Submitter : **Ms. J. Rock Johnson JD** **Date: 10/12/2007**

Organization : **NAMI**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1281-Attach-1.TXT

CMS-2261-P-1281-Attach-2.RTF

#1281

October 10, 2007

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

Re: File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services.

Dear Sir or Madam:

Thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am writing as a member of The National Alliance on Mental Illness (NAMI), the nation's largest grassroots organization representing individuals living with serious mental illnesses and their families. As members of NAMI, we have lived experience with mental illness and bring that unique perspective to our comments on these rules.

We know from personal experience that access to rehabilitative services can make all the difference in a person's life. We have seen people get services to help them recover from their illness. With services and support, individuals with serious mental illness can and do live very well in the community and have strong relationships with family and friends. We have also seen those who can't get help and have seen the pain and trauma from untreated mental illness for the individual and his or her family. Often the person will have multiple stays in hospitals and jails.

NAMI conducted a survey of the 50 state mental health agencies for our *Grading the States* report and found what individuals with mental illness and their family members already know – in all the states, there are gaps in services and many people with serious mental illnesses are not getting the help that they need. The average state grade was a D. So we know that there is much work to be done to ensure that people can get the treatment they need when they need it. NAMI members know that treatment works, if you can get it.

As a result, we are very troubled by the estimate in the proposed regulation that these rules would save the federal government 2.2 billion dollars. Our experiences tell us that creating barriers to vital services will not save money in the long run. Rather, it will increase the costs from hospitalization, incarceration and other bad outcomes that result from a failure to get needed treatment.

We appreciate the emphasis on recovery in the rules. All individuals with mental illness and their families want the system to make it easier to recover. We also like the provisions about the participation of the individual and their family in the rehabilitative

plan and receiving copies of the plan so we can hold the system accountable. We would like to see some flexibility to make sure that providers can still do outreach and provide crisis care, but we very much appreciate the agency's intent to encourage communication between providers, the individual and family members.

However, we have a few areas of deep concern where we hope the agency will reconsider its rules. We would like to see services 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.

Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan:

The proposed regulations require that a written rehabilitation plan set out the services that will be provided. The plan is to be written with the involvement of the individual and the family. We very much applaud the agency for including the person and the family in the planning and for encouraging person centered planning.

We would like to see some flexibility in the rules to allow providers to conduct outreach to individuals who may not be ready to be part of a formal treatment planning process. Sometimes, it takes repeated visits before a person is ready and understands how treatment will be a benefit to him or her.

In addition, there are times when a person is in crisis and needs help. At that point, they might not be able to be part of a planning process. If they are new to a community or have recently been in the hospital or jail, they also may not have a treatment plan on record. The rules should allow treatment in these narrow circumstances.

Recommendation:

Clarify the provisions in the regulation to allow payment for outreach and emergency services.

Section 440.130(d)(1) Rehabilitation and Restorative Services:

Under the proposed regulations and the preamble, rehabilitative goals have to be targeted at progress. They can't be used to maintain stability unless that is linked to another goal where they are still working on improvement. But mental illness does not work in a straight line upward. For many of us and our loved ones, the path to recovery is not straight up or down. It is often a process with periods of progress and periods where symptoms may have to be closely managed to prevent deterioration. The changing course of serious mental illness must be factored into the proposed regulations governing rehabilitative services.

For some of us and our family members who have been hospitalized or in jail, staying stable and in housing is not easy and is an achievement. It also requires services so we

do not deteriorate and get worse. We hope the agency will adjust its regulations to take into account the nature of our illnesses and those of our family members and allow services to prevent deterioration of the illnesses.

Recommendation:

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

Section 441.45(b) Exclusion of services, including those that are an "intrinsic element" of other programs:

Many adults and children with mental illness and their families are also part of other service systems– including criminal justice, juvenile justice, education, housing, and child welfare. In my community, people with mental illness are overrepresented in these systems and we face major challenges to make sure that people with mental illness do not fall through the cracks.

The proposed regulations could make that challenge much more difficult. We are just starting to see some of these other systems provide the help that people with mental illness need. If these regulations are a barrier to getting federal dollars for some of the costs, then other systems will either stop providing the care or they will stop serving people with mental illness. Either way, people with mental illness and their family members are the ones who will get hurt.

We have reviewed this proposed regulation and the preamble and we do not know how to determine whether something is "intrinsic" to another system. We urge the agency to use terms and factors that are easily understandable by those who use these services and their families as well as state policymakers.

Finally, Medicaid is a program that people rely upon to pay for their care. If Medicaid is required to pay for healthcare services, then it should not matter whether the service is "intrinsic" to another system. It is important that Medicaid remain a reliable source of payment for people.

Recommendation:

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

Section 441.45(b) Exclusions for therapeutic foster care and classroom aides:

Many children with mental illnesses rely upon therapeutic foster care. This is a service that works well and creates good outcomes such as going to school more, staying out of trouble with law enforcement, and living in a stable place. The proposed regulations

should give states the ability to get federal resources to support this effective service as long as the services are rehabilitative.

The proposed regulations say that the federal government will not provide resources for recess aides or classroom aides. We believe that the rule also needs to clearly inform schools that Medicaid will pay for behavior aides and other mental health providers who are giving services to a particular child. Children with mental illnesses and their families have been fighting a long battle to get mental heath services provided to children in schools and this regulation should support that effort by clearly encouraging school based mental health services.

Recommendation:

Amend the proposed rule to allow therapeutic foster care and let states combine the services in one rate if that works best for them. The federal government can meet its goals by making sure that the rate only includes rehabilitative services.

Amend the regulation to say that the exclusion does not include behavior aides or other related service providers who are providing services to a particular child.

Section 441.45(b)(2) Exclusion for Mental Retardation and other conditions and Habilitation Services:

The proposed regulations appear to prohibit people with mental retardation or related conditions, like cerebral palsy, from receiving rehabilitation services. As advocates for one group – people with mental illness – we do not support the exclusion of any other group on the basis of their disability.

We also understand that Congress asked the federal agency to determine which habilitation services to cover. It did not give the agency the option to ban all habilitation services.

Recommendation:

The proposed rules should not exclude people with mental retardation and related conditions and habilitation services.

Conclusion:

Rehabilitation services can change the course of a person's life. Our experiences tell us what a difference they can make. The research data confirms what we already know – services are very effective at reducing symptoms, keeping people out of hospitals, and allowing people to live better lives in the community.

We know what works. But we also know that too many people can't access these treatments. And the terrible consequences are seen in every jail and prison in America.

The federal government should be doing everything possible to encourage states to provide better and more effective services for people living with mental illnesses. We 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.

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

Thank you,

J. Rock Johnson JD
1342 S. 11th Street
Lincoln, NE 68502
402-474-0202

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

Organization :

Category : **Social Worker**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I urge you to eliminate the "intrinsic element" standard in the proposed rules (441.45(b)) Without alternate funding lined up, it would be wrong to abruptly pull these services from these kids and families. The services ARE NOT intrinsic to the other programs -- there is no duplication.

Please eliminate this specific part of the proposed rules.

Submitter : Mrs. Debbie Sewell **Date:** 10/12/2007

Organization : Carteret County Public Schools

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-1283-Attach-1.TXT

#1283

October 10, 2007

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

Dear Sir(s) or Madam(s):

The Council for Exceptional Children (CEC) is the largest professional organization of teachers, administrators, parents, and others concerned with the education of children with disabilities, gifted and talents, or both. As a member of CEC, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

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.

Major Issues and Concerns

CEC has major issues with the proposed rule. We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

1) Unjustified and unnecessary, the proposed rule would not further the purposes of Title XIX of the Social Security Act.

A central purpose of the Medicaid law is to provide rehabilitative services. Section 1901 of the Social Security Act reads,

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish...(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

Not only does the proposed rule not further this core goal of Medicaid, it erects new obstacles for Medicaid beneficiaries to receive medically necessary rehabilitative services. It does not justify the need for new rules and it does not provide a reasonable description of the impact of the proposed rule on Medicaid beneficiaries or rehabilitative services providers. The Regulatory Impact Analysis makes numerous assertions that are contradictory and appear intended to mask the impact of the proposed rule. For example, it states that, "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." In reality, the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on providers. The proposed rule also states that, "...because FFP [Federal financial participation] will be excluded for rehabilitative services that are included in other Federal, State, and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This would impose substantial increased costs on states that must change many of their administrative practices and that must either limit access to medically necessary services or increase state spending to provide services that were previously eligible for Medicaid FFP.

2) Contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.

In several instances, we believe that the proposed rule exceeds the Executive's regulatory authority and is inconsistent with Medicaid law.

a. The proposed rule would hinder access to prevention services.

We are troubled that the proposed rule could interfere with states' ability to deliver preventive services, authorized by section 1905(a)(13) of the Social Security Act, as defined by 42 C.F.R. § 440.130(c). Although the proposed rule ostensibly amends only 42 C.F.R. § 440.130(d), it creates the clear impression that numerous preventive services would be prohibited under section 1905(a)(13), even if they could be covered as preventive services.

Any revised rule should make clear that states can continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. § 440.130(c).

b. The proposed rule illegally imposes an intrinsic element test.

The proposed rule would deny FFP for services furnished, through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

c. The proposed rule does not fully comply with the EPSDT mandate for children.

We are very troubled by the potential impact of the proposed rule on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that the proposed rule complies with Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a state's Medicaid plan. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement.

3) Implementation of the proposed rule would severely harm several Medicaid populations.

We believe that the proposed rule could severely restrict access to services and cause significant harm to several Medicaid populations:

a. The proposed rule would harm people with mental illness.

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would place Medicaid beneficiaries with mental illness at risk for poorer health outcomes and this could lead to relapse or new episodes of illness. Such incidents typically result in increased utilization of high cost services such as emergency room care and inpatient care. The proposed rule does not alter Medicaid eligibility, it would simply restrict access to certain services—often those that are most effective and the least costly.

Therefore, we also worry that this proposal could lead to increased Medicaid spending if individuals are forced to get more costly, but less effective or appropriate services. In particular, we are concerned that the proposed rule could lead to increased hospitalizations that would be otherwise preventable, through the provisioning of community-based rehabilitative services.

It should be noted that given the high proportion of Medicaid beneficiaries receiving rehab option services that have mental illness, all of the harms and concerns and raised in these comments should be considered to apply to people with mental illness.

b. The proposed rule would harm people with intellectual and other developmental disabilities

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

Elimination of FFP for habilitation services provided under the rehab and clinic options: In 2006, roughly $808 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities. In the same year, it has been estimated that approximately 52,000 people with intellectual and other developmental disabilities received day habilitation services through the clinic and rehab options (Unpublished estimates, David Braddock, Coleman Institute for Cognitive Disabilities, University of Colorado). We believe that this proposed restriction contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239). This section reads:

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

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

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

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under their state plans to transition to appropriate Medicaid coverage authorities, such as section 1915(c) waivers or the Home and Community-Based Services State plan option under section 1915(i)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

Further, section 1915(c) waivers and the section 1915(i) option are not equivalent to the rehab or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something that is not required for rehab or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the

option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists, something that is not permitted for clinic or rehab option services. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006). Shifting habilitation services to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable.

We strongly recommend that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions: We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehab option services for people with mental retardation and related conditions. CMS policy appears to be that these individuals should receive services only through waiver programs (or the related 1915(i) option), and this is nonsensical in circumstances such as where a person with an intellectual disability has a knee replacement and needs services to regain physical functioning of the knee or where a person with epilepsy develops a substance abuse disorder. Further, this policy is likely to increase federal and state costs, as benefits for home- and community-based services (HCBS) waiver programs tend to be far more extensive than is generally provider under the rehab option.

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. This policy was not the result of Congressional action and preceded a period of significant progress in advancing the civil rights of people with disabilities.

While the Americans with Disabilities Act (ADA) does not apply to federal administration of Medicaid, we believe that this policy violates, at a minimum, the spirit of the ADA, wherein the Congress was intending to impose a comprehensive national prohibition against discrimination on the basis of disability.

We urge the Secretary to rescind this constraint on rehab option services that is so blatantly stigmatizing and discriminatory to people with intellectual and other developmental disabilities.

4) Challenges efforts by states, school districts, and early intervention providers to effectively deliver health care services to children with disabilities in school/early childhood settings.

