**Submitter :** Ms. Susan Constantino **Date:** 10/12/2007

**Organization :** Cerebral Palsy Associations of New York State

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-964-Attach-1.DOC

CMS-2261-P-964-Attach-2.WPD

# 964

**Cerebral Palsy Associations of New York State**

**90 State Street, Suite 929**
**Albany, NY 12207**
**(518) 436-0178 - Fax: (518) 436-8619**

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

**Re: File Code CMS–2261–P**

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. These comments are submitted on behalf of Cerebral Palsy Associations of New York State (CP of NYS) and its Affiliates throughout New York State. CP of NYS was founded over sixty years ago by families of children with cerebral palsy. The mission of CP of NYS is to promote lifelong opportunities for enhanced quality of life for individuals with cerebral palsy and other significant disabilities throughout New York State.

In line with our mission, CP of NYS and its Affiliates provide numerous programs and services that promote lifelong opportunities for enhanced quality of life for children and adults with developmental disabilities. We provide Early Intervention programs for children from birth to three years of age, therapies through our clinics, day services, school programs and other services for individuals with developmental disabilities "and related conditions." Under this proposed regulation, federal Medicaid would no longer provide financial participation for these critically needed services which enhance quality of life, maximize independence and prevent regression so that individuals with developmental disabilities can attain their potential and live their lives to the fullest.

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

The proposed rule would severely harm people with intellectual and other developmental disabilities in two major ways: (1) it eliminates longstanding programs for providing habilitation services to people with developmental disabilities, and (2) it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with intellectual disabilities/mental retardation and related conditions.

**(1) Elimination of FFP for habilitation services provided under the rehabilitative and clinic options** - We believe that this proposed restriction violates 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, P.L. 101-239 (OBRA '89). 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 intellectual disabilities/mental retardation and related conditions. It establishes that the Secretary may not deny federal financial participation (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 provision 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 habilitation services 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 rehabilitative option is not a "custodial" benefit. We agree with the Secretary that state programs operated under the rehabilitative 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 enhances 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 the state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding state plan options. Further, Section 1915(c) waivers and Section 1915(i) are not equivalent to the rehabilitative or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something which is not required for rehabilitative 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 the aspects of section 1915(i), established in the Deficit Reduction Act of 2005, that permit enrollment caps and that do not extend an entitlement to services. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehabilitative 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. 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).

**We strongly recommend that the proposed exclusion of FFP for habilitative services under the clinic and rehabilitative options not be implemented.**

**(2) Discriminatory and arbitrary exclusion from receiving rehabilitative services for people with mental retardation and related conditions** - We strongly oppose the proposed rule's definition of habilitation services [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 rehabilitative option services for people with intellectual and other related disabilities. Additionally, it exposes a false premise that people

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 rehabilitative 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.

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

Sincerely,

*Susan Constantino*

Susan Constantino
President and CEO

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

**Organization :** qsac inc.

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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 :** Ms. Erica Jackson **Date:** 10/12/2007

**Organization :** Barton Child Law & Policy Clinic

**Category :** Academic

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-966-Attach-1.DOC

#966

# Analysis of CMS Proposed Rule CMS 2261-P Regarding Medicaid Rehabilitative Services

This document is submitted on behalf of the Barton Child Law & Policy Clinic, a non-profit research-based student legal clinic affiliated with Emory University School of Law that focuses on advocacy projects that affect how Georgia courts and agencies handle child welfare cases, in response to the proposed rule CMS 2261-P on rehabilitative services published on August 13, 2007.

## Summary

Proposed Rule CMS 2261-P would "amend the definition of Medicaid rehabilitative services in order to provide for important beneficiary protections...and ensure the fiscal integrity of claimed Medicaid expenditures." While certain provisions of the proposed rule are commendable in that they could potentially improve accountability in the delivery of Medicaid rehabilitative services to Georgia's foster care children, the Barton Child Law & Policy Clinic is concerned that the proposed rule could ultimately decrease access to medically necessary rehabilitative health care services for Georgia's vulnerable foster care population.

## Comments

**Implementation would result in significant costs to Georgia**

(a) While the proposed rule will successfully decrease Federal Medicaid spending by approximately $2.2 billion over 5 years, it fails to address the financial burdens it will place on states. Pursuant to Executive Order 13132, before an agency promulgates a rule that will impose "substantial direct compliance costs on States," it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the development process of the rule prior to promulgation. Exec. Order 13132 6(b). If an agency chooses the second option, it must provide a federalism impact summary to the Office of Management and Budget that describes the agency's consultation with the states, summarizes the states' concerns and explains how the agency addressed each concern. Id. at (b)(2). In Proposed Rule 2261-P, CMS contends that these requirements do not apply because no substantial direct compliance costs will be imposed on the states. Proposed Rule Preamble, V.A.

(b) **Concern**: Proposed Rule CMS 2261-P will most likely result in significant costs to Georgia. Georgia will more than likely have to change its billing and prior authorization procedures. Without necessary federal assistance at the front end implementation period of the proposed rule, the increase in administrative and compliance costs will most likely result in a decrease in access to rehabilitative services to Georgia's foster care children.

(c) **Recommendation**: CMS should comply with the requirements of Executive Order 13132 and either provide necessary funds for states to comply with

proposed rule or consult with state officials during the development process of a revised rule prior to promulgation.

