Submitter : Mr. Alec Forsman **Date:** 10/11/2007

Organization : Mr. Alec Forsman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My family member has a severe mental illness, and I understand that the proposed rule changes will severely degrade my state's ability for many of the rehabilitation services he now gets. These services have made a positive effect on his mental health. If they are decreased or cut off, it will increase the chance that he will need to be hospitalized.
Hospitalizations are very traumatic for him and his family, but they are also much more costly. I urge you to reconsider these changes.

Submitter : **Ms. Marlene Jensen** **Date: 10/11/2007**

Organization : **Ms. Marlene Jensen**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

As an educator of preschool children with special needs, I strongly urge you to continue to reimburse rehabilitation services. Working for a school district I see first hand the impact early intervention has on district budgets. We are already considered an "encroachment" on the general education budget. Paying for rehabilitation services would further drain all school budgets. Please reconsider this devastating impact that the proposed CMS regulations for the rehabilitations services option will have on the welfare of children with disabilities. Thank you for your consideration.

Submitter : Mrs. Robin Wintzer **Date:** 10/11/2007

Organization : NAMI of Central Virginia

Category : Individual

Issue Areas/Comments

Background

Background

Limiting funding of psycho-social rehabilitation services for persons with serious and chronic mental illness will result in higher costs for hospitalization, and degeneration of consumers' conditions, requiring more rehab services. This will remove proven, evidence based practices that keep people in the community for much less money, and much more stable lives, than repeated hospitalizations, or incarcerations. Why are we trying to limit or eliminate what actually works !!

Submitter : Catherine Fitzgibbons Scott **Date:** 10/11/2007

Organization : Catherine Fitzgibbons Scott

Category : Academic

Issue Areas/Comments

Background

Background

2. Limitations for Rehabilitative Services

In Sec. 441.45(b)(1) through (b)(8) we set forth limitations on coverage of rehabilitative services in this proposed rule.

We propose in Sec. 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 Sec. 441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid.

It should be noted however, that enrollment in these non-medical programs does not affect eligibility for Title XIX services. 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. Further, Medicaid rehabilitation services must be available for all participants based on an identified medical need and otherwise would have been provided to the individual outside of the foster care, juvenile justice, parole and probation systems and other non-Medicaid systems. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

GENERAL

GENERAL

Enactment of this regulation will have a deleterious impact on students with disabilities in Pennsylvania. School districts in Pennsylvania rely on Medical Access/ Medicaid reimbursement for certain medical services, which are provided as part of the IDEIA requirements. Elimination of the option to seek reimbursement for medical treatments such as Occupational Therapy, Physical Therapy, and Speech/Language Therapy for Medicaid-eligible students will result in a reduction of these necessary services for children. The burden of securing the services will then fall on the students' parents, and will have to be provided outside of the school day. Eliminate this regulation.

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

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-899-Attach-1.DOC

#899

Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

October 17, 2007

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

To Whom It May Concern:

In response to 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.

Some of the proposed rule changes simply reduce this population's access to needed services - without any back up plan to fund services or programs. Many of these services have been working effectively with CMS approved Medicaid funding for more than ten years, However, with the recent changes in CMS practice, they now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need. The net result is that vast numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.

To create, or suddenly start enforcing, bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial cut in services for people who already have more than their fair share of burdens. A reduction or elimination of services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse in our prison system.

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of functioning.' Because recovery from mental illness is often a long term process, this definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

1765 Wili Pa Loop Wailuku Maui Hawaii 96793 Tel 808.984.2156 Fax 808.984.2159 Email: haleolanakila@hawaii.rr.com

Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

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,

Frank F. Molano
325 Mahalani St. #6
Wailuku, HI 96793

Submitter : Mr. Allen Rosen **Date:** 10/11/2007

Organization : Mr. Allen Rosen

Category : Intermediate Care Facility for the Mentally Retarded

Issue Areas/Comments

GENERAL

GENERAL

I have worked with people with disabilities for the past 38 years and have seen how govenment ignorance and apathy has result in abuse and neglect. I have also seen how an enlightened government can make a significant difference in these individuals' lives. I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential services.

Submitter : Dr. Allen Stuckey **Date:** 10/11/2007

Organization : Oaklawn Psychiatric Center

Category : Physician

Issue Areas/Comments

Background

Background

Provision 441.45 (B) Disallows billing MRO for kids who are in TFC's, child welfare, education, child care, vocational, probation, juvenile or public guardianship

Collections of Information Requirements

Collections of Information Requirements

Provision 441.45 (B) discriminates against kids who happen to be in placement in these alternative settings. It assumes that the clinical and case management services we provide are being provided by DCS caseworkers, probation officers, school teachers, etc.

GENERAL

GENERAL

I do not believe that the above referenced services are being provided by DCS caseworkers, probation officers, schoolteachers, etc. in Elkhart Co, Therefore I urge elimination of Provision 441-45(B), or at least give provision of additional time to secure alternative sources of funding.

I would also ask for reconsideration of the 17 point rehabilitation plan and further clarification of "restorative services".

As a child psychiatrist, I believe that investment in case management and clinical services is critical for the future of our emotionally and behaviorally challenged children and adolescents.

Submitter : Ms. Caroline Smith **Date:** 10/11/2007

Organization : Ms. Caroline Smith

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

There are many many people who really need help. Just be sure that the legislators have the whole picture before they make their decisions about who gets help and who does not.

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

Organization : Susanne Tuckerman

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-children who need them the most, children who would have NO support without them!

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

Sincerely,

Susanne Tuckerman

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

Organization : sco family of services

Category : Social Worker

Issue Areas/Comments

Background

Background

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

Collections of Information Requirements

Collections of Information Requirements

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

GENERAL

GENERAL

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

Regulatory Impact Analysis

Regulatory Impact Analysis

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

Response to Comments

Response to Comments

Please stop this now. Make sure that all people get services. If you would think and see yourself in others shoes you would do the right thing. People now and forever as you are one also.

Submitter : **Barbara de Castro** **Date: 10/11/2007**

Organization : **Nevada Youth Care Providers**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

CMS 2261-P-440.130 (d) (2) The words of "maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level is vague and not clarified. These terms are confusing as children currently being served are at various developmental stages and often delayed due to the significance of their emotional and behavioral difficulties making it difficult to determine current status. CMS-2261-P 440.130 (d) (3) Written Rehabilitation Plan: There is concern amongst providers in regard to the written rehabilitation Plan and the need for clarification regarding this plan. Would this plan be a part of the treatment plan or a completely separate plan. There is concern in regard to the wording of qualified provider would write the plan, what does this mean? There is concern in regard to services for Child Welfare clients that on occasion it might be appropriate for services for a client however, the family may not be in agreement with the services. Under the proposed changes it does not appear that it would be possible to provide services unless the family is in absolute agreement with the services. CMS-2261-P 440.120 (d) (4) Impairments to be Addressed: Additionally there is concern that some of the clients currently being served have extensive needs which require a great amount of time to allow for improvement of current conditions. Additionally, on occasion there is a need for service to maintain the gains made by an individual but it does not appear that this is in line with the proposed changes. There is concern in regard to what would occur if a child wanted service but the family did not, whose desire would take precedence. IN regard to 440.130 (d) (xvii) the written rehab plan is to include the individuals relevant history and current medical findings as needed to achieve the rehabilitation goals. The concern is that many children who require services do not have up-to-date medical records or information is not available. Often times these children have no medical documentation which would make it difficult to meet this requirement.

