**Submitter :** Dr. Jane Tilly **Date:** 10/11/2007

**Organization :** Alzheimer's Association

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

CMS-2261-P-740-Attach-1.DOC

#740

October 10, 2007

Maria Reed and Shawn Terrell
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS2261-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Subject: Medicaid Program; Coverage for Rehabilitative Services; Proposed Rule
File Code CMS-2261-P

Dear Ms. Reed and Ms. Terrell:

This letter conveys the Alzheimer's Association's comments on Medicaid's proposed regulations for rehabilitative services. The Alzheimer's Association is the premier source of information and support for the more than 5 million Americans with Alzheimer's disease. Through its national network of chapters, it offers a broad range of programs and services for people with the disease, their families, and caregivers and represents their interests on Alzheimer-related issues before federal, state, and local government and with health and long-term care providers. The largest private funder of Alzheimer research, the Association has committed more than $220 million toward research into the causes, treatment, prevention, and cure of Alzheimer's.

We believe that the proposed regulations could have the effect of inhibiting Medicaid beneficiaries' access to these services, if they have dementia. The proposed regulations' language regarding the types of impairments and the types of services Medicaid will cover is of particular concern. We believe that other parts of the proposed regulations would improve rehabilitation for those with dementia, particularly those provisions regarding development and modification of person-centered rehabilitation plans.

**Background**

Research shows that individuals with dementia are capable of learning and retaining certain types of information. Long-term procedural memory is considered to be quite durable, even in the latest stages of dementia. Procedural memory is the long-term memory of skills and procedures, such as daily activities like dressing or cooking. Performance of these types of activities by individuals with dementia can be improved through appropriate therapeutic interventions, including modifying the environment, verbal cueing, and relearning activities that are stored in the procedural memory. Numerous research studies show that individuals with dementia can benefit from

rehabilitation therapies designed to preserve activities of daily living,[1] mobility,[2] and prevent falls.[3]

Practice guidelines from a number of groups, including the Veteran's Health Administration, the American Physical Therapy Association, the American Occupational Therapy Association, the American Association for Geriatric Psychiatry, and the Alzheimer's Association recommend therapeutic interventions to improve daily activities for those with dementia.

## Comments on the Proposed Regulations

A reader of the proposed regulations might conclude that the population with dementia and others with cognitive impairments would not be covered under rehabilitative services. One source of confusion is that the terms "mental disability," "mental impairment," and "mental health and substance abuse" seem to be used interchangeably and most services discussed are those related to physical impairment or mental health and substance abuse.

This could cause confusion because mental health and substance abuse are just one type of mental disability, which may or may not cause a mental impairment. It would be best to choose one general term, such as mental disability and clarify that the term includes disabilities and impairments affecting brain function, which can result from dementia, stroke, traumatic brain injury as well as mental health conditions and substance abuse related disorders.

There is another use of terms that could cause confusion. Sometimes the proposed regulations refer to restoring the "best possible function" as in the current definition of rehabilitation and other times the proposed regulations say "restore function," or "restoring a person to a previous functional level." The first term is correct because rehabilitation does not necessarily restore function completely, but it can help restore the best possible functioning for people with a broad range of cognitive impairments and other disabilities, including dementia.

### Introduction to the Proposed Regulations

II. Provisions of the Proposed Regulations

B. Scope of Services

The definition of the optional Medicaid rehabilitation service states, in part, "services... for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." This definition is good and would not preclude people with dementia from receiving rehabilitation therapy services.

C. Written Rehabilitation Plan

The way the proposed regulations discuss therapy services under the rehabilitation plan might lead some to interpret the proposed regulations restrictively. Specifically, the rehabilitation plan would have to be reviewed to determine whether there has been "a measurable reduction of disability and restoration of functional level." We recommend restating this to read, "a measurable reduction of disability and *restoration to his or her best possible functional level*." Through rehabilitation, persons with dementia can improve function but they rarely will experience a complete restoration of functional level. The same would likely be true of many people with other forms of cognitive impairment.

The plan would have to specify, "the physical impairment, mental health and/or substance-related disorder that is being addressed" and "identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder." This language does not include mental disabilities such as cognitive impairment that could result from conditions such as dementia, stroke, or traumatic brain injury. We recommend inserting the term "mental impairment or disability" after the term physical impairment in both phrases.

D. Impairments to be Addressed

This part states that "rehabilitative services include services provided...to address the individual's physical needs, mental health needs, and/or substance-related disorder treatment needs." This language does not include needs that stem from dementia, stroke, or traumatic brain injury. It should be adjusted to do so.

E. Settings

We recommend that the language mention that rehabilitative services could be provided in adult day health centers. Many people with dementia receive services in this setting, which is not a residential care setting.

F. Requirements and Limitations for Rehabilitative Services

This section should clarify that rehabilitation training directed at helping family caregivers carry out the rehabilitation plan for the Medicaid eligible person with a disability is a covered Medicaid service. About 70 percent of people with dementia live in the community and they cannot do so without the help of family and friends. These caregivers are essential to the success of any rehabilitation plan for those with dementia and providers should be reimbursed for training them to help their loved ones who have dementia and are Medicaid eligible.

III. Collection of Information Requirements

The written rehabilitation plan must, among other things, "specify the physical impairment, mental health and/or substance related disorder." There is no requirement to specify a mental disability, mental impairment, or cognitive impairment, which could well be the source of the functional disability the plan should be trying to address.

The written rehabilitation plan must: "identify the medical and remedial services intended to reduce the physical impairment, mental health and/or substance related disorder." Again, there is no mention of other types of mental disabilities/impairments.

V. Regulatory Impact Analysis
B. Anticipated Effects

This section states that FFP will be available for "rehabilitative services for treatment of physical, mental health, or substance-related disorder rehabilitation treatment." There is there is no mention of FFP being available for treatment of mental disabilities, mental impairments, or cognitive impairments. This oversight needs to be rectified.

**Specific Revisions to Proposed Regulations**

440.130
d(v) After " Rehabilitation plan means a written plan that specifies the physical impairment," insert "mental impairment or disability."

d(vi) After "Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward," insert "restoring the best possible function."

d(vii) After "Medical services means services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care of a physical," insert "or mental disability."

d(viii) After "Remedial services means services that are intended to correct a physical" insert," insert "or mental disability."

3 (v) After "Specify the physical impairment," insert "or mental disability or impairment."

3(vi) After "identified physical impairment," insert "or mental disability or impairment."

3(xiv) After "there has been no measurable reduction of disability and restoration," insert "to his or her best possible functional level."

4 This section should clarify that rehabilitation training directed at helping family caregivers carry out the rehabilitation plan for the Medicaid eligible person with a disability is a covered Medicaid service.

## Conclusion

The Alzheimer's Association knows that people with dementia and others with cognitive impairments can benefit from rehabilitation therapies designed to improve their functioning. Unfortunately, the proposed regulations, as written, might cause some readers to conclude that the only rehabilitation therapy services that are eligible for federal financial participation are those due to physical impairments, or mental health and substance abuse disorders. Further, a reader might conclude that rehabilitation will only be acceptable if it is designed to restore a beneficiary's function completely.

We believe that this kind of interpretation is a strong possibility. The language modifications we recommend are designed to clarify that rehabilitation for people with dementia and other cognitive impairments is appropriate. The modifications are consistent with the definition of rehabilitation therapy in the original regulations, which has been maintained in the proposed regulations. Finally, it is essential to clarify that caregivers can receive training when it is needed to carry out the beneficiary's rehabilitation plan.

The Alzheimer's Association commends CMS for proposing regulations that would require a rehabilitation plan. This would likely improve care for all persons with disabilities who need rehabilitation.

We look forward to working with you on these regulations. If you need further information about any of our comments, please contact me at 202-638-8662 or at jane.tilly@alz.org.

Sincerely,

Jane Tilly, DrPH
Director, Quality Care Advocacy

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[1]Baldelli MV, R. Boiardi P, Ferrari P, Bianchi S, Hunscott Bianchi M. "Dementia and Occupational Therapy" Archives of Gerontology and Geriatrics. Suppl.1, 2007 pgs 45-48. Gitlin LN, Corcoran M, Winter L, et al. "A Randomized, Controlled Trial of a Home Environmental Intervention: Effect on Efficacy and Upset in Caregivers and on Daily Function of Persons with Dementia". The Gerontologist, 2001 vol.41, no.1, pgs4-14. Graff MJL, Vernooji MJM, Thijssen M, Dekker J, Hoefnagels WHL, Rikkert MGMO. "Community Based Occupational Therapy for Patients with Dementia and their Caregivers: Randomised Controlled Trial. British Medical Journal doi:10.1136/bmj.39001.688843.BE, published 17 November 2006. Rogers, JC, Holm MB, Burgio LD, Granieri E, Hsu C, Hardin JM, McDowell BJ. "Improving Morning Care Routines of Nursing Home Residents with Dementia." Journal of the American Geriatric Society vol 47, pgs.1049-1057. 1999. Teri L, Gibbons LE, McCurry SM, Logsdon RG, Buehner DM, Barlow WE, Kukull WA, LaCroix AZ, McCormick W, Larson EB. "Exercise Plus Behavioral

Management in Patients with Alzheimer's Disease: A Randomized Controlled Trial". JAMA. Vol 290 No 15. Pgs 2015-2022. October 15,2003.

[2] Pomeroy VM, Warren CM, Honeycombe C, Briggs RSJ, Wilkinson DG, Pickenering RM, Steiner A, "Mobility and Dementia: Is Physiotherapy Treatment During Respite Care Effective?" International Journal of Geriatric Psychiatry. Vol 14 Pgs 389-397. 1997. Rolland Y, Pillard F, Klapouszczak A, Reynish E, Thomas D, Andrieu S, Riviere D, Vellas B. "Exercise Program for Nursing Home Residents with Alzheimer's Disease: A 1- Year Randomized, Controlled Trial." Journal of the American Geriatric Society, vol. 55, pgs. 158-165. 2007.

[3] Buettner, Linda L. "Focus on Caregiving: Falls Prevention in Dementia Populations" Feb 2002 Provider, pgs.41-43.

**Submitter :** **Karen Reining** **Date: 10/11/2007**

**Organization :** **Friendship House**

**Category :** **Comprehensive Outpatient Rehabilitation Facility**

**Issue Areas/Comments**

**Background**

Background

Keep medicaid funding for mental health!!!!!!!!!!!!!!!!

**GENERAL**

GENERAL

Please help us to assist our clients in their quest to improve their quality of life. We need to keep MEDICAID FUNDING helping people with mental illness.Revise that proposed rule to allow payment for rehabilitative services to help us help people restore their level of functioning!!!!!!!!!!!!!!!!

**Submitter :** **Mrs. Mary Bedel** **Date: 10/11/2007**

**Organization :** **National Alliance for Mental Illness**

**Category :** **Individual**

**Issue Areas/Comments**

**Background**

Background

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:

**Collections of Information Requirements**

Collections of Information Requirements

I am a parent of a paranoid Schizophrenic adult child . We need these changes.

**GENERAL**

GENERAL

Centers for Medicaid & Medicare Services
Dcpartment of Health and Human Services
Attn: CMS-2261-P
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. The onset of mental illness occurs most often in late adolescence. 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 elose. Persons with mental illness suffer relapse, having to start over again to regain functioning. 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. 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 . Many persons with mental illness take much longer to begin to see improvement. 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

**Submitter :** Ms. Jeanette Castello **Date:** 10/11/2007

**Organization :** PA Treatment Law Advocacy Coalition

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

**GENERAL**

GENERAL

The Assertive Community Treatment (ACT) program is the single most important program for people with a severe mental illness, due to the nature of the individualized, intensive services that this program provides. It should be the last program to ever consider taking funding away from, because, without this program, those with the most need would be left out in the cold.

ACT programs, with a multi-disciplinary team of professionals, including psychiatrist, nurses, vocational specialist, drug/alcohol specialist, peer specialist and various case managers provides all of the support that an individual with a severe illness requires, including help in finding and maintaining employment, as well as help with finding housing. The team members can help to ensure that an individual not loose housing, as sometimes happens, when a landlord evicts someone for not taking care of their apartment. A member of the ACT team can help the person keep the apartment clean and in repair, as well as help with other responsibilities, such as shopping for groceries and keeping bills paid.

I can't possibly imagine who would have looked at the budget and thought that removing funding for this vitally important program made any sense, but I hope, that if there truly is a need to cut the budget, you will consider cutting ACT as the very last, desperate measure that you would need to take. The ramifications of closing down this type of support for those with severe mental illness would be devastating. With the continual closing of state hospitals with individuals relocated to the community, ACT is the next level of service required.