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to a free, appropriate public education and early intervention services in conformity with an individualized education program (IEP) and an individualized family service plan (IFSP). An IEP/IFSP is developed for eligible individuals with disabilities and describes the range of services and supports needed to assist individuals in benefiting from and maximizing their educational/developmental opportunities. The types of services provided under an IEP/IFSP include services such as speech pathology and audiology services, and physical, psychological and occupational therapies. While IDEA confers rights to individuals and obligations on the part of school systems/early intervention providers, it is not directly tied to a specific program or an automatic funding source. For years, the Federal government has failed to provide anywhere near the level of funding promised in the IDEA statute. States' ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP/IFSP helps defray some of the state and local costs of implementing IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IEPs/IFSPs have been a contentious issue in the past. Some time ago, HCFA attempted to limit the availability of Medicaid funding for services under IDEA. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP/IFSP. Under current law, the Social Security Act at section 1903 (c) reads,

> "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 H of such Act."

Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitative services in school and early childhood settings, new requirements of this rule could be disruptive and could make it more difficult to use the school and early childhood environments to assure that children with disabilities receive the rehabilitative services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools and early childhood settings. While we share the

goal of ensuring that all rehabilitative services are of the highest quality and are only provided by providers who meet state credentialing standards, we are concerned that this rule would limit state flexibility to establish provider qualification requirements in school and early childhood settings. Further, we are concerned that the any willing provider requirement could be disruptive to efforts to serve children. We believe that the existing free choice of provider which guarantees parents the right to access medically necessary therapy and other services by other providers—outside of the school/early childhood environment—is an appropriate way to protect parents' right to access the Medicaid qualified provider of their choice. Again, the Secretary has not provided a policy justification for this new requirement, and we believe the net impact will be to make it less desirable for Medicaid programs to use school/early childhood settings to provide essential rehabilitative services to children. The Congress could not have been clearer in its intent that it wants Medicaid to support the goals of IDEA; we believe that these narrow interpretations of the law are inconsistent with that intent.

For these and other reasons, we urge the Secretary to withdraw the proposed rule.

Thank you for allowing the public to provide comments on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid Program and for considering CEC's recommendations.

Sincerely,
Debbie Sewell, EC Director
Carteret County Schools

Submitter : Dr. Louis DeStefano **Date:** 10/12/2007

Organization : Rushford Center, Inc.

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#1284

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 : Dr. Emily Collins **Date:** 10/12/2007

Organization : Council of Administrators of Special Education

Category : Individual

Issue Areas/Comments

Background

Background

I fear the proposed CMS regulations will have a severely damaging effect on children with disabilities,their families and school districts and other agencies serving them. The Administration estimates $2.29 billion will be saved by eliminating reimbursement for rehabilitative services. Rather than a savings, this is a shift in financial responsibility to families, states and school districts with no corresponding increase in federal special education funding.A major purpose of the Medicaid law is to provide rehabilitation services to help families and individuals attain or retain the ability to be independent and care for themselves without being a financial burden to taxpayers. The proposed regulation will impose significant increased costs for states, and increased state spending likely means increased taxpayer costs. The proposed rule would also limit the ability to have preventive serves. The proposed changes appear to discriminate aganst persons with disabilities, especially those with mental illnesses (In 2004,73% of Medicaid recipients receiving rehabilitation serves had a mental health diagnosis,and 79% of the rehabilitation funds were used by them. This could lead to their obtaining more costly, but less effective services (increased hospitalizations or emergency room use rather than communiity-based rehabilitation services).The proposed rule would also significantly harm individuals with intellectual and developmental disabilities as approximately $808 million in 2006 was spent on Medicaid clinic and rehabilitation services for 52,000 persons with intellectual and developmental disabilities, much ofthis for day habilitation that enables them to function more independently and care for themselves. Funding rehabilitation services saves future costs for taking care of these individuals if they are unable to function independently and care for themselves. It's a matter of pay now or pay much more in the future. Therefore I am strongly opposed to these proposed changes in Medicaid funding for rehabilitation.

GENERAL

GENERAL

If policy changes are needed, the legislative process is the route that should be taken after necessary dialogue with representatives of affected Medicaid persons,their families,federal officials,state officials,school districts and rehabilitation services providers.

Submitter : **Ms. Vendella Collins** **Date: 10/12/2007**

Organization : **MI Developmental Disabilities Council**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

T
September 20, 2007

The Honorable Max Baucus The Honorable Charles Grassley
Chairman Ranking Minority Member
Committee on Finance Committee on Finance
United States Senate United States Senate
Washington, D.C. 20510 Washington, D.C. 20510

Dear Chairman Baucus and Ranking Member Grassley:

We are writing to express our strong opposition to the recently proposed regulatory action by the Center for Medicare and Medicaid Services (CMS) that drastically cuts Medicaid funding by reducing school-based and rehabilitative services for children with disabilities. Therefore, we strongly urge you to address our concerns with these policies either by including Sec. 814 of the House CHAMP Act (H.R. 3162) in the final SCHIP conference agreement, or in another legislative vehicle this year.

Recent data about the Medicaid rehabilitative services option illustrates the potential impact of these unilateral CMS actions on our nation s most vulnerable and needy children. An August 2007 study published by the Kaiser Family Foundation found that 47 states provide community-based care through the rehabilitative option to 1.46 million Medicaid beneficiaries, including hundreds of thousands of children with disabilities. Seventy-three percent of recipients have mental health diagnoses consisting of debilitating mental illnesses such as schizophrenia or bipolar disorder. The remaining 27 percent of beneficiaries under the option include children and adults with developmental disabilities and persons living with cancer, heart disease, diabetes and HIV/AIDS.

Because this state option is such an important link to the community for America s most vulnerable children, we were alarmed by a CMS Notice of Proposed Rule Making (72 Fed. Reg. 45201) that prohibits people with developmental disabilities from participating in the program at all. The NPRM also proposes an ill-defined intrinsic element standard that provides the agency with unprecedented discretion to deny reimbursement for such essential services as community skills training, day programs, and employment related services supervised by health professionals.

The NPRM also scales back rehabilitative services provided to children who are Medicaid-eligible in foster care, and children with disabilities participating in the Individuals with Disabilities Education Improvement Act (IDEA). In addition, CMS proposes the elimination of a congressionally mandated protection that authorized 19 states to provide day habilitation services to children with disabilities under the rehabilitation option.

Many of the policy decisions in these proposed rules have no statutory basis whatsoever in Title XIX. In fact, Congress actually rejected the intrinsic element standard for the rehabilitative services option during deliberation of the Deficit Reduction Act in 2005.

As you know, by contrast Section 814 of the House CHAMP Act prohibits CMS from promulgating new rules relative to both rehabilitative and school-based services for one year. This one-year moratorium on the implementation of these rules preserves the Finance Committee s jurisdiction to engage in a thoughtful consideration of the rules and their impact on the provision of services to millions of children with mental illnesses and developmental disabilities. Given the relatively low cost of the moratorium, $100M over five years, we believe that retaining Section 814 in the CHIP compromise bill comports with the primary purpose of CHIP to ensure that low-income children receive the health care services necessary to maintain their health and grow into productive adults.

We strongly urge you to include Section 814 of the House CHAMP bill (H.R. 3162) in the final SCHIP conference report, or in another appropriate legislative vehicle this year. Thank you for your attention to this important matter.

Sincerely,

Bernard Sanders

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

Organization : Youth Law Center

Category : Attorney/Law Firm

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please see attached letter.

CMS-2261-P-1287-Attach-1.PDF

CMS-2261-P-1287-Attach-2.PDF

#1287

youth law center

200 Pine Street, Suite 300
San Francisco, CA 94104
p 415.543.3379
f 415.956.9022

http://www.ylc.org

October 12, 2007

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

Re: File Code CMS-2261-P

Dear Sir or Madam:

Thank you for the opportunity to comment on proposed regulations concerning Coverage for Medicaid Rehabilitative Services.

§ 441.45 (a) If a State covers rehabilitative services

Subsection (a) appears to apply its requirements only to states that elect to cover rehabilitative services in their state plans. However, every state must provide rehabilitative services for children, whether or not those services are included in its state plan. 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(4)(B) & (r).

This subsection should be revised to reflect the definition of early and periodic Screening, diagnostic, and treatment services (EPSDT), 42 U.S.C § 1396d(r), by either (a) specifying that the restrictions of this section apply only to adults and removing references to services for children or (b) reminding states that they must provide necessary health care, diagnostic services, treatment and other measures, including rehabilitative services, for children and revising the language to ensure that the section does not impose impermissible restrictions on EPSDT services.

§ 441.45(b)(1) FFP is not available

This subsection purports to deny federal financial participation (FFP) for Medicaid eligible services if the services are furnished through particular programs. The Centers for Medicare and Medicaid Services (CMS) does not have legal authority to deny FFP for otherwise eligible Medicaid services, particularly services for children. 42 U.S.C. §§ 1396a(a)(10), 1396d (a)(4)(B) & (r). For example, CMS cannot deny FFP for Medicaid covered services delivered by a Medicaid certified provider merely because the service is "furnished through" a program such as foster care, child welfare, or juvenile justice.

In addition, this subsection uses undefined terms that are likely to lead to confusion, interagency disagreements, and delays in services for children. For example, it is

unclear what "furnished through" means. A child welfare agency may contract with or employ a Medicaid provider to deliver health care services to children in foster care. Are these services "furnished through" the child welfare agency? Ineligible services include "services that are intrinsic elements of other programs." "Intrinsic elements" is not further defined and could easily lead to denial of covered services. For example, what elements are "intrinsic to" a foster care program? Given that foster children have a right to necessary health care,[1] would this subsection purport to deny FFP for all health care services for foster children?

At a minimum this subsection will lead to differences of opinion among agencies and disputes about responsibility for payment, undoubtedly delaying necessary services for children. This subsection could also lead to denial of services altogether if a service were deemed "intrinsic to" a program that had no ability or obligation to pay for it. This subsection is also likely to lead to greater cost as a result of increased administrative expenses, administrative appeals, and litigation to resolve interagency differences and delay or denial of services.

The examples of "therapeutic foster care services," "packaged services furnished by foster care or child care institutions," and "adoption services, family preservation, family reunification services" merely demonstrate the problem. Rehabilitative services that are "clearly distinct" from packaged therapeutic foster care services is meaningless when the package of services includes rehabilitative services. Adoption services, family preservation, and family reunification services may include services that are clearly eligible for FFP. For example, psychotherapy many be provided as an adoption or family reunification service through a public or private social service agency that employs or contracts with a psychotherapist.

This subsection should be eliminated. CMS can insure that FFP is limited to eligible services by confirming that the services meet the definition of rehabilitative services and are provided by a qualified Medicaid provider.

§ 441.45 (b)(4) Services provided to inmates

It is not clear why this subsection is necessary, given that 42 C.F.R. §§ 435.1009 and 435.1010 implement the inmate payment exception. 42 U.S.C. § 1396d(a)(28)(A)&(B).

If this subsection is merely a restatement of the inmate payment exception, it should be deleted because restating the inmate payment exception in different terms creates additional confusion in an area that is already quite complicated. For example, "secure custody of law enforcement" does not appear in the current inmate payment

[1] *See, e.g., Norfleet v. Arkansas Dep't of Human Service*, 989 F.2d 289, 293 (8th Cir.1993); *K.H. v. Morgan*, 914 F.2d 846, 856 (7th Cir. 1990); *Hernandez v. Hines*, 159 F.Supp.2d 378, 384 (N.D. Tex. 2001); *Del A. v. Roemer*, 777 F.Supp. 1297, 1318 (E.D.La. 1991); *Wilder v. City of New York*, 568 F.Supp. 1132, 1137 (D.C.N.Y. 1983).

exception regulations. Placements "that are not part of the public institution system" is imprecise because "public institution system" is undefined and may include facilities that do not fall within the inmate payment exception. Services "not used in the administration of other non-medical programs" is vague and overbroad. It is not clear how this phrase is meant to interact with the "intrinsic element" requirement of § 441.45 (b)(1) discussed above. To the extent it purports to add another reason to deny FFP for Medicaid eligible services provided to youth who are "paroled, on probation, on home release, in foster care, in a group home, or other community placement," it is inconsistent with the Medicaid statute as discussed above.

If the proposed language is designed to fulfill a different function, CMS should explain the purpose and legal authority for this subsection. It should also make sure that the regulatory language fulfills that purpose and is consistent with that authority.