**Written rehabilitation plan requirement**

(a) Under Proposed Section 440.130(d)(3), to ensure that rehabilitative services "are designed and coordinated to lead to the goals set forth in state and regulation" and to ensure transparency, covered rehabilitative services must be identified in a written rehabilitation plan that is reasonable and based on the individual's condition and standards of practice.

(b) **Concern**: While the written rehabilitative plan requirement will increase accountability and ensure that progress is being made for beneficiaries, the requirement does not address if and/or how the written plan should be coordinated if the child has other plans, as is the case for foster care children who have written case plans.

(c) **Recommendation**: Include language in Proposed Rule CMS 2261-P that addresses how the written plan should be coordinated if a child has a pre-existing plan.

**Potentially conflicts with EPSDT**

(a) Medicaid's Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) provides that all Medicaid beneficiaries under age 21 must receive all medically necessary services to correct or ameliorate physical or mental illnesses and conditions. 42 U.S.C. § 1396(a)(43), 1396d(r)(5).

(b) **Recommendation:** To ensure that the proposed rule does not conflict with EPSDT the proposed rule should be amended as follows:

   a. In § 441.45(a) clarify that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition

   b. Revise § 441.45(a)(5) to state that even if a state plan does not include certain rehabilitative services, such services must be made available to children when medically necessary to correct or ameliorate a physical or mental illness or condition.

**Maintenance v. Restorative Services**

(a) Proposed Rule CMS 2261-P emphasizes that in order to be reimbursable under Medicaid, rehabilitation services must reduce disability and restore function. § 4440.130(d)(1)(i)(A).

(b) **Concern**: The discussion of services that maintain, rather, than restore, function may lead to denials in medically necessary services. It may appear that progress towards a goal is not being achieved when, in fact, relapse or plateau may be part of the natural progression of recovery. This is often true with physical and mental illnesses and with substance abuse, all of which disproportionably plague children in the foster care system.

(c) **Recommendation**: Add the following language to § 440.130(d)(1)(vi): "Failure to make measurable progress toward a particular goal within the written

rehabilitative plan's specified time period does not necessarily indicate that a rehabilitative service is not needed to help achieve a rehabilitation goal."

**The "intrinsic element" requirement**

(a) Proposed Section § 441.45(b)(1) states that rehabilitation does not include 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...juvenile justice." The term "intrinsic" is not defined, and it will be difficult to understand what CMS meant by the term. This will cause confusion for Georgia and other state Medicaid officials and providers and will most likely result in wrongful denials of coverage for rehabilitative services for foster care children.

(b) **Concern**: By adopting an "intrinsic to" test, the Administration seeks to create by regulation what Congress explicitly rejected when finalizing the 2005 Deficit Reduction Act. Further, the "intrinsic to" test does not adequately consider that children in the foster care system rely heavily on the interaction of various government programs for medical, mental health, developmental, social and educational programs.

(c) **Recommendation:** This section should be deleted in its entirety, because it conflicts with EPSDT requirements, the Medicaid statute, and will most likely result in the denial of coverage for rehabilitative services children in Georgia's foster care system.

## Conclusion

The Barton Child Law & Policy Clinic believes that Proposed Rule CMS 2261-P, as published in the Federal Register on August 13, 2007 will result in the denial of medically necessary rehabilitative services for children in Georgia's foster care system. Medicaid services are commonly available to foster care children through other funding sources. We believe the proposed change would decrease coverage for and access to health services needed by many foster care children in Georgia who need rehabilitative services the most.

Therefore, we respectfully request that CMS retract this proposed rule to the extent that it applies to foster care rehabilitative services provided to or on behalf of children in the foster care system.

CMS-2261-P-967

**Submitter :** Ms. Jay Raycraft **Date:** 10/12/2007

**Organization :** St. Joseph County Intermediate School District

**Category :** Local Government

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-967-Attach-1.DOC

CMS-2261-P-967-Attach-2.DOC

#967

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.**

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

**Submitter :** Mr. Scott Ward, PT, PhD **Date:** 10/12/2007

**Organization :** American Physical Therapy Association

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-969-Attach-1.PDF

#969

APTA
American Physical Therapy Association

October 12, 2007

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2261
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8018

***Submitted via electronic submission***

**RE: Medicaid Program; Coverage for Rehabilitative Services (File Code CMS-2261-P)**

Dear Mr. Weems:

On behalf of the American Physical Therapy Association (APTA), I would like to submit the following comments regarding the "Medicaid Program; Coverage for Rehabilitative Services" proposed rule that was published in the *Federal Register* on August 13, 2007 *(77 FR 45201)*. The APTA is a professional organization representing the interests of over 70,000 physical therapists, physical therapist assistants, and students of physical therapy. This proposed rule contains a number of provisions that would directly affect the delivery and administration of physical therapy services under Medicaid. Therefore, we are very concerned about implementation of the proposed provisions.

Under the Medicaid program, physical therapy falls into the category of "optional benefits" and is currently covered in 37 states. When covered this benefit serves the most vulnerable Medicaid populations—children, individuals with disabilities and frail older adults. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations.