Please look at other services that may not be as esential as ACT.

**Submitter :** **Mrs. Karla Rice** **Date: 10/11/2007**

**Organization :** **Mrs. Karla Rice**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The federal agency that overseas the Medical Assistance Program ( called CMS ) has issued proposed regulations that could potentially and significantly limit wraparound ( formerly know as Behavioral Health Rehabilitation Services or BHRS ) services for children and adolescents with Autism Spectrum Disorders and Mental Retardation.

I believe it is irresponsible for the federal agency (CMS) to adopt their proposed regulations as written as they fail to clarify the potential impact on THOUSANDS of _____(enter your state) children with Autism and MR who currently receive wrap around services.

I recommend that CMS withdraw the proposed regulations and republish them again for further comment only AFTER they have clarified how the proposed regulations would impact wrap around services for children and adolescents with Autism and MR.'

**Submitter :** **Date: 10/11/2007**

**Organization :**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

As the parent of severely mentally disabled daughter, I would like to
be included among those in support of DayHab services remaining under the authority of the state of Massachusetts. The loss of nursing and therapy services in these programs would severely impact their health and they would lose their basic skills. Biannual rate reviews should be maintained or risk loss of DayHabs hiring quality professional nurses and therapists. DayHab clients health would be at risk if not for the close monitoring that these professionals provide. Additionally, if not for DayHab services, our family members would have very empty lives similar to those living in institutions.

**Submitter :** Vivian Zheng **Date:** 10/11/2007

**Organization :** Vivian Zheng

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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

**Submitter :** **Rochelle Rawlings** **Date: 10/11/2007**

**Organization :** **Rochelle Rawlings**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Are you aware that this bill will negatively impact the lives of adults with Developmentally Disabled Adults. ( This includes those with Autism) Eliminating funds for Habilitation services results in the loss of programs that include Day Programs, Supportive Employment, Instruction in Daily Living Skills, Community Living Skills as well as ongoing
Physical and Occupational Therapy. These services are vital to the ability of this population to live and work in the community. Without them they will have to live in restrictive environments like institutions. (Which are mostly closed at this point)
I am a parent of an 18 year old developmentally disabled child. I am trying to plan for his future when I am no longer able to take care of him and /or when I am dead. Imagine my angst at the thought of him sitting in some institutional setting because there are no programs that help him live and work in his community. He will never be fully rehabilitated. But these programs help him to maintain the skills he has that are necessary to survival in the least restrictive environment. How sad that we live in a society that cannot help the people who are the most vulnerable.

**Submitter :** **Date: 10/11/2007**

**Organization :**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The federal agency that oversees the Medical Assistance Program (called CMS ) has issued proposed regulations that could potentially and significantly limit wrap-around (formerly know as Behavioral Health Rehabilitation Services or BHRS) services for children and adolescents with Autism Spectrum Disorders and Mental Retardation.

I believe it is irresponsible for the federal agency (CMS) to adopt their proposed regulations as written as they fail to clarify the potential impact on THOUSANDS of Washington, DC children with Autism and MR who currently receive wrap around services.

I recommend that CMS withdraw the proposed regulations and republish them again for further comment only AFTER they have clarified how the proposed regulations would impact wrap around services for children and adolescents with Autism and MR.

**Submitter :** **Date: 10/11/2007**

**Organization :**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

see Attachment

CMS-2261-P-749-Attach-1.DOC

#749

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,

**Melinda R. Menefee**
**Billing Clerk**

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

**Submitter :** Mrs. SHERREE WRIGHT **Date:** 10/11/2007

**Organization :** Mrs. SHERREE WRIGHT

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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. Rehab services can change the life of M.I.

**Submitter :** Ms. michele kelly **Date:** 10/11/2007

**Organization :** lighthouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

To Whom It May Concern:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country s most vulnerable citizens those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

Although I wholeheartedly support the idea of person centered services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

Therefore it is my opinion that none of the proposed rule changes should be implemented until each state (or the federal government) has a plan actively in place to provide the necessary recovery focused services that would no longer be covered by Medicaid. The plan must not exclude people with mental illness from psychosocial services needed to maintain their recovery progress, such as ICCD Certified Clubhouses.

It is a mistake to re-organize funding for long approved services in an effort to reduce short term spending. A poorly developed strategy will result in unnecessary - and more costly emergency spending and over-reliance on emergency services.

Most importantly, these changes will have a tragic impact on the lives and futures of millions of people struggling to recover from the long term effects of serious mental illness. In the interest of short term spending cuts, these changes will quickly erode the essential support networks that have allowed Americans with serious mental illness to begin the long and difficult process of rebuilding their lives. In my opinion, that would be an unconscionable mistake.

Sincerely,

Michele Kelly
1401 State St Springfield Ma 01109

**Submitter :** Mr. Joseph Price **Date:** 10/11/2007

**Organization :** The Center for Mental Health, Inc.

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#752



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

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

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

**Submitter :** **Sharon Snook** **Date: 10/11/2007**

**Organization :** **Friendship House**

**Category :** **Comprehensive Outpatient Rehabilitation Facility**

**Issue Areas/Comments**

**Background**

Background

I am writing to letCMS 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.

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

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

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

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

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

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

Sincerely,

Sharon Snook

**Submitter :** **Ms. Tina Amador** **Date: 10/11/2007**

**Organization :** **Friendship House**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

These regulations must be revised to insure that funding for the treatment of adults and children with serious mental illness will continue. Any decrease in funding or services will be disasterous.

**Submitter :** **Ms. Tracey Singer** **Date: 10/11/2007**

**Organization :** **Friendship House**

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

**Issue Areas/Comments**

**Background**

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

**Submitter :** **Ms. David Lauterbach** **Date: 10/11/2007**

**Organization :** **The Kent Center for Human & Organizational Develop**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-756-Attach-1.DOC

#756


# THE KENT CENTER
# FOR HUMAN & ORGANIZATIONAL DEVELOPMENT
**2756 Post Road, Suite 104, Warwick, RI 02886-3003**
**(401) 691-6000**


October 5, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Kent Center for Human & Organizational Development is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

The Kent Center is a comprehensive community mental health and substance abuse treatment center which has been providing services to the people of Kent County, RI for over 30 years. It has been recognized as one of 12 outstanding community mental health centers in the country in providing services to consumers with severe and persistent mental illness (Torrey, Erdman, Wolfe, Flynn, 1990). The Kent Center operates a variety of state-licensed substance abuse and mental health treatment programs, and offers a wide range of service options specifically designed to treat adults, children and adolescents at varying levels of care. The Kent Center has an average of 1400 clients in any given month. We receive some financial support through local city and towns, through State contracts and third party insurance but the majority through Medicaid/Medicare.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas of the proposed rule:

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>
This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

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

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest, and it discriminates against persons with severe mental illness.

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
>
> Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

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

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

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

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

440.130(viii)(3) Written Rehabilitation Plan
We do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed. Without attention to our suggestions, this new requirement will add significantly to the administrative time and expense of agencies serving individuals in need of rehabilitative services.

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan?

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

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

We are concerned by the requirement that the plan include information on alternate providers of the same service. In Rhode Island, the number of providers willing to accept Medicaid reimbursement is small, and access is already difficult. To expect that the treating clinical team, responsible for planning with the client, to now become familiar with alternate providers is an unreal expectation, and adds significant administrative burden. What are the implications for the provider who unknowingly omits to mention a possible alternative?

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

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

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

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

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

Section 441.45: Rehabilitative Services
441.45(a)(2)
This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level, as defined in the law. However, it would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

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

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

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

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

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

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

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

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

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

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

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

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

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

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

OTHER ISSUES

Payment and Accounting for Services

Although no specifically designed in this regulation, recent CMS insistence on accounting and billing for services through 15-minute increments and the denial of payment through daily rates, case rates and similar arrangements are supported by language in the regulation, at least by inference.

These new shifts in rate setting methodology are not efficient and are moreover extremely detrimental to the provision of evidence-based mental health services which are more and more frequently being offered as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multi-systemic therapy, therapeutic foster care and others. As proposed, these rules would effectively eliminate the ability to provide these highly effective, evidence-based therapies.

There are alternative ways to hold states accountable for ensuring that non-covered activities are not reimbursed. For example, it is possible to devise rate structures that do not pay providers for time spent on non-covered activities, but that remove the currently imposed extreme administrative burden.

The requirements in this regulation regarding service planning and documentation are relevant here. These new rules should negate the need for overly prescriptive micro-management of Medicaid providers.

Recommendation:

We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support the best practice and the most successful outcomes for children and adults with mental disorders. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The regulation appears to ignore the Title XIX mandate that children under age 21 are eligible for all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness o condition.

Section 441.45(b)(4), which refers to services having to be targeted under the State's plan, should be amended to reference EPSDT for children.

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 process 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,

David S. Lauterbach, ACSW
President/CEO

/dac:DSL07/CMS 100207

CC: U.S. Senator Jack Reed
U.S. Senator Sheldon Whitehouse
U.S. Representative Patrick J. Kenendy
U.S. Representative James R. Langevin
RI Governor Donald L. Carcieri
RI Lieutenant Governor Elizabeth Roberts
RI DMHRH Director Ellen Nelson
RI DHS Director Gary Alexander
RI DCYF Director Patricia Martinez
Council of Community Mental Health Organizations Members

**Submitter :** **Ms. Jacqueline Paul** **Date: 10/11/2007**

**Organization :** **Human Resources Unlimited**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

To Whom It May Concern:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country s most vulnerable citizens those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

Although I wholeheartedly support the idea of person centered services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

Therefore it is my opinion that none of the proposed rule changes should be implemented until each state (or the federal government) has a plan actively in place to provide the necessary recovery focused services that would no longer be covered by Medicaid. The plan must not exclude people with mental illness from psychosocial services needed to maintain their recovery progress, such as ICCD Certified Clubhouses.

It is a mistake to re-organize funding for long approved services in an effort to reduce short term spending. A poorly developed strategy will result in unnecessary - and more costly emergency spending and over-relianee on emergency services.

Most importantly, thesc changes will have a tragic impact on the lives and futures of millions of people struggling to recover from the long term effects of serious mental illness. In the interest of short term spending cuts, these changes will quickly erode the essential support networks that have allowed Americans with serious mental illness to begin the long and difficult process of rebuilding their lives. In my opinion, that would be an unconscionable mistake.

Sincerely,

Jacqueline Paul

**Submitter :** Jim Lesko **Date:** 10/11/2007

**Organization :** Jim Lesko

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-758-Attach-1.DOC

#758

October 10, 2007

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

Dear Sir(s) or Madam(s):

I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

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

**Major Issues and Concerns**

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

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

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

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

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

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

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

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

I am 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.**

I am 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. I 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.**

I 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). I believe that this proposed restriction contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239). This section reads:

(g) DAY HABILITATION AND RELATED SERVICES-

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

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

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

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

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

(B) any requirements respecting such coverage.

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

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

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

I also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. I 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. I 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)." I take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

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

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

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

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions: I 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.

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

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

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

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

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

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

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

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

**Submitter :** Mrs. Karen Burkush **Date:** 10/11/2007

**Organization :** Manchester School District

**Category :** Local Government

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-759-Attach-1.PDF

CMS-2261-P-759-Attach-2.PDF

#759

**MANCHESTER SCHOOL DISTRICT**
**SCHOOL ADMINISTRATION UNIT NO. 37**
286 Commercial Street, Manchester, NH 03101 • Tel: 603.624.6300 • Fax: 603.624.6337

**Michael Ludwell, Ph.D.**
Superintendent of Schools

**Henry J. Aliberti Jr., Ed.D.**
Assistant Superintendent
Elementary Education

**Karen DeFrancis**
Business Administrator

**Karen G. Burkush**
Assistant Superintendent
Student Services

October 10, 2007

Dear State Legislator, U. S. Representative, U. S. Senator:

On behalf of the Manchester School District Board of School Committee, we respectfully request your consideration of our concerns relative to the proposed changes to the Federal Medicaid regulations. In particular, we are concerned with the proposed changes regarding rehabilitation services and specialized transportation. These changes to the Federal Medicaid regulations will have a devastating financial impact on the Manchester School District and local taxpayers.

As you may be aware, currently school districts in New Hampshire can seek Medicaid reimbursement for up to 50% of costs incurred to provide certain health related services to children with disabilities. Pursuant to special education statutes and regulations, these services are required to meet the needs of children with disabilities as outlined in their individualized education programs. The federal government currently funds only 17% of the costs of special education and related services versus the 40% promised in 1975. The Medicaid to Schools Program currently assists local school districts in offsetting some of the costs of special education and related services.