GENERAL

GENERAL

"See Attachment"

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Section 440.130 (d) (3) There is concern regarding the wording qualified provider working within the State scope of practice. Providers are seeking clarification in regard to qualifications and the impact that a proposed changes would have on existing practice. Again, there is concern regarding uncooperative families when working with Child Welfare cases and whether services could be provided if the family is not willing but the child is willing. There is additional concern in regard to the need to indicate the anticipate provider of the service and the extent to which the services may be available from alternate providers of the same service. These appears to be an extreme burden for providers to meet this specific requirement.

Response to Comments

Response to Comments

There is concern amongst providers that if the Federal money is reduced the State might not have money waiting to pick up the costs of services and in such the clients being currently served would not be able to continue to receive services having a negative direct impact on their functioning.

CMS-2261-P-906-Attach-1.DOC

#906

CMS-2261-P
Comments regarding CMS Proposed Rules Regarding Medicaid Rehabilitative Services from Nevada Youth Care Providers. A group of providers of services to Child Welfare children as well as other children currently qualifying for rehabilitative services under the existing Medicaid definitions in the State of Nevada.

There is concern that foster care recruitment and training is not covered under this funding source. It is the understanding of Providers that these services are necessary to allow for options for children in need of alternative living arrangements and without the utilization of these funds these services would be difficult to manage by many Providers.

There is concern in regard to the qualifications proposed for foster parents. There is additional concern in regard to the qualification of any provider of rehabilitation services. If the qualifications are not within the scope of the individuals available to provide these services what would occur for those children needing those services. There are limited qualified providers currently. There is concern in regard to the amount of disruptions that could be caused if the standard of qualification for foster parents is changed or increased. There is a drastic shortage of foster homes currently and with increased requirements it would be more difficult to recruit the amount of homes needed to keep up with the growing numbers of children in need of services. Additionally, there is concern as to the difficulties that could occur in trying to prove qualifications of an individual.

Providers are concerned with the potential impact that could occur if the State is forced to unbundled the core rate of treatment services. The amount of administrative costs for an agency would increase dramatically and agencies would bear the hardship.

There is concern by Providers that rehabilitative services are a necessary service and that if clients are not able to receive these types of services they may require a higher level of care which is more cost prohibitive.

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

Organization : Nevada Division of Child & Family Services

Category : State Government

Issue Areas/Comments

Background

Background

See attachment

Collections of Information Requirements

Collections of Information Requirements

See attachment

GENERAL

GENERAL

See attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment

Response to Comments

Response to Comments

See attachment

#907

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. joseph gordon **Date:** 10/11/2007

Organization : Ms. joseph gordon

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

I am the parent of a 19-year-old child with a developmental dusbility. The proposed regulations pertaining to habilitative services for citizens like my daughter would effectively eliminate essential resources -- already in scarce supply -- that serve as a life line for citizens with wide-ranging neuro-developmental disabilities like autism and other cognitive challenges. Furthermore, the proposed regulations utilize criteria which appear to be bascd on politically expedient motives rather than sound educational, medical, or psycho-social experience and practicc. Well informed practitioners, organizational leaders, and their constituents will continue raising objections with elected representatives, influential bloggers, editorial writers and community leaders. The publicly harmful consequences of these discriminatory regs -- which compromise the health and well being of some of our most vulnerable citizens -- will not be lost on the good people of New York State. I urge you to withdraw the proposed regulations.

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

Organization : Developmental Disabilities Provider Association

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

#909

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 : Janie Sexton **Date:** 10/11/2007

Organization : Developmental Disabilities Provider Association

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2261-P-911-Attach-1.DOC

CMS-2261-P-911-Attach-2.DOC

#911

Developmental Disabilities Provider Association (DDPA)
2020 West 3rd Street, Suite 301
Little Rock, AR 72205-4464
Phone: 501.907.5337
Fax: 501.907.5338

October 11, 2007

Via Electronic Submission

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: Public Comments on Proposed Rule on Coverage for Rehabilitative Services under Medicaid
File Code CMS–2261–P

To Whom It May Concern:

The Developmental Disabilities Provider Association of Arkansas (DDPA) represents forty-seven (47) non-profit community programs that provide an array of medical care and related services and supports to thousands of children and adults with mental retardation and other developmental disabilities. DDPA submits the following comments in response to the August 13, 2007 *Federal Register* notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services.

We have organized our comments around three (3) potential outcomes of the rule promulgation process as follows:

1) Comments supporting withdrawal of the NPRM,
2) Comments suggesting revisions to the NPRM, and
3) Comments seeking clarification if the rule is enacted with substantially the same content as proposed.

It is DDPA's primary position that the NPRM is legally unsound and should be withdrawn. The fact that DDPA proposes alternatives and seeks clarification with regard to the current proposal should not be construed as inconsistent with DDPA's primary position in opposition to the NPRM. DDPA simply recognizes the realities of the rule promulgation process and is prepared to maintain an alternative position.

1. DDPA calls for CMS to withdraw the proposed rule.

DDPA contends that the NPRM is contrary to the legislative intent and plain language of Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA). In its commentary, CMS correctly notes that Section 6411(g) of OBRA "prohibits [CMS] from taking adverse action against States with approved habilitation provisions pending the issuance of a regulation that 'specifies types of day habilitation services that a State may cover under paragraphs (9) (clinic services) or (13) (rehabilitation services) of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions.'" The NPRM is contrary to the explicit language of this Congressional directive because the proposed rule does not "*specify* types of day habilitation services that a State may cover" rather the NPRM eliminates the habilitation option altogether. The acts of specification and elimination are quite different and should not be confused. Nonetheless, the NPRM attempts to inappropriate substitute one for the other.

In addition, the elimination of this service option is in effect an adverse action against the State of Arkansas. For decades, our state has offered approved habilitation services under the Medicaid rehabilitation option as Developmental Day Treatment Clinic Services. DDTCS is available to Medicaid eligible individuals who chose to receive community-based, as opposed to institutional, services. Instead of reviewing the effectiveness of this program and possibly listing it as a type of habilitation service that a State may cover, the proposed rule will eliminate this long-standing program and leave many Arkansans with developmental disabilities without any service option. Adverse action against a state without appropriate regulatory underpinnings is contrary to the plain language of the statute.