Very truly yours,

Alice Bussiere

Submitter : Ms. Elizabeth Chadwick **Date:** 10/12/2007

Organization : The Devereux Foundation

Category : Health Care Professional or 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.

#1288

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 : Mr. Patrick Barrie **Date:** 10/12/2007

Organization : Michigan Department of Community Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-2261-P-1289-Attach-1.PDF

#128

STATE OF MICHIGAN

JENNIFER GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH

JANET OLSZEWSKI
DIRECTOR

October 12, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

The Michigan Department of Community Health, Mental Health and Substance Abuse Administration, offers the following comments on a number of the Proposed Rules central provisions:

I. Regulatory efficacy of the proposed rule:
Section 441.45(b)(2) in its elimination of FFP for habilitation services provided under the rehab and clinic options fails to meet the regulatory burden required under Section 6411(g) of P.L. 101-239: We believe that this proposed restriction not only contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989,

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

P.L. 101-239 but fails to meet the regulatory burden provided thereunder. This section reads:
In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. Further, the Congress anticipated that this protection would also lead to the Secretary issuing a final rule so that all states could cover day habilitation services through the rehab option, with its reference to a, "final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and period of at least 60 days for public comment, that – (A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions." The proposed rule does not specify which day habilitation services that a state may cover as required by section 6411(g). The blanket prohibition on habilitation services [i.e., none may be covered] under paragraphs (9) and (13) of section 1905(a) of the Social Security Act, in our opinion, not only does not meet the regulatory burden, it exceeds the regulatory authority granted by the Congress.

Section 441.45(b)(2) in explicitly defining habilitation services as services provided to individuals with mental retardation or related conditions establishes a discriminatory and arbitrary exclusion from receiving many rehabilitation services for this set of otherwise qualified Medicaid beneficiaries:

This population exclusion violates a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act]. This proposed exclusion and the "general usage" discussion on pages 45205-6, suggests a premise we strongly disagree with - that persons with intellectual disabilities have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. We find nothing in the record that portrays this part of the proposed rule as the result of Congressional action, nor does it seem possible that it was borne of Congressional intent. While the Americans with Disabilities Act (ADA) does not apply to federal administration of Medicaid, we believe that this proposed exclusion violates, at a minimum, the spirit of the ADA, wherein the Congress was intending to impose a comprehensive national prohibition against discrimination on the basis of disability.

Because 42 CFR 441.45(b)(2) as proposed fails to meet the regulatory burden of P.L. 101-239 6411(g), and because it excludes and discriminates against people with intellectual and other developmental disabilities, we recommend the Secretary eliminate it altogether.

42 CFR 440.130(d)(2)'s base *Scope of services* definition and the subordinate delineating definitions @ 440.130(d)(1) taken together appear to significantly restrict the broad, plain language intent of rehabilitation services specified by Congress at Sec. 1901(2), "...to help [Medicaid eligible] families and individuals **attain or retain capability** for independence or self-care..."

We request that the Secretary provide information to assist states and other stakeholders in understanding how Congressional language about "attaining or retaining capability for independence or self care" could be interpreted to mean only restoration of a formerly possessed capacity or functional ability. It would be particularly helpful if the information were to include which Congressional language resulted in the statement on page 45205, last 3rd of the 3rd column, *"As a matter of general usage in the medical community, there is a distinction between the terms ''habilitation'' and ''rehabilitation.'' Rehabilitation refers to measures used to restore individuals to their best functional levels. The emphasis in covering rehabilitation services is the restoration of a functional ability."*

Section V: Regulatory Impact Analysis beginning at the 1st 3rd of the 3rd column on page 45208 does not appear to us to document due diligence or comport with the impact analysis requirements of the outlined Federal statute:

Your statement, "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" does not, in our opinion, relieve CMS from doing due diligence and working with states to help clarify the adjustments/responses needed and the costs accruing from doing so.

In light of your statement, "...nor can we predict the manner in which states would adjust or respond..." we request that the Secretary provide additional information as to how the less-than-$120 million conclusion was reached in, *"...this rule would not mandate spending in any 1 year of $120 million or more,* [and thus] *the requirements of the UMRA [Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995] are not applicable,"* and, as to how the not-applicable conclusion was reached in, *"Since this rule would not impose any* [substantial direct requirement] *costs on State or local governments, preempt State law, or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable"*

II. Limited audience/scope/focus of the proposed rules:
The scope, focus, and guidance provided within the proposed rule seem limited to a fee-for-service environment within states that have not yet embraced the more forward-thinking initiatives promoted by the current administration and CMS. We recommend that the Secretary consider offering - within or prior to finalizing these rules - guidance to those states that have converted their entire systems of services and supports for persons with intellectual disabilities, and/or mental health and/or substance abuse issues to prepaid, capitated managed care systems. We also recommend the Secretary examine the Managed Care arrangements he through CMS has approved, and to work with those states to identify what if any adjustments/changes may be necessary pursuant to the proposed rules. Notable issues needing clarification [and perhaps renegotiation] would include: changes that may be necessary to the state's encounter data definitions and categories; changes to CMS approved actuarially sound capitation rates developed by the state's actuary that may include rehab services/costs that fall into one of the gray, potentially excluded areas; and the impact on CMS-approved additional services that may be made available through savings from state plan services.

III. Authority, responsibility and/or implied obligation:
In the past decade, CMS staff have been very diligent in working with our state to assure that the services offered under the Medicaid specialty services and supports 1915 b/c combination waiver do not duplicate or supplant services that are the responsibility and obligation of other state or federal programs. If in fact the rules become final and some of a state's "rehab services" are definitively determined to be "intrinsic" to another federal program and/or Medicaid is purportedly secondary to the funding obligations under another federal program [e.g., Title IV-B and IV-E], we recommend that the Secretary and CMS work with the other Federal programs and the states to definitively clarify coordination of federal benefits/assist states to access the funds purported to be primary as a prerequisite to disallowing Medicaid FFP under the proposed rules.

Thank your for this opportunity to comment. Should you have questions, please contact Judy Webb at 335-4419, or at Webb@Michigan.gov.

Cordially,

Patrick Barrie

Patrick Barrie, Deputy Director
Mental Health and Substance Abuse Administration

cc: Janet Olszewski
Paul Reinhart
Irene Kazieczko
Judy Webb
Nancy Bishop

Submitter : Ms. J. Rock Johnson JD **Date:** 10/12/2007

Organization : submitted as an individual

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEc Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

Submitter : **Ms. Beverly McCoy** **Date: 10/12/2007**

Organization : **Ms. Beverly McCoy**

Category : **Individual**

Issue Areas/Comments

Background

Background

CMS -2261-P

PROVISIONS OF THE PROPOSED REGULATIONS

This is to object strongly to the plan to eliminate coverage of habilitation services as described in Limitations for Rehabilitation Services.

These changes will be devastating to children who have disabilities, whose medical needs are no less genuine because their disability preceded their capability to perform necessary functions.

These regulations make reference to home and community-based services. These services often have lengthy waiting lists; the new regulations would deny children with disabilities the ability to access these services immediately, when intervention provides by far the greatest return on investment. It is chilling indeed to think that parents may again be forced to place their children in ICF-MR facilities in order for them to get timely access to the services they so desperately need. The human and social costs would be tremendous; the financial costs would be higher as well.

Individuals with difficult problems such as cognitive impairments, genetic disorders and autism must be afforded the same access to the care specific to their conditions as is given to those who need is for services such as dialysis, chemotherapy and organ transplants. All are costly, but all are necessary. The other mechanisms identified by the regulations as able to meet the habilitation needs of people not deemed previously capable of performing a skill simply are not able to meet the needs of this already vulnerable and disadvantaged group.

The proposed changes affecting habilitation services should not be made. In effect, if not in fact, they discriminate against people with disabilities.

GENERAL

GENERAL

CMS -2261-P

PROVISIONS OF THE PROPOSED REGULATIONS

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Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS -2261-P

PROVISIONS OF THE PROPOSED REGULATIONS

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The proposed changes affecting habilitation services should not be made. In effect, if not in fact, they discriminate against people with disabilities.

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

Organization : Kentucky Department for Community Based Services

Category : State Government

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

The Kentucky Department for Community Based Services (DCBS) 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).

DCBS recognizes and appreciates that this proposed rule reinforces program integrity by making rehabilitative services more person-centered and focused on positive outcomes. However, a concern is that adoption of the proposed regulation as written will greatly restrict access to vital community-based services for the vulnerable children in the child welfare system. The complexities of protecting children while simultaneously treating the emotional disturbance emanating from their maltreatment are vast. Frequently, these children must be placed in some type of foster care placement to afford them protection however, foster care, by federal definition, does not include social services, rather it focuses on the physical needs of food, clothing and shelter, along with watchful supervision comparable to that which any parent might provide their child. 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.

Medicaid Rehabilitative Services are especially vital to this population, as they offer an opportunity to reduce the physical and/or mental disabilities that many children in foster care have by restoring the child s functioning level. Effective intervention decreases long-term negative impacts, and ultimately, reduces costs. 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 (CFSRs), 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.

Many children involved with the child welfare and foster care systems are already slipping through the cracks and it is essential to bridge rather than widen the gaps. The CFSR finding that only one state achieved substantial conformity in ensuring that child welfare children s mental health needs were met emphatically points out the necessity of improving access to rehabilitative services rather than restricting it. We sincerely appreciate the opportunity to comment on this proposed rule.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

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).

Children are ever moving through developmental stages; however, many of the children who have the additional trauma of being victims of abuse or neglect experience mental illness and thwarted functional development. Attempting to define the best possible functional level for such a child is difficult at best. A more appropriate alternative would be to allow improving functional level as well as maintaining that improved level .

440.130(d)(3), Written rehabilitation plan: The requirement that the plan be person-centered and allow for involvement of the beneficiary s family or other responsible person is most appropriate. However, we request clarifying language be added deeming representatives of a public agency as an other responsible individual for children in the agency s legal custody.

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

It is our understanding that Congressional debate of the Deficit Reduction Act of 2005 resulted in a rejection of 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 intended 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.

Medicaid 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)). Title IV-B, Child Welfare Services, provides some latitude about permissible activities, but because its primary purpose is not to provide medical assistance, rehabilitative services are not intrinsic to it either.

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 in community residential treatment facilities that are more than 16 beds would most likely drive costs up and force children into more restrictive environments. Some of those children will also go underserved due to lack of access, and these children will be additionally victimized, decline in functionality, or hurt others and become part of the juvenile justice system. Further, the definition adopted by the Secretary that the psych hospital under 21 benefit includes child-caring facilities accredited by JCAHO, COA or any other accrediting organization with comparable standards recognized by the State creates an untenable quandary for states and providers. States have moved toward requiring accreditation to bring a higher standard of practice to the treatment of children, while recognizing that these are community-based programs. To require them to become hospitals and move away from a community-based program model contradicts tenets of the New Freedom Commission as well as the recent CMS demonstration project for Alternatives to Psychiatric Residential Treatment Facilities (PRTF).

Submitter : Mr. James Jones **Date:** 10/12/2007

Organization : Mr. James Jones

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1293-Attach-1.DOC

#1293

Elizabeth:

Following are the links from the A-CHAMP organization. I have attached the pdf document showing the proposed rule change. The changes would be amendments to 42 CFR parts 440 and 441. The proposed rule is published at 72 Federal Register 45201. The actual proposed changes in the regulations start at the bottom of page 45210 and run through the first column of page 45213. Pages 45201 through 45210 are the CMS statements on why they think the regulations need to be changed and the accounting statement showing the anticipated results of the changes. The first section of the proposed rule indicates that public comments must be received no later than 5:00 p.m. on October 12, 2007 and gives addresses for comments.

My understanding of the proposed changes is as follows:

1. The distinction between habilitation and rehabilitation is outlined on page 45205.

2. Autism is considered a "related condition" when the regulations refer to "mental retardation or related conditions" in regard to habilitation or rehabilitation services.

3. Some states, including Wisconsin, currently provide habilitation services to children with autism.

4. The proposed regulation would exclude federal financial participation (FFP) for habilitation services by specifically stating that rehabilitation does not include: "Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include 'services provided to individuals' with mental retardation or related conditions."

