**Submitter :** **Ms. Anne McKenzie** **Date: 10/10/2007**

**Organization :** **Lower Pioneer Valley Educational Collaborative**

**Category :** **Academic**

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2261-P-634-Attach-1.DOC

#634

**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,

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[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 :** Mr. Del mintz **Date:** 10/10/2007

**Organization :** parent

**Category :** Individual

**Issue Areas/Comments**

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

I am alarmed that CMS-2261P will eliminate funding for Behavioral Health Rehabilitation (BHR) services for children with autism or other developmental delays because BHR treatment programs will be mislabeled as habilitative. Young children, including those with Autism and related disorders of development, almost always display some sort of developmental of social skills in infancy. When these skills fail to develop at an age-appropriate rate, developmental delay occurs, and the child needs REhabilitation services to resume development of those latent skills. Unfortunately, not all administrators of State Medicaid plans will appreciate this DETAIL, and will use the revised Medicaid rules to cut Medicaid funding for ALL services to developmentally disabled children.

In the text of the proposed rule-making, the CMS authors describe the REhabilitation of a person to teach him how to use public transportation when he didn't have that skill previously, but had the capacity to develop it. It's the same with communication skills, socialization skills, and other skills that we typically address via BHRS for kids like my son with autism. We are helping children to socialize and communicate effectively (in full sentences for instance) when they DID have the ability to communicate and socialize age-appropriately as younger children. Then, those skills deteriorated, Autism was diagnosed, and now those dormant skills need to be REhabilitated. Just like learning how to take a bus.

With an epidemic of autism (1 in 150), this is not the time to withdraw help from children with autism and related disorders of development help that has been proven to be successful. The other aspects of CMS-2261P related to improving the quality of professional supervision and oversight of BHR services, improving treatment outcome measurement, improving documentation of service delivery will all increase the quality of service rendered to children. It is not necessary to YANK Medicaid funding for services to children with developmental delays in order to save some money now.

Children with such delays in Pennsylvania have been receiving effective treatment via the EPSDT Behavioral Health Rehabilitation (BHR) services covered in 440.130(d) of the Medicaid regulations. These services are among the few that have a 10 year documented history of effectiveness that can be seen at www.ibc-pa.org/research1.htm <http://www.ibc-pa.org/research1.htm> .

**Submitter :** Ms. Willow Cataldo **Date:** 10/10/2007

**Organization :** Oaklawn

**Category :** Comprehensive Outpatient Rehabilitation Facility

**Issue Areas/Comments**

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

I urge elimination of Provision 441.45(b) which makes several problematic assumptions: duplication of service provision, duplication of billing, duplication of clinical and case management services.

I urge more time to contemplate the complex issues involved with Provision 441.45(b) - and that this time be used to investigate professional opinions and examples regarding the faulty assumptions made in the provision.

If 441.45(b) is not eliminated, it is imperative to secure alternate sources of funding so children do not lose these vital services.

I urge reconsideration of the 17-point rehabilitation plan. As is, this plan is onerous, duplicative and bureaucratic.

Finally, I urge for further clarification of "restorative services" when working with children (who are still developing), and chronically mentally ill adults, where continuation of services is essential for functioning at the time.

**Submitter :** Mrs. Jane Liberi **Date:** 10/10/2007

**Organization :** Mrs. Jane Liberi

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

Please withdrawl, revise and republish proposals as these will greatly impact children with Autism Spectrum Disorder and Mental Retardation. Our daughter would not be able to remain in the school that she attends without the behavioral support that she is receiving; thereby forcing her to be in a more institutional environment, which would not only be in violation of the Individuals with Disabilities Education Act (as this would not be the Least Restrictive Environment for our daughter,) but it would greatly impede her ability to learn the skills she needs to be a self-sufficient, behaviorally appropriate, functioning member of society.

**Submitter :** Mrs. Jennifer Claypoole **Date:** 10/10/2007

**Organization :** NAMI East Central

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attached

CMS-2261-P-638-Attach-1.DOC

#638

October 10, 2007

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

To Whom It May Concern:

In response to your request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services, I am submitting the following comments and opinion:

A. Your distinction between "habilitation" services and "rehabilitation" services makes no sense, and will be subject to great abuse. You are creating a very artificial distinction between retaining, maintaining, or discovering new functions.

The onset of mental illness occurs most often in late adolescence. Teenagers have not learned so many life skills that will be necessary for a comfortable existence. Often it takes years of learning to adapt to adult living. These skills are gained, not re-learned. Any good Medicaid program will be teaching new skills to these persons, not rehabilitating old skills. To make a distinction between "habilitation" and "rehabilitation" in mental illness will lead to loss of funding, lack of funding, and repayment of funding. It will force programs very necessary to helping persons with mental illness recover life to close. These young people will either be institutionalized or end up in jail, costing far more in the long run than services will cost in the short run.

Persons with mental illness suffer relapse, having to start over again to regain functioning. This concept of relapse and recovery doesn't fit at all into your artificial distinction between habilitation and rehabilitation. Because recovery from mental illness is often a long term process, with many ups and downs, this distinction between "habilitation" and "rehabilitation" will likely reduce or eliminate many necessary psycho social rehabilitation services.

