

Submitter : Mr. scott mayo **Date:** 10/12/2007

Organization : maine center for integrated rehabilitation

Category : Other Health Care Provider

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I would like to request the definition of rehabilitation include ' for maintenance of a state that would otherwise deteriorate in the absence of the service'. I work for people that have acquired brain injuries and the effects of these injuries are often long term and/or lifelong. I have seen many lives improve with 'maintenance' type services. Some of these changes are: returning to live independently, return to paid employment, decreased maladaptive behavior and a decreased dependence on medications. The list is long the successes cover a multitude of domains. I would also like to advocate for the continuation of bundled rates. Many of the tasks and activities we perform on a daily basis will no longer be services our organization can afford to provide. Ultimately the survivor of the brain injury will be the loser and that isn't right. I know the current war we are in has a signature wound, in this case it is brain injury. I hope our brave men and women serving in the military who unfortunately return home with a brain injury will not be negatively effected by this rule change. I hope that impact is not felt in their short term or long term recovery, they like all brain injury survivors should have thc right to have services that will assist them to live a life with quality. I wonder if any research has been completed to determine if changing the rule would actually save money. Will the elimination of maintenance rehabilitaion be cost effective if the loss of these services ultimately requires more expcnsive services as the individuals deteriorate in their ablities to care and provide for themselves. I also wonder considering all this the ethics of saving these individuals lives from severe injury then not providing services to allow them any quality of life. Thank you for your consideration of my comments.

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

Organization :

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1155-Attach-1.PDF

#1155

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

October 12, 2007

Kerry Weems
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2166-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS 2261-P; Comments on Proposed Rule Medicaid Program;
Coverage for Rehabilitative Services, 72FR 45201

The Michigan Department of Community Health (MDCH), Medical Services Administration respectfully submits this comment document regarding proposed federal rule CMS-2261-P.

Definition of Rehabilitative Services for Children

It is imperative that CMS clarify the definition of rehabilitative services to recognize services for children. The proper definition of rehabilitative services should read as follows:

Rehabilitative services are defined as restorative when the goal is a functional improvement that is significant to the beneficiary's health or ability to perform activities of daily living appropriate to his/her maximum functional capacity, e.g. cognitive, expressive, receptive levels. Rehabilitation means restoration to a previous functional level if the disease or injury occurred after the age at which the beneficiary was able to perform at a specific functional level or to attain the functional level that he/she is capable of achieving with the existence of a medical condition.

Recognizing this definition is a critical component of the regulations for Medicaid coverage of children's services.

School Based Services Program Coverage of Rehabilitative Services

It appears these regulations will eliminate Medicaid coverage of all rehabilitative IDEA/IEP/IFSP services provided in the school setting. The Medicare Catastrophic Coverage Act (MCCA) of 1988 amended Section 1903(c) of the Social Security Act to permit Medicaid payment for medical services provided to children under IDEA that are included in an IEP or IFSP.

Please advise what authority would permit CMS to effectively repeal this provision of the MCCA statute through federal rulemaking. It is our contention that these proposed regulations are in violation of Section 1903(c) of the Act which states: "Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act."

If these regulations are finalized as proposed, CMS must clarify what, if any rehabilitative services may be provided by school providers and include that clarification in the regulations.

State Plan Amendments

Michigan currently has a State Plan Amendment (SPA) for School Based Services Program coverage and reimbursement under review by CMS. How will these proposed regulations impact SPAs currently under review?

Intrinsic Element Restriction

The regulations must define how an intrinsic element test will be devised and what services would be excluded from coverage. The test must not have the impact of mandating services that must be provided by other programs. This information is necessary to assess the impact an intrinsic element restriction would have on Medicaid beneficiaries.

The program funding source should be a factor in determining if a service is an intrinsic element of a program. For example, if no IDEA dollars are used to fund Medicaid School Based Services, we assert that these services are not an intrinsic element of that program.

The language in the regulations must provide more specific detail and not rely on implications described in the preamble language. The language needs to be specific enough to give States the clear direction necessary to implement the regulations.

Rehabilitative Services under EPSDT

Further, the regulations must clarify if CMS will also apply the intrinsic element restriction to rehabilitative services approved and provided under the EPSDT program, including EPSDT rehabilitative services provided under IDEA.

CMS must also clarify if services that are determined to be "habilitative" rather than "rehabilitative" can be covered under the EPSDT program

Habilitative Services

Finally, the regulations must clarify if the intrinsic element restriction will also be applied to habilitative services that are provided either under a waiver or as an established state plan service. The regulations must also confirm that habilitative services provided under a waiver may include any habilitative services provided under IDEA and included in an IEP/IFSP.

We appreciate your review and consideration of Michigan's comments and concerns regarding this proposed rule. The Michigan Department of Community Health, Medical Services Administration strongly objects to any revisions that would eliminate Medicaid coverage in the school setting as established under Federal law.