5. The Omnibus Budget Reconciliation Act of 1989 ("OBRA 89") prohibited CMS from taking adverse actions against States with approved habilitation provisions pending the issuance of a regulation that "specified types of day habilitation services that a State may cover under paragraphs (9) [clinic services] or (13) [rehabilitative services] of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions." In other words, Congress told CMS that it couldn't deny these services to persons with mental retardation, etc., unless CMS explained what services are available to those persons. CMS purports to meet this requirement by stating "that all such habilitation services would not be covered under sections 1905(a)(9) or 1905(a)(13) of the Act." CMS is trying to meet Congress's requirement that it specify the types of habilitation services covered by saying "none."

The sum of these particulars is that habilitation services would be excluded from rehabilitation services for which FFP is provided and FFP would be cut off for habilitation services provided to individuals with mental retardation or related conditions (including autism).

Here are the links from the A-CHAMP site:

When A-CHAMP Learned of the Proposed Cuts We Went to Work to Get the Support of Senators Who Care About Kids
21 Senators Have Spoken Out for Disabled Children-Now You Need to Speak Out Too!
Send A Message that You Support The 21 Senators! Click Take Action to Send a Message!
http://capwiz.com/a-champ/issues/alert/?alertid=10390601&queueid=%5Bcapwiz:queue_id%5D

Click Here to Read The Letter Signed by 21 Senators http://a-champ.org/Medicaid.html

Submitter : Ms. Betsy Schwartz **Date:** 10/12/2007

Organization : Mental Health Association of Greater Houston

Category : Other Association

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

Overview

It is well-known that Medicaid provides a crucial source of funding for community mental health services, comprising the majority of mental health public spending. In many cases, the rehabilitative option is the Medicaid program that presents the best opportunity for individuals with mental illness to receive the services they need in order to achieve recovery. The promotion of recovery, as CMS correctly notes in its Notice of Proposed Rulemaking, is a key theme of the President s New Freedom Commission. However, recovery is not a possible goal without the provision of the types of services available under the rehabilitation option.

While the changes set forth in this proposed rule may reduce some costs under the rehabilitative option, reducing access to these services may actually result in higher costs to other Medicaid programs in the long-run. Without services such as transportation, personal care, etc., Medicaid recipients with mental illness are at risk of functional deterioration, increasing their chances of needing more costly, long-term care.

As CMS has noted, the language in the definition of rehabilitative services has afforded States considerable flexibility under their State plans to meet the needs of their State s Medicaid population. We hope that CMS will think carefully before adopting any changes that would reduce access to needed services for this vulnerable population.

GENERAL

GENERAL

No doubt exists as to the importance of the Medicaid rehabilitation option for person with mental illness. While it is a laudable goal to reduce unnecessary spending and maintain the financial viability of the program, MHA hopes that CMS will carefully consider these comments and ensure that any changes to the program will not unduly affect individuals with mental illness by erecting barriers to the services they need in order to achieve recovery.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Limitations for Rehabilitative Services Sec. 44145(b)(1), (b)(3), (b)(6)

MHA is very troubled by the proposals set forth under these sections. As currently proposed, we believe this language would have a devastating impact on individuals with mental illness. Denying coverage under the rehabilitative services options for services that are intrinsic elements of programs other than Medicaid seems to make two assumptions that may not necessarily be true in a given community: 1) that because rehabilitative services are inherent in these non-Medicaid programs, these programs actually have the capacity to provide such services to the Medicaid population; and 2) that Medicaid recipients will be eligible to receive services through these programs.

In many communities, programs that provide services such as housing, transportation, and vocational services are already very limited in nature, and it is unlikely that they will be able to pick up the slack should these services cease to be covered under the Medicaid rehabilitative option. In many cases, this would lead to loss of services for Medicaid recipients, resulting in possible functional deterioration and utilization of more costly Medicaid services.

Even if such services were available and Medicaid recipients met the program s eligibility requirements, the proposed rule would significantly reduce Medicaid s vital role in ensuring the coordination of mental health services to the detriment of mental health consumers. This would further exacerbate the many problems associated with an already fragmented system, which the New Freedom Commission has cited as one of the key barriers to accessing mental health services. Considering that the United States Congress has already rejected a similar CMS intrinsic elements proposal, MHA believes CMS should proceed cautiously as it tries to implement such a rule at this time.

In Sec. 441.45 (b) (3), the proposed exclusion of personal care services, transportation, vocational and prevocational services from reimbursement through the Medicaid rehabilitation program because they are not primarily focused on rehabilitation overlooks the integral role they play in promoting recovery for individuals with mental illness. While we understand CMS desire to maintain a strict definition of services, the definition unnecessarily creates an arbitrary division between the direct services that are considered rehabilitation and the indirect support services that are crucial components of rehabilitation and recovery.

Evidence-based practices for individuals with mental illness, such as supported education, housing, and employment would also be excluded from reimbursement under the rehabilitation program. This is in direct contradiction to the observation made by the New Freedom Commission, which CMS quotes in its notice of proposed rulemaking: [m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs. MHA strongly urges CMS to reconsider its proposed exclusion of such vital services from reimbursement under the rehabilitative services option.

Submitter : Mrs. Zoe Ann Northcutt **Date:** 10/12/2007

Organization : Options For Southern Oregon, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

This current proposed rule will have a chilling effect on the ability of states and mental health providers to provide evidence based practices, including Supported Employment services. As a provider of Supported Employment Services, I have seen a remarkable impact in peoples lives when they return to the workforce. Any limitations in our ability to deliver quality service to our consumers can be devastating. Work is an extremely important part of the recovery process. Please do not take billions of dollars out of the Medicaid funded system of care for people with mental illness. Supported Employment is an Evidenced Base Practice that truely works in helping people be contributing members of society by returning to the work force. Thank you for you consideration.

Submitter : Mrs. Verla Insko **Date:** 10/12/2007

Organization : North Carolina General Assembly

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1296-Attach-1.DOC

CMS-2261-P-1296-Attach-2.WPD

#1296

NORTH CAROLINA GENERAL ASSEMBLY
House of Representatives
State Legislative Building
Raleigh 27601-1096

Representative Verla Insko
56th House District, Orange County

October 12, 2007

Centers for Medicare and Medicaid Services
PO Box 8018
Baltimore, MD 21244-8018

ATTN: CMS-2261-P

To Whom It May Concern:

Reference: File Code CMS-2261-P

As the House Chairman of the Joint Legislative Oversight Committee on Mental Health Developmental Disabilities and Substance Abuse Services, I have been deeply involved in efforts over the past 6 years to modernize the mental health system of service for North Carolina. It has been a formidable challenge and we have learned from our many mistakes.

In the spring of 2005, CMS approved our new enhanced service definitions. Despite multiple trainings over the past 18-20 months, we still have providers and consumers who are struggling to adapt to the new services – both in terms of the delivery of services and in terms of receiving and understanding the services. At this point, the system needs an opportunity to stabilize.

It is the goal of the State of North Carolina to continue to build our network of providers and services so consumers have a consistent, predictable environment in which to deal with their illness. The Clubhouse model is one of our best service delivery settings. Services provided in this setting can reduce hospitalizations and increase consumer involvement in the community through employment opportunities and higher education. Beginning with only 2 or 3 true clubhouses in the State, we now have 12 sites that use this approach and are working to increase this number. However, these gains are being jeopardized by the daily note requirement for Psychosocial Rehabilitation. Providers have found this requirement very challenging because so many of these services are delivered in group settings. It is causing further destabilization of a fragile provider network.

With regard to the proposed guidelines for rehabilitation, I propose that you add language to 441.45(a)(2) to clarify when services may be furnished in order to retain or maintain functioning. Without a maintenance level of services, consumers will fall into a cycle of decline and recovery.

Regarding the proposed guidelines for restorative services, I propose that you clarify the language to provide for services that are necessary to achieve and maintain the least intensive level of services and the most independence possible. Please consider these comments carefully.

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¶

Very truly yours,

Submitter : **Ms. Kathleen McDermott** **Date: 10/12/2007**

Organization : **The Chase Home for Children**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

My comments of this proposed rule stem from the perspective of residential treatment services for adolescents. I am the Executive Director of a community based residential treatment facility in the seacoast area of New Hampshire. We are licensed for up to 25 adolescents with an average census of 16 to 18. All referrals to our program come to us through the courts. The typical profile of a youth placed in our program is one with adjustment disorder usually with anxiety or depression. These diagnoses frequently necessitate psychiatric treatment including the need for medication. Other complicating factors include substance abuse and trauma which can lead to self harm and other unsafe behaviors.

My comments regarding the proposed rule are in three areas: the definition of rehabilitative services; the supervision arrangements for rehabilitative services; and, freedom of choice.

DEFINITION OF REHABILITATIVE SERVICES
Limiting this definition to reduction of a disability and restoration of the individual to the best possible functional level appears to ignore the standard child and adolescent developmental issues. In our programs, we are assisting the residents in often gaining new skills as they are often emotionally and psychologically developmentally delayed. For example, a resident may consistently use assaultive, aggressive behavior to express anger and anxiety. This may be their standard response to any situation causing anxiety. We believe that interventions used by staff in circumstances such as these should qualify as a rehabilitative service. Also, as one reads the proposed rule, it appears to focus on situations of adults and does not take into account the complicated and difficult psychosocial issues of children and adolescents.

SUPERVISION ARRANGEMENTS FOR REHABILITATIVE SERVICES
New Hampshire rules and regulations for residential treatment facilities require supervision of treatment plans by a licensed clinician who attends treatment planning meetings and signs off on the plan for each individual resident. The licensed clinician also provides clinical oversight and consultation to staff. The implementation of the plan on a 24 hour basis is performed by residential staff who meet the requirements set forth by state rule. In addition, our staff complete daily logs documenting a resident s progress in meeting the specific rehabilitative goals as stated in the treatment plan. If qualification standards for 24/7 staffing go beyond our state standards, salary and wages would be significantly increased placing an extremely difficult. If not impossible, burden on the finances of the program.

IMPLEMENTATION OF FREEDOM OF CHOICE
Insofar as all residents are placed as a result of a court decision, the resident does not have freedom to choose a qualified provider. However, once a court transfers custody to the state, the state then acts as the parent in choosing an appropriate program for the child/adolescent. Birth and/or adoptive parents are still very much involved in the process. Attendance and full participation at treatment plan meetings are always highly encouraged. Consultation with staff is always available and support and back up are provided during visits. As it stands, the proposed rules do not take into account children/adolescents who are court ordered into placement.

Thank you for the opportunity to submit these comments.

Sincerely,

Kathleen A McDermott, Executive Director
The Chase Home for Children
698 Middle Road
Portsmouth, New Hampshire 03801
603-436-2216 ext, 102

Submitter : Ms. Elizabeth Chadwick **Date:** 10/12/2007

Organization : The Devereux Foundation

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

The Devereux Foundation, founded in 1912, is the largest, nonprofit provider of behavioral healthcare in the country for individuals with developmental/intellectual disabilities, behavioral challenges, and mental illness. We are appreciative of the opportunity to comment on the proposed rule pertaining to the Medicaid Program:
Coverage for Rehabilitative Services, published in the Federal Register on August 13, 2007.

As an organization, we have worked with children, youth, and adults in a wide variety of settings, both community-based and residential. Like our founder, we believe in individualized care in the least restrictive setting appropriate to the needs of the individual. We are a significant player in efforts around the country to develop a comprehensive array of treatment options for these individuals and their families.

Medicaid, and the Rehabilitation Option, are an important part of the systems of care for some of the nation s most vulnerable or fragile citizens. Taken as a whole, the proposed rule changes do not advance these systems, and in fact, would be a step back in many instances.

We are greatly concerned that system fragmentation will worsen considerably based on the intent and direction reflected in the proposed rules. Forcing behavioral health treatment interventions to apply the same specific and rigid procedural and billing systems designed for physical disabilities and treatment may in fact force treatment interventions away from evidenced-based best practices. We will go into more detail below based on specific areas of concern in the proposed rules.

General Comments
Due to the complexity of these proposed changes, the lack of definition in some key areas, the lack of a comprehensive fiscal impact analysis, and the availability of other options already available to CMS, we urge that these rule changes, as proposed, be withdrawn.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

While we totally support the need to ensure the quality of providers of services, the wording around qualified providers needs to be carefully thought out to determine the impact across the array of community-based services which have developed to meet the needs of individuals and families. Some of these services, such as therapeutic foster care, have been demonstrated to be effective. Requiring therapeutic foster homes to meet state provider qualifications needs to be reviewed to ensure that required qualifications are commensurate with the level of care. Potentially excellent foster homes could be lost if this requirement is not carefully analyzed and implemented, and children will lose this valuable and needed service. There is a need for further impact analysis of the wording behind this requirement.