The NPRM is also unsound because CMS has exceeded the regulatory authority granted it under Section 6411(g) of OBRA. Congress intended Section 6411(g) to serve as protection for habilitation services. CMS concurs with this statement of legislative intent when it asserts that "[i]f this regulation is issued in final form, the *protections* provided to certain States by section 6411(g) of OBRA 89 for day habilitation services will no longer be in force." However, CMS's actions are inconsistent with the legislative intent and plain language of Section 6411(g), and as such exceed the available regulatory authority.

As noted above, specification and elimination are very different actions. Section 6411(g) indicates that CMS only has the authority to take affirmative action with regard to habilitation services, not negative action. In other words, CMS may identify by rule the types of habilitation services that a State may cover under clinic services or rehabilitation services, but it may not eliminate them. CMS does not have the authority under Section 6411(g) to eliminate habilitation services altogether. Its efforts to do so via the proposed rule do not satisfy the conditions placed on CMS by Congress for promulgation of the proposed rule.

Furthermore, DDPA believes that CMS fundamentally misunderstands the value of habilitation services. Many persons with developmental disabilities need habilitation services, which effectively offset the potential deterioration of the person's health and functional ability to perform daily living skills. These skills are critical to an overall quality of life for persons with developmental disabilities and often help such a person maintain employment or greater independence. Also, habilitation services help avoid a greater need for high intensity medical services that come with a much higher price tag.

There is also a serious workforce issue in Arkansas if CMS decides to move forward with this proposal. The alternatives that CMS proposes to the current service delivery system will require a much higher degree of manpower. We simply do not have the workforce in Arkansas to meet this demand, which will result in many persons going without any services at all.

For all of the above reasons, DDPA requests that the NPRM be withdrawn.

2. DDPA suggests revisions to the NPRM.

If CMS determines not to withdraw the NPRM, DDPA suggests that CMS consider engaging in a collaborative process with interested stakeholders to substantial revise the scope of the NPRM, broaden the scope of rehabilitation so that it is consistent with Medicaid statutes, and specify the types of habilitation that a State may cover under its Medicaid program. The NPRM includes several instances of internal inconsistency, impracticability, and impossibility, all of which justify a substantial revision.

A. The scope of rehabilitation services eligible for coverage under a State's Medicaid program should be expanded.

(1) The scope of rehabilitation services eligible for coverage under a State's Medicaid program should be broadened so that it is consistent with Medicaid statutes and the realities of rehabilitation service delivery.

The Medicaid statute at Section 1901 of the Social Security Act describes rehabilitation services as those that "help ... families and individuals attain or retain capability for independence or self-care." The NPRM completely eviscerates the scope of Medicaid rehabilitation services as envisioned by Congress. DDPA contends that CMS is without authority to make such a change in Medicaid policy. This problem is manifested in several different areas of the NPRM, which are discussed in more detail below.[1]

[1] DDPA supports the public comments submitted by ANCOR, American Network of Community Options and Resources, on this NPRM (File Code CMS-2261-P) and specifically adopts the section discussing attaining or retaining capabilities as core Medicaid goals.

The NPRM should be broadened so that the scope of rehabilitation services eligible for coverage under a State's Medicaid program is consistent with Medicaid statutes and the realities of rehabilitation service delivery.

(2) The scope of rehabilitation services eligible for coverage under a State's Medicaid program should be broadened so that it includes all medically appropriate levels of rehabilitation.

CMS states that "[i]t is important to note that [the rehabilitation] benefit is not a custodial care benefit for individuals with chronic conditions but should result in a change in status." This statement gives the impression that rehabilitation services are generally not available for individuals with chronic conditions. On the other hand, CMS also makes the statement in the commentary and in the proposed definition of "restorative services" that it "recognizes that rehabilitation goals are often contingent on the individuals' maintenance of a current level of functioning". Through these statements, CMS appears to recognize the legitimacy of "maintenance" rehabilitation for individuals with chronic conditions there is a "rehabilitation" goal. CMS's position on this issue is far from definitive. Multiple references to "recovery-oriented" goals indicate that CMS is unclear or perhaps undecided on this issue.

DDPA believes that rehabilitation legitimately includes two different levels of service, both of which may be medically appropriate for individuals with chronic conditions. The two levels of rehabilitation include:

1 – Services necessary to restore functional skills, and
2 – Services necessary to restore functional skills that would decline in the absence of rehabilitation.

Both levels of service generally result in a "change in status" as CMS seems to require. But the change in status for the second level of rehabilitation does not result in traditional linear "improvement" as it generally does in the first level. The change in status for the second level is measured against the decline of an individual's functional skills that is expected to occur as a result of the individual's condition, which may in fact be chronic. The second level is sometimes referred to as "maintenance" rehabilitation.

CMS should clarify its intent on this issue and state affirmatively that what it refers to as "maintenance" rehabilitation (or rehabilitation services necessary to restore functional skills that would decline in the absence of rehabilitation) is a legitimate type of rehabilitation eligible for coverage under the proposed rule. The result of eliminating "maintenance" rehabilitation from the scope of coverage will result in the significant (and costly) decline in condition of thousands of children and adults with developmental disabilities. Deliberately allowing an individual's condition to worsen when rehabilitation has the potential to restore

functional skills that are expected to decline will result in the need for expensive medical care that typically accompanies the anticipated decline in functionality associated with some chronic conditions. Failure to consistently provide appropriate Medicaid coverage for the second category of rehabilitation services undoubtedly will result in greater Medicaid expenditures in the long run.

DDPA recommends that the NPRM be restructured to incorporate all legitimate levels of rehabilitation, including rehabilitation services necessary to restore functional skills that would decline in the absence of rehabilitation.

(2) The scope of rehabilitation services eligible for coverage under a State's Medicaid program should include rehabilitation for cognitive impairments to the same extent as rehabilitation for physical impairments.

CMS is inconsistent in its position on the availability of Medicaid rehabilitative services for mental or cognitive impairments. In the commentary, CMS posits that a rehabilitative activity could address a "mental impairment", which suggests that rehabilitation services may be available for cognitive impairments. (It is unclear in this example whether the individual who is eligible for rehabilitation services for the mental impairment must also suffer from a mental illness.) In addition, the language in 441.45(a)(2) as proposed appears to encompass rehabilitation services for a "mental disability" since the term "mental disability" on its face is not necessarily limited to mental illness.

However, the remainder of the commentary and the proposed regulatory language indicates to the contrary - that rehabilitation is not available for cognitive or mental impairment other than that which might be associated with mental illness. In 440.130(d)(4) as proposed, CMS limits rehabilitative services to those necessary to address the individual's physical needs, mental health needs, and/or substance-related disorder treatment needs. Cognitive needs are omitted. The elements of a written rehabilitation plan listed in 440.130(d)(3)(iv), (v) and (vi) as proposed fail to identify cognitive problems as a condition eligible for rehabilitation.