The proposed changes eliminate the ability of school districts to seek reimbursement for specialized transportation and rehabilitation services through the Medicaid to Schools Program. Based on reimbursement claims for the 2006-07 school year the potential financial impact to the Manchester School District could exceed $825,000 dollars as early as the 2008-09 school year. The proposal to eliminate reimbursement for specialized transportation will take effect October 1, 2008. The effective date of the proposed elimination of reimbursement for rehabilitation services is not clear at this time.

The loss of these reimbursements will significantly reduce the revenues utilized to offset special education costs. As a result, the costs would shift to the local taxpayer through an increase in property taxes.

Enclosed please find for your review, letters of comment that we are submitting to the Centers for Medicare and Medicaid Services. We also respectfully request your attention to the letter and supporting documentation regarding the proposed changes dated September 28, 2007 from representatives from the following educational agencies: NH Association of School Administrators, NH Association of Special Education Administrators, NH School Boards Association and NH Association of School Business Officials.

We are extremely concerned with the proposed changes to the Medicaid regulations and respectfully request your support in ensuring that the Medicaid to Schools Program continues to provide the much needed reimbursement for specialized transportation and rehabilitation services.

Thank you for your time and consideration.

Respectfully,

Frank Guinta
Mayor, City of Manchester
Chairman, Board of School Committee

Leslee Stewart
Vice Chairman
Board of School Committee

Enc.

C: Board of Mayor and Aldermen, Manchester, NH
Lyonel B. Tracy, Commissioner, NH Department of Education
Nicholas Toumpas, Acting Commissioner, NH Department of Health and Human Services

**Submitter :** Mr. james j. lawler **Date:** 10/11/2007

**Organization :** crystal run village

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**Background**

Background

The provisions of this proposed rule will directly negatively affect the rehabilitation and habilitation services offered to people with developmental disabilities.

**GENERAL**

GENERAL

please remove these proposed rules which if enacted would degrade the quality of life of people with developmental disabilities across the nation. They are totally negative and contrary to the values of our country.

**Response to Comments**

Response to Comments

There will be a significant negative impact on funding for people with developmental disabilities so that the programs that allow them to attain and retain skill levels will be curtailed or closed.

**Submitter :** Mrs. SHERREE WRIGHT **Date:** 10/11/2007

**Organization :** Mrs. SHERREE WRIGHT

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Re: File Code CMS-2261-P PLEASE SEE ATTACHMENT.

CMS-2261-P-761-Attach-1.RTF

#761

I wish to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program. We have personally experienced the effectiveness of rehabilitation services and our 26yr old mentally ill son has been able to live, function and participate in our community as a direct result of these services. Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better outcomes, such as stable housing and employment. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses and their families. inre:New Freedom Commission, We particularly agree with the quote from the Commission referenced in the preamble to the rules, "more individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs." As the case is with our son with schizophrenia who has experienced multiple hospitalizations and contacts with law enforcement and who has gained sufficient living skills to maintain stable housing may need services to continue those skills. Withdrawing services as soon as the person's living skills were sufficiently restored to allow him or her to live in home for a brief period is inadvisable because the person's history and severity of illness indicate that he or she is likely to regress without further support. Further support is VITAL to maintaining the level of functioning he currently has achieved! Requiring that a person deteriorate before services can be provided is not cost effective For individuals with serious mental illnesses, a break in services and support can lead to a downward spiral and long period of acute illness. CMS has full authority to allow rehabilitation services which will prevent regression or deterioration. Section 1901 of the Medicaid Act clearly authorizes expenditures for rehabilitation and other services to help families and individuals "attain and **retain** capability for independence and self-care." Medicaid is a critical funding source for evidence based practices for people with serious mental illnesses. SECTION 440.130d5:Rehabilitation services should be available in whatever setting will yield the best results and the appropriate setting should be determined as part of the rehabilitation planning process with input from the individual with mental illness and his or her family.441.45 Research indicates that there are critical shortages of these services in all states. CMS should ensure that its policies facilitate providing more access to effective services such as Assertive Community Treatment!ACT is essential!! The current language in the proposed rule can be read to disallow rehabilitative services that are furnished through a non-medical program as either a benefit or an administrative activity, including those that are intrinsic elements of other programs. However, under the Medicaid statute, a Medicaid eligible individual who resides in a state that has chosen the rehabilitation option is entitled to rehabilitative services paid for by Medicaid regardless of their participation in another program.We believes that if this language is unchanged, it will have a devastating effect on the ability and willingness of other programs to provide quality treatment to adults and children with serious mental illnesses. These other programs are often operating with little resources and growing need. If they are denied Medicaid resources to pay for the treatment for individuals with mental illnesses, some are likely to fail to provide needed services and others may refuse to serve individuals with mental illnesses.

ThePresident's New Freedom Commission report decried a fragmented service system

that denied hope and opportunity to adults and children with serious mental illnesses. We strongly urge CMS to reconsider the current language in this section of the proposed rule which furthers fragmentation by discouraging other systems from offering treatment to individuals with serious mental illnesses!Medicaid eligible individual should receive rehabilitative services if medically necessary to address a functional impairment regardless of any involvement in another program. Recent research studies have confirmed that family support leads to better outcomes from treatment.We urge CMS to amend the rule to add language from the preamble to be clear on this point. PLEASE Add: **Contacts with and services to family members and other non-eligible individuals for the purpose of treating the Medicaid eligible individual may be covered as a rehabilitative service.**

Thank you for the opportunity to comment on the proposed regulations. We appreciate your consideration of our recommendations.

Sincerely,
Sherree Wright

**Submitter :** Dr. Dennice Ward-Epstein **Date:** 10/11/2007

**Organization :** ECHO Joint Agreement

**Category :** Academic

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-762-Attach-1.DOC

#762

I respectfully request that CMS retract the proposed rule 2261 to the extent that it applies to school-based rehabilitative services provided to or on behalf of children with disabilities. 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." I strongly believe that the proposed rule 2261 would seriously undermine the very purpose of the program; thereby eroding coverage for and access to services needed by our most vulnerable citizens, namely children with disabilities. On behalf of children with disabilities and their families, I implore you to please retract proposed rule 2261.

Respectfully,

Dennice Ward-Epstein, Ed.D.
Executive Director
Exceptional Children Have Opportunities

**Submitter :** Mrs. Margaret Baird **Date:** 10/11/2007

**Organization :** Mrs. Margaret Baird

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2261-P-763-Attach-1.DOC

#763

October 10, 2007

Greetings:

As the grandparent of a Pennsylvania child with Autism, I am vitally concerned with the proposed regulations pertaining to services for the special needs community.

As I am sure you are aware, autism is a prison that confines one in every 150 children... in a world of jumbled neurological input. It is also a life sentence for the parents and family of those with autism, often confining them to home because the autistic child is unable to cope with the sensory overload of stores, museums, or church- OR because they have insufficient impulse control to handle being in someone else's home, the library, etc.

As I recently witnessed, even a hospital visit can be torturous for the family of a child with autism. Trying to contain and calm a panicked and hurting child, in a space with mere curtains as dividers, to keep them from screaming and pulling apart the equipment is IMPOSSIBLE. And this is just Autism!

Children/Adolescents with special needs *each* require very specific care, which certainly exceeds that for a normal child. Their parents and families extend themselves, sometimes to the point of emotional, physical and financial ruin. As their national and state family, we have an absolute obligation to put in place services which will assist them in bringing health, therapy, and healing to their/our children!

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

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

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

Most sincerely,

Margaret Baird

**Submitter :** Mrs. Mary Bihan **Date:** 10/11/2007

**Organization :** nami

**Category :** Health Plan or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

while I have 100% agreed with the new health care for children and most especially mentally ill children, I DO NOT BELIEVE THAT AN INCOME OF 80,000.00 A YEAR SHOULD BE A GUIDLINE. IF THEY CANNOT AFFORD THAT HEALTH CARE WHEN THEY MAKE THIS MUCH, THEN THEY HAVE A REAL PROBLEM. ONLY CHILDREN WHO DO NOT HAVE ANY INSURANCE BECAUSE THEIR PARENTS ARE LOW INCOME SHOULD BE COVERED BY THIS. I AM 73 AND MY HUSBANDIS 74, WE HAVE MEDICARE, BUT PAY 13,000.00 A YEAR FOR BC/BS PROVIDER OF SECONDARY. THERE IS CERTAINLY SOMETHING VERY WRONG HERE.

**Submitter :** **Date: 10/11/2007**

**Organization :**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

I'll limit my comments to 441.45(b) -- "intrinsic element standard". I respectfully disagree with the assumption that the clinical and case management services needed by the at-risk kids are provided by foster care, probation, school, or child welfare staff & programs. In fact, these are the very kids that MOST need the additional services.

Please eliminate this part of the proposed rules.

Consider the kids! Consider what is fair and reasonable.

**Submitter :** Edith Clark **Date:** 10/11/2007

**Organization :** Montana Legislative Committee

**Category :** State Government

**Issue Areas/Comments**

**GENERAL**

GENERAL

Attachment

#766



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

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

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

**Submitter :** **Lori Reed** **Date: 10/11/2007**

**Organization :** **Lori Reed**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-767-Attach-1.DOC

#767

October 10, 2007

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

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

Dear Sir or Madam:

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

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. It is obvious 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, I am 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. I would rather have my tax dollars go towards saving people, for that is the difference between receiving treatment and trying to hang on with no assistance.

I know from personal experience that access to rehabilitative services can make all the difference in a person's life. 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. Untreated mental illness leads to pain and trauma for the individual and his or her family. Often the person will have multiple stays in hospitals and jails, families are broken, and whatever may have been that person's purpose in life goes unfulfilled.

**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. I very much applaud the agency for encouraging person centered planning.

I 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. There is a great stigma attached to mental illness. Sometimes people don't want to accept such a diagnosis. They don't want their family or friends to think they're "crazy." They've been admonished to "get over it." Often, suffering has led some people to substance abuse, depression and isolation from family and friends. It may take repeated visits before a person is ready to understand 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 circumstances as well.

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. For many of us and our loved ones, the path to recovery is not straight up or down. It winds left and right; it leads us through swamps that want to bog us down; we are scratched by the brambles; much of it is done as we traipse through a dark forest of rocks and roots; sometimes we reach a clearing and have to stay there awhile. Reaching a plateau should not be penalized; it is more often like we are hanging off a cliff by our fingernails. Two steps forward and one step back is still progress. The changing course of serious mental illness must be factored into the proposed regulations governing rehabilitative services.

All those I love and interact with on a daily basis are affected by my mental illness, even as they are unaware of my condition. I work full time and raise my children alone. This society applauds those who "pull themselves up by their bootstraps," but it takes superhuman strength and dedication to combat the overwhelming loneliness, desolation, stress and struggles of life with the additional burden of being ill. People benefit from a much richer interdependent lifestyle. I need support, treatment and medication, and this enables me to use my gifts and skills in raising the next generation (including their education about mental illness) while I serve adults with cognitive and physical disabilities in my current position. I receive so I can give. I managed to pull myself along for years before diagnosis and treatment, but the quality of life between getting by and being mentally healthy is miles apart!

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 will likely fall through the cracks. The proposed regulations could make the challenge of getting necessary services to them much more difficult.

Who determines whether something is "intrinsic" to another system? I 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. I am employed full-time, but I cannot afford private insurance for my children. I pay premiums and co-pays for Medicaid. Mental health is as important as healthcare services. It should not matter whether the service is "intrinsic" to another system.

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 creates good outcomes such as better school attendance, staying out of trouble with law enforcement, and living in a stable place. States should have the ability to get federal resources to support this effective service.

The proposed regulations say that the federal government will not provide resources for recess aides or classroom aides. 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 an advocate for one group – people with mental illness – I do not support the exclusion of any other group on the basis of their disability.

I 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. Experience tells us what a difference they can make. The research data confirms what I already know – services are very effective at reducing symptoms, keeping people out of hospitals, and allowing people to live better lives in the community.

I know what works. I also know that too many people can't access these treatments. The terrible consequences are seen in every jail and prison in America. OUR federal government (of the people, by the people, for the people) should be doing everything possible to encourage states to provide better and more effective services for people living with mental illnesses. I do not want to see money taken out of the Medicaid funded system of care for people with mental illnesses. I do not want to see adults and children ignored and left behind in school, work, and LIFE. If given a choice, I'm sure most of this population would choose a path to recovery, to be a contributing member of society, to acquire new coping skills, to stay out of jails and hospitals, to raise their children in happy homes, to have lives much like you "normal" people strive toward.

