Submitter : Mrs. Debbie Trammell **Date:** 10/10/2007

Organization : The Center for Mental Health, Inc

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-610-Attach-1.DOC

#610

October 10, 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

I am an employee of The Center for Mental Health, Inc. (CMH) and am 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.

CMH is a private, not-for-profit community mental health center serving 7,000 children, adolescent and adult residents of East Central Indiana annually with serious mental illness and substance use disorders. CMH provides a full continuum of services to include psychiatry and medication, inpatient, outpatient, residential, therapeutic foster care and community-based services including Assertive Community Treatment and case management. CMH also provides specialty services such as HIV Care Coordination, housing services, and Supported Employment. CMH is a managed care provider for the Indiana State Division of Mental Health and Addictions as well as an Indiana Health Care Provider serving Medicare and Medicaid eligibles. CMH also is a provider for other third party payers and serves uninsured individuals under a sliding scale fee. CMH has been a certified community mental health center for 40 years and has been continuously Joint Commission accredited since 1986.

I have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that my agency serves. Below are my recommendations relative to four specific areas of the proposed rule:

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>

Please 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

Please include 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)

Please 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

Please drop this entire section 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,

Debbie Trammell
Human Resources Director

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

Submitter : **Ms. Beth Waterson** **Date: 10/10/2007**

Organization : **Youth Focus**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

2. Pay for rehabilitative services for individuals with serious mental illnesses when they need them and where they need them.

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

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

5. Please revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning. If you see how desperately the services are needed and the good they do in clients' lives, the funding is clearly warranted.

Submitter : Mr. James Skeel **Date:** 10/10/2007

Organization : Mr. James Skeel

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-612-Attach-1.DOC

#612

October 10, 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

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

Sincerely,

James M. Skeel
Director of Quality Improvement

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

Submitter : Mrs. Mira May-Mullins **Date:** 10/10/2007

Organization : Center for Mental Health

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-613-Attach-1.DOC

#613

October 10, 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

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

Sincerely,

Mira May-Mullins
Psychosocial Rehabilitation Coordinator/ Liaison

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

Submitter : Ms. Noreen O'Connor **Date:** 10/10/2007

Organization : Ms. Noreen O'Connor

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am the mother of a seven-year-old child with autism. Please withdraw, revise and republish the proposals with clarification of impact to children with ASD and MR.

The state-funded services are essential to my son's ability to attend our local school and to participate community activities. It is much most cost-effective to keep him in the neighborhood school, and of course better for him to go to school and play sports with the kids in our community.

The "wraparound" services are a life line for other many families of individuals with autism and MR in the state, and we all vote!

Please allow sufficient a sufficient comment period so that individuals and families impacted may respond.

Thank you.

Submitter : Mrs. Carolyn Marsh **Date:** 10/10/2007

Organization : Mrs. Carolyn Marsh

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I have a 32 year old son at RTR Day Habilitation Program. The wonderful job and services provided to him are phenomenal and we do not know what we would do without them. It is extremely important for ALL Day Habilitation Programs to have a nurse, have occupational therapy and physical therapy available. It would be a travesty to eliminate these services. The Massachusetts Commisioner of DMR is in favor of keeping Day Habs with Medicaid. SO AM I. Just the idea of this being a possibility is a nightmare and very unsettling. Please remember these are wonderful individuals that have had a tough life and thrive in these programs. You must keep them in mind when deciding this --- it certainly is not in the best interest for them. Do something decent for once, do something right and keep the day habs operating in the best interest of these individuals. It is they who benefit and need these services -- it is you who can provide them and actually make a huge difference, along with finally standing up for these day hab individuals and making decisions for them, and not just because it is cost-effective. These are people who need these services. How would you feel if someone decided to take your cell phone, your care, your job, your means of transportation, or the medications that you need on a daily basis from you? That is what you would be doing to them. It may seem like a small thing to you but it makes all the difference in the world to them. These services allow them to maximize their potential and lets them continue to function outside the day hab and experience life outside the confines of the program. Please, make the right choice and keep things the way they are. It is always the individuals who need these programs and cannot defend themselves or voice their opinions who are constantly getting the brush off from the government. Important programs such as this are all too easy to eliminate. It is not fair. I am begging you to do the right thing and continue to give these individuals the services they deserve. Thank you for your time.

Submitter : Mrs. Nicole Rizzitiello **Date:** 10/10/2007

Organization : YAI

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

I strongly oppose the provisions related to excluding federal financial participation for habilitation services and urge that this proposed rule be withdrawn.

The proposed rule would severely harm people with intellectual and other developmental disabilities by eliminating longstanding programs for providing habilitation services to people with developmental disabilities. It also imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with intellectual disabilities/mental retardation and related conditions. Many of these individuals are not expected to have a pre-existing skill restored, but, instead, to maintain their level of functionality. For many of these individuals, the fact that they can continue to perform specific tasks is a success and an extreme health benefit. This proposed definition creates a discriminatory and arbitrary exclusion from receiving rehabilitative services for people with mental retardation and related conditions. Defining clinical service eligibility by excluding individuals with mental retardation is discriminatory and is based on false presumptions of individual needs, abilities, etc.

We also take issue with the assertion that there are more appropriate coverage authorities (i.e. waiver services, etc.) In particular, waiver programs operate as discretionary alternatives to our State's core Medicaid program under the state plan. We believe that states should have the flexibility to continue operating habilitation services under the longstanding state plan options in addition to having the waiver options, but should not be forced to utilize only one option.

Submitter : Dr. Gary Timbers **Date:** 10/10/2007

Organization : Appalachian Family Innovations

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-617-Attach-1.DOC

#617

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: Coverage for Rehabilitative Services under the Medicaid Program

Very simply, the plan to eliminate Therapeutic Foster Care (TFC) as a Medicaid-covered service reflects poor planning, poor policy, and poor logic.

As a North Carolina provider of TFC we prevent deeper and more expensive penetration into the residential treatment centers and with other cases allow for a thoughtful step-down from higher level residential services. The maltreatment these children have experienced at home makes them highly vulnerable to severe mental health issues and prolonged mental illness. Our experience is that the Atherapeutic family environment@ is ideally suited to treat those issues that were originally created in abusive family environments. The wisdom is that these children need to learn to live successfully in families and, thus, that is the best place to treat them.

The concept that TFC is somehow replacing funding provided by the states is not accurate in North Carolina. IV-E is used extensively for the provision of basic foster care. But IV-E rules prohibit States from claiming Title IV-E participation for Acosts 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.@ Without Medicaid coverage, children now entering TFC programs (who cannot live at home or in basic foster care even with supports) will simply enter the residential treatment arena at a more restrictive and more expensive level.

The somewhat vague language that perhaps allows limited funding for certain aspects of TFC strips the core program elements of TFC and, in effect, eliminates TFC as a viable option.

As an entity that received an NIMH clinical training grant in 1980 to develop Professional Parenting, and

having seen this effort help to create the concept of TFC as a preferred way to effectively serve children, we believe the policy change currently being considered is doomed to immediate problems and ultimate failure.

Please contact me if can provide additional information.

Cordially,

Gary D. Timbers, Ph.D.
Director
203 Avery Ave.
North Carolina, NC 28655

828-433-7176

Submitter : Ms. Kimberley A. Blagg **Date:** 10/10/2007

Organization : The Center for Mental Health

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

i.e. "See Attachment"

CMS-2261-P-618-Attach-1.PDF

#618

October 10, 2007

Centers for Medicare & Medicaid Services
Dept of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
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Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

Kimberley A. Blagg
Administrative Assistant

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

Submitter : Ms. Shannon Horton **Date:** 10/10/2007

Organization : ECHO Joint Agreement

Category : Individual

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

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

Submitter : Mr. Bill Calmbacher **Date:** 10/10/2007

Organization : Mental Health Resources, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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

1. 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.