Written Rehabilitation Plan
Forcing all treatment services for individuals with mental illness or substance abuse into small, discrete, limited duration blocks may cause certain programs already deemed to be evidenced-based best practices to become ineffective. This particular aspect of this provision is contrary to some best practice therapies or interventions in the treatment of mental illness and addictive disease. Again, a program such as therapeutic foster care, typically provided as a single program, may become unavailable or ineffective based on the imposition of requirements ill-designed for this type of program. Further analysis is required so that states have time to plan and assess impact.

There may be necessary diagnostic and behavioral health assessments and emergency crisis intervention services required and delivered before the development of the rehabilitation plan. When it is not clinically indicated or reasonably possible to develop such a written plan prior to the delivery of a critical service, providers should be able to deliver and be reimbursed for these essential assessments and interventions.

Intrinsic Elements Exclusion
The breadth and lack of definition around this exclusion is of major concern. This broadly stated exclusion has the potential to dramatically further the fragmentation and absence of coordination among service systems. This appears contrary to the intent of the provisions in the President s New Freedom Commission Report on Mental Illness, and other federal agency and commission reports and recommendations in this critical area of U.S. healthcare. This language was also previously explicitly rejected by Congress during the passage of the Deficit Reduction Act.

Restorative Services
The restrictive impact of this narrowed definition may have unanticipated negative consequences when delivering services to individuals whose complete histories and past functioning level are not known, as well as for children whose disabilities were manifested prior to reaching developmental maturity. Their past inability to perform a function may have been due to chronological (age related) developmental issues. The definition should be adjusted to address these situations.
Again, we appreciate the opportunity to comment, and look forward to seeing the response from CMS as we all work together to improve the delivery of these critical services to our citizens who are already facing enough challenges.

Response to Comments

Response to Comments

Regulatory Impact Analysis
Given the responsibility of CMS to analyze the rule s costs and benefits, and the intent behind these requirements, it is clear that the complexity of this rule

change requires much greater fiscal and program analysis. This complexity in assessing impact is heightened by the breadth and variety of state Medicaid plans around the country. This rule should be withdrawn to allow this required and critical analysis to occur.

Submitter : Dr. Shu Cheng **Date:** 10/12/2007

Organization : Asian Association of Utah

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

The new regulations state:

"Individual's must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid." They go on to state the rehabilitation plan must:
"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 requirement raises several questions concerns:

1. Should the centers use state general fund money to pay the match and then be required to provide private providers to benefit at the disadvantage of employed staff?

2. This requirement may signal an expectation that rehabilitation planning will be a separate activity from service provision.

3. Clinicians that are responsible for the provision of services are the same individuals that complete the plan.

(It is highly unusual to expect a practitioner to list all potential providers of a service. If the intent is consumer choice the rehabilitation plan is an unusual and unwieldy method for achieving this.)

4. Managing a provider network of any willing provider and assuming medico-legal risk as an HMO is again unwieldy and of questionable business practice.
Additional concerns:

Collections of Information Requirements

Collections of Information Requirements

5. Requirement for a Written Rehabilitation Plan (pp. 61-63) ,the proposed rule describes the rehabilitation plan as follows:

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, individuals family, the individuals authorized decision maker and/or of the individuals choosing and also ensures the active participation of the individual, individuals family, individuals authorized decision maker and/or of the individuals 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 individuals condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individuals condition(s).

The regulation is silent on the relationship of the rehabilitation plan to the treatment plan, which raises the concern of the addition of a new, potentially duplicative planning requirement that will result in additional administrative time, as well as creating another level of audit and compliance complexity.

As described in the proposed rule, the Rehabilitation plan must include a total of 17 highly prescriptive elements. The time required for clinicians to complete these additional 17 elements is burdensome and will reduce the time available for actually seeing the consumer.
6. Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan .

Again this is a worthwhile goal, and Utah is moving to having this requirement, however, it is quite a leap to now see this requirement enshrined in federal law. Given that all 17 elements of the plan are presented as mandatory, absence of this signature would seem to make services ineligible for Federal Financial Participation, at the very least CMS must allow for a default in the event that the client refuses to sign.

7. Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

It is not clear when this certification is expected to be made, but clear that practitioners and agencies will have to meet a high standard, and be expected to understand and implement all of the requirements set forth in the proposed rule.

It is also not clear how this requirement duplicates the assessment and documentation requirements currently in place.

7. Include the individuals' relevant history, current medical findings, contraindications and identify the individuals care coordination needs, if any, as needed to achieve the rehabilitation goals.

Again, it is not clear when or how our providers can be expected to have this information, or even how they will identify all medical findings and contraindications in our fragmented system. This seems to be a very high standard to meet.

An overriding question regarding all of these standards is whether or not current staff can actually complete this plan as described?
Recommendation:

I recommend that a moratorium on these proposed rules until clarification and changes are made to the rules that would allow for successful implementation and compliance.

Submitter : Mrs. Albert Fisher **Date:** 10/12/2007

Organization : Community Partnerships, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#1300

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 : Dr. Shu Cheng **Date:** 10/12/2007

Organization : AAU

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Recommendation:

I recommend that a moratorium on these proposed rules until clarification and changes are made to the rules that would allow for successful implementation and compliance.

Submitter : Ms. Harriet Meyer **Date:** 10/12/2007

Organization : The Ounce of Prevention Fund

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-1302-Attach-1.DOC

October 5, 2007

RE: File Code CMS-2261-P.

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program submitted by the Ounce of Prevention Fund.

The Ounce of Prevention Fund appreciates this opportunity to submit comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program. The Ounce leverages change for at-risk children, beginning at birth, throughout Illinois and in partnering communities across the country. We combine private support with public funding to provide direct services to children and families, training for early childhood professionals, research on what works, and advocacy for sound early childhood programs and policies for children from birth to age five. Our work is grounded in the developmental needs of children and informed by science, which shows that investments during the earliest years yield great returns for families and society. Because of our commitment to young children, please consider our comments:

Non-covered services: 441.45(b)
The Ounce of Prevention does not support this newly introduced section. It conflicts with the current statute and it denies mandated EPSDT Medicaid mental health services for eligible children if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. The impact of this change on Medicaid eligible young children in foster care, child care, child welfare, and in the educational system will be grave.

Because of the unique developmental needs of young children, mental health services need to be comprehensive and family-centered. Many of the above listed programs provide comprehensive service plans that include social and emotional services for the child and the family. However, few of the above programs have a clear legal obligation to provide services covered under Medicaid. These programs also do not have the resources to provide the services without assistance from Medicaid. If adopted, many young children and their families risk losing the critical comprehensive services approach that ensures the best possibility for healthy development.

This section also indicates that services for the sole benefit of family members who are not themselves Medicaid eligible are no longer covered. Again, because of the unique developmental needs of young children, especially related to social and emotional development, there are times when the non-Medicaid eligible parent needs services as part of their young child's mental health treatment plan, such as parenting classes and parent-child therapy. The impact of this change could be severe.

Recommendation: We strongly recommend that this entire "intrinsic element" section be dropped. This new rule effectively denies all Medicaid-eligible young children and their families medically necessary services entitled to them under EPSDT due to lack of resources in other programs. In addition, we recommend that the department include in the list of eligible rehabilitative services mental health services for children birth to five with non-Medicaid eligible parents when those services to the parent are an essential part of the child's mental health treatment plan.

Please carefully consider the revised rules, as these changes could have a significant impact on the quantity and quality of mental health services that our most vulnerable young children receive.

Thank you for your consideration.

Best,

Harriet Meyer

Harriet Meyer
President
Ounce of Prevention Fund

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

Organization : Maine Developmental Disabilities Council

Category : State Government

Issue Areas/Comments

Background

Background

Collections of Information Requirements

Collections of Information Requirements

GENERAL

GENERAL

Please see attached document.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS-2261-P-1303-Attach-1.DOC

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by Julia J. Bell on behalf of the Maine Developmental Disabilities Council:

Non-covered services: 441.45(b)

Recommendation:

Delete this section from the proposed rule, or revise the language to clarify and limit its application only to those circumstances in which another insurer has a clear legal obligation to pay for the service. Programs operated through capped or discretionary appropriations from states or local governments should be specifically excluded from this provision.

Reason for recommendation:

The language in this section conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, and specifically includes those services that are considered "intrinsic elements" of that other program.

The proposed language suggests that CMS is assuming that non-medical programs are furnishing Medicaid-covered services and billing Medicaid instead of using other resources available to them for paying for those services. However, few of the programs cited in the regulation have a clear legal obligation to provide the Medicaid-covered services or have the resources to do so. For example, in the case of services provided in educational settings for students who qualify for special education services, the applicable federal statute – the Individuals with Disabilities Education Improvement Act (IDEA) – requires that other public funds be utilized for any covered service before any cost is paid for with IDEA funds.

As currently written, this section of the proposed rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r).

The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to a lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the federal statute.

The preamble to the federal Medicaid statute states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service that would have been provided to individuals outside of those other programs. The preamble also makes

clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The proposed rule should be amended to include this language.

The proposed rule would also restrict access to mental health services in the appropriate and least restrictive environment for children and adults. 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.

Mental health rehabilitation services should also be available for a child with a serious mental disorder who is being reunified with his or her family, if the child has specific problems directly stemming from the mental disorder. Addressing those issues would not be included in generic reunification services, but may be critical to the success of the reunification process and the mental health of the child.

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

Recommendation:

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

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

Reason for recommendation:

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice that provides needed services for the child in a community-based setting. The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

The proposed rule denies payment for therapeutic foster care as a single program, requiring instead that each component part be separately billed. If states are not able to create a package of covered services such as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs

Rehabilitative Services : 441.45(a)(2)-

Recommendation:

Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning. Language in the preamble to the proposed rule on page 45204 should be included, which addresses how to determine whether a service is a covered service, based on its purpose.

Reason for recommendation:

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

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

Recommendation:

Add clarification to this section that states that restorative services for a child may include services to enable a child to achieve age-appropriate growth and development, and that it is not necessary for the child to have performed the activity in the past. An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. The proposed rule currently includes an example related to adults.

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

Reason for recommendation:

The definition of restorative services states that the emphasis is on restoring the ability to perform a function, rather than requiring that the person has actually performed the function in the past. This language is important, as loss of function may have occurred long before the restorative services are provided. The example given addresses the use of public transportation for an adult who may not have needed to use this service in the past. However, it does not explain that a child need not demonstrate that he or she was once capable of performing a specific task if it was not possible or age-appropriate for the child to have done so.

This definition also includes as appropriate 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 people with serious mental or emotional disabilities, continuation of rehabilitative services is at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation may result in deterioration of functional abilities, necessitating a reinstatement of intensive services. If this section is interpreted to prohibit coverage of services necessary for retention of improved functioning and for maintaining the highest

possible functional level, many individuals' capabilities will deteriorate to the point where they will be eligible for services and the process can become cyclical, and more costly for all involved. This serves no one's interest.

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

EPSDT Mandate

The proposed rule does not mention the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. In several places, the regulation needs to be amended to reflect the EPSDT provision.

Recommendation:

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

Section 441.45(b)(4), insert a reference to EDPST for children as part of those services having to be targeted under the state's plan.

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

Submitter : Mrs. Bridget Schank **Date:** 10/12/2007

Organization : Mrs. Bridget Schank

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-1304-Attach-1.DOC

#1304

October 12, 2007

RE: File Code CMS-2261-P.

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program submitted by the Ounce of Prevention Fund.

Non-covered services: 441.45(b)

I do not support this newly introduced section. It conflicts with the current statute and it denies mandated EPSDT Medicaid mental health services for eligible children if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. The impact of this change on Medicaid eligible young children in foster care, child care, child welfare, and in the educational system will be grave.

Because of the unique developmental needs of young children, mental health services need to be comprehensive and family-centered. Many of the above listed programs provide comprehensive service plans that include social and emotional services for the child and the family. However, few of the above programs have a clear legal obligation to provide services covered under Medicaid. These programs also do not have the resources to provide the services without assistance from Medicaid. If adopted, many young children and their families risk losing the critical comprehensive services approach that ensures the best possibility for healthy development.

This section also indicates that services for the sole benefit of family members who are not themselves Medicaid eligible are no longer covered. Again, because of the unique developmental needs of young children, especially related to social and emotional development, there are times when the non-Medicaid eligible parent needs services as part of their young child's mental health treatment plan, such as parenting classes and parent-child therapy. The impact of this change could be severe.