Why is alcoholism accepted as a disease? Why is treatment for autism receiving celebrity endorsement? Why is it mandatory to provide treatment, assistance, accommodation and modifications for people with physical disabilities?

Think about people with AIDS 25 years ago. They were stigmatized, no matter what the situation may have been that caused them to be ill. Thank God that has changed for the better, with funding and people willing to come forward for treatment, with education to stop the spread of the disease, although there are still a lot of homophobic opinions out there. In America, it seems only the obese and the mentally ill are still seen as "not trying hard enough," being weak, full of excuses. Will society ever be able to accept that mental

illness is something **that happened to us**, to 1 out of 4 adults, and we are not just lazy, crazy, manipulating, violent, erratic or stuck blaming our mothers for our deficient lives?

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

Thank you,

Lori A. Reed
51 Sweden Road
Waterford ME 04088

**Submitter :** Mrs. Monica Robertson **Date:** 10/11/2007

**Organization :** Mrs. Monica Robertson

**Category :** Other Practitioner

**Issue Areas/Comments**

**Background**

Background

Please withdraw, and revise proposed regulations that could significantly limit wraparound (i.e. BHRS) services for children with Autism Spectrum Disorders & Mental Retardation. Please republish proposed regulations with clarification of impact to children with ASD and MR.

**Collections of Information Requirements**

Collections of Information Requirements

I am the mother of a child with Autism Spectrum Disorder. My daughter has experienced great improvement with the help of Early Intervention Services through wraparound and those services similar. My child was non-verbal and now speaks. This has made an incredible difference in what she can accomplish. Continued support from this system is proving imperative for her to be a self-sufficient individual in society. The proof is in the progress. The window of opportunity has been opened, and can continue with Early Intervention. Early Intervention is my child's only hope to be a productive part of society.

**Submitter :** Lori Reed **Date:** 10/11/2007

**Organization :** Lori Reed

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please see attachment

#769



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

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

**Submitter :** **Ms. Fran Hazam** **Date: 10/11/2007**

**Organization :** **MHASP**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#770



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

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

**Submitter :** **Miss. Jennifer Karbott** **Date: 10/11/2007**

**Organization :** **Road to Responsibility, Inc.**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am opposed to the rule-making change. If implemented, I believe that individuals will run the risk of losing nursing benefits and allied health and therapy services (e.g. RN, OT, PT). Without Day Habilitation remaining under the Medicaid State Plan, a cap on the number of individuals served in the program would place those in need on a waiting list or deny them services. In addition, the new regulations may not cover individuals with developmental disabilities. Furthermore, entitlement and most likely a bi-annual rate review would be lost. The change would increase administrative inefficiencies, and would not be cost-effective. Day Habilitation services are critical to our individuals in this population. Therefore these programs must remain under the Medicaid State Plan so that we may continue to provide vital services to those with developmental disabilities and give them quality of life that they so deserve.

**Submitter :** Ms. Fran Hazam **Date:** 10/11/2007

**Organization :** MHASP

**Category :** Consumer Group

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Atachment

#772



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

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

**Submitter :** Nancy Adinolfi **Date:** 10/11/2007

**Organization :** Nancy Adinolfi

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

I feel lucky to live in the state of Massachusetts where high standards for rehabilitation services are well established and see no need to change current delivery of services for my brother, Richard McDonald, for whom I am a guardian. Richard attends a program run by Road to Responsibility, Inc. of Marshfield, Mass. Richard is Medicaid eligible and has a goal-oriented rehabilitation plan. Therapists evaluate Richard's needs and provide direction for treatment services provided by staff at his program. This is critical for his progress in meeting the goals of his plan including life skills and independence training and promoting his health and well-being. Autistic, with limited communication skills, Richard experienced a dire need for emergency treatment when he vomited blood at his day program. It was the nurse on duty who recognized the urgency of the situation which ultimately resulted in successful identification and treatment of the problem. It is extremely important that there continue to be bi-annual rate reviews of nurse and therapist services to ensure continued delivery by highly competant personnel. Thank you for your attention to these comments.

**Submitter :** **Ms. Lynn Albizo** **Date: 10/11/2007**

**Organization :** **National Alliance on Mental Illness of Maryland**

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

**Issue Areas/Comments**

**Collections of Information Requirements**

Collections of Information Requirements

see attachement

**GENERAL**

GENERAL

See attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

see attachment

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

see attachment

**Regulatory Impact Analysis**

Regulatory Impact Analysis

see attachment

**Response to Comments**

Response to Comments

See attachment

#774



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

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

**Submitter :** Tom Duffy **Date:** 10/11/2007

**Organization :** Tom Duffy

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

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

**GENERAL**

GENERAL

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 pa

#776

**Proposed Medicaid Program Rule CMS 2261-P**

**(Rehabilitative Services)**

**Public Comments**

My name is Frank Bresky from Columbus, Ohio and I am employed as a school consultant. I am writing your agency to express my extreme concern about the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201.

**Overview:**

I strongly believe that the proposed rule is completely contrary to established federal Medicaid law and totally without any legal basis.

**Regulatory 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. If exercising the consultation option, an agency must provide a federalism impact summary to the Office of Management and Budget that describes the agency's consultation with the states, summarizes their concerns and explains how those concerns Ire addressed. *CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states.*

This is nonsense, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, our state will likely be forced to change its medical billing procedures and authorization procedures. 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. **This assertion suggests a complete lack of understanding of the paperwork**

**currently maintained by school rehabilitation providers**. The requirement of the detailed written rehabilitation plan requires a substantial increase in the work planning, documentation system and time necessary to manage patient's services by these providers. This proposed regulation will create an entire new paperwork system to design, implement and monitor within all clinical settings. This expectation will have profound consequences, including a reduction in available time for providers to treat patients, at a time where there is already a national shortage of Rehabilitation therapists in the fields of occupational therapy, physical therapy and speech/language therapy services. In addition, school providers already create a document that contains almost all of the elements of the proposed Rehab plan, this document is the misnamed Individual Education Plan. The new paperwork burden being proposed is onerous at best, and will only serve to decrease the quality of medical services as rehabilitation providers will be "buried in paperwork". Further, this change would create significant audit responsibilities for both the state Medicaid Agency and all individual providers and their respective organizations. 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.

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**. It is very apparent that 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. CMS specifically characterizes the rule as a third party liability rule, 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.

**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) and Individualized Family Service Plan (IFSP) required under IDEA.

**RECOMMENDATION:**

I 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 Ill as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP or IFSP will satisfy Medicaid requirements for rehabilitation service.

Sincerely,

Frank Bresky

**Submitter :** Mr. Frank Bresky **Date:** 10/11/2007

**Organization :** Hilliard City Schools

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-776-Attach-1.DOC

#776

**Proposed Medicaid Program Rule CMS 2261-P**

**(Rehabilitative Services)**

**Public Comments**

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This is nonsense, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, our state will likely be forced to change its medical billing procedures and authorization procedures. 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. **This assertion suggests a complete lack of understanding of the paperwork**

**currently maintained by school rehabilitation providers**. The requirement of the detailed written rehabilitation plan requires a substantial increase in the work planning, documentation system and time necessary to manage patient's services by these providers. This proposed regulation will create an entire new paperwork system to design, implement and monitor within all clinical settings. This expectation will have profound consequences, including a reduction in available time for providers to treat patients, at a time where there is already a national shortage of Rehabilitation therapists in the fields of occupational therapy, physical therapy and speech/language therapy services. In addition, school providers already create a document that contains almost all of the elements of the proposed Rehab plan, this document is the misnamed Individual Education Plan. The new paperwork burden being proposed is onerous at best, and will only serve to decrease the quality of medical services as rehabilitation providers will be "buried in paperwork". Further, this change would create significant audit responsibilities for both the state Medicaid Agency and all individual providers and their respective organizations. 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.

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**. It is very apparent that 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. CMS specifically characterizes the rule as a third party liability rule, 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.

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

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**RECOMMENDATION:**

I 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 Ill as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP or IFSP will satisfy Medicaid requirements for rehabilitation service.

Sincerely,

Frank Bresky

**Submitter :** Ms. Lynn Albizo **Date:** 10/11/2007

**Organization :** National Alliance on Mental Illness of Maryland

**Category :** Consumer Group

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

#777



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

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

**Submitter :** Cynthia Seu **Date:** 10/11/2007

**Organization :** Cynthia Seu

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

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

**GENERAL**

GENERAL

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

We have lived with a child that has been diagnosed with schizophrena. This has led to problems with the criminal justice system and hospitalization in a psychiatric hospital. We know how difficult it is for a family to provide support for someone with serious mental health problems. We appreciate the proposed rule's provisions on family participation in a recovery plan. We also know that the lack of rehabilitative, and MAINTENANCE services, can and does lead to a relapse necessitating the terror of starting over from square one with a person very much loved but whom you no longer know in such a state. Thus, we are very concerned that the proposed rule may preclude services aimed at maintaining a functioning state. It seems to say that funds can be used just for attaining a suitable level of functioning. If this is so, we believe that you are making a grave and costly mistake. We would like to see this provison changed to make clear that maintenance services are included in funding.
Thank you for letting us tell you how this might affect our family.

**Submitter :** Mr. Harold Morrill **Date:** 10/11/2007

**Organization :** Weber Human Services

**Category :** Local Government

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-779-Attach-1.DOC

#779

WEBER HUMAN SERVICES

237 - 26th STREET • OGDEN, UTAH 84401 • (801) 625-3700

October 11, 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

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

Weber Human Services is an Inter-local governmental agency, established in 1993 to provide State mandated and publicly funded substance abuse treatment and prevention services, mental health services, and aging services to the citizens of two (2) Northern Utah counties, one urban and one rural. In State fiscal year 2006, Weber Human Services treated approximately 1,800 clients with a substance abuse or dependence condition and over 5,500 clients with a mental health diagnosis, the majority falling into a Seriously Mentally Ill category. Weber Human Services utilizes a variety of funding sources to serve its clientele including Federal Medicaid and block grant dollars, State general funds and matching Medicaid funds, and local county funds.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas of the proposed rule:

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and remission, and the long-term clinical course of these conditions is difficult to determine. As an illustration, *Mental Health: A Report of the*

*Surgeon General*, notes that for people living with schizophrenia, "...a small percentage (10 percent or so) seem to remain severely ill over long periods of time (Jablensky et al., 1992: Gerbaldo et al., 1995). While these individuals can significantly improve, "most do not return to their prior state of mental function." (Mental Health: Report of the Surgeon General, 1999, pg. 274).

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

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
>
> Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

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

Recommendation:

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

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

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

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

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

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

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

Recommendations:

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

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan includes 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.
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers.

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

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

Recommendation:

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

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

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

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

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

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

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

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

Sincerely,

Harold Morrill
Executive Director
Weber Human Services

CC: Members of the Utah State Congressional Caucus
The Honorable Jon Huntsman, Governor of the State of Utah

**Submitter :** **Ms. Margaret Hurley** **Date: 10/11/2007**

**Organization :** **LPVEC**

**Category :** **Academic**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-780-Attach-1.DOC

#780

**In the Matter of**

**Proposed Medicaid Program Rule CMS 2261-P**

**(Rehabilitative Services)**

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

**Summary:**

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

**Preliminary Comments:**

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

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

services are covered for adults[2].

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

**Regulatory Impact Analysis: Overall Impact**

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

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

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

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

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

**Overview:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] Id.

[13] 72 Fed. Reg. 45209

**Overarching Issue - Conflict with EPSDT**

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

**Recommendations:**

We recommend the following:

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

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

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

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

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

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

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

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

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

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

**Recommendations**:

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

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

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

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

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

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

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

**Recommendations**

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

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

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

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

**Recommendations:**

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

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

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

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

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

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

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

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

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

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

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

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

**Recommendations:**

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

In the alternative:

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

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

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

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

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

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

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

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

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

**Recommendations:**

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

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

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

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

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

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

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

**Proposed Elimination of Transportation Services**

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

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

**Non-covered services: 441.45(b)**

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

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

participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a)[36]. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

**Recommendations:**

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

**Summary:**

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

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

our most vulnerable citizens.

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

**Submitter :** Mr. Robert White **Date:** 10/11/2007

**Organization :** Sweetser

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please see Attachment.

CMS-2261-P-781-Attach-1.DOC

#781

Sweetser

YOUR PARTNER IN BEHAVIORAL HEALTH

October 11, 2007

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

Reference: File code CMS-2261-P

Dear Sir or Madam:

Sweetser respectfully submits the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register on August 13, 2007.