B. Your proposed rule changes simply reduce persons with mental illness' access to needed services without any back up plan to fund these existing services and programs. Many of these services have been working successfully for a decade. With these new regulations, these services will no longer be able to provide the crucial support network that people with serious mental illnesses so desperately need. Vast numbers of people will be deprived of an opportunity to build a meaningful future. No effort has been made for alternative funding from states or the federal government. A reduction in these services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse, in our jails and prisons.

C. Many ACT teams reach out to persons with severe and persistent mental illness who are not cooperating with the system. These persons will not develop or sign any kind of "treatment plan". Hopefully, rapport can be built over time. But to require them to sign a treatment plan at the beginning of their introduction to ACT team is totally unrealistic. An alternative needs to be established for persons who are anosognosic – in denial of their illness and uncooperative. How else will an ACT team reach out to homeless and persons who refuse to cooperate with the system?

D. The need to see rehabilitation in one year is totally unrealistic. Many persons with mental illness take much longer to begin to see improvement. Often they have relapses of their illness and actually decline within a year's time. I agree with your emphasis on treatment plans that include the person and the families or caregivers – but I disagree with your emphasis on time limits.

E. Your emphasis on drawing a line between services that should be reimbursed by Medicaid and services that should be funded by other programs will result in consumers having to go from place to place to find some state agency that will fund a need. This is a huge burden to be placed on a consumer. This coordination should not be the responsibility of a person with serious mental illness.

Often these state agencies are overloaded and out of money. Just because some other agency has the capacity to fund a certain need doesn't mean the money is there or that the consumer meets all of their particular requirements. This coordination should be happening in YOUR OFFICE, not in the communities where individuals suffer and die.

Surely you are hearing a hue and cry from the grass roots about your proposed regulations. Please sit down with America's most vulnerable citizens, persons with mental illness, and develop some workable alternatives before you completely dismantle a system that is already suffering for lack of funding.

Sincerely,

Jennifer Claypoole, LCSW
President, NAMI East Central Indiana Affiliate

**Submitter :** tim kral **Date:** 10/10/2007

**Organization :** Oregon Rehabilitation Associatin

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**Background**

Background

There are many provisions of the proposed rule than are in need of changing. See comments from ANCOR, which we support in full.

Tim Kral, Executive Director, Oregon Rehabilitation Association

**GENERAL**

GENERAL

There are many provisions of the proposed rule than are in need of changing. See comments from ANCOR,submitted Oct 11, 2007, which we support in full.

Tim Kral, Executive Director, Oregon Rehabilitation Association

**Submitter :** Mrs. Amy Morris **Date:** 10/10/2007

**Organization :** Center for Mental Health

**Category :** Comprehensive Outpatient Rehabilitation Facility

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-640-Attach-1.DOC

CMS-2261-P-640-Attach-2.DOC

#640

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,

**Amy Morris, BS, QMHP**
**Employment Specialist**

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

**Submitter :** Cindy Stockton **Date:** 10/10/2007

**Organization :** Riverside Training Centers, Inc.

**Category :** Private Industry

**Issue Areas/Comments**

**GENERAL**

GENERAL

There are many provisions of the proposed rule than need to be revised. Please see the comments from ANCOR, submitted Oct 11, 2007, which we fully support.

Cindy STockton, Executive Director

**Submitter :** Mr. Dan McNamara **Date:** 10/10/2007

**Organization :** Edwards Center, Inc.

**Category :** Long-term Care

**Issue Areas/Comments**

**GENERAL**

GENERAL

We fully support ANCOR's comments submitted October 11, 2007. The issues raised and ramifications are accurately expressed as far as they relate to us and to the people we serve.

**Submitter :** **Mrs. Sharmean Heffernan** **Date: 10/10/2007**

**Organization :** **Specialized Support Services**

**Category :** **Intermediate Care Facility for the Mentally Retarded**

**Issue Areas/Comments**

**GENERAL**

GENERAL

There are many provisions of the proposed rule that are in need of changing. See comments from ANCOR, submitted Oct 11, 2007, which we support in full.

Sharmean Heffernan, Director, Specialized Support Services

**Submitter :** Ms. Loretta Clift **Date:** 10/10/2007

**Organization :** Ms. Loretta Clift

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

It appears the proposed rule as written would put severe limits on the ability to follow through with treatment options for children and young adults with Autism Spectrum Disorder. The limits to wraparound services in particular and lack of insurance coverage creates the risk of an ineffective 'one size fits all' approach to the treatment of individuals with intellectual disabilities. I am asking that CMS withdraw, revise and then republish with sufficient comment time the proposal to limit wraparound services to children with intellectual disabilities.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

There has not been sufficient time made available to families of individuals with ASD to review the proposed regulation and to collect relevant data as to the long range impact on them and to respond with concerns. An extension of the comment period will allow for a more thoughtful debate based on fact as opposed to emotion and /or opinion.