Rehabilitation treatment is a key health service to Medicaid beneficiaries. Therapy services are provided in a variety of settings, including home care, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' education or research centers, hospices and schools. Physical therapy helps a beneficiary achieve his/her best possible function. Specifically, physical therapy services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

In our comments we will address: 1) the definition of "qualified provider", 2) the distinction between habilitative and rehabilitative services, 3) the proposed written rehabilitation plan of care, 4) the need for uniformity in Medicaid documentation requirements 5) limitations on rehabilitative services, and 6) the financial impact of the proposed rulemaking.

**Definition of "Qualified Provider" (42 CFR § 440.130(d)(1)**

In the proposed rule, Center for Medicare & Medicaid Services (CMS) seeks to make significant changes to the definition of "qualified provider". Specifically, the Agency seeks to require: (1) individuals providing rehabilitative services meet the provider qualification requirements applicable to the same when the service is furnished under other benefit categories; (2) provider qualifications be set forth in the Medicaid State Plan; (3) qualifications may include education, work experience, training, credentialing, supervision and licensing; (4) qualifications must be reasonable given the nature of the service provided and population being served; and (5) qualifications must be uniformly applied to ensure free choice of qualified providers.

We applaud CMS for this proposed revision. APTA strongly believes that physical therapy services should only be delivered by qualified and licensed physical therapists. This clarification will substantially improve the quality of care provided to Medicaid beneficiaries. To ensure patient safety and quality of care, it is critical that beneficiaries receive physical therapy services from health care professionals who are trained and educated in the specific discipline.

Physical therapists possess the specialized training to treat children with disabilities and other chronic conditions. APTA is very concerned about the delivery of physical therapy services by non-qualified providers under the Medicaid program. This has become especially apparent in the school-based setting where aides with insufficient training have been utilized to carry out physical therapy plans of care without appropriate supervision by licensed and qualified therapists. This practice is severely diminishing the level of care delivered to children in the school-based setting. As with all patients, these Medicaid beneficiaries deserve only the best quality of care. We strongly believe that access to quality care should not be compromised for any reason.

This proposed revision also bridges the gap between Medicare and Medicaid provider qualification requirements. Under Medicare, therapy services have their own benefit under §1861(P) of the Social Security Act (the Act) and are covered when provided according to the standards and conditions of the benefit described in the Medicare regulations.

At 42 CFR §484.4, "qualified physical therapist" is defined as,

> *"a person who is licensed as a physical therapist by the state in which he or she is practicing and meets one of the following requirements:*
> *• Has graduated from a physical therapy curriculum approved by (1) the American Physical Therapy Association, or by (2) the Committee on Allied Health Education and Accreditation of the American*

#970

October 11, 2007

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

To Whom It May Concern:

Reference: File Code CMS-2261-P

Ozark Guidance Center, Inc., is submitting the follow comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program which was published in the Federal Register on August 13, 2007.

Ozark Guidance Center is a comprehensive, community-based behavioral health care provider with 12 locations in Northwest Arkansas (population 425,000). We serve more 15,000 unduplicated treatment and rehabilitation services recipients annually, have over 500 staff and provide extensive treatment, education, rehabilitation and support services designed to promote, conserve and restore mental health. We are JCAHO accredited, serve children and adults with mental health service needs ranging from common ailments such as depression, ADHD and anxiety disorders to dysfunctional and debilitating disorders such as schizophrenia and bi-polar disorder. Our $33,000,000 annual operations budget includes revenues from fee for service, contracts, grants, insurance, Medicare and Medicaid. Our consumer satisfaction scores are typically positive and our in-house outcomes studies indicate we typically have treatment results comparable to the national benchmarks.

We are taking the unusual step of commenting on the proposed regulations because we are very concerned that portions of them will create access barriers or result in inadequate care for SED children and SPMI adults whom we serve. Though we are concerned about other aspects of the regulations, our comments below focus briefly on seven priority areas of concern.

1. 440.130 (d) (1) (vi). Definition of restorative services. It is important for ill, dysfunctional and disabled children, adolescents and adults to rereach optimal functioning, not just restore lost functioning. Toward these ends, this definition needs to be revised and clarified so children could be helped to and supported in age-appropriate functioning and adults could be helped to and supported in life-stage appropriate functioning. It also needs changing to assure that relapse prevention and the retaining of functional levels achieved by a service recipient are acceptable rehabilitation plan goals. Pre-vocational goals need to be included as part of some rehabilitation plans, so their inclusion needs to be specified as part of the allowed services.

**Submitter :** Mrs. MARIA DIGIOVANNA **Date:** 10/12/2007

**Organization :** MOTHER TO AUTISTIC SON

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

**Issue Areas/Comments**

**Background**

Background

Proposed Medicaid regulations would cut critical services to people with developmental disabilities

These cuts would be devastating to people with developmental disabilities. We must stop them!

A temporary moratoriuma? an order to take no action on these proposalsa? was included in the Childrena?"s Health Insurance legislation. That legislation would have been a temporary solution, but President Bush vetoed it. So now we need to urge the Center for Medicare and Medicaid Services (CMS) to withdraw the proposals.