Sweetser is a private, non-profit agency in Maine which provides mental and behavioral health and educational services. These include, among many other services, rehabilitative services for children, adolescents and adults. Nationally recognized and accredited, Sweetser has close to 200 years of experience in these fields and serves approximately 18,000 people over a wide area of the state. Medicaid is the most significant funding source for the clients which Sweetser serves. Without the Medicaid programs, these individuals would not have access to these medically necessary services.

Sweetser is very concerned that the proposed regulations would create barriers to the recovery process for the children, adolescents and adults whom we serve. Accordingly, we offer the following comments on the proposed rule.

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative

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www.sweetser.org info@sweetser.org 1-800-434-3000

services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. This also needs clarification, to make it clear that covered services include those necessary for retention of improved functioning or for maintaining the highest possible functional level.

Rehabilitation services should not be custodial. For people with serious mental or emotional disabilities, however, continuation of rehabilitative services are at times essential simply to retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and remission. The long-term clinical course of these conditions is difficult to determine. As an illustration, *Mental Health: A Report of the Surgeon General*, notes that for people living with schizophrenia, "..a small percentage (10 percent or so) seem to remain severely ill over long periods of time (Jablensky et al., 1992: Gerbaldo et al., 1995). While these individuals can significantly improve, 'most do not return to their prior state of mental function.'" (Mental Health: Report of the Surgeon General, 1999, pg. 274). Failure to provide a supportive level of rehabilitation could result in deterioration necessitating a reinstatement of intensive services.

We are concerned that the current proposed regulation could be interpreted to prohibit the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level. Denying coverage for such supportive services would result in individuals' deteriorating to the point where they would be eligible for services, but services at a much more intensive and costly level of care. This serves no one's interest.

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

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

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

Recommendations:

First, further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42 CFR 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.

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

Third, clarify that pre-vocational services are allowable services when appropriately tied to a rehabilitation goal.

440.130(viii)(3) Written Rehabilitation Plan

We do recommend some amendments, as noted below. In addition, though, there are some issues on which proposed regulations are unclear or leave important questions unaddressed. Attention to these issues would help significantly to avoid administrative time and expense for agencies serving individuals in need of rehabilitative services.

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

guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

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

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative in some rare cases may be problematic. Severe mental illness is episodic. It is not always possible to determine when an exacerbation of the illness may occur. There may be instances in which a person, because of the nature of his or her illness, may not believe he or she is sick and may not comply with signing the treatment plan. At this point in the individual's life, retention of services may be critical to prevent hospitalization, incarceration, or other public or personal safety consequences. There is also no guarantee that the individual will have appointed a representative, or that the consumer in crisis could identify this person. Therefore, CMS should allow for the documentation by the provider who meets state requirements of reasons that the client or the client's representative is not able to sign the treatment plan.

<u>Recommendations</u>:

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

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

X that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the provider who meets state requirements of reasons that the client or the client's 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 alternate providers).

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals

if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

There is little clarity in the proposed rule on how this provision would be applied. The proposed regulations provide no guidance on how to determine whether a service is an "intrinsic element" of another program. Without revision to clarify its application, 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). The net result of this new rule could well be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other program concerned, effectively denying coverage for medically necessary Medicaid services in contravention of the statute.

Recommendation:

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

Alternatively, the section should be clarified and narrowed so as to specifically focus on situations in which 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.

In addition, 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 regulations 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, and classroom aides may well 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 and administrative processes as well as staff training 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.

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

Very truly yours,

Robert Jay White
Compliance Officer

cc: Carlton Pendleton, President and CEO
Cynthia Fagan, Vice President of Administration
Paul Peterson, Vice President of Child and Family Services

**Submitter :** Ms. Lucille Lane **Date:** 10/11/2007

**Organization :** Ms. Lucille Lane

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-782-Attach-1.DOC

CMS-2261-P-782-Attach-2.PDF

#782

October 11, 2007

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

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

Dear Sir or Madam:

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

I know from personal experience that access to rehabilitative services can make all the difference in a person's life. With services and support, even individuals with serious mental illness can and do live very well in the community and have strong relationships with family and friends. I am also aware that many individuals do not have access to appropriate care and that these individuals, their families and in fact, the entire community can suffer as a result.

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,

Lucille Lane
31195 Park Ridge Dr.,
Brooksville, FL 34602
Tel.: 352-540-9746
Email: walk_a_milein15@yahoo.com

**Submitter :** Mr. Michael White **Date:** 10/11/2007

**Organization :** Mr. Michael White

**Category :** Individual

**Issue Areas/Comments**

**Collections of Information Requirements**

Collections of Information Requirements

I am a disabled individual, who for created hundreds of jobs, in i private, and 2 public start up ventures. These companies which I owned either 100% or controlling interests in paid tens of $milluions of tax dollars, and F.I.C.A. contributions. My last position was as Executive Vice President of a $7 Billion company.

Then as happens, typically on a smaller scale, I got ill, lost my business, eventually was divorced, and between legal and medical costs collectively lost everything, and exist on a very meager subsistance existance. Yet despite my huge financial contributions to the system I face continued compromises to a circumstance where I literally can't afford to eat a healthy diet.

**GENERAL**

GENERAL

See Attachment

**Response to Comments**

Response to Comments

To limit benefits or coverage in any way is cruel and counter productive. Our society provides dramaticaly more support to drug addicts than to people who are mentally ill.

**Submitter :** Dr. Christopher White **Date:** 10/11/2007

**Organization :** WORK, Inc.

**Category :** Health Care Industry

**Issue Areas/Comments**

**GENERAL**

GENERAL

We are opposed to the NPRM that would place Day Habilitation services into the state waiver program for the following reasons: 1) This provision would cap services at current levels and would thereby deny access to individuals who do not currently need such services but will in the future, for whatever reason. Day Habilitation services are the only therapeutic day service option available to our consumers. 2) Services are being currently provided at FY'03 levels, effectively, and placing the program into the state waiver system would take these services out of the bi-annual review system, where there is at least the chance that cost of living adjustments may be made, and relegate the current programs to a system where service quality will slowly erode over time because necessary cost adjustments will not be made. 3) The changes proposed would only shift costs to other sectors of the bureaucracy and will most likely result in greater overall costs than are currently present. This is probable because other state agencies would have to hire people to oversee the waiver system, and in being assigned to specific agencies, this could also result in the unintended consequence of having some current consumers being excluded because they do not meet the criteria for services through the assigned agency. For example, in MA the waiver system would probably fall under the purview of the Dept. of Mental Retardation. While most of the consumers in Day Hab programs are mentally retarded, not all of them are and those exceptions could find themselves out of the therapeutic day service option that they so clearly need. We all understand the need to find ways of reigning in health care spending and great progress has been made in many areas. However, we believe that the proposed changes will not result in the desired cost savings and will only jeopardize much needed services to our most vulnerable members of our population. We believe that keeping the system under CMS and focusing more on treatment outcomes, and revising the severity profiles for how rates are established will have a more beneficial impact on the costs of the system than the current proposal would ever accomplish and would do so in a manner that would protect the integrity of the current services being provided. Thank you for your consideration.

Sincerely,
Christopher T. White, Ed.D
Vice President/Chief Clinical Officer
WORK, Inc.
3 Arlington St.
Quincy, MA 02169

**Submitter :** Ms. Tracy Regal **Date:** 10/11/2007

**Organization :** Ms. Tracy Regal

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachement, thank you, Tracy Regal

CMS-2261-P-785-Attach-1.DOC

#785

# Proposed Medicaid Program Rule CMS 2261-P

# (Rehabilitative Services)

# Public Comments

I am Tracy Regal from Brunswick, Ohio. I am employed as a billing consultant to schools. I am very concerned about the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201 as it violates EPSDT law and imposes unnecessary paperwork requirements on educational entities

**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 is duplicative of the individualized education programs (IEP) and Individualized Family Service Plan (IFSP) required under IDEA.

**RECOMMENDATION:**

I 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 or IFSP will satisfy Medicaid requirements for rehabilitation service.

**Legal Issue - Conflict with EPSDT Legislation**

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. There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements. First, 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 that medical assistance to 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 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 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. 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].

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 has no basis in statute**. 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.

**Recommendations:**

I 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.

Sincerely,

Ms. Tracy Regal

**Submitter :** Mr. Robert Fiese **Date:** 10/11/2007

**Organization :** Pacific Clinics

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

#786



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

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

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

**Submitter :** **Ms. Carla Ransom** **Date: 10/11/2007**

**Organization :** **Pacific Clinics**

**Category :** **Health Care Provider/Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

#787



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

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

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

**Submitter :** **Date: 10/11/2007**

**Organization :**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

Wrap around servies are heavily misused. Funding should be cut because there are families that have been getting 55 hours of services a week for 15 years or more. Other states do just fine without the wrap around sevices. These services are costing taxpayers too much money. I say cut them now and stop the entitlement.

**Submitter :** **Ms. Sandy Loerch Morris** **Date: 10/11/2007**

**Organization :** **DSHS, DDD, Infant Toddler Early Intervention Prog.**

**Category :** **State Government**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment.

The Washington Infant Toddler Early Intervention Program has attached document with questions, comments and concerns about these proposed regulations.

**Response to Comments**

Response to Comments

See Attached

CMS-2261-P-789-Attach-1.DOC

#789

**CENTER FOR MEDICAID AND MEDICARE (CMS) PROPOSED RULE**
**42 CRF PARTS 440 AND 441: Coverage for Rehabilitative Services**
**October 11, 2007**

| SUMMARY | ITEIP QUESTIONS/COMMENTS/IMPACTS |
|---|---|
| **This proposed rule would amend the definition of rehabilitative services to provide for important individual protections and to clarify that Medicaid rehabilitative services must be coordinated with, but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs.** These services and programs include, but are not limited to, foster care, child welfare, **education**, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and **any other non-Medicaid services from Federal, State or local programs.** We believe this proposed rule is the best approach to clarifying the covered rehabilitative services, and also because all stakeholders will have the opportunity to comment on the proposed rule. These comments will then be considered before the final document is published. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures. | Possible 2.2 billion dollar federal reduction between 2008 – 2012, 180 million for 2008<br><br>This is of high concern. It could heavily impact IDEA, Part C early intervention services which are funded by health, public and private insurance, social and education funding. Federal Part C regulation clearly defines Medicaid as a funding source that must be used before IDEA, Part C funding.<br><br>The State of Washington only bills Medicaid for services defined as medically necessary and within our State Medicaid Plan<br><br>The proposed Medicaid rule is not clear. Does this include children who are dually eligible through Medicaid and Part C? Or is this aimed at older children and/or adults? Does it only include rehabilitation service or does it also include habilitation services?<br><br>How does EPSDT fit into this rule – where treatment needs to be provided to children found with concerns through a well-child exam, even if the service is not in the state plan? |
| The broad language of the current statutory and regulatory definition has, however, had some unintended consequences. It has also led to some confusion over whether otherwise applicable statutory or regulatory provider standards would apply under the rehabilitative services benefit. For example, it appears some states have used Medicaid to fund services that are included in the provision of foster care and in the **Individuals with Disabilities Education Improvement Act (IDEA).** | Mentions using the Medicaid rehabilitation benefit as a "catch all" to cover services included in other Federal, State, and local programs.<br><br>We are required to use Medicaid as a funding source per IDEA, Part C. These proposed rules do not address conflicting federal rules or acknowledge the need to coordinate rules and funding of therapies.<br><br>To the extent early intervention services, schools and other programs that serve individuals with mental retardation and related conditions rely on funding via the |

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| | rehab option, these regulations will eliminate or reduce that funding and the availability of those services.<br>• Based on current practice, it is likely the greatest impact will be a reduction in services for children (i.e., birth to 18).<br>• This will result in greater pressure on the DDD waiver program and DDD waivers do not currently assist in the early intervention funding or coverage<br>o Increased number of enrollment requests<br>o Increased provision of occupational therapy, physical therapy, and speech and language services under a waiver for current waiver enrollees. |
| 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. | How will Medicaid school based services program be impacted?<br><br>• A concern that funding for needed services for children will be significantly reduced. Washington only bills services that meet medical definition. We do not bill for special education as it does not meet the medical definition.<br>1. This proposed rule would amend the definition of rehabilitative services to provide important protections.<br>2. The proposed regulations would also impact school-based programs and perhaps foster care. |
| This proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are, in fact, **rehabilitative outpatient services**, are furnished by qualified providers, are provided to Medicaid eligible individuals according to goal-oriented rehabilitation plan, and **are not for services that are included in programs with a focus other than that of Medicaid.** | Reference to Outpatient services, in conflict with IDEA, Natural Environments<br><br>Early Intervention Services, including medically defined services, must occur in home or community settings. Medicaid rules and practices must be made consistent with this practice.<br><br>The apparent automatic exclusion of services for individuals with "mental retardation and other conditions" ignores the fact that individuals with developmental disabilities can achieve functioning in many areas and that such functioning may deteriorate over time for a variety of reasons. In those instances, provision of services under the rehab option would be appropriate.<br><br>Please consider removing the automatic exclusion of services to individuals with mental retardation and related conditions from the rehab option.<br><br>Again, this is an area of concern that funding that is currently available for services for children will be significantly reduced. |
| **Definitions.** In 440.130(d)(1), we propose to define the terms used in this | For infants and toddlers, services are to enhance development, across health, social |