**Response to Comments**

Response to Comments

The lack of insurance coverage coupled with the cessation of wraparound services to individuals with intellectual disabilities will create a "one size fits all" treatment approach to the affected individuals. The possibility of families needing to forgo more naturalistic approaches (i.e. DIR) in favor of medication due to lack of ability to access treatment will have an effect on future school resource allocation, work force training and support costs and future medical costs.

**Submitter :** Cheryl Fortunato **Date:** 10/10/2007

**Organization :** Cheryl Fortunato

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am the parent of a 10 year old child diagnosed with PDD-NOS, a diagnosis on the Autism Spectrum. He has been receiving rehabilitation services and has truly come a long way. Changes to the Rehabilitation Option would only confuse matters in the minds of some bureaucrats, ultimately closing the door for my child to receive these services.

CMS-2261P would eliminate the funding for BEhavioral Health Rehabiliation services because BHR treatment programs will be mislabeled as habilitative. My child, as is the case with all children with autism and other types of developmental disorders clearly had signs of social skills during infancy. However, these skills have not developed like those of other children at an age-appropriate rate. As a result, he has needed rehabilitative services. I am concerned that the passing of this proposal will result in administrators of State Medicaid plans cutting Medicaid funding for services to developmentally disabled children.

My son has the capacity to develop the appropriate communication and social skills. These services have helped him to socialize and communicate more effectively.

Certainly, with an epidemic of autism spreading across the nation, this is not the time to withdraw help from children with autism and related disorders of development, especially help that has been proven to be successful.

There are aspects of CMS-2261P that can be followed through and will have a direct impact on the quality of service rendered to these children. Specifically, focusing on improving the quality of the quality of professional supervision and oversight of BHR services, improving treatment outcome measurement, and improving documentation of service delivery.It is not necessary to utterly deny Medicaid funding for services to children with developmental delays in order to save some money.

**Submitter :** Ms. Trix Niernberger **Date:** 10/10/2007

**Organization :** NAMI-New York State

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

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

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

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

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

Recommendation:

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

**GENERAL**

GENERAL

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

We know what works. But we also know that too many people can t access these treatments. And the terrible consequences are seen in every jail and prison in America.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

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

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

For some of us and our family members who have been hospitalized or in jail, staying stable and in housing is not easy and is an achievement. It also requires services so we do not deteriorate and get worse. We hope the agency will adjust its regulations to take into account the nature of our illnesses and those of our family members and allow services to prevent deterioration of the illnesses.

Recommendation:

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

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

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

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

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

Recommendation:

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

**Regulatory Impact Analysis**

Regulatory Impact Analysis

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

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

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

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

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

Recommendation:

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

**Response to Comments**

Response to Comments

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

Many children with mental illnesses rely upon therapeutic foster care. This is a service that works well and creates good outcomes such as going to school more, staying out of trouble with law enforcement, and living in a stable place. The proposed regulations should give states the ability to get federal resources to support this effective service as long as the services are rehabilitative.

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

Recommendation:

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

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

**Submitter :** **Frederica Teer** **Date: 10/10/2007**

**Organization :** **Frederica Teer**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

With the ever increasing stresses of living in our world today, the last thing we can afford to do is to make cuts in mental health support and care. As an individual who has an extensive family history of clinical depression and bipolar disorder, the sister of a bipolar brother who successfully commited suicide, and the mother of an adult bipolar son, I beseach you to not only refrain from making cuts in services, but to find greater funding for mental health services. These are people who make great contributions to society, who deserve our compassion and support. Conversely, what happens when we don't intervene and provide compassion and support? We get tragedies such as those that happen on an all to regular basis, such as the shooting at VA Tech, and many more not so newsworthy tragedies. We must strive to better support, not neglect, our most needy citizens.

**Submitter :** Ms. Kathy Burton Avsar **Date:** 10/10/2007

**Organization :** University of Alabama in Birmingham

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Mental illness is difficult for the individual and their families, but most families want to help and be involved if someone just gives them some direction. A proactive approach is necessary and in the long run the most cost efficient. It is time that we stopped trying to dodge the bullet and face the problem

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

**Organization :**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I believe CMS should withdraw, revise and republish proposals with clarification of impact to children with ASD and MR. Additionally, CMS should allow a sufficient comment period so that individuals and families impacted may respond.

**Submitter :** **Ms. Mari Cabrera** **Date: 10/10/2007**

**Organization :** **Ms. Mari Cabrera**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-650-Attach-1.DOC

#650

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

Dear Sir or Madam:

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

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

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

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

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

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

individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

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

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

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

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

Recommendation:

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

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

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

For some of us and our family members who have been hospitalized or in jail, staying stable and in housing is not easy and is an achievement. It also requires services so we do not deteriorate and get worse. We hope the agency will adjust its regulations to take into account the nature of our illnesses and those of our family members and allow services to prevent deterioration of the illnesses.

Recommendation:

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

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

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

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

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

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

Recommendation:

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

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

Many children with mental illnesses rely upon therapeutic foster care. This is a service that works well and creates good outcomes such as going to school more, staying out of trouble with law enforcement, and living in a stable place. The proposed regulations should give states the ability to get federal resources to support this effective service as long as the services are rehabilitative.