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

3. 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.

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

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

Regulatory Impact Analysis

Regulatory Impact Analysis

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Submitter : Mr. John Marker **Date:** 10/10/2007

Organization : Center For Mental Health

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2261-P-621-Attach-1.DOC

#624

October 10, 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

I am an employee of The Center for Mental Health, Inc. (CMH) and am 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.

CMH is a private, not-for-profit community mental health center serving 7,000 children, adolescent and adult residents of East Central Indiana annually with serious mental illness and substance use disorders. CMH provides a full continuum of services to include psychiatry and medication, inpatient, outpatient, residential, therapeutic foster care and community-based services including Assertive Community Treatment and case management. CMH also provides specialty services such as HIV Care Coordination, housing services, and Supported Employment. CMH is a managed care provider for the Indiana State Division of Mental Health and Addictions as well as an Indiana Health Care Provider serving Medicare and Medicaid eligibles. CMH also is a provider for other third party payers and serves uninsured individuals under a sliding scale fee. CMH has been a certified community mental health center for 40 years and has been continuously Joint Commission accredited since 1986.

I have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that my agency serves. Below are my recommendations relative to four specific areas of the proposed rule:

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>

Please 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

Submitter : Ms. Marlene Moyer **Date:** 10/10/2007

Organization : St. Johns County School District

Category : Health Care Professional or Association

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

The State Medicaid Reimbursement that the District receives is very important not only for our sepcial education children, but also for our general education children. We provide nurses and necessary supplies and equipment for these students, largely from this reimbursement. Both groups of students will suffer greatly.

Submitter : Ms. Mary Lou Dyer **Date: 10/10/2007**

Organization : Maine Association for Community Service Providers

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

MAINE ASSOCIATION FOR COMMUNITY SERVICE PROVIDERS
P.O.Box 149
Hallowell, ME 04347
(207) 623-5005
mldyermacsp@msn.com

October 11, 2007

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

Re: File Code CMS-2261-P

To Whom It May Concern:

I am submitting these comments on the above referenced proposed regulation affecting Medicaid Coverage for Rehabilitative Services on behalf of the Maine Association for Community Service Providers (MACSP). MACSP represents over 65 providers of services to individuals with cognitive and developmental disabilities. These services are delivered in all counties of Maine to people from birth to death.

MACSP joins many of its colleagues nationally who are calling for the withdrawal of this proposed rule. MACSP maintains that the proposed rule cannot be legally promulgated due to the following reasons:

" CMS interprets incorrectly ?6411(g) of the Omnibus Reconciliation Act of 1989 (OBRA 89) which results in an inaccurate interpretation of Congressional intent of the statute.
" Federal and state fiscal and public policies are in conflict with the proposed regulation.
" And, lastly, there is a lack of equivalency between state plan rehabilitation and clinical option and 1915(c), 1915 (i), and ICFMRs/MR alternatives.

Based on the three points above, MACSP calls for the rescission of the proposed rule. We endorse the excellent analytical piece submitted by the American Network of Community Options and Resources (ANCOR) of which MACSP and many of its providers are members. We will not repeat that excellent analysis. We will, however, point out that this rule will affect the lives of the thousands of Maine children and adults for whom rehabilative services provide life lines to the every day activities many of us take for granted.

While CMS may have some legitimate policy concerns, this change omits any national discussion on how these people currently receive services, who provides them, what are the outcomes, and, most importantly, what results should the services go away. These services meet the needs of some of the most vulnerable citizens in this country and withdrawal of the services will have serious consequences..

People who are now in community-based day habilitation programs will have to seek services in capped waiver programs (capped both by number of people and by hours of service). The result is easily adults sitting in homes watching television with no outside activities for many hours per week. The dreams of normal integrated lives will disappear. Again, this happens in at atmosphere of threats to remove services, not discussion of appropriate services with appropriate funding sources.

What CMS has not been able to accomplish legislatively must not come to pass administratively. People of good will would welcome the opportunity to engage in the public discourse on service options. Thank you for this opportunity to comment on the proposed regulation.

Sincerely,

Mary Lou Dyer, Esq.
Managing Director

Submitter : Jeffrey Wise **Date:** 10/10/2007

Organization : New York State Rehabilitation Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-624-Attach-1.PDF

#624

NYSRA
NEW YORK STATE REHABILITATION ASSOCIATION, INC.

FORMAL COMMENTS
OF THE NEW YORK STATE REHABILITATION ASSOCIATION

RE: **CMS 2261-P**

DATE: **October 4, 2007**

This document contains the formal comments of the New York State Rehabilitation Association (NYSRA), a 501 (c)(6) not-for-profit trade association. NYSRA comprises approximately 130 not-for-profit agency provider-members and affiliated business partners and associate members. Provider-members deliver a wide range of services to thousands of New Yorkers with developmental disabilities or mental health issues through contractual arrangements with, among others, the State of New York's Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health, and State Education Department programs run by its Vocational and Education Services for Individuals with Disabilities unit.

The subject regulation is designated as CMS 2261-P, published August 13, 2007 at page 45201 of the Federal Register under the caption Medicaid Program: Coverage for Rehabilitative Services.

POSITION:

On balance, we **oppose** this rule as a restriction on delivery of services to people with disabilities. The Medicaid rehabilitation option has been an essential tool in designing service delivery systems that result in individuals experiencing increased access to community living and a departure from inefficient and outdated institutional services. At the same time, the option serves the critical purpose of helping states help residents lead more independent lives while becoming more integrated into their communities.

Current rules have indeed seen growth in the use of the rehabilitation option. While we understand that growth leads to increased Federal expenditures, we would suggest that the growth is a strong indicator of the need for services and the importance of providing services to meet that need.

Thus, we believe scaling back the rehabilitation option is the precise opposite of what is needed. Put another way, we do not see sound policy in changing a rule on the basis that it is too useful.

SUMMARY OF COMMENTS:

NYSRA offers the following comments after careful analysis of the impact of the regulation on individuals receiving services, funded in part by the Medicaid program, within the State of New York.

We would summarize the following comments at the outset by noting that, while there are elements of the rule that we would support, we must oppose final adoption of the rule as it is currently drafted. We believe that reduced Federal Financial Participation (FFP) that would be realized by this rule would serve to 1) eliminate services to individuals whose needs necessarily rely on those services; and 2) ultimately lead to higher costs as un-served individuals seek to access programs at other points.

NYSRA supports the requirement in the rule that a written rehabilitation plan be developed for each individual receiving services. We strongly oppose, however, the rule's provisions that create an "intrinsic element" standard for preclusion of FFP in several services. We also oppose the arbitrary exclusion of habilitation services currently provided under the rehabilitation and clinic options from FFP, as well as the rule's exclusion of people with mental retardation and related conditions from receiving rehabilitative services. Moreover, we would argue that elements of the rule violate provisions of the Omnibus Budget Reconciliation Act of 1989 (PL 101-239) related to the authority of the Secretary of Health & Human Services in regulation of this specific area.

SPECIFIC COMMENTS:

The following comments are arranged in sequence based on the order of their appearance in the proposed rule.

§440.130 (d)(3) Written Rehabilitation Plan

The proposal would add a requirement that covered services for each individual be identified in a written rehabilitation plan.

On a conceptual basis, NYSRA supports the requirement that a written rehabilitation plan be in place for each individual who receives services. We do not oppose the accountability and documentation of the provision of services. We do, however, have concerns over some of the administrative burdens and lack of clarity that the language of the proposed rule sets out.