Recommendation: I *strongly* recommend that this entire "intrinsic element" section be dropped. This new rule effectively denies all Medicaid-eligible young children and their families medically necessary services entitled to them under EPSDT due to lack of resources in other programs. In addition, I recommend that the department include in the list of eligible rehabilitative services mental health services for children birth to five with non-Medicaid eligible parents when those services to the parent are an essential part of the child's mental health treatment plan.

Please carefully consider the revised rules, as these changes could have a significant impact on the quantity and quality of mental health services that our most vulnerable young children receive.

Thank you for your consideration.

Best,

Bridget Schank

Submitter : Mr. Dale Rinard **Date:** 10/12/2007

Organization : TERROS, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1305-Attach-1.DOC

#1305

October 12, 2007

Centers for Medicare & Medicaid Services
Dept 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

TERROS, Inc. is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

TERROS, founded in 1969, is a non-profit, community based organization offering a wide variety of behavioral health treatment, intervention, education and prevention services. Our programs include:

- mobile Crisis services for adults, adolescents and children;
- substance abuse and mental health treatment for adults;
- HIV prevention education, counseling and testing services;
- co-occurring disorder treatment;
- wellness and recovery services for person with serious mental illness;
- the Families F.I.R.S.T. (Families in Recovery Succeeding Together) program, and
- the Canyon Corridor Youth Development Program, a prevention program for the youth of West Phoenix

TERROS has provided services for approximately 17,000 residents of Maricopa County, AZ during the past year under contract with Magellan of Arizona and ValueOptions, the current and recent past Regional Behavioral Health Authorities for the county under the Arizona Department of Health Services/Behavioral Health Services division (ADHS/BHS).

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas 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 critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services those 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 people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and remission, and the long-term clinical course of these conditions is difficult to determine. As an illustration, *Mental Health: A Report of the Surgeon General*, notes that for people living with schizophrenia, "..a small percentage (10 percent or so) seem to remain severely ill over long periods of time (Jablensky et al., 1992: Gerbaldo et al., 1995). While these individuals can significantly improve, "most do not return to their prior state of mental function." (Mental Health: Report of the Surgeon General, 1999, pg. 274).

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would 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 individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Similarly, CMS in the Medicare program explicitly acknowledges the importance of maintenance of current functioning as an acceptable goal:

> 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."

Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

Additionally, the preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss has a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

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

Secondly, 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.

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

440.130(viii)(3) Written Rehabilitation Plan

We do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed. Without attention to our suggestions, this new requirement will add significantly to the administrative time and expense of agencies serving individuals in need of rehabilitative services.

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for every encounter will become a major burden, especially when services are delivered to a group.) We would recommend that progress notes be required at least monthly, leaving it to states to require, or providers to make, more frequent notes in cases where that may be appropriate. The guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the

nature and course of services being provided.

Is it allowable for a service planning team to create a single plan of services that address both treatment issues and rehabilitation issues? Frequently in mental health service delivery clinical issues (such as medication and therapy) are planned in conjunction with rehabilitation needs (skill building, etc.). Requiring two separate planning processes and two separate planning documents is burdensome not only on providers but also on the individual consumer. Clearly, multiple service plans do not facilitate coordination or accountability. The regulation does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

We are puzzled by the requirement that the plan include information on alternate providers of the same service. In almost all communities, the number of providers willing to accept Medicaid reimbursement is small. This reality is even more problematic in rural and frontier areas of the country. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation.

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative in some rare cases may be problematic. There are two factors to consider.

First, severe mental illness is episodic, and it is not always possible to determine when an exacerbation of the illness may occur. There may be instances in which a person, because of the symptoms of their illness, may not believe they are sick or comply with the signing the treatment plan, and it is also true, that at this point in the individual's life, retention of services are critical to prevent hospitalization, incarceration, or other public or personal safety consequences. There is also no guarantee that the individual has appointed a representative, or that the consumer in crisis could identify this person. Therefore, CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.

<u>Recommendations</u>:

We recommended inclusion of the following requirements regarding the written rehabilitation plan:

X that this plan be written in plain English so that it is understandable to the individual.

X that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.

X that the plan of services be based on a strengths-based assessment of needs;

X that the plan include intermediate rehabilitation goals;

X that, as indicated, the plan include provisions for crisis intervention;

X that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

X substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers.

CMS should also clarify that a single treatment and rehabilitation plan is acceptable and encourage a single planning team and service planning meetings.

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

Insert additional language into this section (from the preamble) to state that it is helpful to scrutinize the purpose of the service as defined in the care plan in order to determine whether a specific service is a covered rehabilitative benefit.

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered Aintrinsic elements@ of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an Aintrinsic element@ of another program.

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

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

Recommendation:

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

Alternatively, the section should be clarified and narrowed so as to specifically focus on

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

Some subsections of Section 441.45(b) include language that ensures that children in the other settings that are 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 of the subsections (i) through (iv).

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 preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

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

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

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 both the state and provider agency level. The development of new forms as well as staff training, administrative processes all pose significant challenges at the Agency level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of the State Plan Amendment by the Agency.

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

Sincerely,

Dale Rinard
President/CEO
TERROS

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

Organization : Scott Nash

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

October 10, 2007

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

Re: File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services.

Dear Sir or Madam:

Thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am writing as a member of The National Alliance on Mental Illness (NAMI), the nation s largest grassroots organization representing individuals living with serious mental illnesses and their families. As members of NAMI, we have lived experience with mental illness and bring that unique perspective to our comments on these rules.

We know from personal experience that access to rehabilitative services can make all the difference in a person s life. We have seen people get services to help them recover from their illness. With services and support, individuals with serious mental illness can and do live very well in the community and have strong relationships with family and friends. We have also seen those who can t get help and have seen the pain and trauma from untreated mental illness for the individual and his or her family. Often the person will have multiple stays in hospitals and jails.

NAMI conducted a survey of the 50 state mental health agencies for our Grading the States report and found what individuals with mental illness and their family members already know in all the states, there are gaps in services and many people with serious mental illnesses are not getting the help that they need. The average state grade was a D. So we know that there is much work to be done to ensure that people can get the treatment they need when they need it. NAMI members know that treatment works, if you can get it.

As a result, we are very troubled by the estimate in the proposed regulation that these rules would save the federal government 2.2 billion dollars. Our experiences tell us that creating barriers to vital services will not save money in the long run. Rather, it will increase the costs from hospitalization, incarceration and other bad outcomes that result from a failure to get needed treatment.

We appreciate the emphasis on recovery in the rules. All individuals with mental illness and their families want the system to make it easier to recover. We also like the provisions about the participation of the individual and their family in the rehabilitative plan and receiving copies of the plan so we can hold the system accountable. We would like to see some flexibility to make sure that providers can still do outreach and provide crisis care, but we very much appreciate the agency s intent to encourage communication between providers, the individual and family members.

However, we have a few areas of deep concern where we hope the agency will reconsider its rules. We would like to see services 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.

Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan:

The proposed regulations require that a written rehabilitation plan set out the services that will be provided. The plan is to be written with the involvement of the individual and the family. We very much applaud the agency for including the person and the family in the planning and for encouraging person centered planning.

We would like to see some flexibility in the rules to allow providers to conduct outreach to individuals who may not be ready to be part of a formal treatment planning process. Sometimes, it takes repeated visits before a person is ready and understands how treatment will be a benefit to him or her.
Thank you

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

Organization : Autism Society of America

Category : Consumer Group

Issue Areas/Comments

Background

Background

The Autism Society of America (ASA) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on proposed regulations with respect to Medicaid coverage of rehabilitative services that were published in the Federal Register on August 13, 2007. The ASA supports comments submitted on behalf of the Consortium for Citizens with Disabilities (CCD), however, is providing these comments specific to individuals with autism spectrum disorders. The ASA is the oldest and largest organization advocating on behalf of individuals with autism spectrum disorders, their families, and the professionals who serve them. ASA s membership includes individuals with autism spectrum disorders, including autistic disorder, Asperger disorder and pervasive developmental disorder-not otherwise specified, along with family caregivers, and professionals concerned with the health and well-being of individuals with autism spectrum disorders.

ASA is concerned that the broad definitions contained in the proposed regulations will result in a lack of rehabilitative services for individuals with autism spectrum disorders (hereunto referred to as autism). Autism is a unique disorder in that children and adults with autism often have interfering behaviors that mask typical functional abilities. In fact, autism, once considered a mental illness, is now classified by the DSM as a developmental disorder however individuals with autism straddle the mental health and developmental disabilities service systems due to the communication, sensory, and behavioral characteristics of the disability. Discussing children with autism, the 1999 Report on Mental Health by the Surgeon General states that the goal for treatment is to promote the child s social and language development and minimize behaviors that interfere with the child s functioning and learning. (italics mine). Within the medical system, children and adults with autism receive significant amounts of rehabilitative services under the care of therapists and behavioral and mental health professionals to address rehabilitative goals: 1) the reduction and elimination of interfering behaviors, 2) the reduction and elimination of hyper- and hypo- sensitivities, and 3) the increased use of speech and communication. Separately and taken together these characteristics of autism interfering behaviors, sensory dysfunction, and communication deficits are a set of symptoms that mask normal functioning that may or may not have been observed prior to treatment. Overall, we are very concerned that proposed regulatory language regarding restorative services and functional loss does not recognize the masking effect of these symptoms and thus the rehabilitative needs of individuals with autism. As well, because autism is defined as a developmental disability under the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), we are concerned that individuals with autism who have justified rehabilitation needs will be restricted from accessing rehabilitation services as individuals with mental retardation and related conditions, limitations we call into question and that are addressed in the Consortium of Citizens with Disabilities (CCD) comments.

We suggest the following changes to the proposed regulations to ensure that individuals with autism who require rehabilitation services receive those services:

SECTION 440.130 DIAGNOSTIC, SCREENING, PREVENTATIVE AND REHABILITATIVE SERVICES

42 CFR Part 440.130 (d)(i)(A)
Change the current proposed regulations to read:
(A) Determined that receipt of rehabilitative services would result in reduction of the individual's physical or mental disability or related symptomatology and restoration to the best possible functional level of the individual or establishment of a state of function that was otherwise masked by symptoms; and

Collections of Information Requirements

Collections of Information Requirements

42 CFR Part 440.130 (d)(v)

Change the current proposed regulations to read:

(v) Rehabilitation plan means a written plan that specifies the physical impairment, behavioral disorder, 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 serviees. 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).

42 CFR Part 440.130 (d)(vi)

Change the current proposed regulations to read:

(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 or an individual who has symptoms that mask function and has a specific rehabilitative goal toward demonstrating 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. Likewise, an individual with a

disability such as autism may have perseverative behaviors that interfere with their ability to interact, but with rehabilitation can reduce those interfering behaviors. 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 rebabilitative 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 seope of rehabilitation services.

42 CFR Part 440.130 (d)(vii)

Change the current proposed regulations to read:
(vii) Medieal services means services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care of a physical, behavioral, 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, behavioral intervention, and mental health and substance-related disorder rehabilitative services.
42 CFR Part 440.130 (d)(viii)

Change the current proposed regulations to read:
(viii) Remedial services means services that are intended to correct a physieal, behavioral, or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.
New Definition

Add a definition of Interfering Behaviors :

Interfering behaviors are any behaviors that mask function by preventing or hindering the processes of learning or interaction. In most cases, an interfering behavior represents an individual s most readily available strategies for handling the situation at hand (i.e. self-stimulatory behaviors, self-injurious behaviors, etc.) and can

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

42 CFR Part 440.130 (d)(viii)

Change the current proposed regulations to read:
(viii) Remedial services means services that are intended to correct a physical, behavioral, or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.
New Definition

Add a definition of Interfering Behaviors :

Interfering behaviors are any behaviors that mask function by preventing or hindering the processes of learning or interaction. In most cases, an interfering behavior represents an individual s most readily available strategies for handling the situation at hand (i.e. self-stimulatory behaviors, self-injurious behaviors, etc.) and can be reduced or eliminated with behavioral interventions as part of a rehabilitation plan.