The proposed regulations say that the federal government will not provide resources for recess aides or classroom aides. We believe that the rule also needs to clearly inform schools that Medicaid will pay for behavior aides and other mental health providers who are giving services to a particular child. Children with mental illnesses and their families

have been fighting a long battle to get mental heath services provided to children in schools and this regulation should support that effort by clearly encouraging school based mental health services.

Recommendation:

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

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

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

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

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

Recommendation:

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

**Conclusion:**

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

We know what works. But we also know that too many people can't access these treatments. And the terrible consequences are seen in every jail and prison in America. The federal government should be doing everything possible to encourage states to provide better and more effective services for people living with mental illnesses. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

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

Thank you,

Mari Cabrera
310-202-1967

**Submitter :** Mr. Scott Wood **Date:** 10/10/2007

**Organization :** Options for Southern Oregon

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Mental Health Colleagues,

People with mental illness, family members, and mental health services providers need your help immediately.

A current rule proposed by the Center for Medicare and Medicaid Services (CMS) will have a chilling effect on the ability of states and mental health providers to provide evidence based practices, including Supported Employment services.

Please let CMS know strongly and loudly that psychiatric rehabilitation services are important and CMS should be working to make those services more readily available to people with mental illness.

WE 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.

**Submitter :** **Ms. Paula DeSanto** **Date: 10/10/2007**

**Organization :** **Ms. Paula DeSanto**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachmcnt

CMS-2261-P-652-Attach-1.DOC

#652

Dear Mental Health Colleagues,

People with mental illness, family members, and mental health services providers need your help immedi

A current rule proposed by the Center for Medicare and Medicaid Services (CMS) will have a chilling ef mental health providers to provide evidence based practices, including Supported Employment services.

Please let CMS know strongly and loudly that psychiatric rehabilitation services are important and CMS services more readily available to people with mental illness.

WE RECOMMEND THE FOLLOWING SPECIFIC NAMI ENDORSED CHANGES RELATED TO W SEVERE MENTAL ILLNESS

1. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people w 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 m and where they need them.

3. We ask that you revise these regulations to make it clear that the federal government encourages any s 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 o 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 a

WHAT YOU CAN DO NOW

PLEASE EMAIL YOUR COMMENTS TO CMS (FEEL FREE TO CUT AND PASTE THE ABOVE R EMAIL)
Comments must be received by 5:00 pm on October 12, 2007. They may be submitted electronically to http://www.cms.hhs.gov/eRulemaking (click on the link ``Submit electronic comments on CMS regulatic

We have included information in this e-mail from the Bazelon Center and the National Alliance on Ment advocates.
http://www.bazelon.org/takeaction/2007/RehabRule08-16-07.htm
http://www.nami.org/TextTemplate.cfm?Section=About_Recovery&template=/ContentManagement/Co

Dartmouth Psychiatric Research Center
http://dms.dartmouth.edu/prc/

**Submitter :** **Patricia Dunn** **Date: 10/10/2007**

**Organization :** **Patricia Dunn**

**Category :** **Individual**

**Issue Areas/Comments**

**Regulatory Impact Analysis**

Regulatory Impact Analysis

Health care for those with mental illness is critical. Without continued health care benefits, most of these folks will end up on the street or in jail. With health care, they may possibly be able to contribute to society in some small or bigger way.

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

**Organization :** **Oregon Advocacy Center**

**Category :** **Consumer Group**

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2261-P-654-Attach-1.DOC

CMS-2261-P-654-Attach-2.DOC

#654

OREGON ADVOCACY CENTER

Working for the Rights of Individuals with Disabilities

October 10, 2007

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

**Re: File Code CMS–2261–P**

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. These comments are being submitted on behalf of the Oregon Advocacy Center, a public interest law firm created by Congress to protect and enforce the rights of people with disabilities, including people with mental illness, people with developmental disabilities, children receiving foster care, people with physical disabilities, and other populations directly impacted by this proposed rule.

We are organizing our comments into major issues and concerns.

**Major Issues and Concerns**

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

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

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

Not only does the proposed rule not further this core goal of Medicaid, it erects new obstacles for Medicaid beneficiaries to receive medically necessary rehabilitative services. It does not justify the need for new rules and it does not provide a reasonable description of the impact of the

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620 S.W. Fifth Avenue, 5th Floor • Portland, Oregon 97204-1428

proposed rule on Medicaid beneficiaries or rehabilitative services providers. The Regulatory Impact Analysis makes numerous assertions that are contradictory and appear intended to mask the impact of the proposed rule. For example, it states that, "the Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act." In reality, the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on providers. The proposed rule also states that, "...because FFP [Federal financial participation] will be excluded for rehabilitative services that are included in other Federal, State, and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This would impose substantial increased costs on states that must change many of their administrative practices and that must either limit access to medically necessary services or increase state spending to provide services that were previously eligible for Medicaid FFP.