The rule is unclear as to the types of notations needed to document progress toward achievement of goals articulated by the plan. Moreover, we have concerns over the challenges created when attempting to outline, and document incremental progress

toward, specific functional goals when dealing with individuals who have mental health issues or other cognitive disabilities. A "lack of progress" may indeed not be present, yet the inability to document tangible progress over a brief period could, we believe, be grounds for an unjustified and inadvisable termination of funded services. Any such requirements should be clarified, with thought given to the difficulty in documenting progress in these cases in brief increments, as well as sensitivity to the administrative burdens placed on providers in complying with the plan.

§441.45 (b)(1) Limitations – "Intrinsic Elements"

The rule proposes at § 441.45(b)(1) that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, and public guardianship. It also proposes that coverage of rehabilitative services would not include services that are "intrinsic elements" of programs other than Medicaid.

NYSRA strongly opposes this "intrinsic element" analysis. While it may appear on first reading that the language reinforces the notion of Medicaid as a payer of last resort, we believe the language would, in fact, do serious damage to the Medicaid safety net. This standard would exempt FFP for services that are allowed under, but may not be actually provided or paid for by, programs in several fields that may be essential. States would be hard-pressed to have locally funded programs pick up large numbers of former Medicaid program cases. Resources will be stretched and perhaps cut as a result.

We would note also that imposing such an intrinsic element standard would appear to have considerable fiscal impact on states, yet CMS analysis of the proposed rule concludes that its adoption would not impose any costs on state or local governments. We believe the only way to reconcile these two statements would be for states to drop programs altogether – a result we cannot support.

§441.45 (b)(2) – Habilitation Exclusion

The language of the rule excludes FFP for habilitation services, including those services provided to persons with "mental retardation or related conditions" as defined in the state Medicaid Manual. The CMS regulatory analysis also notes a distinction between the terms *habilitation* and *rehabilitation. Rehabilitation* refers to measures used to restore individuals to their best functional levels, while *habilitation* refers to helping persons acquire new functional abilities. The latter person could no longer be served under the rehabilitation option, according to the proposed rule.

NYSRA strongly objects to this proposal. First, we see the distinction as one that arbitrarily discriminates between those seeking to attain a function and those seeking to

see restoration of a previous level of function. Both cases involve the delivery of services to persons working toward achieving or maintaining a certain level of function. There is no rational distinction, in our view, between those working to achieve a certain level and those wishing to maintain a certain level. It would appear that the rule contemplates a distinction with only a fiscal difference.

Second, NYSRA believes the proposed rule violates the intent behind Section 6411 (g) of the Omnibus Budget Reconciliation Act of 1989. That section prohibits regulatory elimination of coverage of day habilitation services for people with developmental disabilities in those states that had chosen to include such services in their State Medicaid Plans prior to the OBRA enactment. We recognize that Section 6411 (g) was worded in such a way as to keep this moratorium in place only until a regulation was issued clarifying which habilitation services states could cover in their State Medicaid Plans. While our understanding is that CMS believes the issue of this proposed rule qualifies as this long-awaited regulation contemplated in 1989, we would characterize this proposal differently: The proposal does not expound on what habilitation services can be covered by the states, it simply prohibits any habilitation services to be covered. This is contrary to the plain language of the OBRA moratorium conditions. The OBRA section does not say the moratorium expires upon promulgation of regulations that strip away all protection. Indeed, it requires that it would expire upon the promulgation of a regulation that "specifies the types of day habilitation and related services that a State may cover . . . " (Section 6411 (g)(2)(a).

Surely Congress did not intend to protect such services from regulatory *diminution* only until regulations completely *extinguished* them.

Additionally, the regulation analysis notes that current Medicaid policy provides for habilitation services in the ICF/MR setting, and through waiver arrangements reached by states under various paragraphs of Section 1915 of the Social Security Act. We find this to be insufficient consolation in light of the proposed regulatory changes. In our view, funding only ICF/MR settings results in a system that is inflexible and may not be responsive to the individual needs of certain persons. We also believe that Section 1915 waivers, while capable of achieving valid goals, can be problematic. Quite simply, waiver programs are not the same as programs available under the rehabilitation and clinic options that this regulation would affect. Instead, waivers carry stricter income limitations and eligibility criteria, usually have enrollment caps, and in some cases require individuals to be in need of nursing-facility levels of care in order to qualify. It cannot be over-emphasized that waivers function as a complement or supplement to Medicaid that can give states certain flexibilities. They should not be considered adequate substitutes for Medicaid services.

CONCLUSION:

For the foregoing reasons, NYSRA strongly urges that the subject proposed regulation be withdrawn. While we would support continued discussion of ways to make the system responsive, effective and efficient, we firmly believe the proposed rule would result in a system incapable of dealing with the needs of thousands of New Yorkers who rely on the supports of the Medicaid system to help them live as independently and as productively as possible.

Thank you for your consideration of our views on this important matter.

Submitted by:

Jeff Wise, JD
President/CEO
New York State Rehabilitation Association

Submitter : **Malcolm Small** **Date: 10/10/2007**

Organization : **Malcolm Small**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I respectfully request that you do whatever is in your power to insure that File Code CMS-2261-P is NOT enacted, that it go no further than it already has.

My interest as the father of a 46 year old non verbal, retarded, and cerebral palsy daughter who is currently in a day-habilitation program run by Road to Responsibility in Mashfield, MA is to let you know my opinion. I know first-hand the problems of raising and dealing with a handicapped child/woman.

Based on my many years of experience with Michelle's problems I fear that there is a HUGE RISK of LOSING nursing benefits and therapy services, all of which are currently provided to Michelle and which have greatly improved the quality of her life!

I am afraid that there would be a cap on the number of people in programs like hers who would then be on a waiting list or denied services all together!

People with developmental disabilities may not be covered at all!

The Rehabilitation Option proposed by CMS would increase administrative inefficiencies and would NOT BE COST EFFECTIVE. In fact, it would cost much more in the long term!

Entitlement and most likely a bi-annual rate review would be lost. Valuable staff could be lost due to restricted funding!

I can not begin to imagine the HORRIBLE SITUATION, THE YEARS AND YEARS OF WAITING FOR SERVICES TO BE PROVIDED TO A HANDICAPPED CHILD, TRYING TO COPE WITH A DEVELOPMENTALLY DISABLED CHILD AT HOME WITH NO REHAB SERVICES AVAILABLE FOR THEM. IMAGINE IF YOU WERE IN THIS SITUATION AND THERE WERE VERY LIMITED REHAB FACILITIES AVAILABLE TO YOU, THERE WERE NO OPENINGS FOR YOUR CHILD, OR IF THERE WAS AN OPENING, THE STAFF WERE FAR FROM EXPERIENCED AND KNOWLEDGABLE AND THEREFORE NOT ABLE TO PROVIDE THE BEST SERVICE TO YOUR CHILD!

If you can possibly see yourself and your family in this type of situation I know you will understand my feelings.

Please, please, please take whatever actions you can to see that the changes proposed by CMS are prevented and instead support the CHAMP ACT.

Very sincerely yours,

Malcolm W. Small (phone: 508-230-0193)

Submitter : Mrs. Tonya Nichols **Date:** 10/10/2007

Organization : Mrs. Tonya Nichols

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachmcnt

CMS-2261-P-626-Attach-1.PDF

#626

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : Mr. Gene Sparks **Date:** 10/10/2007

Organization : Seven Counties Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Please do not cut this funding. It would make it very difficult to provide services

Submitter : Mr. James Covert **Date:** 10/10/2007

Organization : Seven Counties Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Please do not change rehab services for our clients.