CMS's approach completely ignores the legitimate, medical need for cognitive rehabilitation in certain situations and has the practical effect of eliminating Medicaid coverage for critical and medically necessary rehabilitation treatment for patients with traumatic brain injury (TBI) and other conditions in which a patient's cognitive abilities have been impacted. CMS's approach assumes that cognitive and physical rehabilitation can be clearly distinguished, but this is not always the case. Cognitive and physical rehabilitation are often highly interrelated, especially in the area of TBI. In fact, elements of physical rehabilitation in the case of TBI are often depending on progress in rehabilitating cognitive functions. To attempt to separate physical and cognitive rehabilitation in situations in which they are highly interrelated will have the practical effect of

arbitrarily denying physical rehabilitative services to persons with cognitive impairments. CMS has attempted to address this contingency but without success. It is impossible, in many situations, to categorize rehabilitation services as strictly as CMS proposes.

The proposed rule should be clarified to authorize FFP for Medicaid rehabilitation services to individuals with cognitive impairments when the rehabilitation services "support the maximum reduction of ... mental disability and restoration of a recipient to his [or her] best possible functional level."

(3) The scope of rehabilitation services eligible for coverage under a State's Medicaid program should not exclude coverage for rehabilitation services for specific classes of persons when the class is defined by a common or related diagnosis.

The NPRM seems to be based on an assumption that all mental retardation is present from birth and that an individual with mental retardation would never have had any cognitive functionality capable of being restored. By excluding services that address cognitive needs from rehabilitation services and specifically targeting persons with mental retardation or a related condition, CMS ignores the fact that (1) environmental circumstances can cause mental retardation later in the developmental period of a child's life, and (2) cognitive rehabilitation is medically necessary in a variety of situations that do not necessary involve mental retardation or a related condition[2]. In this situation, an individual could have acquired skills as a child that may have been lost as a result of a trauma during the developmental period and for which rehabilitation is appropriate.

Also, many adults with mental retardation might have obtained a higher level of functioning if the person had received early intervention services a child. Rehabilitation services provided in this instance, but for the fact they are provided to an individual with mental retardation, would fall within the acceptable parameters of rehabilitation as set forth in the proposed rule in that rehabilitation would "restore" the individual to a capability level that was never achieved due to lack of appropriate treatment earlier in life even through the capability was there. If a person had the *capability* to perform a function in the past, but was never able to develop his or her capability for any reason, then the individual should be

[2] Interestingly, autism is not considered a condition related to mental retardation in CMS's State Medicaid Manual (as available on the CMS website) although the State Medicaid Manual "approves" placements for individuals with autism in an ICR/MR setting. It is unclear whether rehabilitation services under the NPRM will be available for individuals with autism spectrum disorders. However, since there is no specific exclusion in the NPRM, it appears that individuals with autism spectrum disorders would be able to receive services under the NPRM while individuals with similar rehabilitation needs but a diagnosis that falls within the definition of "related condition" would not. This distinction on the basis of an individual's diagnosis is arbitrary, discriminatory, and without justification.

eligible for rehabilitation services without regard to any other condition that the individual may have. If rehabilitation services are medically necessary, they should not be limited arbitrarily by the condition or disorder of the individual who might need to receive them.

As a practical matter, this proposed rule may result in a situation in which two individuals have lost similar skills and have a similar potential for skill or function reacquisition but they are treated differently solely because one has mentally retardation and the other does not. This arbitrary result with regard to individuals with mental retardation or related conditions is discriminatory and contrary to the purpose of the Americans with Disabilities Act.

The blanket of exclusion of individuals with mental retardation or related conditions from the scope of the NPRM as well as the exclusion of rehabilitation services for individual with cognitive impairments should be reversed. The proposed rule should be revised to authorize FFP for Medicaid rehabilitation services to individuals with cognitive impairments and individual with mental retardation or related conditions when the rehabilitation services "support the maximum reduction of ... mental disability and restoration of a recipient to his [or her] best possible functional level."

(4) The scope of rehabilitation services eligible for coverage under a State's Medicaid program should include prevocational services to the extent the services are delivered as part of a written rehabilitation plan with appropriate rehabilitation goals.

The NPRM opines that "[p]revocational services address underlying habilitative goals that are associated with performing compensated work." This conclusion is too narrow. Certainly, some prevocational services are associated with performing compensated work, but not all and not exclusively. Further, prevocational services are not limited to achieving habilitation goals. Some services typically categorized as prevocational actually involve the development of a skill necessary to increase an individual's functionality and reduce his or her disability and thus are associated legitimately with rehabilitation. The same skill may also be helpful in performing compensated work but the secondary purpose does not eliminate the primary rehabilitative purpose. Skill development services typically categorized as prevocational frequently serve multiple purposes and support rehabilitative goals in several areas of major life activity. It is impossible to box each service in an individually-wrapped single-purpose package. This expectation belies the realities of rehabilitation service delivery.

The fact that a service has multiple purposes, one of which has the potential to be categorized as prevocational, should not result in the wholesale exclusion of the service from coverage as rehabilitation services. This type of blanket denial is

arbitrary, capricious, and contrary to the person-centered philosophy of rehabilitation that CMS advocates. A more appropriate treatment of rehabilitation coverage for services supporting skill development with multiple purposes is to evaluate the services as part of a written rehabilitation plan with appropriate rehabilitation goals.

CMS's discussion of prevocational services from a Medicaid coverage perspective creates further disorder in this area. CMS indicates on page 45206 that prevocational services provided for the purpose of reducing disability and restoring a person to previous functional level have the potential to be viewed as rehabilitative services and thus covered under a state's Medicaid program. However, CMS indicates later on page 45206 that Medicaid is only available for prevocational services under section a 1915(c) waiver or a home and community-based services program.

To the extent that prevocational services are meeting rehabilitative goals, they should be covered under Medicaid as rehabilitation services. The language in 42 CFR 441.45(b) as proposed that specifically excludes all prevocational services from the definition of rehabilitation and prohibits the use of FFP for expenditures related to prevocational services should be stricken.

B. The use of "prior capability" as a measure to determine the appropriate scope of rehabilitation services should be abandoned.

There is no reasonable and accurate methodology to determine whether or not an individual receiving rehabilitation services had the capability to perform an activity in the past. There is no instrument available that can retroactively measure an individual's former capabilities if the individual never had the opportunity to use or interest in using those capabilities prior to the onset of the disabling condition. For example, a child is seriously injured and during the course of several years of physical rehabilitation reaches driving age. The provider cannot know if the child was capable of driving a car when the child was injured well in advance of developing the particular skill set necessary for driving a car. It will difficult if not impossible for any regulatory authority to prove that an individual did not have the prior capability to perform an activity for which rehabilitation was provided. The "prior capability test' will often have to include an assessment of an individual's cognitive ability at the same time that SMA is attempting to eliminate rehabilitative services for individuals with cognitive impairments. This approach does not make sense.

Using the "prior capability test" as described in the definition of "restorative services" as a mechanism to eliminate potential recipients of rehabilitation services is unworkable and should be eliminated from the NPRM.

C. Providers should be able to deliver habilitation services in the same settings as proposed for rehabilitation services.