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

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

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

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

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

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

The proposed rule would deny FFP for services furnished, through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin,

Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

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

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

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

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

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

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

otherwise preventable, through the provisioning of community-based rehabilitative services.

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

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

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

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

In

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

enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." (Report of the House Budget Committee, "Explanation of the Commerce and Ways and Means Committees Affecting Medicare-Medicaid Programs," Sept. 20, 1989). It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

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

We also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. We believe the proposed rule represents a missed

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

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

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

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

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions: We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on

habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

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

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

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

**c. The proposed rule would harm children receiving foster care**

According to an Urban Institute analysis, 869,087 children were enrolled in Medicaid on the basis of receiving foster care in 2001, and 509,914 of these children were enrolled for Medicaid for the full year (Geen, Sommers, and Cohen, Urban Institute, August 2005). An analysis of Medicaid spending on these children found that 13.1% of Medicaid spending was for rehabilitative services. Prior research has shown that children receiving foster care have more health problems, especially mental health problems, than the general population or the

population of poor children (Geen and others). As many as 80% of young people involved with child welfare have emotional or behavioral disorders, developmental delays, or other issues requiring mental health intervention (Farmer and others, *Social Service Review* 75(2):605-24). A Department of Health and Human Services (HHS) review found that only one state met federal standards for the provisioning of health and mental health services to children involved in the child welfare system (DHHS, 2005, "General Findings from the Federal Child and Family Services Review"). We are deeply concerned that the proposed rule will significantly harm Medicaid beneficiaries receiving foster care in two major ways: It could restrict access to Medicaid rehabilitative services for children receiving foster care by determining that such services are intrinsic to other foster care programs, and it would eliminate coverage for therapeutic foster care services.

Restriction on access to Medicaid rehabilitative services for children receiving foster care by determining that such services are intrinsic to other foster care programs: Medicaid is the major provider of health and long-term services to children receiving foster care. The other federal programs that fund or support the child welfare system do not have primary responsibility for providing medical assistance services—this is Medicaid's role. Ten percent of federal child welfare spending comes from Medicaid (*Profiles of Medicaid's High Cost Populations*, Kaiser Commission on Medicaid and the Uninsured, December 2006). We are deeply concerned by the proposed intrinsic element test—and the rule's specific invocation of services for children receiving foster care that would be uncoverable by Medicaid as a result of the proposed rule. There seems to be a perception that other funding components of the child welfare system should assume responsibility for medical assistance services currently provided by Medicaid. This is inconsistent with past Congressional action. In particular, the Title IV-E foster care program exists to help states provide safe and stable out-of-home care for children the until the children are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements for permanency (HHS Administration for Children and Families). The purpose of the IV-E program does not include medical assistance, and children in the IV-E program are entitled to Medicaid coverage.

As children eligible for Medicaid, these children are entitled to EPSDT services. However, under the proposed rule, FFP would not be available for rehabilitative services "furnished through" the foster care or child welfare system, "including services that are intrinsic elements of programs other than Medicaid." This restriction on coverage of rehabilitative services is clearly in conflict with the EPSDT mandate. The fact that a service is "furnished through" another system such as the foster care or child welfare system has nothing to do with whether it should be covered by Medicaid. The reference to services "that are intrinsic elements of programs other than Medicaid " is also meaningless when considering whether a service should be covered for a Medicaid-eligible child. The proposed rule does not define "intrinsic element," and this lack of definition is likely to lead to uncertainty for beneficiaries, their families, and health care providers as states grapple with figuring out what can and cannot be covered under this vague test.

The implementation of an intrinsic element test could make children receiving foster care unable to receive medically necessary mental and physical health services even when another

component of the child welfare system is not available to shoulder Medicaid's current responsibility for providing medical assistance services.

It would eliminate coverage for therapeutic foster care services: The proposed rule also prohibits the use of federal Medicaid funds for therapeutic foster care, designed for children with serious mental illness. For most children, therapeutic foster care — in which children are placed in a private home with foster parents who are specially trained to help them improve their condition — is an alternative to more costly care in a residential treatment program or psychiatric hospital (*Mental Health—A Report of the Surgeon General*, 1999).

**4) Implementation of the proposed rule would create an unreasonable barrier for states seeking to effectively deliver evidence-based practices and efficiently administer rehabilitation programs under Medicaid.**

A major goal of Medicaid mental health treatment programs in recent years has been to re-orient the delivery of services to support recovery. Recovery is defined as a process of restoring or developing a positive and meaningful sense of identity apart from one's condition, and then rebuilding one's life despite, or within the limitations imposed by that condition. In a report issued in 2003, the President's New Freedom Commission on Mental Health recognized the importance of Medicaid services and urged that they be focused on recovery because this could have, "a powerful impact on fostering consumer's independence and their ability to live, work, learn and participate fully in their communities." This challenges many common conceptions of rehabilitation, as it suggests that the goal of treatment is not to cure or eliminate a condition, but it focuses the delivery of services on long-term management of a condition. Unlike individuals recovering from a physical injury in which intensive rehabilitation may be needed for a short, time-limited period, rehabilitative services needed by people with mental illness may be medically necessary over a lifetime.