Submitter : Ms. Laurie Oyler **Date:** 10/10/2007

Organization : LPVEC

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-629-Attach-1.DOC

#629

In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

This document is submitted on behalf of LPVEC an Educational Service Agency located in Western Massachusetts in response to the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201

Summary:

We believe the proposed rule is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[1]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed changes would undermine the very purpose of the Title XIX program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Preliminary Comments:

We believe these proposed regulations would result in the denial of coverage for medically necessary services. This is especially a problem with regard to coverage of services for beneficiaries under 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those

[1] Social Security Act, Section 1905(a)(13)]

services are covered for adults[2].

We further believe that the proposed definitions impermissibly narrow the scope of services that can be covered under the rehabilitation option. Moreover, the proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals attain or retain capability for independence or self-care . . .[3]"

Regulatory Impact Analysis: Overall Impact

Executive Order 13132 imposes certain requirements when an agency promulgating a proposed rule that will impose "substantial direct compliance costs on States." Among other requirements, before an agency promulgates a rule that will impose such costs on states, it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the process of developing the rule prior to promulgation[4]. If exercising the consultation option, an agency must provide a federalism impact summary to the Office of Management and Budget hat describes the agency's consultation with the states, summarizes their concerns and explains how those concerns were addressed[5]. CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states[6].

To the contrary, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, most states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them,

[2] 42 U.S.C. § 1396d(r)(5)
[3] 42 U.S.C. § 1396 (emphasis added)
[4] Exec. Order 13132, § 6(b)
[5] Id., at (b)(2).
[6] 72 Fed. Reg. at 45209 (Preamble, V.A)

they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the requirements of Executive Order 13132.

In addition, CMS asserts that this rule will not have a direct impact on providers of rehabilitation services[7]. This is also incorrect. These regulations narrow the scope of the service and, directly and indirectly, impose requirements that will have significant, direct impact on providers. The requirement of the detailed written rehabilitation plan will also require additional work by providers. The discussion of how providers need to separate "incidental" personal care functions from rehabilitation services for billing, record keeping and administration shows how many additional duties will be necessary for providers[8].

Overview:

The proposed rule is typical of a long-standing campaign undertaken by CMS to restrict federal Medicaid payment policies. In the case of 2261-P, these restrictions were considered and expressly rejected by Congress during debate on the Deficit Reduction Act of 2005.9

This regulation suffers from a fundamental legal flaw under Title XIX. This proposed rehabilitation rule attempts to introduce into the statute precisely the type of "educational" and "social" exclusions barred by Medicaid as a result of mandatory early and periodic screening diagnostic and treatment (EPSDT) benefit.

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called "rehab option," which has been given broad and expansive administrative interpretation. This section says, inter alia, that medical assistance to

[7] 72 Fed. Reg. at 45208 (Preamble, V.A.)
[8] 72 Fed. Reg. at 45206 (Preamble, II.F.2)

be provided at state option includes "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level."

The current rule[10] emanating from this statute is the target of the current CMS proposal. For more than forty years, the rehabilitation benefit has been the authority for a range of medically necessary services, including mental illness, developmental disabilities, children with behavioral and emotional afflictions, and those who fail to reach developmental milestones. Without disputing the need for these services or the efficiency of providing them in any appropriate environment, CMS has proposed a rule that severely limits the flexibility of the current rule, which would make it far more burdensome and expensive to provide these services within the Medicaid framework and, in some cases, would restrict coverage altogether.

In proposing this rule, CMS has excluded services that are furnished through programs other than Medicaid from the definition of "rehabilitation." This is direct conflict with Title XIX, which has long recognized that Medicaid-reimbursable services may be provided through other state programs.

The rehabilitation benefit is optional for adults but required for categorically needy individuals under age 21 as a result of their entitlement to services under the Early and Periodic Screening, Diagnostic, and Treatment services. All benefits and services that fall within the definition of "medical assistance" under EPSDT are required when medically necessary as a result of an EPSDT screen. Rehabilitative services fall within this benefit and are codified within the definition of "medical assistance" and are therefore required under federal law for individuals under twenty-one.

There have been previous attempts to curtail federal Medicaid contributions for covered benefits furnished to Medicaid-enrolled children who also are receiving

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[9] See discussion of the DRA in Jeff Crowley and Molly O'Malley, Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues (Kaiser Commission on Medicaid and the Uninsured, August, 2007).
[10] (42 C.F.R. 440 130(d))

services through public educational or social programs. The first such attempt occurred in 1988, when the Reagan Administration attempted to halt federal payments for medical assistance furnished as a related service under a child's special education plan. In response, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized education plan[11]. The prohibition specifies as follows:

> Nothing in this chapter shall be construed as prohibiting or restricting or authorizing the Secretary to prohibit or restrict payment under subsection (a)[relating to federal payments generally] for medical assistance for covered services furnished to5 a child with a disability because such services are included in the children's individualized education program established pursuant to part B of the [IDEA] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of [the IDEA][12]

The CMS proposal would replace the current definition of rehabilitative services, which is one sentence long, with an eight-part definition of the scope of services and a mandated seventeen-part "rehabilitation plan" for each service recipient.

In sum, even when the benefits are furnished by qualified providers and the treatment is covered, the rehabilitation service NPRM would add a payment exclusion that simply has no basis in the statute. Indeed, the proposed rule contravenes the statute's EPSDT benefit and its federal financing provisions. As such, the proposed rule goes far beyond Secretarial powers under Medicaid. Most astoundingly perhaps, CMS specifically characterizes the rule as a third party liability rule[13], even though doing so would appear to be a direct admission that the agency is attempting to achieve in regulation what was rejected in statute.

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[11] 42 U.S.C. §1396b(c). Interestingly CMS concedes the existence of this statute in the school administration regulations but ironically, as justification for denying federal payments for administrative services. 72 Fed. Reg. 51398.

[12] Id.

[13] 72 Fed. Reg. 45209

Overarching Issue - Conflict with EPSDT

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a States' plan[14]. There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements.

Recommendations:

We recommend the following:

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

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

Amend § 441.45(b)(4) to refer to the EPSDT requirement and instruct states to comply with it.

Proposed § 440.130(d)(1)(v)-(vii) - Maintenance v. Restorative Services

The discussion of services that maintain, rather than restore, function may lead to inappropriate denials of services that should be covered as rehabilitative, particularly the discussion of the requirements of the written rehabilitation plan. Throughout the

preamble and proposed regulations, CMS emphasizes that rehabilitation services must reduce disability and restore function in order to be reimbursable under Medicaid15. The discussion of a written rehabilitation plan in the preamble emphasizes the "ultimate goal" of reduction of medical care[16]. Moreover, the preamble states that "[i]t is important to note that this benefit is not a custodial care benefit but should result in a change in status.[17]" Id. At the same time, the proposed regulations acknowledge that maintaining a functional level may be necessary to achieve a rehabilitation goal[18]. But, the discussion of the written plan in the preamble states that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . .[19]"

This discussion creates confusion. This emphasis on change in status and on achievement of specific goals may lead states to deny coverage for medically necessary rehabilitation services because such services may not lead to immediate results. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse. Again, the Medicaid statute, which CMS is apparently attempting to bypass, emphasizes the importance of rehabilitation services to attain independence and health[20]. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations.

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[14] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5)
[15] 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A))
[16] Id. at 45203 (Preamble, II.C)
[17]
[18] Id. at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi))
[19] Id. at 45204 (Preamble, II.C)
[20] 42 U.S.C. § 1396

This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is an even greater likelihood that the actual service needed will be covered. Moreover, this agency has a long-standing policy of recognizing that maintenance therapy may be covered[21]. The overly restrictive definition and interpretation in this area may conflict with longstanding agency policy.

Recommendations:

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

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

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

Proposed § 440.130(d)(5) - Settings for Service Provision

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be

[21] See, e.g., Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, Medicaid State Bulletin, 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991).

provided.[22]" This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

Clarify that rehabilitation services should be covered in any setting permitted by state law, including schools.

Add the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to § 440.130(d).