CMS is proposing to allow rehabilitative services to be furnished on a variety of settings, including facilities, homes or other settings. However, CMS makes at least one reference to "clinically-appropriate" rehabilitation services leaving open the question of where rehabilitation services may be provided. If CMS is proposing to allow rehabilitative services to be furnished on a variety of settings, a similar variety of service options should also be available for habilitation services.

Providers should be able to deliver habilitation services in the same settings as proposed for rehabilitation services. The NPRM should be revised to reflect this change.

D. The time frame proposed to transition service delivery should be extended.

If CMS proceeds with finalizing the substantive content of the propose rule as written, the proposed time frames for transitioning service delivery should be expanded. It generally takes much longer for a State to get a waiver application approved by CMS than the time frame proposed by CMS to transition habilitation services. A State should have a minimum of eighteen (18) months after the final CMS decision on a waiver program to transition service delivery for habilitation services. With regard to a state plan amendment, a State should have a minimum of eighteen (18) months to transition service delivery.

The time frame proposed to transition service delivery should be extended.

E. The use of potential fiscal savings to justify the NPRM is inaccurate and misleading.

If States that currently offer habilitation services as part of Medicaid rehabilitation services are forced to provide these services under a related waiver program, federal financial participation in the services may actually go up because of the wider array of services offered under waiver programs and related administrative costs. CMS has admitted that "there is a significantly wide range of possible [fiscal] impacts" so this rule should not go forward on the assumption that it will result in fiscal savings. Narrowing the scope of rehabilitative services in Arkansas is likely to cost more money in the long run than it will save.

The use of potential fiscal savings to justify the NPRM is inaccurate and misleading and should be eliminated from the NPRM.

In concluding Section 2 of these comments, DDPA suggests that if CMS determines not to withdraw the NPRM, CMS consider engaging in a collaborative process to substantial revise the scope of the NPRM, broaden the scope of rehabilitation so that

it is consistent with Medicaid statutes, and specify the types of habilitation that a State may cover under its Medicaid program.

3. Clarifications Needed if Current Proposal Becomes Effective.

A. Is there a distinction between "maximum reduction of physical or mental disability" and "restoration of the individual to his or her best possible functional level"?

Under 441.445(a)(2) as proposed, States must ensure that "rehabilitative services are limited to services furnished [for the purpose of] the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level." This purpose is reflected in the requirement that a rehabilitation plan must be revised if there has been "no measurable reduction of disability and restoration of functional level". See 440.130(d)(3)(xiv) as proposed. CMS should provide further information about the relationship between the concepts of "reduction of disability" and "restoration of functional level". These concepts seem very similar – like two sides of the same coin. But the use of the conjunctive "and" indicates that they might be viewed separately. How does CMS envision theses concepts being measured in a reevaluation process? Are they interrelated in that an increase in one results in an increase other? Or does CMS view them as separate concepts? If they are viewed separately, should different measurements be used and what should those measurements be?

B. Is the written rehabilitation plan part of the documentation of a client's overall treatment plan or a separate document?

The written rehabilitation plan should be part of the documentation of a client's overall treatment plan. There should be no requirement that the written rehabilitation plan be an individually identifiable document. The proposed rule is unclear on this point and contains a number of provisions that appear to work against an integrated document. For example, the requirement that the client sign and receive a copy of the plan indicates that CMS may be expecting the plan to be a separate document.

If CMS intends the written rehabilitation plan to be a separate document, it should consider that a separate document will diminish the effectiveness of the requirement. If the written rehabilitation plan is written in isolation from all other components of a comprehensive treatment plan, the likely result will be gaps in service delivery, unnecessary overlaps in services, and conflicting goals and objectives by different service providers Furthermore, the preparation of a separate document will likely duplicate or be inconsistent with other client records and be unreasonably burdensome under paperwork reduction laws.

C. What is the impact of the omission of "restorative services" from the types of service components allowable for rehabilitation services?

Confusion arises from CMS's references to "remedial services", "restorative services", and "restoration of function". "Remedial services" along with medical services, which are both defined terms in the NPRM, are listed the two types of services potentially available under the rehabilitative service umbrella.

The phrase "restorative services" is defined as a term in the NPRM but otherwise is not used. The phrase "restoration of function", which is suggestive of the term "restorative services", is used to describe one of the two requisite goals of rehabilitation. The similarity of word usage with regard to what appears to be different concepts invites confusion.

The omission of "restorative services" with regard to scope of services under 440.130(d)(1)(v) as proposed and from the written rehabilitation plan under 440.130(d)(3)(vi) as proposed may be an effort to narrow the scope of rehabilitative services for which federal financial participation (FFP) is available. Usually, an omission in drafting is deliberate and intended to exclude the omitted item from the class of items being defined. However, the substantive content of the term "restorative services", especially the language establishing the "prior capabilities" test, is consistent with a conclusion that restorative services are considered a part of rehabilitative services. CMS should modify its word usage or clarify its intent on this point.

In closing, DDPA reiterates that it strongly opposes the NPRM as it currently exists and respectfully requests its withdrawal for the reasons discussed. In the alternative, DDPA suggests that CMS engage in a collaborative process to substantial revise the scope of the NPRM, broaden the scope of rehabilitation so that it is consistent with Medicaid statutes, and specify the types of habilitation that a State may cover under its Medicaid program. DDPA further suggests that CMS clarify any remaining issues of confusion as identified in these comments.

Thank you for your time and attention to this matter.

Respectfully,

Janie Sexton, President

Randy Laverty, Executive Director

cc: Governor Mike Beebe
U.S. Senator Blanche Lincoln
U.S. Senator Mark Pryor
Representative Marion Berry
Representative Vic Snyder
Representative Mike Ross

Representative John Boozman
John M. Selig, Director, Arkansas Department of Human Services
Roy Jeffus, Director, DHS-Division of Medical Services
Charlie, Director, DHS-Division of Developmental Disabilities Services
Suellen Galbraith, Director of Government Relations, ANCOR

Submitter : Ms. annamae vener **Date:** 10/11/2007

Organization : bronx mr council

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

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

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to comment on the notice of proposed rulemaking with respect to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007.

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

The proposed rule would severely harm people with intellectual 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 rehabilitation services for people with mental retardation and related conditions.

Day Habilitation is the only community-based therapeutic daytime service for adults with developmental disabilities in Massachusetts. These programs provide a combination of clinical services (OT, PT, SLP), medical oversight, and life skills/adult daily living training. Services are offered six hours/day, five days/week for 52 weeks/year. Persons served have various abilities, with the majority having mental retardation. Some participants require complex clinical and medical supports to sustain their life's functions. For individuals who live with families or in their own homes, Day Habilitation is often the only component in the community care system that provides these vital services.

The proposed rulemaking would amend the definition of Medicaid rehabilitation services to prohibit payment for day habilitation services. If enacted, this rule would force Massachusetts to move the Day Hab program from the Rehabilitation Option in the Massachusett State Plan to a capped community-based waiver program. This move will have devastating consequences (loss of clinical services, caps on the number of individuals served, bi-annual rate review would be lost) for the Day Hab programs and the thousands of people they serve. Please keep Day Habs under the State Plan!