Psychiatric rehabilitation services are designed to assist the recovery of adults with serious mental illness and children and youth with emotional, behavioral, and mental disorders. Such disorders cause significant deficits in functioning, including deficits in daily living skills, impaired social interactions and behavior, ineffective problem solving, a diminished ability to maintain relationships and a marked impairment in role function, including age-appropriate behavior and functioning in children.

We are deeply concerned that the implementation of the proposed rule would hinder state efforts to operate evidence-based treatment programs.

Starting in the late 1990s, the Robert Wood Johnson Foundation and other public and private funders, including the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Johnson & Johnson, the West Family Foundation, and the John D. and Catherine T. MacArthur Foundation have funded the Dartmouth Psychiatric Research Center to operate an Evidence-Based Practice Project. The project has convened a consensus panel of a broad range of mental health practitioners and other stakeholders to review the evidence for various mental health practices. The panel identified the following practices for which there is a consensus that the practices were evidence-based and represented the best practices for the treatment of

schizophrenia and severe mental illness:

- Assertive community treatment (ACT);
- Family psychoeducation;
- Illness management and recovery;
- Integrated dual disorders treatment;
- Medication management; and,
- Supported employment.

In June 1999, federal officials acknowledged through a State Medicaid Directors letter that Medicaid funds could be used to pay for ACT programs (See June 7, 1999 State Medicaid Director letter from Sally K. Richardson). The letter references an evaluation of the Schizophrenia Patient Outcomes Research Team (PORT) that was funded by the Agency for Health Care Policy and Research and the National Institute for Mental Health that found that,

> "randomized trials have demonstrated consistently the effectiveness of these programs [ACT and a related program, Assertive Case Management or ACM] in reducing inpatient use among such high-risk patients. Several studies also support improvements in clinical and social outcomes. These studies suggest that both ACT and ACM are superior to conventional case management for high-risk cases."

CMS has recognized all of these practices as promising practices and has confirmed (with certain restrictions) that these practices (or aspects of these practices) can be covered under the rehab option (*Medicaid Support of Evidence-Based Practices in Mental Health Programs*, Centers for Medicare and Medicaid Services, October 2005).

The proposed rule appears to continue disturbing CMS administrative practices to restrict flexibility in states use of various payment methodologies to pay for rehabilitative services. Several of our member organizations represent rehabilitative services providers in numerous states that have reported that CMS has tied approval of state plan amendments to the adoption of fee-for-service payment methodologies in which specific services are billed in discrete time increments, such as fifteen minute units of service. States and service providers need greater flexibility to use case rate payment methodologies, to pay daily rates, or use other payment methodologies. Current CMS restrictions are inconsistent with the efficient administration of the Medicaid program because such rigidity will lead to increased administrative costs. Further, numerous services providers report that many of the proven, effective, evidence-based practices cannot be efficiently administered without greater flexibility in using alternative payment methodologies. The Administration position also appears inconsistent with HHS policy to promote capitated managed care, and it does not recognize that per diem and other payment methodologies are used in other parts of the Medicaid program. For example, per diem nursing home payments are a much larger drain on the federal treasury, and we are not aware of any HHS policy to eliminate and transition away from per diem nursing home payments.

We do not ignore the federal responsibility to ensure accountability for significant federal resources that are being used to fund rehabilitative services. This is just one specific instance,

however, where the Secretary should engage in a collaborative dialogue with states and rehabilitative services providers to maximize payment flexibility that leads to improved services, yet which also responds to federal obligations to ensure transparency and accountability.

**5) Challenges efforts by states and school districts to effectively deliver health care services to children with disabilities in school settings.**

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

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

> "Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act."

Under separate cover, the CCD will comment on the NPRM issued on September 7, 2007 to restrict Medicaid coverage for school-based administration and transportation services. Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitative services in school settings, new requirements of this rule could be disruptive to schools and could make it more difficult to use the school environment to assure that children with disabilities receive the rehabilitative services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools. While we share the goal of ensuring that all rehabilitative services are of the highest quality and are only provided by providers who meet state credentialing standards,

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

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

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

Sincerely,

OREGON ADVOCACY CENTER

**Voice: 503.243.2081 1.800.452.1694 • TTY: 503.323.9161 1.800.556.5351 • Fax: 503.243.1738**
**620 S.W. Fifth Avenue, 5th Floor • Portland, Oregon 97204-1428**

**Submitter :** Ms. Christina McMahan **Date:** 10/10/2007

**Organization :** Oregon Juvenile Department Directors Association

**Category :** Local Government

**Issue Areas/Comments**

**Background**

Background

Please See Attached Word Document

**Collections of Information Requirements**

Collections of Information Requirements

Please see attached Word Document

**GENERAL**

GENERAL

See attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

Please see Attached Word Document

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

Please see attached Word Document

**Regulatory Impact Analysis**

Regulatory Impact Analysis

Please see attached Word Document

**Response to Comments**

Response to Comments

Please see Attached Word Document

CMS-2261-P-655-Attach-1.DOC

#655

# Oregon Juvenile Department Directors Association Comments on the following proposed Centers for Medicare and Medicaid Services (CMS) rules:

42 CFR Parts 440 and 441
In Reference to File Code CMS-2261-P
RIN 0938-A081
Medicaid Program; Coverage for Rehabilitative Services
CMS, Department of Health and Human Services

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**Oregon Juvenile Department Directors Association (OJDDA) Contact Information:**

**David Koch, OJDDA President**
Assistant Director, Juvenile Services Division,
Multnomah County Dept. of Community Justice
1401 NE 68th Ave.
Portland, OR 97213
**Phone**: 503-988-4171
**Fax:** 503-988-3409
**E-Mail:** david.m.koch@co.multnomah.or.us

**Lisa Smith, OJDDA President-Elect**
Director, Lane County Dept. of Youth Services
2727 Martin Luther King Jr. Blvd., Eugene, OR 97401
**Phone**: 541-682-4700
**Fax:** 541-682-4732
**E-Mail:** Lisa.D.Smith@co.lane.or.us


## Overview of Comments and Concerns

In the Background Overview of the proposed rules, it states "This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused on social or educational development goals in programs other than Medicaid." The programs that currently receive the Federal financial funds are treatment oriented, not social and educational oriented. Without the proposed changes provided below, this treatment service will be eliminated which is not consistent with the intent.

The purpose for the provision of "rehabilitative services" as outlined was to fund a level of care for maximum reduction of physical and/or mental disability and restoration of the recipient to his/her best possible functional level. Funding for that care would only be allocated when the remedial services were recommended by an approved medical provider or practitioner, where the costs for the specific care was not covered in the individual and/or family's current medical plan, when the individual was eligible for coverage under the Medicaid Social Security Act, and where there was clear rehabilitative benefit.

Medicaid treatment services for rehabilitation are intended to serve only eligible youth. The act never included any definitions that would "rule out" the provision of rehabilitative

services to a specific population of youth who meet all criteria for receiving those services **and** are not incarcerated in a youth correctional facility but who are otherwise involved with the Child Welfare System, county mental health system, Juvenile Justice System or other public operated system. To assume these youth are not worthy or eligible under this Act for a level of care and the provision of services specifically to meet rehabilitative medical and mental needs fails to meet some of the basic purposes of the Medicaid Social Security Act.

## Issues of Agreement:

- Person-centered planning inherent in the written rehabilitation plan.
- Mandating a periodic reevaluation of a person's rehabilitation plan.
- Drawing a distinction between a functional impairment of daily living and a specific physical impairment or mental health and/or substance-related disorder that the rehabilitative service addresses.

## Issues of Concern:

- Issue #1: Provide a definition of a "public institution system" or delete the term from the proposed rule.
- Issue #2: Clarify whether rehabilitation services can be provided in a public institution if the services are freely chosen and the person is Medicaid eligible.
- Issue #3: The rules need to clarify the definition of restorative services.
- Issue #4: Remove the term "intrinsic element."
- Issue #5: Assure that free choice of providers includes parents or legal guardians or representatives rather than only individuals, and clarify that free choice can apply to rehabilitative programs, within which there are a limited set of providers associated with each rehabilitative program.
- Issue #6: Clarify that rehabilitative services are an optional service for adults and children.
- Issue #7: Provide further guidance on a compliant written rehabilitation plan.
- Issue #8: Clarify how rule affects current HCPCS coding for packaged services.

## Issue #1: The definition of a "public institution system."

*Section in proposed rules: 441.45(b) (4).*

**Concerns:** Section 441.45 (b)(4) states Rehabilitation does not include "Services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offense in, or confined involuntarily to public institutions." This portion of the section is not problematic.

441.45(b)(4) goes on to state that "[r]ehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs." The underlined portion of this phrase creates significant concerns and is inconsistent with the first sentence of the paragraph this passage was taken from, That first sentence proposes to exclude payment for services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. But the underlined portion above would prevent youth (who are not living in secure custody) from receiving treatment in a public institution setting or provided by a public entity. This penalizes youth who chose treatment provided in a public setting over treatment provided by a private entity. In many jurisdictions it therefore limits the choices available to receive treatment or prohibits youth from receiving services at all.

**Proposed changes:** CMS should provide a definition of a "public institution system" or delete the phrase "that are not part of the public institution system" from the proposed rule. CMS should clarify that a youth on probation or parole who voluntarily enters treatment in a program run by the juvenile justice system is eligible for reimbursement so long as the youth is not "in the secure custody of law enforcement." Voluntary residence in a public institution alone should not make a youth ineligible for rehabilitative services.

## Issue #2: Services provided within a public institution

*Section in proposed rules: 441.45 (b) (5).*

**Concerns:** This section clearly prohibits payment for rehabilitative services for inmates living in the secure custody of law enforcement in a public institution. It is less clear that rehabilitative services may be provided it Medicaid-eligible individuals who receive these services voluntarily at a public institution.