Proposed § 440.130(d)(1)(vi) – Restorative Services

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option[23]. As CMS acknowledges in the letter, this is an important service for individuals with mental illness and substance abuse services. Given its obvious importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in the regulations.

Recommendations:

Section 440.130(d)(1)(vi), which describes "restorative services" should be amended and language added stating that peer guidance is a covered rehabilitation service.

[22] 72 Fed. Reg. at 45205 (Preamble, II.E)
[23] Dear State Medicaid Director, Peer Support Services – SMDL #07-011 (August 15, 2007)

Proposed § 441.45(b)(1) – Non-Covered Services

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid[24]. The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services. Moreover, it is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. Thus, these children will all be eligible for EPSDT, under which a service should be covered if it is necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity and ambiguity in promulgation of regulation never works in favor of the regulated community.

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included under the IDEA[25]. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services[26]. Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . .[27]" Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party[28]. Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

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[24] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))
[25] 72 Fed. Reg. at 45202
[26] 42 U.S.C. § 1396b(c)
[27] 42 U.S.C. § 1396a(a)(25)(A)
[28] 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007).

The proposed rule excludes Medicaid reimbursement for rehabilitative services that are "intrinsic element of other programs" even if they meet all of the other requirements in the proposed rule at 441.45(b). This exclusion is has no legal foundation. Title XIX does not exempt Medicaid reimbursement for services merely because they are part of another program. In fact, Title XIX was designed by Congress to work in concert with child welfare, special education, and other complementary health care and social services. Medicaid is a financial services program and as such is the payer of items and services known as medical assistance. In addition, it is the enabler of medical assistance and program administrative activities. The other programs the proposed rule would eliminate are the means by which this medical assistance financing actually delivers health care services and support to children. The Medicaid law was designed to augment and enhance education, social support, and child welfare programs, not duplicate them.

It is difficult to understand what CMS means by the term "intrinsic." When the administration attempted to advance its "intrinsic" argument in 2005[29], it became evident that the concept reflected a fundamental misunderstanding of Medicaid's interaction with other programs serving children and the recommendation was rejected. Now the Administration seeks to do by regulation what Congress already has rejected by statute. The rehabilitation NPRM resuscitates the "intrinsic" exclusion once again, this time broadening it still further. As before, the Administration excludes payments for "intrinsic" elements while offering no definition of "intrinsic elements." But the NPRM also goes beyond the vagaries of the "intrinsic element" test to exclude payment for covered rehabilitation benefits in the case of children who are receiving services in the case of other specific programs. As a result, the rule adds a coverage condition not contemplated by the statute, which functions as the type of coverage exclusion common to commercial insurance.30 In the proposed regulations, CMS states:

> This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused

[29] Medicaid's Rehabilitation Service Option, op. cit. p. 13
[30] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

> on social or educational development goals in programs other than Medicaid. . . . We propose . . . that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole, and probation, juvenile justice or public guardianship. We also proposed that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid[31].

This specific exclusion of payment in the case of children whose medical assistance covered treatments are being arranged for by other programs represents a blatant attempt to add conditions of coverage not permitted under the statute. It grafts onto Medicaid a payment exclusion that simply does not exist. The exclusion is a reflection of a desire on the part of the Administration to push Medicaid, in terms of coverage design, in the direction of commercial insurance, a direction that Congress has rejected in the case of children[32].

Recommendations:

We believe this section should be omitted in its entirely, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Section 441.45(b)(1)(iv) should be amended to restate that Medicaid coverage should not be denied merely because a service is provided in an individual education plan.

The responsibilities for states regarding third party payers, and the third party payers'

[31] 72 Fed. Reg. 45201, 45202 and 42505
[32] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

Proposed § 441.45(b)(2) - Habilitation Services

The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function[33]. The discussion and regulation regarding habilitation is problematic for several reasons.

First, it seems to be based on the premise that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate.

Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy[34]. These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services.

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental health and/or substance related disorders can be appropriately treated with rehabilitation services[35]. See However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

Recommendations:

[33] 42 C.F.R. § 441.45(b)(2), see also 72 Fed. Reg. at 45205 (Preamble,II.F.2)
[34] 42 C.F.R. § 435.1010 (2007)
[35] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2))

Add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health services.

Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy) and medical or other remedial care provided by licensed practitioners, defined at 42 C.F.R. § 440.60."

Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.

Proposed § 440.130(d)(3) - Written Rehabilitation Plan

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

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

Proposed Elimination of Transportation Services

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

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

Non-covered services: 441.45(b)

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

There appear to be only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service, 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)[36]. 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.

Recommendations:

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

Summary:

As we have discussed above, we believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[37]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of

[36] 42 U.S.C. §§ 1396a(a)(10), 1396d(r)
[37] [Social Security Act, Section 1905(a)(13)]

our most vulnerable citizens.

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

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Our 38 yr. old daughter lives in a group home and attends a day hab. program. She was operated on for a brain tumor when she was 18 mths. old and as result has had a complicated medical history. She had radiation, has adrenal insufficiency, seizures, VNS stimulator implant to aid in controlling seizures, is legally blind, has a profound hearing loss in R. ear, has had a subdural hematoma and a fractured skull due to falls and now requires the use of a wheelchair. She needs (2) person assist when ambulating and needs to be exercised daily because of her left-sided weakness, therefore PT, OT and the RN is extremely important. If CMS-2261-P is passed and she does not receive the existing services her condition will surely deteriorate. We are requesting members of Congress to oppose changes to Rehabilitation Option (proposed by CMS) CMS-2261-P and support the CHAMP ACT.

Submitter : Ms. Erin Duchesne **Date:** 10/10/2007

Organization : L.P.V.E.C.

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-631-Attach-1.DOC

#631

In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

This document is submitted on behalf of LPVEC an Educational Service Agency located in Western Massachusetts in response to the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201

Summary:

We believe the proposed rule is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[1]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed changes would undermine the very purpose of the Title XIX program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Preliminary Comments:

We believe these proposed regulations would result in the denial of coverage for medically necessary services. This is especially a problem with regard to coverage of services for beneficiaries under 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those

[1] Social Security Act, Section 1905(a)(13)]

services are covered for adults[2].

We further believe that the proposed definitions impermissibly narrow the scope of services that can be covered under the rehabilitation option. Moreover, the proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals attain or retain capability for independence or self-care . . .[3]"

Regulatory Impact Analysis: Overall Impact

Executive Order 13132 imposes certain requirements when an agency promulgating a proposed rule that will impose "substantial direct compliance costs on States." Among other requirements, before an agency promulgates a rule that will impose such costs on states, it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the process of developing the rule prior to promulgation[4]. If exercising the consultation option, an agency must provide a federalism impact summary to the Office of Management and Budget hat describes the agency's consultation with the states, summarizes their concerns and explains how those concerns were addressed[5]. CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states[6].

To the contrary, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, most states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them,

[2] 42 U.S.C. § 1396d(r)(5)
[3] 42 U.S.C. § 1396 (emphasis added)
[4] Exec. Order 13132, § 6(b)
[5] Id., at (b)(2).
[6] 72 Fed. Reg. at 45209 (Preamble, V.A)

they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the requirements of Executive Order 13132.

In addition, CMS asserts that this rule will not have a direct impact on providers of rehabilitation services[7]. This is also incorrect. These regulations narrow the scope of the service and, directly and indirectly, impose requirements that will have significant, direct impact on providers. The requirement of the detailed written rehabilitation plan will also require additional work by providers. The discussion of how providers need to separate "incidental" personal care functions from rehabilitation services for billing, record keeping and administration shows how many additional duties will be necessary for providers[8].