Submitter : Mr. Pat Mooney **Date:** 10/12/2007

Organization : Retired

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

AS the parent of a person with schizophrenia, I wholly endorse the changes recommended by NAMI. In particular, those having to do with family involvement. Our son would be on the streets, or dead, if we had not maintained our full support of him in hospitalizations, therapy, evaluations, and providing him room and board in our house.

Submitter : Mr. Chris Traylor **Date:** 10/11/2007

Organization : Health and Human Services Commission

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-915-Attach-1.PDF

CMS-2261-P-915-Attach-2.PDF

#915

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

October 12, 2007

Department of Health and Human Services
Center for Medicare and Medicaid Services

CMS-2261-P.P.O Box 8018
Baltimore, MD 21244-8018

Dear Center for Medicare and Medicaid Services:

Thank you for the opportunity to comment on the proposed rule to amend the definition of Medicaid rehabilitative services. The Health and Human Services Commission (HHSC) thanks the Centers for Medicare and Medicaid Services (CMS) for consolidating various standing policies and stating those policies in direct reference to rehabilitative services. The additional clarification provided by CMS is appreciated, most notably the inclusion of the recovery model for mental health and substance abuse treatment. Texas has reviewed the recommended amendment and has comments and concerns and seeks clarification on the impact to early childhood intervention, mental health, assistive living and habilitation and rehabilitative services.

HHSC has the following issues and comments:

1. The proposed rule would require clarification to support early childhood intervention services. The proposed rule as written would minimize the services that could be provided to children. Children age birth to three years would not necessarily have restoration of functional ability as a goal. Children may require these services to meet development goals as they are growing and changing since they have not yet developed all of their functional abilities. A child that is exhibiting a delay in development, a disability or atypical development may require intervention. The rehabilitative services provided are intended to minimize the delay in development of the child's functional ability to prevent, reduce and/or overcome delays in functional abilities or disabilities and limitations.

In addition to the issue detailed above, HHSC requests clarification on the following items:

1. Habilitation versus Rehabilitation –HHSC requests clarification that providers of rehabilitative services will not have to prove the loss of capability to perform an activity on an individual.
2. Maintenance versus Measurable Reduction –

a. HHSC requests clarification from CMS that goals such as "maintaining home maintenance skills" or "maintaining meal preparation skills" are acceptable goal statements for the rehabilitation plan. Such goals facilitate achievement of providing services in the least restrictive environment, and help prevent the more costly and challenging setting of inpatient care.
b. The proposed rule indicates that if there is no measurable reduction of disability and restoration of functional level, then there must be a revision in the treatment plan goals. This requirement does not appear to be consistent with CMS' allowance for rehabilitative services to maintain functioning. Maintenance of functioning can be an important rehabilitative goal for individuals with severe mental illness. Often the symptoms of mental illness are cyclic, varying in severity and affect on functioning over time. There is no reliable way to predict the course of the illness. Also, one person's symptoms may be very different from those of another even if diagnosis is the same. HHSC respectfully requests the proposed rule language be modified as follows:
    - "440.130(d)(3)(xiv) Be re-evaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If the rehabilitative service is not maintaining current functioning and/or it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goal, services and/or methods."
    - "441.45(a)(4)(v) For non-crisis and non-maintenance rehabilitative services, the progress made toward functional improvement and attainment of the individual's goals as identified in the rehabilitation plan and case record."

3. Pre-vocational Services – HHSC requests that CMS provide examples, perhaps in 441.45(b)(1), of pre-vocational services to assist the states in determining the activities that are not allowable under the rehabilitative option. For example, is training on how to conduct oneself in a job interview considered pre-vocational? Is training on how to complete a job application or write a resume in a manner that emphasizes one's strengths considered pre-vocational? Is training on how to broach reasonable accommodations (for the individual's mental illness) with an employer considered pre-vocational?
4. Crisis Services – Medical services are defined as "services specified in the rehabilitation plan." Given the nature of crisis services, this definition is not realistic and would be a barrier to emergency life saving services if it is enforced. HHSC respectfully requests the proposed language be modified as follows:
    - 440.130(d)(1)(vii) *"Medical services"* means services that are required for the diagnosis, treatment, or care of a physical or mental disorder and are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State Law. Medical services may include physical therapy, occupational therapy,

speech therapy, and mental health and substance-related disorder rehabilitative services. Medical services that are not provided in response to a crisis must be specified in the rehabilitation plan."

- 441.45(a)(3) "Require that providers maintain case records for all individuals. The case record must contain a copy of the rehabilitation plan for the provision of all non-crisis rehabilitative services."
- 441.45(a)(4)(i) "A copy of the rehabilitative plan for non-crisis services."
- 441.45(a)(4)(v) "For non-crisis and non-maintenance rehabilitative services, the progress made toward functional improvement and attainment of the individual's goals as identified in the rehabilitation plan and case record."

5. Alternate providers – Expecting providers to be aware of all other potential providers in the area is unrealistic and outside their scope of responsibility. The freedom of choice issue is a state implementation issue, not a treatment planning issue. Please remove "and the extent to which the services may be available from alternate provider(s) of the same service" from the treatment plan requirements stipulated in 440.130(d)(3)(xi). If HHSC is misinterpreting CMS' intent with this language, HHSC requests that CMS rephrase the directive to ensure correct interpretation of the requirement.
6. Provider types- Our Early Childhood Intervention Specialists (EISs) are included in the State Plan Amendment (SPA) No. 583, transmittal no. 00-18, as eligible providers of EPSDT Developmental Rehabilitation Services (DRS). DRS are performed by or under the supervision of a licensed physician or other health care professional acting within their scope of practice. The services are established by or in consultation with a licensed physician, a licensed occupational therapist, licensed physical therapist, licensed speech language pathologist, licensed professional counselor, licensed master social worker-advanced clinical practitioner, or registered nurse. The Individual Family Service Plan (IFSP) is developed by an interdisciplinary team consisting of a minimum of two fully qualified professionals from different disciplines, the assigned service coordinator, and the parent(s) or guardian(s) of the child. The EIS professionals are listed as one of the providers that may provide DRS; however, they must provide DRS under the supervision of a physician or other health care professional acting within their scope of practice. The EIS is certified through the ECI Competency Demonstration System. There are specific qualifications and educational requirements that must be met in order to become an EIS. Please clarify that EIS will remain acceptable provider types for Medicaid as outlined in the state plan amendment.
7. Services to family - During the American Public Human Services Association teleconference, representatives from CMS indicated that when the child is in an institution, federal financial participation under the rehabilitative option can be used for the training provided to the parent in preparation for the child's return to the home. HHSC requests that the following language be added to 441.45(b)(7): "This does not preclude contacts with individuals who are not Medicaid eligible for the purpose of

treating the Medicaid eligible individual, including Medicaid eligible individuals who are currently an inmate of a public institution or resident of an IMD."