**GENERAL**

GENERAL

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 :** **Ms. ruelinda griffin** **Date: 10/12/2007**

**Organization :** **qsac**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

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 :** **Barbara Corner** **Date: 10/12/2007**

**Organization :** **Ohio Legal Rights Service**

**Category :** **Attorney/Law Firm**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-974-Attach-1.PDF

#974

# Ohio Legal Rights Service

50 West Broad Street, Suite 1400, Columbus, Ohio 43215-5923
olrs.ohio.gov

Telephone 614-466-7264
TOLL FREE 1-800-282-9181
TTY TOLL FREE 1-800-858-3542
FAX 614-644-1888

October 12, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

**RE: File Code CMS-2261-P**
**Notice of Proposed Rule**
**Medicaid Coverage: Coverage for Rehabilitative Services**

Dear Sir or Madam:

Ohio Legal Rights Service is (OLRS) is an independent state agency and the federally and state designated Protection and Advocacy (P&A) system and Client Assistance Program for people with disabilities in the State of Ohio. The mission of OLRS is to protect and advocate, in partnership with people with disabilities, for their human, civil and legal rights. OLRS submits these comments in response to the Notice of Proposed Rule entitled "Medicaid Program: Coverage for Rehabilitation Services," published in the Federal Register on August 13, 2007.

OLRS opposes the regulations as proposed. Ohioans, and especially Ohio children, have already been significantly impacted by CMS' efforts to limit the scope of services under rehabilitation services. Rehabilitation Services under Medicaid are a critical support for persons with physical and mental disabilities. As recently as 2004 over 70% of individuals receiving these services were receiving them for mental health needs. [1] The proposed regulations are especially harmful to children because they conflict with their entitlement to services under the EPSDT provisions of the Medicaid Act. The full scope of restricting this service is not known since many Ohio children have not even received the EPSDT screenings that may have identified the needs for these services[2]. Ohio children have yet to recover the services to which they are entitled under EPSDT after the takedown of the Medicaid program that provided rehabilitative services to individuals with mental retardation and developmental disabilities for well over a decade.

The proposed definitions seek to establish in rule a narrower scope of services to be covered under the rehabilitation option. This is made clear in the Regulatory Impact Analysis at B which projects a savings of over 2 billion dollars between 2008 and 2012 on rehabilitative services alone with the

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[1] Crowley, Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues*, 7.
[2] Ohio's last reported EPSDT participation ratio was 47%. See http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/downloads/epsdtfy2004.pdf

implementation of these rules. The proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals *attain* or retain capability for independence or self-care . . ." 42 U.S.C. § 1396 (emphasis added).

**Section § 441.45 should be eliminated in its entirety**

The majority of these regulations are added to a section of the Code of Federal Regulations that, for several services, provides limitations to service. These limitations are not supported by statute [See 42 U.S.C. § 441.10]. The only basis for the limitations in these proposed regulations is the Secretary's general authority to issue regulations. There is no other basis in the Act for the restrictions proposed in new section § 441.45 rules. Congress has not restricted FFP for these services, and has specifically not adopted some of the language proposed in these regulations (for example "intrinsic element").

In contrast to these regulations, there have been a variety of ways that Congress, HHS and CMS have provided flexibility to states to serve the individuals in need of services. Some examples include the Money Follows the Person grants, the alternatives available under the DRA, New Freedom Initiatives, and others. Yet for this service, so critical for individuals with disabilities, CMS has promulgated rules that will restrict services and limit a state's flexibility to provide needed services for persons with disabilities.

**Conflict with EPSDT**

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a State's plan. 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5). OLRS is representing a proposed class of children who have not received the treatment to which they are entitled under EPSDT.

In Ohio, children have already been restricted from receiving services under EPSDT that were considered habilitative in nature. This has been done in spite of the fact that therapy services such as physical therapy, occupational therapy, and speech therapy can be provided outside of the "rehabilitation" benefit. For example, physical therapy and related services are specifically listed in 42 U.S.C. § 1396d(a)(11) and medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice is covered in 42 U.S.C. §1396d(a)(6). Ohio's Medicaid agency has informed OLRS that the basis for this restriction is that CMS has applied this restriction beyond the rehabilitation services category of service to other covered state plan services both in Ohio and through audits of programs in other states.. These proposed regulations fail to clarify that the restrictions on habilitation, and restorative services, cannot be applied to deny needed services to children.

There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements. OLRS suggests an overall restatement of the EPSDT requirement in these regulations. At a minimum we suggest the following changes:

- Insert a new paragraph in § 441.45(a) clearly stating that states must ensure that children receive

all federally-covered Medicaid rehabilitation services when necessary to correct or ameliorate a physical or mental illness or condition.

- Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct or ameliorate a physical or mental illness or condition.
- Amend § 441.45(b)(4), to refer to the EPSDT requirement and instruct states to comply with it.

**Proposed § 440.130(d)(1)(v)-(vii), (2) - Maintenance v. Restorative services**

The proposed regulations create as much confusion as they seek to dispel. When confusion exists denials of services that should be covered are likely to occur. An example of the confusion created is the discussion of services that maintain, rather than restore, function. Throughout the preamble and proposed regulations, CMS emphasizes that rehabilitation services must reduce disability and restore function in order to be reimbursable under Medicaid. S*ee, e.g.,* 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A)). The discussion of a written rehabilitation plan in the preamble emphasizes the "ultimate goal" of reduction of medical care. *Id.* at 45203. Moreover, the preamble states that "[i]t is important to note that this benefit is not a custodial care benefit but should result in a change in status." *Id.* At the same time, the proposed regulations acknowledge that maintaining a functional level may be necessary to achieve a rehabilitation goal. *Id.* at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi)). But, the discussion of the written plan in the preamble states that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . ." *Id.* at 45204 (Preamble, II.C).