Sincerely,

Paul Reinhart, Director
Medical Services Administration

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

Organization : **parent**

Category : **Individual**

Issue Areas/Comments

Background

Background

Please have an open forum on plan. What you are planning to delete with severly effect my son services

CMS-2261-P-1157

Submitter : Mr. Daniel Prince **Date:** 10/12/2007

Organization : State of NV Division of Child and Family Services

Category : Individual

Issue Areas/Comments

Background

Background

See Attachment

Collections of Information Requirements

Collections of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Response to Comments

Response to Comments

See Attachment

CMS-2261-P-1157-Attach-1.DOC

CMS-2261-P-1157-Attach-2.DOC

#1158

JIM GIBBONS
Governor

MICHAEL J. WILLDEN
Director

STATE OF NEVADA

FERNANDO SERRANO
Administrator

DAN PRINCE
Deputy Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD AND FAMILY SERVICES
JUVENILE JUSTICE SERVICES
6171 West Charleston Boulevard, Building No. 14
Las Vegas, Nevada 89146
Telephone: (702) 486-5095 • Fax: (702) 486-5089

MEMORANDUM

DATE: October 12, 2007

TO: Centers for Medicaid & Medicaid Services
Department of Health and Human Services

FROM: Daniel Prince, Deputy Administrator
Nevada Division of Child and Family Services

RE: CMS – 2261 - P

Comments Regarding the Proposed Rule for Coverage for Rehabilitative Services
Written Rehabilitative Plan: 440.130 (d) (3)

- The requirement for a Written Rehabilitative Plan adds another plan required for recipients of mental health services. Potentially a single recipient could have a treatment plan, a targeted case management plan and a rehabilitative plan.

  Recommendation: Allow for a rehabilitative plan as either a stand-alone plan or as part of a treatment or targeted case management plan to support single coordinated behavioral health plans for a recipient. This would support stronger care coordination and integration of behavioral health services for the recipient.

- The expectation for the involvement of the beneficiary child's family in the re-evaluation of the rehabilitative plan is a positive addition to the regulations.

  Recommendation: Strengthen the family involvement further by requiring the involvement of the beneficiary, family or other responsible individuals in the development and re-evaluations of plans.

Requirements for Rehabilitative Services

- **Requirement that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for maximum reduction of physical or mental**

disability and restoration of the individual to the best possible functional level: 441.45 (a) (2)

Recommendation: Add language describing when rehabilitative services may be used to retain or maintain functioning.

Limitations for Rehabilitative Services

- **Exclusion of coverage of rehabilitative services that are furnished through a non-medical program...such as foster care, child welfare, education, child care, vocational and pre-vocational training, parole and probation, juvenile justice, or public guardianship...intrinsic elements: 441.45 (b) (1)**

  There is no clear definition of "intrinsic elements." This section would deny covered Medicaid services for a covered Medicaid recipient if that recipient is involved in other public programs. This proposed rule would deny medically necessary services to a Medicaid recipient, in direct contradiction of federal statute 42 U.S.C. 1396.

  The provision of services to non-Medicaid eligible recipients through other federal and/or state funding sources should not deny Medicaid participation by a Medicaid recipient. Per the proposed language in this section, "enrollment in these non-medical programs does not affect eligibility for Title XIX services."

  In addition, Rehabilitative Services are community-based and in a facility, home, or other setting per 440.130 (d) (5). They need to be provided in the community-settings that best meet the rehabilitative needs of the recipient. For children with serious emotional disturbances, they may need rehabilitative services in their family home or their foster home; in their child care center or school classroom, etc. Rehabilitative services address the child's functional impairment rehabilitative needs, not their caretaking or education, and therefore are not duplicative of other services.

  Recommendation: Delete this entire section

- **Therapeutic Foster Care is denied reimbursement as a single service type: 441.45 (b) (1)**

  Therapeutic foster care is the least restrictive level of residential treatment care for a child with a serious emotional disturbance. It has been established as an evidence-based practice over multiple research studies. Therapeutic foster care is not and should not be a treatment service type that is limited to children in the child welfare system. In Nevada, children in parent/family custody and children in public custody are eligible for therapeutic foster care if they meet medical necessity criteria. Many of these children meet medical necessity criteria for residential treatment center care and are treated in therapeutic foster care as the least restrictive level of care that can meet their needs. This regulation would require that each component of therapeutic foster care be billed separately. This will greatly increase administrative work – from direct treatment providers through support functions such as billing and a resultant increase in costs for this service.

  Recommendation: Therapeutic foster care/treatment homes should be listed as a Rehabilitative Option service type and paid through a single rate. It should be listed as a

covered service for children with serious emotional disturbances whose least restrictive level of treatment is residential treatment.

Regulatory Impact Analysis

Only the impact to Federal Medicaid spending on Rehabilitative Services was analyzed. It appears that because Fee for Service will be excluded from rehabilitative services that are included in other federal, state and local programs these costs are being shifted to other federal streams as well as state and local funding streams.

Recommendation: CMS in collaboration with other federal agencies such as the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, Department of Education, Office of Juvenile Justice and Delinquency Prevention should analyze the impact of the proposed regulation changes on other federal programs as well as the impact on state and local funding streams.