Overview:

The proposed rule is typical of a long-standing campaign undertaken by CMS to restrict federal Medicaid payment policies. In the case of 2261-P, these restrictions were considered and expressly rejected by Congress during debate on the Deficit Reduction Act of 2005.9

This regulation suffers from a fundamental legal flaw under Title XIX. This proposed rehabilitation rule attempts to introduce into the statute precisely the type of "educational" and "social" exclusions barred by Medicaid as a result of mandatory early and periodic screening diagnostic and treatment (EPSDT) benefit.

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called "rehab option," which has been given broad and expansive administrative interpretation. This section says, inter alia, that medical assistance to

[7] 72 Fed. Reg. at 45208 (Preamble, V.A.)
[8] 72 Fed. Reg. at 45206 (Preamble, II.F.2)

be provided at state option includes "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level."

The current rule[10] emanating from this statute is the target of the current CMS proposal. For more than forty years, the rehabilitation benefit has been the authority for a range of medically necessary services, including mental illness, developmental disabilities, children with behavioral and emotional afflictions, and those who fail to reach developmental milestones. Without disputing the need for these services or the efficiency of providing them in any appropriate environment, CMS has proposed a rule that severely limits the flexibility of the current rule, which would make it far more burdensome and expensive to provide these services within the Medicaid framework and, in some cases, would restrict coverage altogether.

In proposing this rule, CMS has excluded services that are furnished through programs other than Medicaid from the definition of "rehabilitation." This is direct conflict with Title XIX, which has long recognized that Medicaid-reimbursable services may be provided through other state programs.

The rehabilitation benefit is optional for adults but required for categorically needy individuals under age 21 as a result of their entitlement to services under the Early and Periodic Screening, Diagnostic, and Treatment services. All benefits and services that fall within the definition of "medical assistance" under EPSDT are required when medically necessary as a result of an EPSDT screen. Rehabilitative services fall within this benefit and are codified within the definition of "medical assistance" and are therefore required under federal law for individuals under twenty-one.

There have been previous attempts to curtail federal Medicaid contributions for covered benefits furnished to Medicaid-enrolled children who also are receiving

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[9] See discussion of the DRA in Jeff Crowley and Molly O'Malley, Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues (Kaiser Commission on Medicaid and the Uninsured, August, 2007).
[10] (42 C.F.R. 440 130(d))

services through public educational or social programs. The first such attempt occurred in 1988, when the Reagan Administration attempted to halt federal payments for medical assistance furnished as a related service under a child's special education plan. In response, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized education plan[11]. The prohibition specifies as follows:

> Nothing in this chapter shall be construed as prohibiting or restricting or authorizing the Secretary to prohibit or restrict payment under subsection (a)[relating to federal payments generally] for medical assistance for covered services furnished to5 a child with a disability because such services are included in the children's individualized education program established pursuant to part B of the [IDEA] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of [the IDEA][12]

The CMS proposal would replace the current definition of rehabilitative services, which is one sentence long, with an eight-part definition of the scope of services and a mandated seventeen-part "rehabilitation plan" for each service recipient.

In sum, even when the benefits are furnished by qualified providers and the treatment is covered, the rehabilitation service NPRM would add a payment exclusion that simply has no basis in the statute. Indeed, the proposed rule contravenes the statute's EPSDT benefit and its federal financing provisions. As such, the proposed rule goes far beyond Secretarial powers under Medicaid. Most astoundingly perhaps, CMS specifically characterizes the rule as a third party liability rule[13], even though doing so would appear to be a direct admission that the agency is attempting to achieve in regulation what was rejected in statute.

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[11] 42 U.S.C. §1396b(c). Interestingly CMS concedes the existence of this statute in the school administration regulations but ironically, as justification for denying federal payments for administrative services. 72 Fed. Reg. 51398.

[12] Id.

[13] 72 Fed. Reg. 45209

Overarching Issue - Conflict with EPSDT

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a States' plan[14]. There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements.

Recommendations:

We recommend the following:

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

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

Amend § 441.45(b)(4) to refer to the EPSDT requirement and instruct states to comply with it.

Proposed § 440.130(d)(1)(v)-(vii) - Maintenance v. Restorative Services

The discussion of services that maintain, rather than restore, function may lead to inappropriate denials of services that should be covered as rehabilitative, particularly the discussion of the requirements of the written rehabilitation plan. Throughout the

preamble and proposed regulations, CMS emphasizes that rehabilitation services must reduce disability and restore function in order to be reimbursable under Medicaid[15]. The discussion of a written rehabilitation plan in the preamble emphasizes the "ultimate goal" of reduction of medical care[16]. Moreover, the preamble states that "[i]t is important to note that this benefit is not a custodial care benefit but should result in a change in status.[17]" Id. At the same time, the proposed regulations acknowledge that maintaining a functional level may be necessary to achieve a rehabilitation goal[18]. But, the discussion of the written plan in the preamble states that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . .[19]"

This discussion creates confusion. This emphasis on change in status and on achievement of specific goals may lead states to deny coverage for medically necessary rehabilitation services because such services may not lead to immediate results. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse. Again, the Medicaid statute, which CMS is apparently attempting to bypass, emphasizes the importance of rehabilitation services to attain independence and health[20]. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations.

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[14] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5)
[15] 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A))
[16] Id. at 45203 (Preamble, II.C)
[17]
[18] Id. at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi))
[19] Id. at 45204 (Preamble, II.C)
[20] 42 U.S.C. § 1396

This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is an even greater likelihood that the actual service needed will be covered. Moreover, this agency has a long-standing policy of recognizing that maintenance therapy may be covered[21]. The overly restrictive definition and interpretation in this area may conflict with longstanding agency policy.

Recommendations:

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

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

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

Proposed § 440.130(d)(5) - Settings for Service Provision

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be

[21] See, e.g., Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, Medicaid State Bulletin, 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991).

provided.[22]" This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

Clarify that rehabilitation services should be covered in any setting permitted by state law, including schools.

Add the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to § 440.130(d).

Proposed § 440.130(d)(1)(vi) – Restorative Services

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option[23]. As CMS acknowledges in the letter, this is an important service for individuals with mental illness and substance abuse services. Given its obvious importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in the regulations.

Recommendations:

Section 440.130(d)(1)(vi), which describes "restorative services" should be amended and language added stating that peer guidance is a covered rehabilitation service.

[22] 72 Fed. Reg. at 45205 (Preamble, II.E)
[23] Dear State Medicaid Director, Peer Support Services – SMDL #07-011 (August 15, 2007)

Proposed § 441.45(b)(1) – Non-Covered Services

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid[24]. The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services. Moreover, it is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. Thus, these children will all be eligible for EPSDT, under which a service should be covered if it is necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity and ambiguity in promulgation of regulation never works in favor of the regulated community.

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included under the IDEA[25]. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services[26]. Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . .[27]" Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party[28]. Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

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[24] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))
[25] 72 Fed. Reg. at 45202
[26] 42 U.S.C. § 1396b(c)
[27] 42 U.S.C. § 1396a(a)(25)(A)
[28] 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007).

> on social or educational development goals in programs other than Medicaid. . . . We propose . . . that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole, and probation, juvenile justice or public guardianship. We also proposed that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid[31].

This specific exclusion of payment in the case of children whose medical assistance covered treatments are being arranged for by other programs represents a blatant attempt to add conditions of coverage not permitted under the statute. It grafts onto Medicaid a payment exclusion that simply does not exist. The exclusion is a reflection of a desire on the part of the Administration to push Medicaid, in terms of coverage design, in the direction of commercial insurance, a direction that Congress has rejected in the case of children[32].

Recommendations:

We believe this section should be omitted in its entirely, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Section 441.45(b)(1)(iv) should be amended to restate that Medicaid coverage should not be denied merely because a service is provided in an individual education plan.