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| rule as listed below:<br>• Recommended by a physician or other licensed practitioner of the healing arts;<br>• Other licensed practitioner of the healing arts;<br>• Qualified providers of rehabilitative services;<br>• Under the direction of;<br>• Written rehabilitation plan;<br>• **Restorative services;**<br>• Medical services;<br>• **Remedial services.** | services, and education. For children, we can't break out what is "medical/rehabilitative" and what is "developmental" and "habilitative." This rule needs clarity and to assure funding is maintained for children's services.<br><br>Part C enhances child development and doesn't seem to fit into the definition that it be restorative – to bring back to the original state OR remedial – meant to correct – provide a remedy. Need careful wording for children's services. |
| **Scope of Services.** Consistent with the provision of section 1905(a) (13) of the Act, we have retained the current definition of rehabilitative services in § 440.130(d) (2) as including "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." | Where do services that are developmental enhancements fit in? |
| **Written Rehabilitation Plan.** We propose to add a new requirement, at § 440.13(d) (3) that covered rehabilitative services for each individual must be identified under a written rehabilitation plan. This rehabilitation plan would ensure that the services are designed and coordinated to lead )to the goals set forth in statute and regulation (maximum reduction of physical or mental disability and restoration to the best possible functional level). | Requires a written rehabilitation plan – could the individual family service plan (IFSP) be this plan for the state for Medicaid/Part C eligible children? Need clarification and comprehensive plans for children and their families. Part C states the IFSP must be the global plan for all early intervention services regardless of funding, including Medicaid. |
| In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the lease intrusive level possible, which sustains health. The Medicaid goal is to deliver and pay for the clinically appropriate, Medicaid-covered services that would contribute to the treatment goal. | States these are not benefits for custodial care for persons with chronic conditions, but should result in a "change of status". This plays out when kids get early intervention services paid by Medicaid and they reach a "plateau" and don't progress any further, they get "discharged" by therapists, while still are in the Part C system. |
| Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services. | There is no wording in this rule to "improve" or "enhance." Talks about "restored functional abilities", "recovery oriented goals" "restoration of the individual to the best functional level." Children served in Part C are not being "restored", but "enhanced" by Medicaid funds and other early intervention services. |
| At § 441.45(a)(2), we propose to **require that the state ensure that rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.** | |

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| We propose in §441.45(b)(1) that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. **We also propose in §441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid.** | Need to define "intrinsic elements of programs other than Medicaid and avoid eliminating Medicaid defined services that are also defined as early intervention or Special Education therapies that also meet the medical definitions, such as PT, OT, speech and language pathology services, psychology services, etc. |
| **Rehabilitation services may be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met.** Medicaid rehabilitative services must be coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals and are available as part of other services or programs. | |
| In §441.45(b)(2), we **propose to exclude Federal Financial Participation (FFP) for expenditures for habilitation services, including those provided to individuals with mental retardation** or "related conditions" as defined in the State Medicaid Manual §4398. | We would want to have assurances and clarity added that this means habilitation services will continue to be covered. This proposed statement could be taken more than one way and need clarification. |
| **Habilitation typically refers to services that are for the purpose of helping persons acquire new functional abilities**. Current Medicaid policy explicitly covers habilitation services in two ways: (1) when provided in an intermediate care facility for persons with mental retardation (ICF/MR), or (2) when covered under sections 1915I, (d), or (i) of the Act as a home and community-based service. Habilitation services may also be provided under some 1905(a) service authorities such as Physician services defined at 42 CFR 440.50. Therapy services defined at 42 CFR 440.110 (such as Physical Therapy, Occupational Therapy, and Speech/Language/Audiology Therapy) and Medical or other remedial care under the 1915(i) State Plan Home and Community Based Services pursuant to the Deficit Reduction Act of 2005. | Align with IDEA, Part C Rules & Regulations. Recommend adding "including Part C services that meet Medicaid Definitions and included in state plans.<br><br>Where do Part C infants and toddlers fit in here, under habilitation services? How is CMS working within IDEA requirements regarding non-supplanting and maintenance of effort? States may not use IDEA, Part C funds to make up for losses (state and federal) created by Medicaid, with other federal, state or local funding. Thus, these reductions may be so severe that states will no longer be able to participate in the federal early intervention program (IDEA, Part C). |
| However, effective rehabilitation of eligible individuals may require some contact with non-eligible individuals. For instance, in developing the rehabilitation plan for a child with a mental illness, it may be appropriate to include the child's parents, who are not eligible for Medicaid, in the process. In addition, counseling sessions for the treatment of the child | |

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| might include the parents and other non-eligible family members. In all cases, in order for a service to be a Medicaid coverable service, it must be provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual. | |
| Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government agencies or geographic regions under Executive Order 12866. | See above comments. |
| Rehabilitation does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.130(d) of this chapter if the following conditions exist: (1) The services are 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. Examples of services that are intrinsic elements of other programs and that would not be paid under Medicaid, include, but are not limited to, the following: (2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include services provided to individuals with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.) | See above comments. |

**This document was submitted electronically to: http://www.cms.hhs.gov/Rulemaking on Thursday, October 11, 2007 by Sandy Loerch Morris, Washington Part C Coordinator/ks**

**Submitter :** **Ms. Berlinda Davison** **Date: 10/11/2007**

**Organization :** **The Center For Mental Health**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2261-P-790-Attach-1.PDF

CMS-2261-P-790-Attach-2.PDF

#790

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

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

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

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

**Submitter :** **Pauline D. Burke** **Date: 10/11/2007**

**Organization :** **None (co-guardian)**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

As co-guardian for my brother, Stephen Dunn, who receives day hab services from Road to Responsibility, Inc., I am concerned that his excellent services will erode if this change is enacted. Stephen is a 51 year old adult with severe developmental abilities. His care at RTR under the Medicaid plan has enhanced his quality of life immeasurably. The various therapies available to him as well as nursing care are an important part of his daily living.

**Submitter :**

**Date: 10/11/2007**

**Organization :**

**Category : Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

CMS-2261-P-792-Attach-1.DOC

#792.

October 10, 2007

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

Dear Sir(s) or Madam(s):

I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

CEC (the Council for Exceptional Children) is the largest professional organization of teachers, administrators, parents, and others concerned with the education of children with disabilities, gifted and talents, or both. CEC has major issues with the proposed rule, and after reviewing the data **I fully concur. I am including their comments below because it echoes my own concerns as the parent of a child with special needs.** The schools with which we have been involved have been exceptional in their efforts to meet my child's needs. They have also been critically underfunded, thus not allowing them to implement or utilize critical programs. The proposed rule would exacerbate this situation. Below is an excerpt from CEC regarding the proposal – please consider it very carefully.

> I am deeply concerned about the devastating impact that the proposed CMS regulations for the rehabilitation services option will have on the welfare of children with disabilities. The elimination of these reimbursements would inevitably shift the financial responsibility for rehabilitation claims to individual school districts and early childhood providers across the nation. The Administration estimates that the elimination of the reimbursement for the Medicaid rehabilitation services option will provide a savings of $2.29 billion over the next five years. However, there is no corresponding increase in funding for the federal special education law, the Individuals with Disabilities Education Act (IDEA), that will enable schools and early childhood providers to make up for the reduction in Medicaid reimbursements for rehabilitation services option provided to children with disabilities.
>
> **Major Issues and Concerns**
>
> We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:
>
> **1)Unjustified and unnecessary, the proposed rule would not further the purposes of Title XIX of the Social Security Act.**
>
> A central purpose of the Medicaid law is to provide rehabilitative services. Section 1901 of the Social Security Act reads,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the

> (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.

Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

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

We also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you for the opportunity to express my concerns.

Kimberly Webb

**Submitter :** **Mr. Christopher Weldon** **Date: 10/11/2007**

**Organization :** **AABR**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment. Original letters faxed to appropriate parties.

CMS-2261-P-793-Attach-1.DOC

CMS-2261-P-793-Attach-2.DOC

#793

October 11, 2007

Senator Hillary Rodham Clinton
476 Russell Senate Office Building
Washington, DC 20510-3204

Dear Senator Clinton

There is an important issue that concerns us regarding habilitation and rehabilitation regulations. In 2006 unofficial estimates indicate that roughly $800 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities.

In addition, it has been estimated that approximately 52,000 people with intellectual and other disabilities received necessary habilitation services through clinic and rehab options that are now being eliminated by these regulations

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

The proposed rule would severely harm people with intellectual and other developmental disabilities in two major ways:

1) it eliminates longstanding programs for providing habilitation services to people with developmental disabilities, and

2) it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with intellectual disabilities/mental retardation and related conditions.

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

The definition creates a discriminatory and arbitrary exclusion from receiving rehabilitative services for people with mental retardation and related conditions.

We strongly oppose the proposed rule's definition of habilitation services [#441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions."

Defining clinical service eligibility by excluding individuals with mental retardation is discriminatory and is based on false presumptions of individual needs and abilities.

We are counting on your support on this important issue.

Regards,

Christopher Weldon
Executive Director

Association for the Advancement of Blind and Retarded Inc.
15-08 College Point Blvd.
College Point, New York 11356

**Submitter :** **Date: 10/11/2007**

**Organization :**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**GENERAL**

GENERAL

'The federal agency that oversees the Medical Assistance Program ( called CMS ) has issued proposed regulations that could potentially and significantly limit wraparound ( formerly know as Behavioral Health Rehabilitation Services or BHRS ) services for children and adolescents with Autism Spectrum Disorders and Mental Retardation.

I believe it is irresponsible for the federal agency (CMS) to adopt their proposed regulations as written as they fail to clarify the potential impact on THOUSANDS of _____(enter your state) children with Autism and MR who currently receive wrap around services.

I recommend that CMS withdraw the proposed regulations and republish them again for further comment only AFTER they have clarified how the proposed regulations would impact wrap around services for children and adolescents with Autism and MR.'

**Submitter :** **Mr. Ron Fugatt** **Date: 10/11/2007**

**Organization :** **AIM Center**

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

**Issue Areas/Comments**

**Background**

Background

To Whom It May Concern:

State funded Medicaid programs, such as psychiatric rehabilitation, continue to become under-funded. The CMS budget proposal for cuts to Medicaid will severely restrict and/or reduce services that are currently provided by AIM Center--Chattanooga, Tennessee s only psychiatric rehabilitation services center.

Such a proposal would have disastrous consequences for individuals and families that depend on Medicaid and who receive psychiatric rehabilitation.

Currently, AIM Center budget is comprised of nearly one-third (1/3) Medicaid dollars. If federal Medicaid reform is passed, such is proposed by CMS, it would dramatically reduce our ability to provide services for persons with mental illness. If the reform is passed it would result in discontinuing some of our current services.

Please note, that AIM Center provides life-time follow along employment services which are free to the mental health consumer (yet greatly UNDER-funded by Voc Rehab, DRS), free education services and wellness and recovery services with emphasis on certified peer specialists and evidence-based practices. These services are NOT funded by other sources and there are no other service providers within 100+ miles who provide these critical unmet needs.

The current Medicaid proposal would result in cuts in eligibility and coverage for both mandatory and optional populations and would be extremely harmful to children and adults living with mental illnesses. These proposals would inevitably threaten the viability of the already fractured public mental health care system.

I implore the CMS committees charged with the proposals to reconsider the reductions in rehabilitation services for persons with mental illness. AIM Center's Medicaid funding is absolutely necessary.

Thank you.

Ron Fugatt
Chairman, AIM Center Board
Chattanooga, TN 37401

**Submitter :** Mrs. Mary Barton **Date:** 10/11/2007

**Organization :** Vermont Special Education Council

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attached

#796



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

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

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

**Submitter :** Mrs. Mary Barton **Date:** 10/11/2007

**Organization :** Vermont Council for Exceptional Children

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

#797



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

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

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

**Submitter :** Dr. Dalia Zwick **Date:** 10/11/2007

**Organization :** YAI/Premier Healthcare

**Category :** Physical Therapist

**Issue Areas/Comments**

**Background**

Background

It is important for people with developmental disability to be on active rehabiltation process. Here is what one of our consumer says:

**Collections of Information Requirements**

Collections of Information Requirements

"A long stretch to success continuance:

I am almost there! Today I realized that I have accomplished a lot. The movements and stretches that I couldn t do over a month ago I am doing much easier now with just a little help from my therapist. On my last visit we had a guest observe the session. I was excited to show someone what physical therapy has done to improve my mobility. I am very happy with my progress and recommend physical therapy sessions at YAI to anyone with my condition."