Concerns regarding Medicaid coverage of services that are intrinsic elements of other programs are raised in CMS 2261-P and are disallowed in 441.45 (b) (1) while it is affirmed that enrollment in these non-medical programs does not affect eligibility for Title XIX services.

Recommendation: CMS in collaboration with other federal agencies that fund or oversee the program cited under intrinsic elements map out how services can be coordinated and how funding streams can be utilized to develop rate methodologies.

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

The inclusion in this definition on covering rehabilitative services for an individual who may not have had the ability in the past is important for children and adolescents who may never have achieved a functional ability that is an age-appropriate functional ability. This definition also recognizes that services which provide assistance in maintaining functioning may be considered rehabilitative when necessary to help attain a rehabilitative goal. This language is not included in the Requirements and Limitations for Rehabilitative Services, section 441.45.

Recommendation:

- Include the above cited language in section 441.45.
- Clarify the language further that a child does not have to have achieved a functional ability in the past, as may not have been age or developmentally appropriate
- Clarify when services which provide assistance in maintaining functioning may be considered rehabilitative and add an example for both children and adults

Other Issues Related to CMS – 2261 – P

Covered Services

Services that have been established and recognized nationally as evidence-based practices are not covered.

Recommendation: Add evidence-based practices with the most appropriate rate methodology to the particular practice (e.g. daily) such as therapeutic foster care, multi-dimensional treatment foster care, multi-system therapy, day treatment, etc.

Rate Methodology

The proposed regulation does not specifically address rate methodology. It does however, support rates in 15 minute increments as CMS has begun to require. A change to 15 minute increment billing for many of these services will increase administrative functions and costs which will increase rates and/or decrease direct services to recipients.

Recommendation: CMS work with other federal agencies, states and providers to develop efficient and appropriate rate methodologies for Rehabilitative Services types.

Submitter : Karen Kincaid Dunn

Date: 10/12/2007

Organization : Club Nova Community, Inc.

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

See Two Attachments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I ask for consideration in several areas:

1. At a bare minimum -- time! These proposed rules will drastically undercut our current mental health system, and there is no fall-back funding opportunity. This will cause systemic chaos and people will suffer. Really. Please allow us 12-24 months, if this must happen.

2. Clarification of definitions, especially as it related to rehabilitation and when services can be legitimately billed. I've been through CMS audits and we all suffer when things are vague. These rules are vague.

3. What about kids? How does "restorative" language fit with children who are developing? It doesn't make sense and leaves us in that vague place described in #2.

4. A 16 or 17 point rehabilitation plan? Give us a break on the bureaucratic, mind-numbing documentation that adds no real value. We document carefully now and are happy to do that but let's remember the reason for documentation -- to tell the clinical story, to communicate with other providers, to communicate with the family.

5. Why should we have to list (over and over as we do our plans) a list of other providers? Who does this serve?

6. "Intrinsic elements" of service. Those services are NOT part of therapeutic foster care, probation, welfare or school programming now. Who is going to add them? Who would pay for them? The services won't be provided.

7. How can kids who are placed by the courts into foster care or residential treatment facilities NOT be eligible for MRO services in the same way as other children? Isn't medically necessity the issue rather than where the kid happens to be living or under the court's jurisdiction?

I apologize if there is a negative tone to my comments. I mean no disrespect. I just care about these vulnerable people.

Thank you.

Submitter : **Mr. Mark Trail** **Date: 10/12/2007**

Organization : **Georgia Department of Community Health**

Category : **State Government**

Issue Areas/Comments

Background

Background

see attached

GENERAL

GENERAL

see attachement

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attached

CMS-2261-P-1160-Attach-1.WPD

#1160

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-2261-P, Comments on Proposed Rule *Medicaid Program: Coverage for Rehabilitative Services, 72 FR 45201*

The Georgia Department of Community Health and the Department of Human Resources' Division of Mental Health, Developmental Disabilities, and Addictive Diseases have reviewed the Centers for Medicare and Medicaid Services (CMS) notice of proposed rule making (NPRM) on the coverage for Rehabilitative Services in the Federal Register (72 FR 45201). We appreciate the opportunity to make the following comments on the proposed rule.

1) Section 440.130: Diagnostic, screening, preventative and rehabilitative services; 440.130(d)(1)(ii) "Other licensed practitioner of the healing arts":

   The proposed definition of this term specifies that a licensed practitioner of the healing arts is an individual "who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue". In Georgia, Medicaid rehabilitative services are only provided to those individuals who have verified diagnoses from those who are licensed in the state to diagnose mental illnesses and addictive diseases and services are required to be provided by qualified providers in accordance with the state's practice acts.

   In Georgia, there are three types of licensed practitioners (Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists) who provide treatment for mental illnesses and addictive diseases and who are authorized in the State's practice acts to assess and evaluate, recommend a course of treatment and provide such treatment in independent practice. However, these clinicians are not granted the authority to assign formal diagnoses. Under the proposed definition, they would be unable to perform the statutorily defined function of recommending a course of rehabilitative treatment.