42 CFR Part 440.130 (3)(v)

Change the current proposed regulations to read:
(v) Specify the physical impairment, behavioral disorder, mental health and/or substance related disorder that is being addressed.
42 CFR Part 440.130 (3)(vi)

Change the current proposed regulations to read:
(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, behavioral disorder, mental health and/or substance related disorder.
42 CFR Part 440.130 (4)

Change the current proposed regulations to read:
(4) Impairments to be addressed. For purposes of this section, rehabilitative services include services provided to the Medicaid eligible individual to address the individual's physical, sensory, and communication impairments, interfering behaviors, mental health impairments, and/or substance-related disorder treatment needs.
SECTION 441.45 REHABILITATIVE SERVICES
42 CFR Part 441.45 (a)(2)

Change the current proposed regulations to read:
(2) Ensure that rehabilitative services are limited to services furnished for the maximum reduction of physical or mental disability or related symptomatology and restoration of the individual to their best possible functional level or establishment of a state of function that was otherwise masked by symptoms.
42 CFR Part 441.45 (b)(2)

Change the current proposed regulations to read:
2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include ``services provided to individuals' with mental retardation or related conditions. (Most physical impairments, behavioral disorders, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.)
Comments: The ASA is concerned that the unintended consequences of this section is that individuals with autism and other developmental disabilities that require rehabilitative services (behavioral interventions, speech therapy, occupational therapy, etc) to reach justifiable rehabilitation goals will not be able to do so due to narrow interpretations of this section by States. The ASA concurs with CMS that some States have historically and inappropriately used Medical Day Programs for individuals with developmental disabilities who did not have rehabilitation goals, however, the proposed regulation needs clarifying language to assure that individuals with autism and other developmental disabilities that have rehabilitation needs are provided needed rehabilitation services without regard to their disability. Currently individuals with developmental disabilities receiving Medicaid are often denied rehabilitative services based on their disability, even when the service has a rehabilitative goal. This is particularly true of individuals with autism whose behaviors are seen as an inherent part of their disability as opposed to interfering behaviors that mask function and are treatable through appropriate behavioral, occupational, and speech therapies. As written, this section will exacerbate existing discrimination and res

Provisions of the Proposed Rule

Provisions of the Proposed Rule

42 CFR Part 440.130 (3)(v)

Change the current proposed regulations to read:
(v) Specify the physical impairment, behavioral disorder, mental health and/or substance related disorder that is being addressed.
42 CFR Part 440.130 (3)(vi)

Change the current proposed regulations to read:
(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, behavioral disorder, mental health and/or substance related disorder.
42 CFR Part 440.130 (4)

Change the current proposed regulations to read:
(4) Impairments to be addressed. For purposes of this section, rehabilitative services include services provided to the Medicaid eligible individual to address the individual's physical, sensory, and communication impairments, interfering behaviors, mental health impairments, and/or substance-related disorder treatment needs.
SECTION 441.45 REHABILITATIVE SERVICES
42 CFR Part 441.45 (a)(2)

Change the current proposed regulations to read:
(2) Ensure that rehabilitative services are limited to services furnished for the maximum reduction of physical or mental disability or related symptomatology and restoration of the individual to their best possible functional level or establishment of a state of function that was otherwise masked by symptoms.
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Change the current proposed regulations to read:
2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include ``services provided to individuals' with mental retardation or related conditions. (Most physical impairments, behavioral disorders, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.)
Comments: The ASA is concerned that the unintended consequences of this section is that individuals with autism and other developmental disabilities that require rehabilitative services (behavioral interventions, speech therapy, occupational therapy, etc) to reach justifiable rehabilitation goals will not be able to do so due to narrow interpretations of this seetion by States. The ASA concurs with CMS that some States have historically and inappropriately used Medical Day Programs for individuals with developmental disabilities who did not have rehabilitation goals, however, the proposed regulation needs clarifying language to assure that individuals with autism and other developmental disabilities that have rehabilitation needs are provided needed rehabilitation services without regard to their disability. Currently individuals with developmental disabilities receiving Medicaid are often denied rehabilitative services based on their disability, even when the service has a rehabilitative goal. This is particularly true of individuals with autism whose behaviors are seen as an inherent part of their disability as opposed to interfering behaviors that mask function and are treatable through appropriate behavioral, occupational, and speech therapies. As written, this section will exacerbate existing discrimination and result in increased disability and higher Medicaid costs over time.
42 CFR Part 441.45 (b)(3)

Change the current proposed regulations to read:
(3) Recreational or social aetivities that are not focused on rehabilitation and not provided by a Medicaid qualified provider; personal care services; transportation; vocational and prevocational services; or patient education not related to reduction of physical or mental disability or related symptomatology and the restoration of an individual to his or her best possible functional level or establishment of a state of function that was otherwise masked by symptoms.

Regulatory Impact Analysis

Regulatory Impact Analysis

OTHER CONCERNS

ASA would like to highlight several other key concerns:

" As drafted the proposed rule does not comply with Medicaid s Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements and will have a significant impact on children with autism. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement and clarification that children with developmental disabilities such as autism have unfettered access to these services.

" ASA shares the concern of other CCD members that the proposed regulations contradict Section 6411(g) of OBRA 89, in that the proposed rule does not specify which day habilitation services that a state may cover, but rather prohibits the provision of any habilitation services under paragraphs (9) and (13) of section 1905(a) of the Social Security Act.

" ASA believes that the provision of rehabilitation services as part of the Medicaid State Plan to individuals with autism and other developmental disabilities is a cost-effective way to provide services and by narrowing definitions of rehabilitation services, this proposed regulation will force States to:

1) Deny services to individuals with autism thereby increasing disability and resulting health care costs.

If interfering behaviors in individuals with autism are not addressed quickly, they become part of a larger pattern of behaviors that can increase in severity and are more difficult to reduce and eliminate. For example, access to timely rehabilitative services to address a single interfering behavior (i.e. a self-injurious behavior) is more cost effective than a 6-week stay at a hospital neurobehavioral unit (or medical costs to address a detached retina caused by the self-injurious behavior), as well as better for the individual and his or her family.

2) Force individuals who do not require home and community based services onto HCBS waivers at greater cost and at the expense of individuals who require habilitative services.

From a fiscal standpoint, the availability of timely, evidence-based rehabilitation services through the State Plan is a means to address individuals with autism low level rehabilitative needs thus averting the need for greater and more costly habilitative services provided under HCBS waivers. Once in a comprehensive HCBS waiver, individuals are entitled to all needed services under the waiver. The availability of rehabilitative services under the State Plan reduces disability and symptomatology and allows limited waiver slots for individuals with higher levels of disability.
" ASA believes the Rehabilitation Option, section 1915(c) waivers, and section 1915 (i) of the Deficit Reduction Act (DRA) of 2005 serve different functions (rehabilitative vs. habilitative) and should be viewed as a continuum of services for individuals with autism who have both rehabilitative and habilitative needs. Language in the proposed rules limit the availability of rehabilitation services to individuals with autism (if not by design, by interpretation).
AREAS OF AGREEMENT AND OPPORTUNITY

Despite our areas of concern, there is much about the proposed regulations that ASA supports. We believe that the revised requirements for the Rehabilitation Plan provide for greater accountability, increased collection of data, and the use of evidence-based practices. These requirements, we believe, will force treating professionals to improve rehabilitation services and result in improved outcomes for individuals with autism, along with reduced medical and long-term care costs. In fact, if the recommended changes are made clarifying that individuals with autism have rehabilitation needs in the areas of interfering behaviors, sensory dysfunction, and communication deficits which would be covered by services under the Rehabilitation Option , we believe that the populations outcomes would be significantly improved.

Response to Comments

Response to Comments

Because there are significant concerns from a broad community of disability groups, the ASA recommends that the Secretary withdraw the proposed rule and work collaboratively with stakeholder groups to redraft regulations. The ASA would welcome the opportunity to be involved in such a redrafting and once again, thanks CMS for this opportunity to comment.

Sincerely,

Lee Grossman
President and CEO

Submitter : Dr. Mary Kealy **Date:** 10/12/2007

Organization : CEC

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

#1308

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 : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Mary Kealy **Date:** 10/12/2007

Organization : CASE

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-1310-Attach-1.DOC

#131

COUNCIL OF ADMINISTRATORS OF SPECIAL EDUCATION, INC
A DIVISION OF THE COUNCIL FOR EXCEPTIONAL CHILDREN
1005 State University Drive Fort Valley, Georgia 31030
Tel: 478/825-7667 - FAX: 478/825-7811 - E-mail: lpurcell@bellsouth.net
Website: www.casecec.org
Luann L. Purcell, Ed.D., Executive Director

October 12, 2007

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

Dear Sir(s) or Madam(s):
The Council of Administrators of Special Education, Inc., (CASE) is a non-profit professional organization which provides leadership and support to approximately 5,000 members by influencing policies and practices to improve the quality of education. CASE is a division of the Council for Exceptional Children (CEC), which is the largest professional organization of teachers, administrators, parents, and others concerned with the education of children with disabilities, giftedness, or both.

As the CASE policy and Legislation Chair and member of CEC, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

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.

Major Issues and Concerns

CASE has major issues with the proposed rule. We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and

procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

1) Unjustified and unnecessary, the proposed rule would not further the purposes of Title XIX of the Social Security Act.

A central purpose of the Medicaid law is to provide rehabilitative services. Section 1901 of the Social Security Act reads,

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish...(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

Not only does the proposed rule not further this core goal of Medicaid, it erects new obstacles for Medicaid beneficiaries to receive medically necessary rehabilitative services. It does not justify the need for new rules and it does not provide a reasonable description of the impact of the proposed rule on Medicaid beneficiaries or rehabilitative services providers. The Regulatory Impact Analysis makes numerous assertions that are contradictory and appear intended to mask the impact of the proposed rule. For example, it states that, "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." In reality, the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on providers. The proposed rule also states that, "...because FFP [Federal financial participation] will be excluded for rehabilitative services that are included in other Federal, State, and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This would impose substantial increased costs on states that must change many of their administrative practices and that must either limit access to medically necessary services or increase state spending to provide services that were previously eligible for Medicaid FFP.

2) Contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.

In several instances, we believe that the proposed rule exceeds the Executive's regulatory authority and is inconsistent with Medicaid law.

a. The proposed rule would hinder access to prevention services.

We are troubled that the proposed rule could interfere with states' ability to deliver preventive services, authorized by section 1905(a)(13) of the Social Security Act, as defined by 42 C.F.R. § 440.130(c). Although the proposed rule ostensibly amends only 42 C.F.R. § 440.130(d), it creates the clear impression that numerous preventive services would be prohibited under section 1905(a)(13), even if they could be covered as preventive services.

Any revised rule should make clear that states can continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. § 440.130(c).

b. The proposed rule illegally imposes an intrinsic element test.

The proposed rule would deny FFP for services furnished, through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

c. The proposed rule does not fully comply with the EPSDT mandate for children.

We are very troubled by the potential impact of the proposed rule on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that

the proposed rule complies with Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a state's Medicaid plan. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement.

3) **Implementation of the proposed rule would severely harm several Medicaid populations.**

We believe that the proposed rule could severely restrict access to services and cause significant harm to several Medicaid populations:

a. The proposed rule would harm people with mental illness.

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would place Medicaid beneficiaries with mental illness at risk for poorer health outcomes and this could lead to relapse or new episodes of illness. Such incidents typically result in increased utilization of high cost services such as emergency room care and inpatient care. The proposed rule does not alter Medicaid eligibility, it would simply restrict access to certain services—often those that are most effective and the least costly. Therefore, we also worry that this proposal could lead to increased Medicaid spending if individuals are forced to get more costly, but less effective or appropriate services. In particular, we are concerned that the proposed rule could lead to increased hospitalizations that would be otherwise preventable, through the provisioning of community-based rehabilitative services.

It should be noted that given the high proportion of Medicaid beneficiaries receiving rehab option services that have mental illness, all of the harms and concerns and raised in these comments should be considered to apply to people with mental illness.

b. The proposed rule would harm people with intellectual and other developmental disabilities

The proposed rule would severely harm people with intellectual disabilities (formerly called mental retardation) and other developmental disabilities in two major ways: it eliminates longstanding programs for providing day habilitation services to people with developmental disabilities, and it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative

services for people with mental retardation and related conditions (a statutory term for people with intellectual and other developmental disabilities).