8. Omnibus Budget Reconciliation Act (OBRA) – In the preamble is the statement, "a rehabilitative service is not an inpatient benefit." There is, however, a federal mandate under OBRA that rehabilitative services are provided to individuals residing in nursing homes. HHSC respectfully requests that the proposed language be modified to acknowledge the OBRA requirement: "440.130(d)(5) Settings. Rehabilitative services may be provided in a nursing home (if required under the Omnibus Budget Reconciliation Act of 1987), facility, home, or other setting."

HHSC requests that CMS consider the following modifications:

- Modify the proposed language at 440.130(d)(3)(xiv) as follows: "Be re-evaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan have contributed to meeting the stated goals. If the rehabilitative service is not maintaining current functioning and/or it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goal, services and/or methods."
- We recommend a change to PART 440 –SERVICES: GENERAL PROVISIONS, 440.130(d) (1) (vi) Restorative services and 440.130(d) (2) Scope of services. Definition and reference under "Scope of services" does not apply to children less than three years of age as stated above. We recommend the definition be revised to include young children and be expanded to include the words "and family" in the definition.
- Further PART 440 –SERVICES: GENERAL PROVISIONS, 440.130(d) (1) (vii) Medical services and (viii) Remedial services Medical services and/or remedial services, does not include the EPSDT DRS as defined in the SPA No. 583, transmittal no. 00-18. SPA # 583, transmittal no. 00-18 which states:
  "DRS include diagnostic, evaluative and consultative service for the purposes of identifying or determining the nature and extent of, and rehabilitating an individual's medical and other health –related condition. They are medical and/or remedial services that integrate therapeutic intervention strategies into the daily routines of a child and family in order to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay." We recommend including "to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay" in the definitions and references to restored functional abilities as well as adding the following clarification for children ages birth to three years. *"The rehabilitative services include continuous monitoring of a child's progress in the acquisition and mastery of functional skills to reduce or overcome limitations resulting from disabilities or developmental delays."*
- For the purposes of adding further clarification, HHSC understands the reference cited in *§441.45(b) (1) "coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid"* to include IDEA Part C. HHSC

understands this would not apply to medical services provided to Medicaid eligible children in the ECI, and they would still be covered as Medicaid services for Medicaid eligible children. We recommend the addition of a reference to clearly state that it does not apply to children enrolled in the Medicaid program. These services are approved in SPA No. 583 as noted above. We would like to preserve the ability to continue to receive reimbursement through Medicaid for services which are approved in our current state plan.

- To avoid inadvertently limiting the care provided to children that receive ECI services with a diagnosis of mental retardation, HHSC recommends CMS clearly state in this section of the rule that the rule does not apply to children age birth through three who are enrolled in the ECI program and have a diagnosis of mental retardation or mental/physical impairments that result in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, and mobility.

Thank you again for the opportunity to comment on the proposed rule to amend the definition of Medicaid rehabilitative services.

Sincerely,

Chris Traylor

Chris Traylor,
State Medicaid CHIP Director

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a mother of twins on the autism spectrum, I rely on our wraparound services to allow my children to attend a "typical" school. Our TSS worker is phenominal in helping the boys deal with the noise of a classroom, transitioning from one thing to another and helping them deal with the social politics of school. Without her, I am afraid that my children would not be able to attend a regular classroom. They need the added help to flow with the day. She provides a service that without her, they would be a disruption and the class would not get thru the curriculum on the scheduled time allowed. PLEASE do not take my wraparound away. My children need this to be included in the "typical" school. They are extremely intelligent and are getting the education that they deserve!!

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

Organization : Carolyn LeBel

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Mrs. Susan Groom **Date:** 10/12/2007

Organization : Winchester Public Schools

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#918

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. Jeffrey Tomlinson **Date:** 10/12/2007

Organization : NYS Occupational Therapy Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

sea attachment

CMS-2261-P-919-Attach-1.DOC

#919

http://www.cms.hhs.gov/eRulemaking

October 12, 2007

To: DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

From: Jeffrey Tomlinson, OTR, LMSW, FAOTA
NewYork State Occupational Therapy Association

Re.: CMS 2261–P

I am writing as a representative for occupational therapists and occupational therapy assistants in New York State, regarding the proposed rule by the Centers for Medicare & Medicaid Services that would amend the definition of Medicaid rehabilitative services. I would like to respectfully submit the following comments.

In § 440.130(d)(1)(iii), the proposal would define "'qualified providers of rehabilitative services' to require that individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories....We require uniform application of these qualifications to ensure the individual free choice of qualified providers, consistent with section 1902(a)(23) of the Act."

We strongly urge that the "uniform application of these qualifications" include the requirement that state's license or certify all providers of rehabilitation services in their State Medicaid Plan, so that there may be adequate regulation of these providers to protect the public and a reasonable level of quality in services provided under Medicaid.

In § 440.110 it is mentioned that the definition of occupational therapy is not correct "insofar as the following—Occupational Therapists must be certified through the National Board of Certification for Occupational Therapy, not the American Occupational Therapy Association."

We would urge the removal of language regarding national certification and that provider qualifications be certified at the state level. Certification of professions should be the statutory authority of states. Each state could then determine whether to recognize the certification procedures offered by national boards.

In § 440.110 regarding the proposed definition of the term ''under the direction of,'' the proposal would clarify that the term means that "the therapist providing direction is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuming professional responsibility for services provided, and ensuring that all services are medically necessary."

We would strongly support such a definition as providing appropriate licensed professional oversight in the delivery of rehabilitation services, with the exception of the initial contact. We believe that there are instances in which an occupational therapy assistant may make the initial contact or screen a patient and then alert the occupational therapist that the client may be a candidate for further evaluation and treatment. In progressive community service models this approach is very safe and is the most efficient way to utilize professional personnel.

In § 440.130(d)(3), the proposal includes:

"If there is no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy."

"Services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan."

"Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services."

While we recognize that the primary purpose for Medicaid coverage of rehabilitation services is to achieve the restoration of health and function, there are certain populations with chronic disabilities that benefit greatly from professional licensed rehabilitation services while not achieving significant observable gains in functioning over an extended period of time. For these populations change or recovery is not linear, constant, nor easily measured. These populations include individuals with serious and persistent mental illness, such as schizophrenia, or individuals with cerebral palsy. Clinical experience shows that in the absence of professional rehabilitation services these populations are unable to maintain functioning and are at risk for more extensive disability. In addition, we find that gains in health and function with these populations are often made in immeasurable increments that are not observable. For example, the individual with schizophrenia who is working on social skills may slowly gain greater comfort being with others as a prerequisite to further interaction skills. Such subjective comfort levels may not be observable and may be difficult for a client to quantify in subjective reports. We urge CMS to be provide exemptions for such populations who truly benefit from professional rehabilitation services and who would be severely harmed by the withdrawal of those services.

In § 440.130(d)(3)(iii) it is proposed that the written rehabilitation plan include the active participation of the individual (or the individual's authorized health care decision maker) in the development, review, and reevaluation of the rehabilitation goals and services, the use of a person-centered planning process.