This definition would be extremely detrimental to the public behavioral healthcare system by limiting the pool of available licensed practitioners able to evaluate and recommend medically necessary services for Medicaid recipients to only physicians and psychologists. This would be particularly problematic for Georgia where 72% of counties are designated in whole or in part as mental health professional shortage areas and where it is already difficult for provider agencies to recruit and retain these licensed practitioners. Adoption of this restrictive definition will exacerbate the situation, limit access to medically necessary services, and would challenge the state's ability to comply with the Medicaid "state wideness" tenet.

2) Section 440.130: Diagnostic, screening, preventative and rehabilitative services; 440.130(d)(1)(iv) Definition of "under the direction of":

We have the same concerns as expressed above regarding the definition of "under the direction of". This section describes the direction and supervision of therapies such as physical therapy, occupational therapy and language services, but specifies that this is "not meant to exclude appropriate supervision arrangements for other rehabilitative services." We wholeheartedly agree that services should be provided by or under the direction of qualified providers. In the provision of behavioral healthcare services such as, but not limited to, individual, family, and group therapy, addictions counseling, and community support services, the independently licensed practitioners listed above may, according to state law. perform the direction and supervisory functions for other mental health professionals who operate under their professional responsibility.

The new definition would restrict this function to only those who can diagnose mental illnesses and addictive diseases and there are simply not enough of these professionals (doctoral-level psychologists and physicians) in Georgia to provide appropriate supervision. In addition, although physicians are qualified to diagnose mental illnesses and addictive diseases and prescribe medications to treat these conditions, they are not appropriate clinical supervisors for the provision of services such as psychotherapy, which they themselves are not trained to provide. In Georgia, this would leave only doctoral-level psychologists and psychiatrists to provide supervision for all of the counseling and psychotherapy services provided under the Medicaid program. This is neither practically possible nor economically efficient. Where services could be provided, the costs would be higher and access to medically necessary rehabilitative services would be severely limited.

It appears from the language in this section that CMS meant to include supervision provided by qualified "therapists" and not just physicians,

psychiatrists and psychologists. Again, we recommend removing the requirement that a licensed practitioner of the healing arts must be authorized by the state to diagnose in order to avoid severe restriction of the state's ability to provide needed rehabilitative services. We recommend that CMS continue to permit states to determine their own definition of allowable practitioners within state law.

3) 440.130(d) (1) (vi), Restorative services.
Covered rehabilitative services under the proposed definition are dependent upon the individual having experienced a functional loss and having had the capability to perform the function in the past. The application of this definition has the potential to be quite subjective. It will be extremely difficult for providers to comply with this requirement when delivering services to individuals whose complete histories and past functioning levels are not known as well as in the provision of services to children or those whose disabilities were manifested prior to reaching developmental maturity. These individuals may not have had the capability to perform the function in the past simply because of their age or the developmental stage at which their disability began to impair their functioning. We recommend that CMS make specific allowances for these circumstances in the definition.

4) Section 440.130(d)(3)(v) – (vii) Written rehabilitation plan:
There are certain services that need to be provided prior to the development of the written rehabilitation plan or are an essential part of developing the written rehabilitation plan. Diagnostic and behavioral health assessments must be delivered prior to and as part of the development of the rehabilitation plan. Emergency crisis intervention services may be the first behavioral healthcare services provided to a Medicaid beneficiary and must be provided where the individual needs them and without delay. When it is not clinically indicated or reasonably possible to develop a written rehabilitation plan prior to the delivery of a service, providers should continue to be able to deliver and be reimbursed for these essential assessments and interventions.

5) Section 440.130(d)(3)(xv) Written rehabilitation plan:
The requirement that the individual must sign the rehabilitation plan will pose a barrier in some circumstances in providing needed services to individuals who verbally indicate their agreement with the written plan but refuse to sign. This is a situation which frequently arises with mentally ill individuals who have paranoid symptoms that lead them to be suspicious and refuse to sign any documentation. This occurs even when the individual is willing to participate in the development of rehabilitative goals and are receptive to treatment. CMS should provide a remedy which specifically permits providers to document this circumstance while they continue with attempts at each subsequent treatment plan review to acquire the signature on the rehabilitation plan.

6) Section 441.45(b)(1) Rehabilitative Services: We would like to express our concerns regarding the inclusion of the term "intrinsic element" without adequate

definition of the term or a description of how determinations would be made to assess whether a service was intrinsic to another program. Additionally, there appears to not be consideration of the fact that even though other federal, state or local programs may sometimes provide or identify the need for services, these other programs may not be obligated to provide such services and there may not be adequate funding to assure provision of such services. We believe that this conflicts with Medicaid's obligation to provide funding for all medically necessary services covered by the state Medicaid plan.

DCH appreciates the opportunity to comment on this important NPRM. We look forward to hearing the final decision for the NPRM.