**Proposed changes:** CMS should clarify that rehabilitative services can be provided in a public institution so long as the person or the person's representative or legal guardian chose the person to be there voluntarily, rather than placed in the program involuntarily (against the wishes of the individual or the individual's representative or legal guardian.)

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## Issue # 3: Further clarification defining Rehabilitative Services

*Section in proposed rules: 440.130(d) (1) (vi).*

**Concerns:** The definition of "Restorative services" includes services that help an individual maintain a certain level of functioning in order to reach a rehabilitative goal. Based on this language, it may be difficult to demonstrate that a bona fide rehabilitative goal relates directly to a service maintaining a certain level of functioning. Defining restorative services to include maintenance services collapses the distinction between habilitative and rehabilitative services. This concern is evident for children at risk of missing a developmental milestone. Not treating a diagnosed condition that places a child at risk of achieving a developmental milestone would be inconsistent with Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

**Proposed changes:** In the rule, CMS should provide language that is more explicit so that states will understand how some services maintaining a level of functioning relate to a bona fide rehabilitative goal. For example, are only providers listed under the rehabilitation option able to provide these functional maintenance services? How do services that maintain a level of functioning meet criteria as rehabilitative for children at risk for losing developmental milestones? States need more clarity to comply with this definition.

## Issue # 4: Definition of "intrinsic element."

*Section proposed rules: 441.45(b) (1).*

**Concerns:** Because "intrinsic element" is not defined in the proposed rule, its inclusion may result in unintentional state non-compliance. The proposed rule provides only a few examples of programs in which rehabilitative services may be improperly claimed, and there are no formal criteria to determine whether the intrinsic element standard is met. The rule seems to give CMS great discretion in interpreting the intrinsic element standard. For example, it would be difficult to determine if rehabilitative services provided to a child in a foster care setting met the intrinsic element standard.

**Proposed changes:** CMS should remove the intrinsic element standard from the rule. Federal regulations for Medicaid programs discuss the program itself, rather than the relationship between two programs. If CMS defines the rehabilitative services option in and of itself, then the states will be able to bill services to the appropriate Medicaid program more effectively.

## Issue #5: Free choice of providers.

*Section in proposed rules: 440.130 (d) (1) (iii)*

**Concerns:** This rule asserts that individuals must have free choice of providers. Under certain programs paid through the rehabilitative option, the individual or his or her parent, guardian, or representative chooses the program but the program only has a limited set of specialized providers. This is analogous to managed health care medical coverage.

**Proposed changes:** The rule should be revised to state that "Individuals *or their parents, legal guardians, or representatives* must have a free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid. Further, the department asks CMS to assure

that if there is a free choice among specialized programs, then it is sufficient to meet the free choice of providers requirement in the proposed rule. Providers will maintain consent to treatment documents signed by every client served by the program.

## Issue #6: Rehabilitative Services Option for Adults and Children

**Concern:** In the Notice of Proposed Rulemaking, CMS describes rehabilitative services as "an optional service for adults" (72 FR 45204).

**Proposed Changes:** CMS should clarify that rehabilitative services are an optional service for adults and for children.

## Issue #7: Definition of the Written Rehabilitation Plan.

*Section in proposed rules: 440.130 (d) (3).*

**Questions:**

- The department defines a treatment plan as "written individualized program of treatment goals, measurable objectives, and services to be provided." State administrative rule allows the individual to develop a treatment plan with the provider, the treatment plan will be revised and the provider will approve the plan annually. Can state administrative rule continue to refer to its written rehabilitative plan as a "treatment plan" as long as the plan satisfies all 17 criteria in the rule?

- The proposed rule requires that the rehabilitation plan, "Document(s) that the services have been determined to be rehabilitative services consistent with the regulatory definition." Is the service provider responsible for determining that the written rehabilitative plan meets the regulatory definition, or is it the state Medicaid agency or its designee?

- If a person receiving rehabilitative services has a moderate or mild functional impairment, requiring brief treatment, do the 17 criteria of the written rehabilitation plan still apply?

**Proposed changes:**

- In regulation, CMS should allow states to retain the authority to determine if a written rehabilitation plan complies with the regulatory definition.

- In regulation, CMS should provide states and providers with flexibility to determine if the 17-criteria written rehabilitation plan is appropriate for individuals with moderate or mild function impairments. This flexibility would be consistent with the Social Security Act's principle of providing services with economy, efficiency, and quality of care (Section 1902(a) (30) (A).

## Issue #8: Bundled Rates for Packaged Services

*Section in Proposed Rules: 441.45(b) (1) (i-ii).*

**Concern:** The proposed rule change prohibits states from paying for packaged services, such as therapeutic foster care for children and Assertive Community Treatment (ACT) for adults under the rehab option. However, both of these interventions are approved as evidence-based practices by the Substance Abuse and Mental Health Services Administration (SAMHSA), and Healthcare Common Procedure Coding System (HCPCS) codes are available for these services. The CMS HCPCS Workgroup approved these codes.

**Proposed Changes:** CMS should clarify if the rule changes prevent states from using nationally approved HCPCS codes for packaged services.