Elimination of FFP for habilitation services provided under the rehab and clinic options: In 2006, roughly $808 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities. In the same year, it has been estimated that approximately 52,000 people with intellectual and other developmental disabilities received day habilitation services through the clinic and rehab options (Unpublished estimates, David Braddock, Coleman Institute for Cognitive Disabilities, University of Colorado). We believe that this proposed restriction contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239). This section reads:

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

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

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

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under their state plans to transition to appropriate Medicaid coverage authorities, such as section 1915(c) waivers or the Home and Community-Based Services State plan option under section 1915(i)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

Further, section 1915(c) waivers and the section 1915(i) option are not equivalent to the rehab or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something that is

not required for rehab or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists, something that is not permitted for clinic or rehab option services. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006). Shifting habilitation services to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable.

We strongly recommend that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions: We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehab option services for people with mental retardation and related conditions. CMS policy appears to be that these individuals should receive services only through waiver programs (or the related 1915(i) option), and this is nonsensical in circumstances such as where a person with an intellectual disability has a knee replacement and needs services to regain physical functioning of the knee or where a person with epilepsy develops a substance abuse disorder. Further, this policy is likely to increase federal and state costs, as benefits for home- and community-based services (HCBS) waiver programs tend to be far more extensive than is generally provider under the rehab option.

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior

capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. This policy was not the result of Congressional action and preceded a period of significant progress in advancing the civil rights of people with disabilities. While the Americans with Disabilities Act (ADA) does not apply to federal administration of Medicaid, we believe that this policy violates, at a minimum, the spirit of the ADA, wherein the Congress was intending to impose a comprehensive national prohibition against discrimination on the basis of disability.

We urge the Secretary to rescind this constraint on rehab option services that is so blatantly stigmatizing and discriminatory to people with intellectual and other developmental disabilities.

4) **Challenges efforts by states, school districts, and early intervention providers to effectively deliver health care services to children with disabilities in school/early childhood settings.**

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to a free, appropriate public education and early intervention services in conformity with an individualized education program (IEP) and an individualized family service plan (IFSP). An IEP/IFSP is developed for eligible individuals with disabilities and describes the range of services and supports needed to assist individuals in benefiting from and maximizing their educational/developmental opportunities. The types of services provided under an IEP/IFSP include services such as speech pathology and audiology services, and physical, psychological and occupational therapies. While IDEA confers rights to individuals and obligations on the part of school systems/early intervention providers, it is not directly tied to a specific program or an automatic funding source. For years, the Federal government has failed to provide anywhere near the level of funding promised in the IDEA statute. States' ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP/IFSP helps defray some of the state and local costs of implementing IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IEPs/IFSPs have been a contentious issue in the past. Some time ago, HCFA attempted to limit the availability of Medicaid funding for services under IDEA. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to

Medicaid-eligible children under an IEP/IFSP. Under current law, the Social Security Act at section 1903 (c) reads,

> "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 H of such Act."

Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitative services in school and early childhood settings, new requirements of this rule could be disruptive and could make it more difficult to use the school and early childhood environments to assure that children with disabilities receive the rehabilitative services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools and early childhood settings. While we share the goal of ensuring that all rehabilitative services are of the highest quality and are only provided by providers who meet state credentialing standards, we are concerned that this rule would limit state flexibility to establish provider qualification requirements in school and early childhood settings. Further, we are concerned that the any willing provider requirement could be disruptive to efforts to serve children. We believe that the existing free choice of provider which guarantees parents the right to access medically necessary therapy and other services by other providers—outside of the school/early childhood environment—is an appropriate way to protect parents' right to access the Medicaid qualified provider of their choice. Again, the Secretary has not provided a policy justification for this new requirement, and we believe the net impact will be to make it less desirable for Medicaid programs to use school/early childhood settings to provide essential rehabilitative services to children. The Congress could not have been clearer in its intent that it wants Medicaid to support the goals of IDEA; we believe that these narrow interpretations of the law are inconsistent with that intent.

For these and other reasons, we urge the Secretary to withdraw the proposed rule.

Thank you for allowing the public to provide comments on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid Program and for considering CASE's recommendations.

Sincerely,
Mary V. Kealy, EdD
Chairperson, Policy and Legislation Committee
Council of Administrators of Special Education

Submitter : Dr. Mary Kealy **Date:** 10/12/2007

Organization : CEC

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-1311-Attach-1.DOC

#1311

Loudoun County Public Schools

Department of Pupil Services
21000 Education Court
Ashburn, Virginia 20148
Telephone: 571-252-1200
FAX: 571-252-1242

October 12, 2007

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

Dear Sir(s) or Madam(s):

I am a member of the Council for Exceptional Children (CEC), Chair of the Policy and Legislation Committee of the Council of Administrators of Special Education (CASE) and an assistant superintendent for pupil services, Loudoun County Public Schools, VA, a large school district in the metropolitan Washington DC area. CEC and CASE are the largest professional organizations of teachers, administrators, parents, and others concerned with the education of children with disabilities, gifted and talents, or both. As a member of CEC and CASE, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

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.

Major Issues and Concerns

CEC has major issues with the proposed rule. We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by

the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

1) **Unjustified and unnecessary, the proposed rule would not further the purposes of Title XIX of the Social Security Act.**

A central purpose of the Medicaid law is to provide rehabilitative services. Section 1901 of the Social Security Act reads,

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish... (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

Not only does the proposed rule not further this core goal of Medicaid, it erects new obstacles for Medicaid beneficiaries to receive medically necessary rehabilitative services. It does not justify the need for new rules and it does not provide a reasonable description of the impact of the proposed rule on Medicaid beneficiaries or rehabilitative services providers. The Regulatory Impact Analysis makes numerous assertions that are contradictory and appear intended to mask the impact of the proposed rule. For example, it states that, "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." In reality, the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on providers. The proposed rule also states that, "...because FFP [Federal financial participation] will be excluded for rehabilitative services that are included in other Federal, State, and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This would impose substantial increased costs on states that must change many of their administrative practices and that must either limit access to medically necessary services or increase state spending to provide services that were previously eligible for Medicaid FFP.

2) **Contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.**

In several instances, we believe that the proposed rule exceeds the Executive's regulatory authority and is inconsistent with Medicaid law.

a. The proposed rule would hinder access to prevention services.

We are troubled that the proposed rule could interfere with states' ability to deliver preventive services, authorized by section 1905(a)(13) of the Social Security Act, as defined by 42 C.F.R. § 440.130(c). Although the proposed rule ostensibly amends only 42 C.F.R. § 440.130(d), it creates the clear impression that numerous preventive services

would be prohibited under section 1905(a)(13), even if they could be covered as preventive services.

Any revised rule should make clear that states can continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. § 440.130(c).

b. The proposed rule illegally imposes an intrinsic element test.

The proposed rule would deny FFP for services furnished, through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

c. The proposed rule does not fully comply with the EPSDT mandate for children.

We are very troubled by the potential impact of the proposed rule on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that the proposed rule complies with Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a state's Medicaid plan. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement.

3) Implementation of the proposed rule would severely harm several Medicaid populations.

We believe that the proposed rule could severely restrict access to services and cause significant harm to several Medicaid populations:

a. The proposed rule would harm people with mental illness.

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health

diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would place Medicaid beneficiaries with mental illness at risk for poorer health outcomes and this could lead to relapse or new episodes of illness. Such incidents typically result in increased utilization of high cost services such as emergency room care and inpatient care. The proposed rule does not alter Medicaid eligibility, it would simply restrict access to certain services—often those that are most effective and the least costly. Therefore, we also worry that this proposal could lead to increased Medicaid spending if individuals are forced to get more costly, but less effective or appropriate services. In particular, we are concerned that the proposed rule could lead to increased hospitalizations that would be otherwise preventable, through the provisioning of community-based rehabilitative services.

It should be noted that given the high proportion of Medicaid beneficiaries receiving rehab option services that have mental illness, all of the harms and concerns and raised in these comments should be considered to apply to people with mental illness.

b. The proposed rule would harm people with intellectual and other developmental disabilities

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

Elimination of FFP for habilitation services provided under the rehab and clinic options: In 2006, roughly $808 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities. In the same year, it has been estimated that approximately 52,000 people with intellectual and other developmental disabilities received day habilitation services through the clinic and rehab options (Unpublished estimates, David Braddock, Coleman Institute for Cognitive Disabilities, University of Colorado). We believe that this proposed restriction contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239). This section reads:

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

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

We also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that individuals receive the highest quality habilitative and rehabilitative services according to current standards of treatment. The preamble of the proposed rule states that the rehab option is not a "custodial" benefit. We agree with the

Secretary that state programs operated under the rehab and clinic options should set high standards for delivering active treatment and for innovating to develop programs for people with intellectual and other developmental disabilities that maximizes their ability to attain, maintain, and retain their maximum ability to function, consistent with the original conception of rehabilitation, as found in section 1901 of the Social Security Act.

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under their state plans to transition to appropriate Medicaid coverage authorities, such as section 1915(c) waivers or the Home and Community-Based Services State plan option under section 1915(i)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

Further, section 1915(c) waivers and the section 1915(i) option are not equivalent to the rehab or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something that is not required for rehab or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists, something that is not permitted for clinic or rehab option services. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006). Shifting habilitation services to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable.

I strongly recommend that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions : We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehab option services for people with mental retardation and related conditions. CMS policy appears to be that these individuals should receive services only through waiver programs (or the related 1915(i) option), and this is nonsensical in circumstances such as where a person with an intellectual disability has a knee replacement and needs services to regain physical functioning of the knee or where a person with epilepsy develops a substance abuse disorder. Further, this policy is likely to increase federal and state costs, as benefits for home- and community-based services (HCBS) waiver programs tend to be far more extensive than is generally provider under the rehab option.

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. This policy was not the result of Congressional action and preceded a period of significant progress in advancing the civil rights of people with disabilities. While the Americans with Disabilities Act (ADA) does not apply to federal administration of Medicaid, we believe that this policy violates, at a minimum, the spirit of the ADA, wherein the Congress was intending to impose a comprehensive national prohibition against discrimination on the basis of disability.

We urge the Secretary to rescind this constraint on rehab option services that is so blatantly stigmatizing and discriminatory to people with intellectual and other developmental disabilities.

4) Challenges efforts by states, school districts, and early intervention providers to effectively deliver health care services to children with disabilities in school/early childhood settings.

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to a free, appropriate public education and early intervention services in conformity with an individualized education program (IEP) and an individualized family service plan (IFSP). An IEP/IFSP is developed for eligible individuals with disabilities and describes the range of services and supports needed to assist individuals in benefiting from and maximizing their educational/developmental opportunities. The types of services provided under an IEP/IFSP include services such as speech pathology and audiology services, and physical, psychological and occupational therapies. While IDEA confers rights to individuals and obligations on the part of school systems/early intervention providers, it is not directly tied to a specific program or an automatic funding source. For years, the Federal government has failed to provide anywhere near the level of funding promised in the IDEA statute. States' ability to appropriately rely on

Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP/IFSP helps defray some of the state and local costs of implementing IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IEPs/IFSPs have been a contentious issue in the past. Some time ago, HCFA attempted to limit the availability of Medicaid funding for services under IDEA. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP/IFSP. Under current law, the Social Security Act at section 1903 (c) reads,

> "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 H of such Act."

Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitative services in school and early childhood settings, new requirements of this rule could be disruptive and could make it more difficult to use the school and early childhood environments to assure that children with disabilities receive the rehabilitative services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools and early childhood settings. While we share the goal of ensuring that all rehabilitative services are of the highest quality and are only provided by providers who meet state credentialing standards, we are concerned that this rule would limit state flexibility to establish provider qualification requirements in school and early childhood settings. Further, we are concerned that the any willing provider requirement could be disruptive to efforts to serve children. We believe that the existing free choice of provider which guarantees parents the right to access medically necessary therapy and other services by other providers—outside of the school/early childhood environment—is an appropriate way to protect parents' right to access the Medicaid qualified provider of their choice. Again, the Secretary has not provided a policy justification for this new requirement, and we believe the net impact will be to make it less desirable for Medicaid programs to use school/early childhood settings to provide essential rehabilitative services to children. The Congress could not have been clearer in its intent that it wants Medicaid to support the goals of IDEA; we believe that these narrow interpretations of the law are inconsistent with that intent.

For these and other reasons, I urge the Secretary to withdraw the proposed rule.

Thank you for allowing the public to provide comments on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid Program and for considering CEC's recommendations.

Sincerely,
Mary V. Kealy, EdD
Assistant Superintendent for Pupil Services