Sincerely,

Mark Trail, Chief
Division of Medical Assistance Plans

Cc: Judy Hagebak
Chris Gaunt
Maya Carter
APHSA

Submitter : Mrs. Melissa Lee

Date: 10/12/2007

Organization : Mrs. Melissa Lee

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1178-Attach-1.DOC

#1178

October 12, 2007

Centers for Medicare & Medicaid Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

To Whom It May Concern:

Reference: File code CMS-2261-P

I am a graduate student at UNC-Chapel Hill. In the last two years I have had the privilege of working with people in clubhouses, which are community based models for people who have mental disabilities. Threshold, in Durham, NC, is one such clubhouse. It provides people with mental illnesses with a place to work, and it gives them a sense of community and safety. I cannot emphasize how important these programs are. If they did not exist, people with mental disabilities would no longer have a supportive environment to thrive in.

It is my understanding that proposed regulations by CMS will withdraw services to some of these vulnerable citizens. The proposed regulations will force clubhouses like Threshold to shut down. By forbiding long-term supportive services for people with mental illness, CMS will simply increase Medicaid costs. More expensive psychiatric hospitalizations will result if community supports, like Threshold, no longer exist. The time limited services, which CMS has proposed, clearly will not work. It is impossible to manage chronic illness with a short-term treatment.

Please re-evaluate your proposed regulations.

Thank you for your time and consideration.

Sincerely,

Melissa Lee, BA, OTS

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

Organization : QSAC INC

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I urge you to withdraw the proposed regulations regarding habilitive 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 recieving these essential services.

Submitter : **Mrs. JoAnn Dolan** **Date: 10/12/2007**

Organization : **parent**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

I strongly urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would be a serious setback to our society as it 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 : **Ms. Helen Bailey** **Date: 10/12/2007**

Organization : **Disability Rights Center of Maine**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2261-P-1181-Attach-1.RTF

#1181

24 Stone Street • P.O. Box 2007 • Augusta, Maine 04338-2007

October 12, 2007

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

Reference: **File code CMS-2261-P**

To Whom it May Concern:

These comments are being submitted on the Medicaid program proposed rule regarding "Coverage for Rehabilitative Services" published in the Federal Register on August 13, 2007.

GENERAL COMMENTS:

Regulatory Impact Analysis

CMS has stated in its Regulatory Impact Analysis that this rule will not impose any costs on State or local governments, preempt State law, or otherwise have federalism implications," such that the requirements of Executive Order 13132 are not implicated. We believe this analysis to be incorrect.

Maine is one of the states that has been providing day habilitation services as a state plan option. Not all individuals receiving services under this option will meet eligibility requirements under the applicable waiver program and the state will incur costs in meeting the needs of these individuals. Some other services that now receive federal financial participation ("FFP") will be considered intrinsic to other programs but are actually unfunded or under funded by those programs and the state will incur direct costs in continuing these services. Finally, this rule will have a significant impact on billing practices. The costs to providers in altering their practices will be overwhelming, and the cost to the state in altering its billing procedures will be significant.

Recommendation: We recommend that you revise the impact analysis and comply with the requirements of Executive Order 13132.

Reference to other requirements, EPSDT

As others have commented, we are concerned that these proposed regulations make no reference to the requirements of 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5) governing the requirements of Early Periodic Screening Diagnosis and Treatment. The facial conflicts and inconsistencies in these regulations could result in denial of services to children in need of those services, being children who are indeed entitled to receive them. For this reason we join the National Health Law Program (NeHELP) and others in urging CMS to include reference to the EPSDT requirements in this rule.

Recommendation: Insert a new paragraph in § 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when necessary to correct or ameliorate a physical or mental illness or condition.

Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct a physical or mental illness or condition.

Amend § 441.45(b)(4), to specifically refer to the EPSDT statutory and regulatory requirements, 42 U.S.C. § 1396d(r)(5), 42 C.F.R. § 440.40(b), and instruct states to comply with them.

SPECIFIC COMMENTS:

440.130(d)(1)(v) Rehabilitation Plan

Elsewhere, in the sub-section on "written rehabilitation plan," there is reference to recovery goals for individuals receiving mental health or substance abuse related rehabilitation services. The reference is encouraging, although not repeated in this sub-section. The content of both sub-sections, however, does not promote the establishment of recovery goals by a process that is consistent with the philosophy of recovery. We strongly recommend that this section be revised so that the role of the individual who is in recovery has a far more pronounced participation than mere "input."

Recommendation: We recommend that the language of the proposed rule be revised to reflect that the goals include recovery goals, that the goals as stated be those that reflect the wishes of the individual, in language the individual understands and that were developed by the individual and the qualified provider through a collaborative process.

440.130(d)(1)(vi) Restorative Services

The preamble to the regulations includes clarification that services necessary to maintenance of function can indeed be a reimbursable rehabilitation service if necessary to achievement of a rehabilitation goal. This acknowledgement is absolutely critical for

children, generally, and for individuals with conditions such as mental illness or substance abuse disorders where relapse, decompensation or other deterioration of function are significant risks that would interfere with achievement of rehabilitation goals. Yet the focus of this section is exclusively on improvement of function, and does not acknowledge that services that are oriented to the ancillary, necessarily supportive goal of maintenance of function, could be reimbursable as a rehabilitation service or under other Medicaid options as a personal care or preventive service. For this reason we join with others in supporting revision of this section so that it references maintenance of function.