This emphasis on change in status and on achievement of specific goals is likely to result in states denying coverage for medically necessary rehabilitation services, because such services may not lead to immediate results. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse. The Medicaid statute emphasizes the importance of rehabilitation services to *attain* independence and health. 42 U.S.C. §1396. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations. This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is a greater likelihood that the actual service needed will be covered.

Your agency has a long-standing policy of recognizing that maintenance therapy may be covered. *See, e.g.,* Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, *Medicaid State Bulletin,* 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991). Thus, the overly restrictive definition and interpretation in this area conflicts with longstanding agency policy.

OLRS recommends the following changes:

- Delete the definition of restorative services. It creates unnecessary confusion.
- Add the following language to proposed regulation § 440.130(d)(1)(vi): "Failure to make

measurable progress toward a particular goal within a certain time period does not necessarily indicate that a service is not necessary to help achieve a rehabilitation goal."

In the alternative:

- Add the recommended language to proposed 440.130(d)(1)(vi) listed above; **AND**
- Add a new subsection (c) to § 441.45, with the following language: "If a service cannot be covered as a rehabilitative service, states shall determine whether the service can be covered under another category of Medicaid services." Also, add discussion to Section II.C. of the preamble that maintenance services could qualify for coverage under another category of services and give examples of other categories.
- Delete the language at 72 Fed. Reg. at 45204, Section II.C of the preamble stating that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . ."

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

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option. *Dear State Medicaid Director,* Peer Support Services – SMDL #07-011 (August 15, 2007). As CMS acknowledges in the letter, this is an important service for individuals with mental illness and substance abuse services. Given its importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in the regulations.

OLRS recommends that if the definition of "restorative services" is not eliminated as recommended, Section 440.130(d)(1)(vi), which describes those services should be amended and language added stating that peer guidance is a covered rehabilitation service.

**Proposed § 440.130(d)4) Impairments to be addressed**

OLRS strongly requests that§ 440.130(d)4) be struck from the regulations. For the first time the regulations include "impairments to be addressed" and identify individuals with physical impairments, mental health impairments, and/or substance-related disorder treatment needs. This section will be used to deny needed services to otherwise eligible recipients and is beyond the authority of the agency. As noted above, the statutory definition of "Rehabilitation services" encompasses <u>any</u> services that "help such families and individuals attain or retain capability for independence or self-care", 42 U.S.C. 1396(b) (emphasis added). There is no authority for the limitations proposed in this subsection. Individuals with cognitive impairments [including mental retardation, stroke, and brain injury] could be denied services under this section of the proposed regulations. There is no rational basis for limiting rehabilitation services to address only the individual's physical or mental health impairments or substance disorder needs and thus this subsection could violate the Equal Protection clause of the U.S. Constitution, as well as the comparability requirements of Medicaid.

The proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. While the proposed regulations acknowledge that physical impairments and mental health and/or substance related disorders can be appropriately treated with rehabilitation services [*See* 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2)], there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered

services for a population that already faces significant barriers to care.

**Proposed § 440.130(d)(5): Settings for service provision**

The preamble indicates that states "have the authority to determine in which settings a particular service may be provided." 72 Fed. Reg. at 45205 (Preamble, II.E). This provision conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13) and the fundamental right under Medicaid to the free choice of provider. The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided. Medicaid recipients are also entitled to free choice of provider, and states should not be given the latitude to require services to be provided only in an office or facility setting.

OLRS recommends the following:

- Clarify that rehabilitation services are covered in a facility, a home, or other setting.
- Add *as examples* of other settings those listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to § 440.130(d).

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

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid. 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1)). The term "intrinsic element" is not defined. During consideration of the Deficit Reduction Act of 2005 (Pub. L. 109-171), Congress considered but rejected an "intrinsic element" test for rehabilitation services. See Jeff Crowley, Kaiser Commission on Medicaid and the Uninsured, Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues, 1 (August 2007). This is indicative that the "intrinsic element" test conflicts with Congressional intent with regard to coverage of rehabilitation services.

The "intrinsic element" requirement under the proposed regulations is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. These children will all be eligible for EPSDT. Services under EPSDT should be covered if they are necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation touches on this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity. This will cause confusion for state Medicaid officials and providers and will cause erroneous denials of coverage for services.

This requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included under the IDEA. 72 Fed. Reg. at 45202. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services. 42 U.S.C. § 1396b(c). Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . ." 42 U.S.C. § 1396a(a)(25)(A). Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from

the liable third party. 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007). Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

OLRS recommends that § 441.45(b) should be omitted, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

- Omit the intrinsic element test.
- Amend Section 441.45(b)(1)(iv)to clarify that Medicaid coverage should not be denied merely because a service is provided in an individualized education plan.
- The responsibilities for states regarding third party payers, and the third party payers' own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

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

The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function. 42 C.F.R. § 441.45(b)(2), *see also* 72 Fed. Reg. at 45205 (Preamble,II.F.2). The discussion and regulation regarding habilitation is especially disconcerting to OLRS, especially given the experience in Ohio. This restriction severely impacts children and their rights to rehabilitation services under EPSDT because they are in the process of learning and attaining new skills. This argument has also been used to narrow not only rehabilitation services but also services in other state plan categories. For example, physical therapy, occupational therapy and speech therapy are specifically covered under 42 C.F.R. § 440.110. Again, the Medicaid statute emphasizes the importance of rehabilitation services to *attain* independence and health. 42 U.S.C. §1396.