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

My proposal is that rehabilitation services would be continuing with better supervision and documentation.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

Please be in touch if you need me to explain this further. Dalia Zwick PT PhD YAI / Premier Health Care 212-273-6100 Ext 2590

**Submitter :** Mrs. Mary Barton **Date:** 10/11/2007

**Organization :** Vermont Council for Exceptional Children

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

#799



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

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

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

**Submitter :** Mr. C. Richard DeHaven **Date:** 10/11/2007

**Organization :** The Center for Mental Health, Inc.

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-800-Attach-1.DOC

CMS-2261-P-800-Attach-2.DOC

#800

# The Center for Mental Health, Inc.


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Anderson, IN 46012
(765) 649-8161
**FAX** (765) 641-8238

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10731 S. R. 13
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1969 Conner Street
Noblesville, IN 46060
(317) 776-3730
**FAX** (317) 770-5424

**Mailing Address**
P. O. BOX 1258
Anderson, IN 46015

1-866-264-2020
www.cfmh.org


October 11, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Center for Mental Health, Inc. (CMH) is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

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.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas of the proposed rule:

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

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

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

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

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

For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."

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

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

Recommendation:

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

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

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

includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

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

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

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

<u>Recommendations</u>:

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

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

X that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the provider who meets state requirements of reasons that the

client, or their representative is not able to sign the treatment plan.

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including

when they are considered "intrinsic elements" of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

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

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

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

Recommendation:

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

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

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

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

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

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

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

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

Sincerely,

C. Richard DeHaven
President and CEO

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

**Submitter :** Ms. Cindi Jones **Date:** 10/11/2007

**Organization :** Dept. of Medical Assistance Services

**Category :** State Government

**Issue Areas/Comments**

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

On page 45205 of the CFR (last paragraph of section F.1.), it states that if a state desires to cover Rehabilitative Services, it must amend its State Plan in accordance with the (new) 42 CFR 441.45(a)(5). Does CMS expect states already in compliance to submit a new State Plan Amendment?
The proposal requies that the State Plan describe the services, specify provider qualifications, and specify the payment methodology.
State Plans are already required to specify the payment methodolgy. Will these proposed regulations be used as the authority for changing from payments for an entire program to 15 minute payments for a specific provider?
The proposed regs state that the provider must keep a record of who delivers services and the amount of time. It doesn't state that this must be the basis for payment. Does having a payment methodology specified in the current State Plan meet the requirement or must the methodology be based on the specific provider and the exact amount of time the service is provided? This specificity in billing ean be an administrative burden for providers.

Can a state meet the requirement that the client must sign the plan of care through guidance documents or must it be in the State Plan to be in compliance with the proposed regulation?

Additionally, providers are concerned about the statement on page 45204 of the CFR that states that maintaining function in order to achieve a rehabilitation goal is allowed, but maintaining function in and of itself rather than being directed at a rehabilitation or recovery goal is not allowable. Providers are concerned that the service might be denied as progress may be in small increments over a longer period than the review period (e.g., measurable over a two-year retrospective, but not over last twelve months). Can CMS provide further guidance on this point?

**Submitter :** Mrs. Mary Barton **Date:** 10/11/2007

**Organization :** Vermont Special Education Advisory Council

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attached

CMS-2261-P-802-Attach-1.DOC

#802

October 11, 2007

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

Dear Sir(s) or Madam(s):

On Behalf of the Vermont Special Education Advisory Council, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

The mission of the Vermont Special Education Advisory Council regarding the education of children with Special needs is to identify critical issues and advocate for educational excellence to insure a quality of life for all children; and to advise the Vermont Commissioner of Education and the Vermont State Board of Education on the unmet need of children with special needs. This council provides opportunity for dialogue among diverse stakeholders regarding philosophy and policy that will result in successful outcomes for persons with special needs.

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

**Major Issues and Concerns**

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

the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would

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

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

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

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

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

(g) DAY HABILITATION AND RELATED SERVICES-

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

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

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

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

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

(B) any requirements respecting such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Mary Barton
Vermont Special Education Advisory Council

**Submitter :** Mr. Thomas Fanning **Date:** 10/11/2007

**Organization :** Ability Beyond Disability

**Category :** Long-term Care

**Issue Areas/Comments**

**GENERAL**

GENERAL

The proposed rules strike at the very core of community services that make it possible for people with developmental disabilities, brain injury and other cognitive disabilities to live healthy lives with a level of independence and dignity as a citizen. The proposed rules smack of efforts to save money at the expense of those who have little or no voice and who most need these services. This is not only bad policy: it is disgraceful policy.

**Submitter :** Mr. Martin Nephew **Date:** 10/11/2007

**Organization :** Mr. Martin Nephew

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Re: File Code CMS 2261 P

To Whom It May Concern:

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

**Submitter :** Mrs. Mary Barton **Date:** 10/11/2007

**Organization :** Vermont Council for Exceptional Children

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attached

CMS-2261-P-805-Attach-1.DOC

#805

October 11, 2007

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

Dear Sir(s) or Madam(s):

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

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

**Major Issues and Concerns**

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

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

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

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

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

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

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

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

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

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

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

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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.

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

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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.

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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:

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

(B) any requirements respecting such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Mary Barton
VT CEC President

**Submitter :** Mrs. Mary Barton **Date:** 10/11/2007

**Organization :** Vermont Special Education Advisory Council

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attached

CMS-2261-P-806-Attach-1.DOC

#806

October 11, 2007

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

Dear Sir(s) or Madam(s):

On Behalf of the Vermont Special Education Advisory Council, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

The mission of the Vermont Special Education Advisory Council regarding the education of children with Special needs is to identify critical issues and advocate for educational excellence to insure a quality of life for all children; and to advise the Vermont Commissioner of Education and the Vermont State Board of Education on the unmet need of children with special needs. This council provides opportunity for dialogue among diverse stakeholders regarding philosophy and policy that will result in successful outcomes for persons with special needs.

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

**Major Issues and Concerns**

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

the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would

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

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

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

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

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

(g) DAY HABILITATION AND RELATED SERVICES-

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

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

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

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

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

(B) any requirements respecting such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Mary Barton
Vermont Special Education Advisory Council

**Submitter :** **Miss. Katrina Spond** **Date: 10/11/2007**

**Organization :** **Seven Counties Services**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**GENERAL**

GENERAL

As a mental health professional,I believe that the proposed rehab option does not act in the best interest of the consumer. Continued rehab services may be indicated to retain their functional level and failure to provide level of care needed may result in decompensation and increased hospitalizations/crisis management. I feel it's of utmost importance to be able to assist the individual through their growth and into recovery.

**Submitter :** **Ms. Sandy Loerch Morris** **Date: 10/11/2007**

**Organization :** **DSHS, DDD, Infant Toddler Early Intervention Prog.**

**Category :** **State Government**

**Issue Areas/Comments**

**Background**

Background

42 CFR Parts 440 and 441: Coverage for Rehabilitative Services

**GENERAL**

GENERAL

Please see attached document. The Washington Infant Toddler Early Intervention Program has attached document with questions, concerns and comments about these proposed regulations.

**Regulatory Impact Analysis**

Regulatory Impact Analysis

Please see Attached Document.

CMS-2261-P-808-Attach-1.PDF

#808

**CENTER FOR MEDICAID AND MEDICARE (CMS) PROPOSED RULE**
**42 CRF PARTS 440 AND 441: Coverage for Rehabilitative Services**
**October 11, 2007**

| SUMMARY | ITEIP QUESTIONS/COMMENTS/IMPACTS |
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| **This proposed rule would amend the definition of rehabilitative services to provide for important individual protections and to clarify that Medicaid rehabilitative services must be coordinated with, but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs.** These services and programs include, but are not limited to, foster care, child welfare, **education**, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and **any other non-Medicaid services from Federal, State or local programs.** We believe this proposed rule is the best approach to clarifying the covered rehabilitative services, and also because all stakeholders will have the opportunity to comment on the proposed rule. These comments will then be considered before the final document is published. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures. | Possible 2.2 billion dollar federal reduction between 2008 – 2012, 180 million for 2008<br><br>This is of high concern. It could heavily impact IDEA, Part C early intervention services which are funded by health, public and private insurance, social and education funding. Federal Part C regulation clearly defines Medicaid as a funding source that must be used before IDEA, Part C funding.<br><br>The State of Washington only bills Medicaid for services defined as medically necessary and within our State Medicaid Plan<br><br>The proposed Medicaid rule is not clear. Does this include children who are dually eligible through Medicaid and Part C? Or is this aimed at older children and/or adults? Does it only include rehabilitation service or does it also include habilitation services?<br><br>How does EPSDT fit into this rule – where treatment needs to be provided to children found with concerns through a well-child exam, even if the service is not in the state plan? |
| The broad language of the current statutory and regulatory definition has, however, had some unintended consequences. It has also led to some confusion over whether otherwise applicable statutory or regulatory provider standards would apply under the rehabilitative services benefit. For example, it appears some states have used Medicaid to fund services that are included in the provision of foster care and in the **Individuals with Disabilities Education Improvement Act (IDEA).** | Mentions using the Medicaid rehabilitation benefit as a "catch all" to cover services included in other Federal, State, and local programs.<br><br>We are required to use Medicaid as a funding source per IDEA, Part C. These proposed rules do not address conflicting federal rules or acknowledge the need to coordinate rules and funding of therapies.<br><br>To the extent early intervention services, schools and other programs that serve individuals with mental retardation and related conditions rely on funding via the |

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| | rehab option, these regulations will eliminate or reduce that funding and the availability of those services.<br>• Based on current practice, it is likely the greatest impact will be a reduction in services for children (i.e., birth to 18).<br>• This will result in greater pressure on the DDD waiver program and DDD waivers do not currently assist in the early intervention funding or coverage<br>o Increased number of enrollment requests<br>o Increased provision of occupational therapy, physical therapy, and speech and language services under a waiver for current waiver enrollees. |
| 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. | How will Medicaid school based services program be impacted?<br><br>• A concern that funding for needed services for children will be significantly reduced. Washington only bills services that meet medical definition. We do not bill for special education as it does not meet the medical definition.<br>1. This proposed rule would amend the definition of rehabilitative services to provide important protections.<br>2. The proposed regulations would also impact school-based programs and perhaps foster care. |
| This proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are, in fact, **rehabilitative outpatient services**, are furnished by qualified providers, are provided to Medicaid eligible individuals according to goal-oriented rehabilitation plan, and **are not for services that are included in programs with a focus other than that of Medicaid.** | Reference to Outpatient services, in conflict with IDEA, Natural Environments<br><br>Early Intervention Services, including medically defined services, must occur in home or community settings. Medicaid rules and practices must be made consistent with this practice.<br><br>The apparent automatic exclusion of services for individuals with "mental retardation and other conditions" ignores the fact that individuals with developmental disabilities can achieve functioning in many areas and that such functioning may deteriorate over time for a variety of reasons. In those instances, provision of services under the rehab option would be appropriate.<br><br>Please consider removing the automatic exclusion of services to individuals with mental retardation and related conditions from the rehab option.<br><br>Again, this is an area of concern that funding that is currently available for services for children will be significantly reduced. |
| **Definitions.** In 440.130(d)(1), we propose to define the terms used in this | For infants and toddlers, services are to enhance development, across health, social |