Recommendation:
Add the following language to proposed regulation § 440.130(d)(1)(vi): "Failure to make measurable progress toward a particular goal within a certain time period does not necessarily indicate that a service is not necessary to help achieve a rehabilitation goal."

Add the following language to, and withdraw from, proposed regulation § 440.130(d)(1)(vi): "In these instances services that provide assistance in maintaining functioning may be considered rehabilitative ~~only~~ when necessary *to prevent regression based on a documented history and severity of illness* or to help an individual achieve a rehabilitation goal . . ."

Add a new subsection (c) to § 441.45, with the following language: "If a service cannot be covered as a rehabilitative service, states shall determine whether the service can be covered under another category of Medicaid services." Also, add discussion to Section II.C. of the preamble to the effect that that maintenance services could qualify for coverage under another category of services and give examples of other categories.

Delete the language at 72 Fed. Reg. at 45204, Section II.C of the preamble stating that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . ."

440.130(d)(2) Scope of Services

This section only includes reference to medical or remedial services, and not to restorative services, which are otherwise defined and presumably included as a rehabilitation service.

Recommendation: The rule should be revised to include within the scope of services reference to restorative services (with the definition, as revised, as recommended above.

440.130(d)(3) Written Rehabilitiation Plan

We wish to reiterate the concerns expressed above, when commenting on the

definition of rehabilitation plan, and incorporate those comments and recommendations here.

We also are concerned that this section could unwittingly promote uncoordinated services, unnecessary and intrusive over-assessment of people with disabilities at significant personal and financial cost and that the rule could interfere with the efforts of states to promote coordinated, consumer friendly, accessible, non-duplicative, quality services. Individuals with mental illness, for example, may receive rehabilitation services from more than one provider. In an effort to assure coordination, they may designate one of these agencies as their lead agency, responsible for conducting assessments and developing their comprehensive plan with overall goals. Services that support achievement of these goals may include rehabilitation and other Medicaid reimbursable medical or personal support services, as well as non-Medicaid reimbursed services. Each provider then works from this overall plan and assessments when developing more specific plans for their individual service. Such a system promotes coordination and non-duplication of services, guarantees that the goals of the individual are fully supported and not thwarted across venues, and reduces unnecessary costly and intrusive procedures.

We are concerned that in response to this proposed rule, should it be adopted, in order to assure reimbursement of their services, may feel that they each must conduct their own comprehensive assessments and may independently develop goals irrespective of the goals included in the individual's overall plan and may do so simply with "input" from the individual.

Recommendation: Clarify in this section of the rule, that states are encouraged to promote coordinated and non-duplicative services, and that the requirements of this section can be met if the individual otherwise has a comprehensive plan and assessments, upon which each individual provider may rely in developing plans specific to their services.

441.45(a)(2) Rehabilitative Services

This definition limits rehabilitative services to those that reduce disability and restore the individual to best possible functional level. As with the definition of restorative services, on which we have commented above, this section of the rule neglects to take into account the acknowledgement that is included in the preamble, that services necessary to maintenance of function can indeed be reimbursable under Medicaid as a rehabilitation service.

Recommendation: Insert language, such as is included in the preamble to this proposed rule, describing when services that are designed to maintain function may be a rehabilitation service.

441.45(b) FFP not available

This proposed rule would exclude coverage of services that are intrinsic elements of programs other than Medicaid. Although the rule offers some examples of programs for which services would be construed to be intrinsic elements, the rule is lacking in sufficient guidance. After reviewing these proposed regulations several interested parties in Maine have discussed them in a variety of forums. The interpretations of what the rule would exclude were extraordinarily divergent both in terms of what constituted "programs other than Medicaid" and what was an "intrinsic element." Under the circumstances, the risks are significant that individuals could be wrongfully denied Medicaid coverage for needed services, in preference for the liability of an alternative program that could be unfunded or underfunded.

We also share NeHELP's and the Bazelon Center's interpretation of the proposed rule that it conflicts with other laws, most notably IDEA. For these reasons we join in the following recommendation.

Recommendation: § 441.45(b) should be withdrawn, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Omit the intrinsic element test as a general exclusion and define explicitly and narrowly those exclusions (not including services otherwise available under IDEA or EPSDT) that are based upon another the legal obligation of another entity to pay for the exact service for that individual. This would not permit a denial of service to an individual who may have a generalized claim for services from a program that delivers services on a discretionary basis or that caps expenditures.

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

The manner in which this propose rule designs reimbursement for therapeutic foster care threatens the fidelity of the therapeutic foster care model that has been tested for effectiveness. Little will be gained in costs and much will be lost by the children whom this model serves if the services need be unbundled as proposed. We recognize that Medicaid is not designed to pay for room and board, and these costs should not be included. Otherwise "therapeutic foster care" should be recognized as a rehabilitation service, with states establishing provider requirements to assure quality and having the option to develop an appropriate rate for reimbursement that does justice to the model.

Recommendation: Delete reference to therapeutic foster care in the context of uncovered services, include it as a covered service with a notation that the rate may not include the costs of room and board.