The regulations and discussion appear to suggest that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate. Persons with mental retardation may lose functional abilities that are very appropriate for "rehabilitation". Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy. 42 C.F.R. § 435.1010 (2007). These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services, even under CMS' narrower restrictions.

Finally, we commend CMS for clarifying that states may cover habilitation services under other service authorities, but suggest that interested persons be informed of this in the regulations.

OLRS recommends:

- Add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health or other rehabilitation services.
- Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy) and medical or other remedial care provided by licensed practitioners, defined at 42

C.F.R. § 440.60."

- Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.
- Clarify children are eligible to receive rehabilitation services that correct or ameliorate defects and physical and mental illnesses and conditions.

**Proposed § 441.45(b)(4)**

Among the excluded services listed are "services . . . provided to inmates living *in the secure custody* of law enforcement and residing in a public institution." It is not clear whether this is intended to be a narrower category of individuals than those for whom FFP is not available because they are living in a public institution, as defined by 42 C.F.R. § 435.1010 (2007). If so, this would be undesirable. If not, it would be unnecessary and confusing.

OLRS recommends: omit the phrase "in the secure custody of law enforcement."

**Conclusion:**

Rehabilitation services under Medicaid are a critical support for individuals with disabilities. They are an important component of services that Medicaid eligible children may need to "correct or ameliorate" a physical or mental illness or condition. These regulations will have a negative impact on persons with disabilities, because the regulations significantly restrict the service and the state's flexibility to meet the needs of its citizens with disabilities.

The proposed regulations inhibit accomplishment of statutory purpose of Medicaid coverage of rehabilitation services - "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals *attain* or retain capability for independence or self-care . . ." 42 U.S.C. § 1396 (emphasis added). OLRS urges CMS to withdraw the proposed regulations and work with affected stakeholder to address current policy concerns. Like other disability advocacy organizations we are concerned by CMS' 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 option.

We appreciate your thoughtful consideration of these comments.

Sincerely,

/s/

Julianne Johnson
Disability Rights Advocate

/s/

Barbara S. Corner
Attorney at Law

**Submitter :** Mrs. Peggy Defazio **Date:** 10/12/2007

**Organization :** Republic R-III Schools

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

To think that to stop full funding of services provided to children in schools will benefit the community at large is ludicrous. The majority of children receiving services at school would NEVER receive these services if their families had to be responsible. Most of our families cannot transport their children to another agency due to a lack of time off from work, lack of transportation services, or lack of money to pay for transportation. Providing services in the school setting is the most cost efficient and effective way to serve children; this is where they spend the majority of their waking moments. Let's serve them in their 'natural' environment as much as we can.

Please stop and consider the tremendous impact that discontinuing school based services will have on communities all over the country. These children will grow up angry and frustrated because their needs have never been addressed. And, what happens with angry and frustrated children ? They grow up to be angry and frustrated adolescents and adults. And, who commits the majority of our crimes ? Angry and frustrated adolescents and adults. If you decide to take away funding for school based services, you might as well give it to the penal system because we will be needing more and more prisons in the very near future.

Your idea to save money this way will FAIL -- that's been proven over and over again. You cannot ignore our children's needs and expect our communities to bc healthy and safe.

**Submitter :** Mr. Nick Chirco **Date:** 10/12/2007

**Organization :** Block Institute

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-976-Attach-1.DOC

#976



NYSACRA

NEW YORK STATE ASSOCIATION OF COMMUNITY & RESIDENTIAL AGENCIES



October 11, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007. These comments are submitted on behalf of the New York State Association of Community and Residential Agencies (NYSACRA). NYSACRA is a catalyst and leading advocate for people who have developmental disabilities and organizations that support them. NYSACRA represents the collective voice of its almost 200 provider members in promoting the full participation of persons with developmental disabilities in the communities of New York State. We are commenting on the impact of the proposed rule on people with intellectual and other developmental disabilities and access to habilitation services.

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

Day habilitation (day hab) offers people with developmental disabilities services and supports to help them grow as people first, with interests, values and goals. The day hab provides the opportunity for someone to spend the day engaged in productive, meaningful activities that relate to the individual. Picture a young person with a developmental disability, 21 years old, newly graduated from high school, and seeking some help with the next steps along the path to adulthood. A day hab can provide some structure in terms of schedule and place, as a starting point; the

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appropriately furnished under the rehabilitative 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.

4. Section (V) (Regulatory Impact Analysis) of the Proposed Regulation, beginning on page 45208 of the Federal Register, claims "this major rule would not have a direct impact on providers of rehabilitative services." Such a statement is a misrepresentation.

A reduction in federal support for rehabilitation services would force States to make a choice between continuing service provision at the same level at a greater cost in state/local dollars; decreasing the amount and quality of essential services individuals receive; reducing eligibility, benefits, or payments to providers; cutting back on other state programs and using those funds to replace federal Medicaid dollars lost; or a combination of all of the above. Clearly this impacts providers.