We strongly support this proposal, as it certainly represents the standards of practice in our profession, and properly empowers the Medicaid beneficiary as an active participant in their health care.

In regards to "impairments to be addressed" in § 440.130(d)(4) the proposal suggests that a State has flexibility to determine whether rehabilitative services would be limited to certain rehabilitative services (for example, only physical rehabilitative services) or will include rehabilitative treatment for mental health or substance-related disorders as well.

This is a tragic proposal since it allows for a disparity in the availability of rehabilitation and the discrimination against individuals with mental illness and substance abuse disorders. As the proposal points out itself, "the provision of rehabilitative services to individuals with mental health or substance-related disorders is consistent with the recommendations of the New Freedom Commission on Mental Health. CMS should put forward a policy that strongly promotes making Medicaid services available to individuals with mental illness and substance abuse disorders.

With regard to "Requirements and Limitations for Rehabilitative Services," in § 441.45(a)(3) and (a)(4), the proposal would require that providers of the rehabilitative services maintain case records that contain a copy of the rehabilitation plan.

We would want to seek further guidance regarding how long such case records must be maintained?

Also in regards to "Limitations for Rehabilitative Services" 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 .... prevocational training.

We would urge that prevocational training be allowed under Medicaid program as an essential rehabilitation service for returning the individual to meaningful recovery and a productive role in the community. The primary purpose of prevocational training is not to acquire specific job skills but rather to recover basic functional skills that are an antecedent to vocational training.

In § 441.45(b)(2), the proposal would exclude Federal Financial Participation for expenditures for habilitation services including those provided to individuals with mental retardation or ''related conditions'' as defined in the State Medicaid Manual.

NYSOTA opposes this proposal. The withdrawal of FFP from habilitation services for individuals with mental retardation will result in states being unable to finance essential services that help thousands of individuals to lead more independent and productive lives. This population benefits greatly from professional rehabilitation services for gradual incremental improvement in function. The argument that habilitation is different from rehabilitation may be conceptually accurate, however, the consequences of this policy

decision will be harmful to a vulnerable population. We urge CMS to reconsider this policy. We believe expenditures under this section can be effectively managed by other means, including the documentation of habilitation plans.

In § 441.45(b)(7), we propose to preclude payment for services furnished for the rehabilitation of an individual who is not Medicaid eligible. This provision reinforces basic program requirements found in section 1905(a) of the Act that require medical assistance to be furnished only to eligible individuals. An ''eligible individual'' is a person who is eligible for Medicaid and requires rehabilitative services as defined in the Medicaid State plan at the time the services are furnished.

NYSOTA urges CMS to reconsider this proposal and allow the States to provide for a limited benefit coverage for individuals that are not Medicaid eligible. In instances where individuals who are visiting this country temporarily and are poor and without insurance, a disabling accident or illness may make it necessary for a very limited rehabilitation intervention in order to assure a safe discharge to the community and possiblke return to their place of origin.

Thank you for the opportunity to submit these comments. We hope that your final decisions will take into consideration the impact that these policies will have on the individuals who struggle each day to over come severe disabilities.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

1. Do do not take billions of dollars out of the Medicaid funded system of care for people with mental illnesses. These individuals, adults and children will beleft behind in school, work, and life without suffcient access to appropriate treatment and rehabilitative care.

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

4. Services should be provided to help prevent deterioration of an individual. Other systems need to be encouraged, not discouraged, to provide help to adults and children with serious mental illnesses.

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

Submitter : Mr. Jerry Kurowyckyj **Date:** 10/12/2007

Organization : Mr. Jerry Kurowyckyj

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Mrs. Waynette Chambers **Date:** 10/12/2007

Organization : CEC

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-922-Attach-1.TXT

#922

October 10, 2007

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

Dear Sir(s) or Madam(s):

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

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

Major Issues and Concerns

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) DAY HABILITATION AND RELATED SERVICES-

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

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

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

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

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

(B) any requirements respecting such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Submitter : Mr. James Page-Quail **Date:** 10/12/2007

Organization : Cobb County School District

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#923

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : Mr. Joe DeVizia **Date:** 10/12/2007

Organization : Office of Human Services

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

Eliminating people with autism as mentioned in the proposed "Rehabilitation Services" regulations could interrupt much progress that has been made for people with autism. In our opinion this would have long range increase in costs and a debilitating impact on people with autism.

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

Organization : Paragould School District - CEC

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#925

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. Loretta Casoreo **Date:** 10/12/2007

Organization : Adventure House

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My name is Loretta Casoreo . I stated coming to Adventure House five years ago. Before I got to Adventure House life was a mess. I had a drug problem. Ive been diagnosed with a mental illeness. I was getting tired of being sent to one place and another to get help; I just wanted to die on a dailly basis. Than one of the caseworkers I had knew of a place that would fit my needs . I was reluctant at first but I was willing to follow her directions.the name of this place ic Adventure House.Adventure House has alot of units you can choose to work in, I work in the kitchen and do transportation for members who need to get to appointments such as doctors, dentist, ect.The more I came to Adventure House the less depressed I started to feel, the thoughts of suicide started going away. I keep very busy at Adventure House . I feel I have a purpose to live. Adventure House also has apartments which gives me a place to live. If Adventure House was taken away from me I would get depressed and feel lonely again. Adventure House has a out reach program if you don't come in they call to see if your okay. Staff will even bring lunch to you. Aventure House feeds between 60-80 people a day. Adventure House offers a wide range of things to do. We also have a drama club to get the message to try and take away the stigma of mental illness. A teacher comes bi-weekly to help some members to comtinue their education.We have social night once a week. We have a transitional employment program where members can have a chance to get back into the work force. Confidence and self esteem is what member of adventure House gains from the program. Staff and members maintain the property together.It makes me sad to think there is a chane that Adventure House could no longer exist.

Loretta Casorio
833 Charles Road Apt 3-B
Shelby, N.C. 28152

Submitter : Mrs. Maria Engel **Date:** 10/12/2007

Organization : Mrs. Maria Engel

Category : Other

Issue Areas/Comments

Background

Background

Change in rules for habilitation care for mentally retarded not fair to those needing this service. Federal financial participation is needed to keep sevices at a steady level and not leave people out in the cold. This proposed definition creates a discriminatory and arbitrary exclusion for people with mental retardation and related conditions. As a family member of one such person, I urge you to rethink this.

GENERAL

GENERAL

This rule should not exclude people already receiving these services as there is often no other funding to cover it. Many families cannot afford to cover these costs themselves, as some are retirees with lower incomes themselves.

Submitter : Mrs. Laura Jackson **Date:** 10/12/2007

Organization : Center for Mental Health

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

Submitter : **Dr. Thomas Thrasher** **Date: 10/12/2007**

Organization : **North Georgai College**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

Please do not support legislation that will terminate Medicaid support for children needing rehabilitative services, as this will put debilitating strain on schools, and likely significantly decrease critical services to special needs children.

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

Organization : Rosalie Hughes

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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