441.45(b)(2)(i) Habilitation Services

This proposed rule excludes habilitation services as a rehabilitation option. It does not state what type of day habilitation services may be provided on behalf of persons with mental retardation or other related conditions under the rehabilitation and clinic options, as OBRA 89 would straightforwardly require, before any action is taken against states that offer state plan option habilitation services. Maine is one such state.

And although Maine has provided alternatives, not all individuals currently receiving services under its day habilitation option would be covered by the waivers or be able to receive the currently covered services under alternative options. Until such time that CMS establishes by rule what habilitation services may be covered "as a rehabilitation" or clinic service (as opposed to excluding habilitation services) to replace the current services for the individuals covered, it should not be taking this adverse action.

Furthermore, the explanation provided for habilitation services is dangerously subject to an interpretation that the service is actually defined by the diagnosis of the individual receiving the service, such that all individuals with mental retardation might be improperly excluded.

Recommendation: Delete this reference to habilitation services as an excluded service.

441.45(b)(3) Recreational or Social Activities

The preamble includes several examples of social, recreational, and pre-vocational type services that could in fact be considered rehabilitation services. Reference to the distinction in this section would be helpful, to assure that these services are not wrongfully denied. The section should also include the language regarding maintenance of function.

Recommendation: Import language from the preamble into this section that demonstrates how social, recreational and pre-vocational type services can be rehabilitative and include reference to maintenance of function.

Thank you for consideration of these comments.

Sincerely,

Helen M. Bailey, Esq.
Public Policy Director

HMB/st

Submitter : Ms. LISA AMES **Date:** 10/12/2007

Organization : PARENT

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that CMS withdraw, revise and re-issue the regulations proposed under Section 441.45(b)(2), with greater clarity as to the implications for children and adolescents with special needs who are currently receiving necessary medical services here in Pennsylvania.

As written, these proposed regulations raise questions as to whether the federal government will use them to force Pennsylvania to restrict these vital services for our children.

It is also urged that CMS provide opportunity for public comment.

Sincerely,

LISA AMES

Submitter : **Mr. Arne Duncan** **Date: 10/12/2007**

Organization : **Board of Education for the City of Chicago**

Category : **Local Government**

Issue Areas/Comments

Background

Background

On behalf of the Board of Education for the City of Chicago I would like to present to the Centers for Medicare and Medicaid Services (CMS) our comments on CMS s proposed rule 2261 regarding rehabilitative services.

We believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. [Social Security Act, Section 1905(a)(13)] As the Bazelon Center for Mental Health Law points out, the fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. [http://www.bazelon.org/issues/medicaid/9-05TalkingPoints.htm] Like Bazelon, we believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Therefore, we respectfully request that CMS retract this proposed rule to the extent that it applies to school-based rehabilitative services and/or Medicaid administrative activities provided to or on behalf of children with disabilities.

Our strong objections to rule 2261 are described in more detail, below.

Proposed Elimination of School-Based Rehabilitative Services

Proposed rule 2261 redefines Medicaid reimbursable rehabilitative services and, among other things, excludes from Medicaid reimbursement the rehabilitative services that are intrinsic elements of programs other than Medicaid, such as& education& . We cannot believe that CMS intends to find that Medicaid services delivered in an educational setting are not reimbursable; the rule should be revised to avoid this conclusion.

CMS failed to define the term intrinsic elements , as used in the proposed rule, leading to an easy conclusion that CMS intends to use this proposed rule to eliminate all Medicaid reimbursement for rehabilitative services and administrative activities provided in a school setting. However, the proposed regulation states, In ?440.130(d)(5), consistent with the provisions of section 1905(a)(13) of the Act, we propose that rehabilitative services may be provided in a facility, home, or other setting. For example, rehabilitative services may be furnished in freestanding outpatient clinics and to supplement services otherwise available as an integral part of the services of facilities such as schools, community mental health centers, or substance abuse treatment centers. Research shows that healthy students have better attendance and perform better in school, academically. In full support of this research, Chicago now has nineteen school-based health clinics sponsored jointly with hospitals and clinics. We are committed to expanding our linkages to social service agencies through a network of community schools. The attempt by CMS to reduce specific federal costs in fact creates reimbursement disincentives for schools to provide wrap-around services where they are intrinsic elements of programs other than Medicaid, such as & education .

Collections of Information Requirements

Collections of Information Requirements

Overall, Chicago Public Schools (CPS) currently serves 52,000 students with disabilities and health related needs by providing 1,000 case managers and counselors as well as 1,600 clinical professionals including social workers, psychologists, nurses, speech pathologists, physical and occupational therapists and hearing/vision technicians to these students at over 600 school sites. We provide these services not only to comply with federal Individuals with Disabilities Education Act (IDEA) requirements, but because we know that health is a prerequisite to success in school as measured in No Child Left Behind goals. Furthermore, the policy of Early Prevention Screening Diagnosis and Treatment (EPSDT) will contribute to the life-long goal of reducing future health needs and costs for our communities. Reports have shown that states are not fully complying with EPSDT requirements and need more, not less, collaborative assistance from their local partners in schools and health clinics.