The responsibilities for states regarding third party payers, and the third party payers'

[31] 72 Fed. Reg. 45201, 45202 and 42505
[32] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

Proposed § 441.45(b)(2) - Habilitation Services

The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function[33]. The discussion and regulation regarding habilitation is problematic for several reasons.

First, it seems to be based on the premise that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate.

Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy[34]. These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services.

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental health and/or substance related disorders can be appropriately treated with rehabilitation services[35]. See However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

Recommendations:

[33] 42 C.F.R. § 441.45(b)(2), see also 72 Fed. Reg. at 45205 (Preamble,II.F.2)
[34] 42 C.F.R. § 435.1010 (2007)
[35] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2))

Add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health services.

Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy) and medical or other remedial care provided by licensed practitioners, defined at 42 C.F.R. § 440.60."

Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.

Proposed § 440.130(d)(3) - Written Rehabilitation Plan

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

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

Proposed Elimination of Transportation Services

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

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

Non-covered services: 441.45(b)

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

There appear to be only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service, 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)[36]. 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.

Recommendations:

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

Summary:

As we have discussed above, we believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[37]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of

[36] 42 U.S.C. §§ 1396a(a)(10), 1396d(r)
[37] [Social Security Act, Section 1905(a)(13)]

our most vulnerable citizens.

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

Submitter : Ms. Terry Edelstein **Date:** 10/10/2007

Organization : Connecticut Community Providers Association

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-632-Attach-1.PDF

#632

Community Providers Association
Caring for Connecticut.

October 3, 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

The Connecticut Community Providers Association 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.

The Connecticut Community Providers Association represents organizations which provide services and supports for children and adults with disabilities and special needs including people with addictions, mental illness, developmental and physical disabilities. CCPA operates three divisions: Adult Behavioral Health, Children's Mental Health & Substance Abuse, and Developmental Disabilities, and is the lead advocate for rehabilitation and behavioral health service providers, supporting services for people with disabilities and special needs at the state legislature and with state agencies.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our member agencies serve. 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.

CCPA
35 Cold Springs Rd., Suite 522, Rocky Hill, CT 06067-3165
(P)860-257-7909 • (F)860-257-7777
www.ccpa-inc.org

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 Arehabilitation and other services@ to help individuals Aretain@ 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.

Recommendations:

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,

Terry Edelstein
President/CEO

CC: Members of the Connecticut State Congressional Caucus
Senator Joseph I. Lieberman
Senator Christopher J. Dodd
Congressman Joe Courtney
Congresswoman Rose DeLauro
Congressman John B. Larson
Congressman Christopher Murphy
Congressman Christopher Shays

The Honorable M. Jodi Rell, Governor of the State of Connecticut

Submitter : Mrs. Donna Smyth **Date:** 10/10/2007

Organization : LPVEC

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

"see attachment"

CMS-2261-P-633-Attach-1.DOC

#633

In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

This document is submitted on behalf of LPVEC an Educational Service Agency located in Western Massachusetts in response to the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201

Summary:

We believe the proposed rule is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[1]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed changes would undermine the very purpose of the Title XIX program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Preliminary Comments:

We believe these proposed regulations would result in the denial of coverage for medically necessary services. This is especially a problem with regard to coverage of services for beneficiaries under 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those

[1] Social Security Act, Section 1905(a)(13)]

services are covered for adults[2].

We further believe that the proposed definitions impermissibly narrow the scope of services that can be covered under the rehabilitation option. Moreover, the proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals attain or retain capability for independence or self-care . . .[3]"

Regulatory Impact Analysis: Overall Impact

Executive Order 13132 imposes certain requirements when an agency promulgating a proposed rule that will impose "substantial direct compliance costs on States." Among other requirements, before an agency promulgates a rule that will impose such costs on states, it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the process of developing the rule prior to promulgation[4]. If exercising the consultation option, an agency must provide a federalism impact summary to the Office of Management and Budget hat describes the agency's consultation with the states, summarizes their concerns and explains how those concerns were addressed[5]. CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states[6].

To the contrary, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, most states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them,

[2] 42 U.S.C. § 1396d(r)(5)
[3] 42 U.S.C. § 1396 (emphasis added)
[4] Exec. Order 13132, § 6(b)
[5] Id., at (b)(2).
[6] 72 Fed. Reg. at 45209 (Preamble, V.A)

they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the requirements of Executive Order 13132.

In addition, CMS asserts that this rule will not have a direct impact on providers of rehabilitation services[7]. This is also incorrect. These regulations narrow the scope of the service and, directly and indirectly, impose requirements that will have significant, direct impact on providers. The requirement of the detailed written rehabilitation plan will also require additional work by providers. The discussion of how providers need to separate "incidental" personal care functions from rehabilitation services for billing, record keeping and administration shows how many additional duties will be necessary for providers[8].

Overview:

The proposed rule is typical of a long-standing campaign undertaken by CMS to restrict federal Medicaid payment policies. In the case of 2261-P, these restrictions were considered and expressly rejected by Congress during debate on the Deficit Reduction Act of 2005.9

This regulation suffers from a fundamental legal flaw under Title XIX. This proposed rehabilitation rule attempts to introduce into the statute precisely the type of "educational" and "social" exclusions barred by Medicaid as a result of mandatory early and periodic screening diagnostic and treatment (EPSDT) benefit.

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called "rehab option," which has been given broad and expansive administrative interpretation. This section says, inter alia, that medical assistance to

[7] 72 Fed. Reg. at 45208 (Preamble, V.A.)
[8] 72 Fed. Reg. at 45206 (Preamble, II.F.2)

be provided at state option includes "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level."

The current rule[10] emanating from this statute is the target of the current CMS proposal. For more than forty years, the rehabilitation benefit has been the authority for a range of medically necessary services, including mental illness, developmental disabilities, children with behavioral and emotional afflictions, and those who fail to reach developmental milestones. Without disputing the need for these services or the efficiency of providing them in any appropriate environment, CMS has proposed a rule that severely limits the flexibility of the current rule, which would make it far more burdensome and expensive to provide these services within the Medicaid framework and, in some cases, would restrict coverage altogether.

In proposing this rule, CMS has excluded services that are furnished through programs other than Medicaid from the definition of "rehabilitation." This is direct conflict with Title XIX, which has long recognized that Medicaid-reimbursable services may be provided through other state programs.

The rehabilitation benefit is optional for adults but required for categorically needy individuals under age 21 as a result of their entitlement to services under the Early and Periodic Screening, Diagnostic, and Treatment services. All benefits and services that fall within the definition of "medical assistance" under EPSDT are required when medically necessary as a result of an EPSDT screen. Rehabilitative services fall within this benefit and are codified within the definition of "medical assistance" and are therefore required under federal law for individuals under twenty-one.

There have been previous attempts to curtail federal Medicaid contributions for covered benefits furnished to Medicaid-enrolled children who also are receiving

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[9] See discussion of the DRA in Jeff Crowley and Molly O'Malley, Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues (Kaiser Commission on Medicaid and the Uninsured, August, 2007).
[10] (42 C.F.R. 440 130(d))

services through public educational or social programs. The first such attempt occurred in 1988, when the Reagan Administration attempted to halt federal payments for medical assistance furnished as a related service under a child's special education plan. In response, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized education plan[11]. The prohibition specifies as follows:

> Nothing in this chapter shall be construed as prohibiting or restricting or authorizing the Secretary to prohibit or restrict payment under subsection (a)[relating to federal payments generally] for medical assistance for covered services furnished to5 a child with a disability because such services are included in the children's individualized education program established pursuant to part B of the [IDEA] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of [the IDEA][12]

The CMS proposal would replace the current definition of rehabilitative services, which is one sentence long, with an eight-part definition of the scope of services and a mandated seventeen-part "rehabilitation plan" for each service recipient.