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| rule as listed below:<br>• Recommended by a physician or other licensed practitioner of the healing arts;<br>• Other licensed practitioner of the healing arts;<br>• Qualified providers of rehabilitative services;<br>• Under the direction of;<br>• Written rehabilitation plan;<br>• **Restorative services;**<br>• Medical services;<br>• **Remedial services.** | services, and education. For children, we can't break out what is "medical/rehabilitative" and what is "developmental" and "habilitative." This rule needs clarity and to assure funding is maintained for children's services.<br><br>Part C enhances child development and doesn't seem to fit into the definition that it be restorative – to bring back to the original state OR remedial – meant to correct – provide a remedy. Need careful wording for children's services. |
| **Scope of Services.** Consistent with the provision of section 1905(a) (13) of the Act, we have retained the current definition of rehabilitative services in § 440.130(d) (2) as including "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." | Where do services that are developmental enhancements fit in? |
| **Written Rehabilitation Plan.** We propose to add a new requirement, at § 440.13(d) (3) that covered rehabilitative services for each individual must be identified under a written rehabilitation plan. This rehabilitation plan would ensure that the services are designed and coordinated to lead )to the goals set forth in statute and regulation (maximum reduction of physical or mental disability and restoration to the best possible functional level). | Requires a written rehabilitation plan – could the individual family service plan (IFSP) be this plan for the state for Medicaid/Part C eligible children? Need clarification and comprehensive plans for children and their families. Part C states the IFSP must be the global plan for all early intervention services regardless of funding, including Medicaid. |
| In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the lease intrusive level possible, which sustains health. The Medicaid goal is to deliver and pay for the clinically appropriate, Medicaid-covered services that would contribute to the treatment goal. | States these are not benefits for custodial care for persons with chronic conditions, but should result in a "change of status". This plays out when kids get early intervention services paid by Medicaid and they reach a "plateau" and don't progress any further, they get "discharged" by therapists, while still are in the Part C system. |
| Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services. | There is no wording in this rule to "improve" or "enhance." Talks about "restored functional abilities", "recovery oriented goals" "restoration of the individual to the best functional level." Children served in Part C are not being "restored", but "enhanced" by Medicaid funds and other early intervention services. |
| At § 441.45(a)(2), we propose to **require that the state ensure that rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.** | |

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| We propose in §441.45(b)(1) that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. **We also propose in §441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid.** | Need to define "intrinsic elements of programs other than Medicaid and avoid eliminating Medicaid defined services that are also defined as early intervention or Special Education therapies that also meet the medical definitions, such as PT, OT, speech and language pathology services, psychology services, etc. |
| **Rehabilitation services may be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met.** Medicaid rehabilitative services must be coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals and are available as part of other services or programs. | |
| In §441.45(b)(2), we **propose to exclude Federal Financial Participation (FFP) for expenditures for habilitation services, including those provided to individuals with mental retardation** or "related conditions" as defined in the State Medicaid Manual §4398. | We would want to have assurances and clarity added that this means habilitation services will continue to be covered. This proposed statement could be taken more than one way and need clarification. |
| **Habilitation typically refers to services that are for the purpose of helping persons acquire new functional abilities**. Current Medicaid policy explicitly covers habilitation services in two ways: (1) when provided in an intermediate care facility for persons with mental retardation (ICF/MR), or (2) when covered under sections 1915I, (d), or (i) of the Act as a home and community-based service. Habilitation services may also be provided under some 1905(a) service authorities such as Physician services defined at 42 CFR 440.50. Therapy services defined at 42 CFR 440.110 (such as Physical Therapy, Occupational Therapy, and Speech/Language/Audiology Therapy) and Medical or other remedial care under the 1915(i) State Plan Home and Community Based Services pursuant to the Deficit Reduction Act of 2005. | Align with IDEA, Part C Rules & Regulations. Recommend adding "including Part C services that meet Medicaid Definitions and included in state plans.<br><br>Where do Part C infants and toddlers fit in here, under habilitation services? How is CMS working within IDEA requirements regarding non-supplanting and maintenance of effort? States may not use IDEA, Part C funds to make up for losses (state and federal) created by Medicaid, with other federal, state or local funding. Thus, these reductions may be so severe that states will no longer be able to participate in the federal early intervention program (IDEA, Part C). |
| However, effective rehabilitation of eligible individuals may require some contact with non-eligible individuals. For instance, in developing the rehabilitation plan for a child with a mental illness, it may be appropriate to include the child's parents, who are not eligible for Medicaid, in the process. In addition, counseling sessions for the treatment of the child | |

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| might include the parents and other non-eligible family members. In all cases, in order for a service to be a Medicaid coverable service, it must be provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual. | |
| Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government agencies or geographic regions under Executive Order 12866. | See above comments. |
| Rehabilitation does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.130(d) of this chapter if the following conditions exist: (1) The services are 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. Examples of services that are intrinsic elements of other programs and that would not be paid under Medicaid, include, but are not limited to, the following: (2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include services provided to individuals with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.) | See above comments. |

**This document was submitted electronically to: http://www.cms.hhs.gov/Rulemaking on Thursday, October 11, 2007 by Sandy Loerch Morris, Washington Part C Coordinator/ks**

**Submitter :** Mr. Hubert Wirtz **Date:** 10/11/2007

**Organization :** The Ohio Council of Behavioral Healthcare Provider

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment under General Comments

CMS-2261-P-809-Attach-1.PDF

#809

The Ohio Council of Behavioral Healthcare Providers
Website: www.ohiocouncil-bhp.org
35 E. Gay Street ▪ Suite 401 ▪ Columbus, OH 43215-3138 ▪ Phone: 614/228-0747 ▪ Fax: 614/228-0740

October 11, 2007

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

To Whom It May Concern:

The Ohio Council of Behavioral Healthcare Providers is submitting these comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the August 13, 2007 Federal Register. We want to express our appreciation for the opportunity to comment on these very important rules.

The Ohio Council represents over 160 private, nonprofit community mental health service and addiction treatment provider organizations throughout Ohio that serve over 500,000 Ohioans annually. Many of these persons are seriously ill, disabled and vulnerable, with many being eligible to receive services through the Medicaid program in Ohio.

Our members are committed to improving the health status of their communities by promoting effective, efficient and sufficient behavioral healthcare. While these provider organizations receive revenues from many different funding sources, Medicaid is an increasingly critical component that enables many consumers to receive the services that will move them toward recovery and successful integration into their communities.

There are several areas of the proposed rules that are of most concern to the Ohio Council and its members and for which clarification would be most helpful:

1. 440.130(d)(1)(iii) Qualified Providers of Rehabilitative Services

   We would urge CMS to reconsider the potential implications of the requirements related to the definition of "qualified providers of rehabilitation services". The behavioral health system in Ohio, like in many other states, is challenged by serious problems around consumer access, provider capacity and attraction/retention of a skilled workforce necessary to deliver the quality services expected by consumers and payers. As with the treatment plan comments that follow, states should have the flexibility to establish rigorous regulatory/certification standards related to the professionals who can diagnose and treat persons with behavioral illnesses and those that can provide services under appropriate levels of supervision. This must be consistent with state laws and regulations related to professional licensure/scope of practice and be incorporated in the state Medicaid plan.

2. 440.130(d)(1)(vi) Definition of Restorative Services

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer. This should also be clarified for elderly persons at the other end of the age spectrum in that restoration of certain functions may no longer be feasible.

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

Given this clinical reality, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This services no one's interest. Consideration should be given to revising the definition of when services may be furnished to maintain or sustain functioning to include as an acceptable goal of rehabilitation planning retaining functional levels for individuals who can be expected to otherwise deteriorate.

3. C. Written Rehabilitation Plan

We applaud the emphasis that CMS has placed on the expectation in the written rehabilitation plan that include the individual consumer in the treatment planning process. We fully support this consumer-centered focus.

What is not clear is the relationship of this rehabilitation plan to existing treatment plans for individuals. In Ohio, provider organizations certified by the State to provide behavioral health services, including Medicaid services, have to already meet very rigorous treatment planning regulatory standards.

We hope the intent is not to add another potentially duplicative requirement. Providers are already heavily burdened with layers of administrative requirements and this could add another level of audit and compliance.

4. 441.45(b) Non-Covered Services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. 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.

We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for 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 programs cited in the proposed regulation have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396?? (1396d(r)). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

5. Section 441.45(b)(4)

Clarification is needed related to the definition of an inmate living in the secure custody of law enforcement and residing in a public institution. It is unclear whether services would only be denied if the individual has been convicted of a crime and is serving a criminal sentence or if any person detained in a public institution as defined by this rule, would no longer be eligible to receive Medicaid reimbursed services. Individuals may be held in or remain in local jails and detention centers when they have been charged with a crime, but have not yet been convicted and need mental health services covered under the rehabilitation option. Similarly, children may be held in detention centers awaiting the procurement of an appropriate placement in the community and are not being held due to alleged criminal acts or pending criminal charges.

We believe that Ohio's Medicaid program and the implementation of rehabilitation option services are consistent with the thrust of these proposed rules. However, clarification of the issues noted above would be very helpful for ensuring that we are able to both continue addressing the needs of Ohio's Medicaid eligible citizens and meeting the expectations of the federal government. Thank you again for the opportunity to comment.

Sincerely,

Hubert Wirtz
Chief Executive Officer

cc: Bev Young, Ohio Council Board President

**Submitter :** **Ms. Karen Bresky** **Date: 10/11/2007**

**Organization :** **Healthcare Process Consulting**

**Category :** **Health Care Industry**

**Issue Areas/Comments**

**GENERAL**

GENERAL

My comments are contained in the attached Word document. Karen Bresky, President, Healtheare Process Consulting.

CMS-2261-P-810-Attach-1.DOC

#810

# In the Matter of

# Proposed Medicaid Program Rule CMS 2261-P

# (Rehabilitative Services)

# Public Comments

This document is submitted on behalf of Healthcare Process Consulting, Inc., an Ohio Medical Consulting and Billing Corporation representing a significant number of the largest Ohio School Districts in the State, in response to the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201.

**Overview:**

We strongly assert that the CMS proposed rule is completely 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 certain 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

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

to correct or ameliorate a physical or mental condition, regardless of whether those 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 that 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, they will be forced to pay for them with state funds, or make drastic changes to the

[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)

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 assertion suggests a complete lack of understanding of the paperwork currently maintained by clinical rehabilitation providers. The requirement of the detailed written rehabilitation plan requires a substantial increase in the work planning, documentation system and time necessary to manage patient's services by these providers. Currently, rehabilitation service providers do not write formalized clinical plans for every patient they evaluate and treat to support their clinical decision to provide therapy services. That expectation imposed by a new rule such as this will create an entire new paperwork system to design, implement and monitor within all clinical settings. This expectation will have profound consequences, including a reduction in available time for providers to treat patients, and at a time where there is already a national shortage of Rehabilitation therapists in the fields of occupational therapy, physical therapy and speech/language therapy services. The new paperwork burden being proposed is onerous at best, and will only serve to decrease the quality of medical services as rehabilitation providers will be "buried in paperwork". Further, this change would create significant audit responsibilities for both the state Medicaid Agency and all individual providers and their respective organizations. 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

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

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 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

[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))

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 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,

[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.

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.

**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

[13] 72 Fed. Reg. 45209
[14] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5)

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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[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 reality 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

[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).

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 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 must be covered in any setting permitted by state law, including public school districts.

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 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

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

amended and language added stating that peer guidance is a covered rehabilitation service.

**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

[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).

party payer.

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' own responsibilities, should be recognized and clarified in §

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

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]. 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:**

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

[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))

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) and Individualized Family Service Plan (IFSP) 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 or IFSP will satisfy Medicaid requirements for rehabilitation service.

**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?

**The fact that federal education programs provide funding for educational services does not imply that those resources cover all services provided to children in one program setting, such as a school district. Further, the education programs in public schools do not preclude medical services from also being delivered in the education environment (in addition to education), nor does that reality allow federal Medicaid to abdicate its responsibility to pay for medical rehabilitative services delivered to eligible children. Federal education program dollars do not subsidize the cost for the necessary medical rehabilitative services delivered to children in the school setting. If the children were not receiving the services in school, their parents would be required to take the child out of school to a rehabilitation clinic that the federal Medicaid Program will pay for. The providers in these rehabilitation clinics have the same credentials as those employed by school districts to provide the same rehabilitation services to the children affected. There is an obvious assumption in this proposed rule that there is never cross-over between federal programs provided to the population in any specific environment, or if there is cross-over, CMS appears to want to**

**arbitrarily decide to assign fiscal responsibility to any other program then Medicaid to pay for all eligible and necessary services .**

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.**

[36] 42 U.S.C. §§ 1396a(a)(10), 1396d(r)

**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 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.**

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

**Submitter :** Ms. Cathryn Moore **Date:** 10/11/2007

**Organization :** Catsdreams Productions,WTBTN

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Mental Health Consumers are often chronic patients with on-going life needs. An outcome based system utilizing Medicaid will be an injustice to these patients. How are you going to know that your depression is going to improve with specific treatment when the root causes of it are so deep that it takes regular professional care just to function in the bare bones way that many of us do.

Also, I do not know about the viability of "wilderness camps" but I do know that thousands of Americans send their young to outdoors experiences each year and if the result does not appear measurable to some perhaps it is because the measuring tool has not been designed.

There are many ways of healing.

Do not legislate a system that will cause thousands of Americans to receive limited professional assistance. We can find other ways to pay for it just as this nation continues to find ways to fund war.