CPS also currently provides and receives Medicaid reimbursement for the health screening, evaluation and therapeutic services we directly provide each year to approximately 25,000 Medicaid-eligible children with chronic disabilities that impede them from participation in normal activities of daily living, including education. Rule 2261 states, This proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers. CPS related service providers (i.e. occupational and physical therapists, psychologists, social workers, etc.) are qualified and hold appropriate state licensure to provide rehabilitative services which is in the best interest of the students receiving a service.

Children with disabilities served by CPS are entitled access to a free and appropriate public education under IDEA. CPS makes every effort, in accordance to IDEA, to ensure that these children have access to an education with their peers in the least restrictive environment, as determined by each student s specific health care and special education needs. No one can reasonably dispute that providing these services in schools is a significant financial benefit to the Medicaid program and an important enhancement to the health and well-being of our nation.

According to Dr. Vernon K. Smith of Health Management Associates based on CBO Medicaid Baseline, March 2007, the elderly and disabled account for 26% of

enrollees but 68% of Medicaid spending, while children account for 48% of enrollees but only 19% of spending. A goal to slow the growth in costs in the long run would be to slow the demand for treatment in such areas as chronic disease including diabetes and obesity, asthma and depression. Proactive cost containment involves assuring that reimbursement systems reward higher performance in areas like disease management and other care management approaches, not sending patients to higher cost treatment alternatives in emergency rooms, hospitals and doctor s offices.

GENERAL

GENERAL

SEE ATTACHMENT

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS has historically taken the position that services provided pursuant to IDEA are education services and, therefore, not subject to Medicaid reimbursement. However, in 1988 the United States Supreme Court made it perfectly clear, in Bowen v. Massachusetts (47 U.S. 879), that Medicaid is responsible for paying for medically necessary services provided by education programs to Medicaid-eligible children with disabilities.

In Bowen, the Supreme Court upheld a determination by the United States Court of Appeals, First Circuit, that it is the nature of the services, not what the services are called or who provides them that determines whether the services qualify for Medicaid reimbursement. Based on this decision, CMS cannot determine that a service is not eligible for Medicaid reimbursement by calling a medical service education or by pointing out that the services are provided by education personnel. Likewise, if the nature of a school-based service is medical or therapeutic, CMS cannot determine that the service is not eligible for Medicaid reimbursement by labeling it as an intrinsic element of an education program.

Subsequent to the Bowen decision, the United States Congress amended federal Medicaid law, at Section 1903(c) of the Social Security Act, to further clarify Medicaid s responsibility to pay for school-based health services provided in accordance with IDEA. Proposed rule 2261 that would exclude Medicaid reimbursement for school-based health services because they are identified as intrinsic elements of an education program appears to be an effort by CMS to blatantly defy current Medicaid law as established by the United States Congress and United States Supreme Court.

CMS s proposed rule 2261 may also have the impact of circumventing the federal Medicaid laws and rules requiring EPSDT services for children. EPSDT requires state Medicaid agencies to provide health services to children when the services are determined medically necessary through EPSDT screenings. Medicaid must pay for the health services even if the services are not included in the State s plan for Medicaid. This would include rehabilitative services; however, proposed Rule 2261 may be interpreted by CMS to preclude reimbursement for rehabilitative service when provided through an education program, such as IDEA. This is clearly not the intent of Congress.

Proposed Elimination of Transportation Services

Proposed rule 2261 would eliminate Medicaid reimbursement for transportation services that are provided for under the rehabilitative services option (rehab option) under a state s plan for Medicaid.

The Illinois School-Based Health Services program, including school-based transportation services, is included under the rehab option in the State plan for Medicaid. The Illinois State plan was approved by CMS and allows Medicaid payments for school-based transportation services provided for a child with a disability using a specially adapted bus and only on days that the child receives a medical service identified in the IEP and the child s specialized transportation needs are specifically identified in the IEP.

Under proposed rule 2261, CMS seems to imply that transportation services are not appropriate rehabilitative services under the rehab option and that elimination of reimbursement for the services is the appropriate remedy to correct the state plan amendments that CMS previously approved. This approach is extreme, unreasonable and fundamentally unfair to school districts unless CMS is only requiring that the State Medicaid agency to amend the State plan to provide for school-based transportation services under an alternative section. This can be done without any disruption in current school-based transportation services or Medicaid revenue.

Provisions of the Proposed Rule

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Imposition of Proposed Requirements for Rehabilitation Plans

If proposed rule 2261 is interpreted by CMS to allow continued Medicaid reimbursement for school-based rehabilitative services, CPS staff would be required by the proposed rule to develop and implement individualized rehabilitation plans which may be duplicative of the individualized education programs (IEP) required under IDEA.

CPS believes that the IEP developed in accordance with IDEA should satisfy CMS s stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student s physical or mental disability and restoration of the student to the best functional level. The IEP process includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore, CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Response to Comments

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Unless these requirements above are clarified, the rule could result in the elimination of all of the Medicaid reimbursements to the Chicago Public Schools for a loss of $38 million annually. In that case, CPS cannot support proposed rule 2261 and we, hereby, request that CMS retract the proposed rule in its entirety.