5. This section (V) also claims that "since this rule would not mandate spending in any 1 year of $120 million or more, the requirements of the UMRA (Unfunded Mandates Reform Act) are not applicable." For the same reasons stated above, this claim is false. States and local governmental units would most certainly be severely financially impacted by the implementation of this rule, and by CMS' own admission a few paragraphs below this claim, in the accompanying chart, it shows that the rule would impact $180 million in FY 2008 alone.

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

Sincerely,

Ann M. Hardiman
Executive Director
NYSACRA

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

**Organization :** Manhattan Mothers & Others

**Category :** Consumer Group

**Issue Areas/Comments**

**GENERAL**

GENERAL

As an evocate for and a family member of a person with developmental disabilitites I urge you to withdraw the proposed regulatioons regarding havilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disaibilities and related cconditions to iimprove or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people witth dd from receiving these essential services.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

Proposed Medicaid regulations would cut critical servicves to people with developmental disabilities including: Day treatment for adults, Occupational, physical and speech therapy and psychological and rehabilitation counseling in Article 16 and 28 clinics. Cutting these services would also make it difficult for providers to afford to provide high cost medical and dentl services and consumers to receive them.

**Submitter :** Dr. Alisa Minkin **Date:** 10/12/2007

**Organization :** Dr. Alisa Minkin

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

As a pediatrician and mother of a teen with developmental disabilities, i implore you to adequately fund rehabilitation services. Please do not cut these funds!
Alisa Minkin M.D.

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

**Organization :** Annie Mandel

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

**Submitter :** Mrs. Betsy Greer **Date:** 10/12/2007

**Organization :** NAMI

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

I join NAMI-National in expressing concern about the effect that proposed regulatons might have on Medicaid State Option rehabilitation services. For many of our family members, rehabilitative services -- either through psychosocial programs or assertive communit treatment teams -- are critical for their community-basede services. As an advocate for 20-plus years, I have seen how these services have worked, have positive outcomes and have enabled some critically ill individuals to achieve independence in their community. I am especially wary of any regulatory change that would inhibit staff outreach to encourage individuals to attend supportive programs or to prevent decompensation. Any cutback at the federal level is a green light to states to follow, and Medicaid funding for rehabilitation services is a major way of state support for those with mental illness. I concur with the comments made by NAMI-National. I ask for their serious consideration. Thank you.

**Submitter :** **Ms. Ellen Witman** **Date: 10/12/2007**

**Organization :** **NACBHDD**

**Category :** **Other Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-981-Attach-1.DOC

#981


October 12, 2007

Kerry Weems
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

**Re: File Code CMS-2261-P. Comments on Proposed Rule Medicaid Program: *Coverage for Rehabilitative Services,* 72 *FR* 45201**

Dear Mr. Weems,

The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) urges the Centers for Medicare and Medicaid Services (CMS) to withdraw its proposed rule CMS-2261-P published on August 13, 2007 in the *Federal Register*. The proposed rule would severely restrict the ability of states and counties to provide essential services to vulnerable populations in the community.

NACBHDD members are county sponsored authorities in mental health, substance abuse and developmental disabilities. Our members depend upon Medicaid to assist them in serving individuals in their communities. County and city governments and other local authorities are charged with assuring that essential mental health, developmental disability, and substance abuse services are provided to vulnerable and often disabled residents. County/city governments and local authorities contribute over $20 billion to behavioral health and developmental disability services in both Medicaid match and non-Medicaid services. County/city governments and other local authorities in 22 states either directly or indirectly provide a range of behavioral health services (e.g. mental health, addictions, mental retardation and developmental disability services) to 70% of the U.S. population. In 18 states, county-sponsored behavioral health authorities ensure delivery of substance abuse services to 60% of the US population. County-sponsored

local authorities are also responsible in 15 states for the delivery of developmental disability services that reach over 50% of the US population.

Given these service responsibilities and local financial contributions to the safety net, any reduction in federal support will shift costs to states and localities and place further stress on systems of care.

Vulnerable populations, including individuals with severe and persistent mental illness and addictions, often rely on local authorities for their health care. The proposed rule will weaken this safety net through a variety of mechanisms. A Kaiser Commission on Medicaid and the Uninsured report includes 2004 data which indicates that 73% of Medicaid beneficiaries receiving rehab services were individuals with mental illness. Stressing the importance of this essential service that affords individuals a right to live in communities and receive needed care. Elimination of effective community based rehabilitation services could lead to increased Medicaid spending on less effective or appropriate services.

A core purpose of the Medicaid law is to provide rehabilitation 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."

Any action taken regarding rehabilitation services should foster this core goal. We believe the issuance of this proposed rule misses that mark and places new barriers for Medicaid beneficiaries to receive medically necessary rehabilitation services.

Further, NACBHDD questions CMS authority to issue the revised rule. In recent years, Congress rejected changes to the rehab option and explicitly discarded certain changes in the Notice of Proposed Rule Making (i.e. intrinsic element test) when enacting the Deficit Reduction Act of 2005 (DRA).

## PROVISIONS OF THE PROPOSED RULE

### Section 440.130 Diagnostic, screening, preventive, and rehabilitative services.

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

**Comments**: NACBHDD generally supports the intention of the development of a rehabilitation plan in an effort to identify goals and track outcomes. However, individuals with chronic mental illness often experience shifts in their recovery and treatment requiring changes in services. For

instance, our members identify Assertive Community Treatment (ACT) is a cost effective and beneficial means of continually supporting individuals with severe mental illness within community settings.