In sum, even when the benefits are furnished by qualified providers and the treatment is covered, the rehabilitation service NPRM would add a payment exclusion that simply has no basis in the statute. Indeed, the proposed rule contravenes the statute's EPSDT benefit and its federal financing provisions. As such, the proposed rule goes far beyond Secretarial powers under Medicaid. Most astoundingly perhaps, CMS specifically characterizes the rule as a third party liability rule[13], even though doing so would appear to be a direct admission that the agency is attempting to achieve in regulation what was rejected in statute.

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[11] 42 U.S.C. §1396b(c). Interestingly CMS concedes the existence of this statute in the school administration regulations but ironically, as justification for denying federal payments for administrative services. 72 Fed. Reg. 51398.

[12] Id.

[13] 72 Fed. Reg. 45209

Overarching Issue - Conflict with EPSDT

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a States' plan[14]. There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements.

Recommendations:

We recommend the following:

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

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

Amend § 441.45(b)(4) to refer to the EPSDT requirement and instruct states to comply with it.

Proposed § 440.130(d)(1)(v)-(vii) - Maintenance v. Restorative Services

The discussion of services that maintain, rather than restore, function may lead to inappropriate denials of services that should be covered as rehabilitative, particularly the discussion of the requirements of the written rehabilitation plan. Throughout the

preamble and proposed regulations, CMS emphasizes that rehabilitation services must reduce disability and restore function in order to be reimbursable under Medicaid[15]. The discussion of a written rehabilitation plan in the preamble emphasizes the "ultimate goal" of reduction of medical care[16]. Moreover, the preamble states that "[i]t is important to note that this benefit is not a custodial care benefit but should result in a change in status.[17]" Id. At the same time, the proposed regulations acknowledge that maintaining a functional level may be necessary to achieve a rehabilitation goal[18]. But, the discussion of the written plan in the preamble states that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . .[19]"

This discussion creates confusion. This emphasis on change in status and on achievement of specific goals may lead states to deny coverage for medically necessary rehabilitation services because such services may not lead to immediate results. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse. Again, the Medicaid statute, which CMS is apparently attempting to bypass, emphasizes the importance of rehabilitation services to attain independence and health[20]. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations.

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[14] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5)
[15] 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A))
[16] Id. at 45203 (Preamble, II.C)
[17]
[18] Id. at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi))
[19] Id. at 45204 (Preamble, II.C)
[20] 42 U.S.C. § 1396

This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is an even greater likelihood that the actual service needed will be covered. Moreover, this agency has a long-standing policy of recognizing that maintenance therapy may be covered[21]. The overly restrictive definition and interpretation in this area may conflict with longstanding agency policy.

Recommendations:

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

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

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

Proposed § 440.130(d)(5) - Settings for Service Provision

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be

[21] See, e.g., Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, Medicaid State Bulletin, 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991).

provided.[22]" This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

Clarify that rehabilitation services should be covered in any setting permitted by state law, including schools.

Add the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to § 440.130(d).

Proposed § 440.130(d)(1)(vi) – Restorative Services

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option[23]. As CMS acknowledges in the letter, this is an important service for individuals with mental illness and substance abuse services. Given its obvious importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in the regulations.

Recommendations:

Section 440.130(d)(1)(vi), which describes "restorative services" should be amended and language added stating that peer guidance is a covered rehabilitation service.

[22] 72 Fed. Reg. at 45205 (Preamble, II.E)
[23] Dear State Medicaid Director, Peer Support Services – SMDL #07-011 (August 15, 2007)

Proposed § 441.45(b)(1) – Non-Covered Services

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid[24]. The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services. Moreover, it is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. Thus, these children will all be eligible for EPSDT, under which a service should be covered if it is necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity and ambiguity in promulgation of regulation never works in favor of the regulated community.

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included under the IDEA[25]. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services[26]. Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . .[27]" Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party[28]. Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

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[24] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))
[25] 72 Fed. Reg. at 45202
[26] 42 U.S.C. § 1396b(c)
[27] 42 U.S.C. § 1396a(a)(25)(A)
[28] 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007).

The proposed rule excludes Medicaid reimbursement for rehabilitative services that are "intrinsic element of other programs" even if they meet all of the other requirements in the proposed rule at 441.45(b). This exclusion is has no legal foundation. Title XIX does not exempt Medicaid reimbursement for services merely because they are part of another program. In fact, Title XIX was designed by Congress to work in concert with child welfare, special education, and other complementary health care and social services. Medicaid is a financial services program and as such is the payer of items and services known as medical assistance. In addition, it is the enabler of medical assistance and program administrative activities. The other programs the proposed rule would eliminate are the means by which this medical assistance financing actually delivers health care services and support to children. The Medicaid law was designed to augment and enhance education, social support, and child welfare programs, not duplicate them.

It is difficult to understand what CMS means by the term "intrinsic." When the administration attempted to advance its "intrinsic" argument in 2005[29], it became evident that the concept reflected a fundamental misunderstanding of Medicaid's interaction with other programs serving children and the recommendation was rejected. Now the Administration seeks to do by regulation what Congress already has rejected by statute. The rehabilitation NPRM resuscitates the "intrinsic" exclusion once again, this time broadening it still further. As before, the Administration excludes payments for "intrinsic" elements while offering no definition of "intrinsic elements." But the NPRM also goes beyond the vagaries of the "intrinsic element" test to exclude payment for covered rehabilitation benefits in the case of children who are receiving services in the case of other specific programs. As a result, the rule adds a coverage condition not contemplated by the statute, which functions as the type of coverage exclusion common to commercial insurance.30 In the proposed regulations, CMS states:

> This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused

[29] Medicaid's Rehabilitation Service Option, op. cit. p. 13
[30] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

> on social or educational development goals in programs other than Medicaid. . . . We propose . . . that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole, and probation, juvenile justice or public guardianship. We also proposed that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid[31].

This specific exclusion of payment in the case of children whose medical assistance covered treatments are being arranged for by other programs represents a blatant attempt to add conditions of coverage not permitted under the statute. It grafts onto Medicaid a payment exclusion that simply does not exist. The exclusion is a reflection of a desire on the part of the Administration to push Medicaid, in terms of coverage design, in the direction of commercial insurance, a direction that Congress has rejected in the case of children[32].

Recommendations:

We believe this section should be omitted in its entirely, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Section 441.45(b)(1)(iv) should be amended to restate that Medicaid coverage should not be denied merely because a service is provided in an individual education plan.

The responsibilities for states regarding third party payers, and the third party payers'

[31] 72 Fed. Reg. 45201, 45202 and 42505
[32] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

Proposed § 441.45(b)(2) - Habilitation Services

The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function[33]. The discussion and regulation regarding habilitation is problematic for several reasons.

First, it seems to be based on the premise that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate.

Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy[34]. These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services.

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental health and/or substance related disorders can be appropriately treated with rehabilitation services[35]. See However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

Recommendations:

[33] 42 C.F.R. § 441.45(b)(2), see also 72 Fed. Reg. at 45205 (Preamble,II.F.2)
[34] 42 C.F.R. § 435.1010 (2007)
[35] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2))

Add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health services.

Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy) and medical or other remedial care provided by licensed practitioners, defined at 42 C.F.R. § 440.60."

Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.

Proposed § 440.130(d)(3) - Written Rehabilitation Plan

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

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

Proposed Elimination of Transportation Services

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

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

Non-covered services: 441.45(b)

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

There appear to be only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service, 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)[36]. 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.

Recommendations:

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

Summary:

As we have discussed above, we believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[37]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of

[36] 42 U.S.C. §§ 1396a(a)(10), 1396d(r)
[37] [Social Security Act, Section 1905(a)(13)]

our most vulnerable citizens.

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