**Recommendation**: NACBHDD urges CMS to allow for increased flexibility in the development of rehabilitation plans that will enable crisis and stabilization planning. CMS should also allow authorities and providers to anticipate relapse and take into account provisions that will allow the team to respond should crisis arise.

Section 440.130(viii)(3) Written Rehabilitation Plan

NACBHDD commends CMS' identification of person centered planning in the development of a written rehabilitation plan and are encouraged by the use of a planning team to work with the active participation of the individual to develop goals. Further, the rehabilitation plan should be included as part of an overall treatment plan, not separate from another treatment plan used to assist the individual. It is not clear that multiple service plans facilitate coordination or accountability and furthermore become burdensome to providers and consumers.

**Recommendation:** CMS should allow rehabilitation goals to be included in a single treatment plan that incorporates a single planning team. In the review of the plan, should goals have not been achieved, treatments should be modified so as to continue care management and support an individual's recovery.

Section 440.130(d)(1)(v): Restorative Services

**Comments**: CMS defines restorative services as those services provided to an individual to regain a level of functioning that has been lost. The definition also stipulates that appropriate rehabilitation services are those designed to maintain a current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While, cited in the proposed rule, the services are not intended to be custodial; rehabilitation services are at times essential to retain a functional level. Failure to provide these services would result in an individual's deterioration requiring more intensive and likely costly services.

**Recommendation**: CMS should allow services to be furnished to maintain functioning to include, as an acceptable goal of a rehabilitation plan, the retaining of functional level for individuals who can be expected to otherwise deteriorate.

Section 441.45(a)(5)(iii) Payment Methodology

Counties weave together various funding streams to ensure wide arrays of services are accessible in communities. States, localities and providers need greater flexibility to use case rate, daily rates, or other similar arrangements. States and counties should be afforded this flexibility to use a payment method that allows access to effective, evidence based practices. These entities are

situated to ensure appropriate use of funds for treatment and services are available to individuals in communities.

Further, CMS policy allows managed care arrangements to use bundled payment methodologies. This should be consistent with review of state rehabilitation plan amendments.

**Recommendation**: CMS should engage in a collaborative dialogue with states and localities to maximize payment flexibility that support best practices and the most successful outcomes, while taking into consideration federal obligations to ensure transparency and accountability.

Section 441.45 (b) Intrinsic element standard

**Comments:** The NPRM prohibits federal financial participation when the "services are furnished through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice or public guardianship." As noted previously, Congress has rejected this provision. We believe that CMS incorrectly asserts that other programs are shifting costs to Medicaid and no guidance has been given on how to determine whether a service is an intrinsic element of another program. This lack of clarity creates an ambiguous criterion.

County and local programs use many mechanisms to fund an array of services and made available to both Medicaid and non-Medicaid individuals. Denying coverage to Medicaid eligible individuals will further stress local safety net systems. Appropriate third party liability requirements shield Medicaid's financial integrity while protecting access to services. An intrinsic element test would deny Medicaid coverage whether or not another program is available to pay for services.

Cost shifting needed care to already stressed local programs will likely result in individuals not receiving essential treatment. The costs will not only be shifted other State and/or local program, but also to other Medicaid eligible services. The cost to human lives and other expensive as well as less effective methods of care, such as inpatient hospitalization, emergency department use and jails will result.

**Recommendation**: NACBHDD strongly urges CMS to eliminate this provision. Congress has made a statement by previously rejecting consideration of this provision.

Section 441.45(b)(2) Habilitation Services

This section specifies that FFP will not be available for habilitation services provided under the rehab and clinic options. This is in opposition to the intent of Congress when it enacted section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239. We believe Congress clearly intended to protect access to day habilitation programs for people with mental retardation

and related conditions. Further, it appears the prohibition on habilitation services under paragraphs (9) and (13) of section 1905 of the Social Security Act exceeds the regulatory authority granted by Congress.

Though the preamble to the proposed rule states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitation 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)"; these options do not appear to be more appropriate. In particular, waivers are optional alternatives to core Medicaid programs that function under state plans.

Further, section 1915(c) waivers and section 1915(i) option are not equivalent to the rehab or clinic options. 1915(c) waivers require a nursing facility level of care, not required for rehab or clinic option services. In addition, section 1915(c) and 1915(i) coverage have different financial eligibility standards. We believe the addition of section 1915(i) was not intended to supplant the rehab and clinic services option, but provided additional flexibility.

**Recommendation:** NACBHDD believes shifting to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable. We stress that this provision not be implemented.

We appreciate the opportunity to comment on the proposed rule. If you have any questions, please feel free to contact our Executive Director, Ellen Witman at ewitman@nacbhd.org or 202-661-8816.

Sincerely,

Leon Evans

Leon Evans, Chair
The National Association of County Behavioral Health
and Developmental Disability Directors

Ellen G. Witman

Ellen Witman, Executive Director
National Association of County Behavioral Health
and Developmental Disability Directors

**Submitter :** Mr. Jeff Carr **Date:** 10/12/2007

**Organization :** Special Education District of McHenry County

**Category :** Academic

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-982-Attach-1.DOC

#982

October 12, 2007

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

Dear Sir(s) or Madam(s):

The Council 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.

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Jeff Carr
Associate Superintendent, Business Services
Special Education District of McHenry County