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

To Whom It May Concern:

I am writing to **oppose** regulations **CMS-2261-P**, which would change the definition of rehabilitation services. This would eliminate day habilitation services for our 33 year old severely handicapped daughter who lives at home with us. This service, provided by Rensselaer County NYARC, is the difference between her continuing to live with us or having to live in an institution, as we are senior citizens. Day habilitation is an enormous help to her and her well being. It is the only, and much needed, service we receive to enable us to continue to have her live at home with us.

Our pro-life President and administration certainly cannot allow this regulation change to take place to severely disabled people and their families.

I thank you for correcting this.

Sincerely,

Sarah R. Dunbar

Sarah R. Dunbar
1 Golden Eagle Court
Troy, NY 12180

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October 2, 2007

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

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

Dear Sir or Madam:

I have been working in the field of mental health since 1975 and I thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. As I see it, the rules are making more paper, more administrative work and take the focus off those individual's who need services to support their recovery process.

As a result, we are very troubled by the estimate in the proposed regulation that these rules would save the federal government 2.2 billion dollars, in fact, this would not be a savings. It would make it harder for people to get what they need, more barriers, more red tape and rules to fit into and less services to those in need. I have seen it occur over and over again over the past decades, "saving money" is not what happens. Increasing barriers and difficulty getting what is needed to encourage recovery is what results.

We appreciate the emphasis on recovery in the rules. However, we have a few areas of deep concern where we hope the agency will reconsider its rules. We would like to see services provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan:
The proposed regulations require that a written rehabilitation plan set out the services that will be provided. The plan is to be written with the involvement of the individual and the family. We very much applaud the agency for including the person and the family in the planning and for encouraging person centered planning.

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

Section 440.130(d)(1) Rehabilitation and Restorative Services:
Under the proposed regulations and the preamble, rehabilitative goals have to be targeted at progress. They can't be used to maintain stability unless that is linked to another goal

where they are still working on improvement. But mental illness does not work in a straight line upward. For many of us and our loved ones, the path to recovery is not straight up or down. It is often a process with periods of progress and periods where symptoms may have to be closely managed to prevent deterioration. The changing course of serious mental illness must be factored into the proposed regulations governing rehabilitative services.

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

Section 441.45(b) Exclusion of services, including those that are an "intrinsic element" of other programs:
Many adults and children with mental illness and their families are also part of other service systems– including criminal justice, juvenile justice, education, housing, and child welfare. In my community, people with mental illness are overrepresented in these systems and we face major challenges to make sure that people with mental illness do not fall through the cracks.

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

Section 441.45(b) Exclusions for therapeutic foster care and classroom aides:
The proposed regulations say that the federal government will not provide resources for recess aides or classroom aides. We believe that the rule also needs to clearly inform schools that Medicaid will pay for behavior aides and other mental health providers who are giving services to a particular child. Children with mental illnesses and their families have been fighting a long battle to get mental heath services provided to children in schools and this regulation should support that effort by clearly encouraging school based mental health services.

Recommendation:
Amend the proposed rule to allow therapeutic foster care and let states combine the services in one rate if that works best for them. The federal government can meet its goals by making sure that the rate only includes rehabilitative services. Amend the regulation to say that the exclusion does not include behavior aides or other related service providers who are providing services to a particular child.

Section 441.45(b)(2) Exclusion for Mental Retardation and other conditions and Habilitation Services:
People are not a diagnosis. The proposed regulations prohibit people with mental retardation or related conditions, like cerebral palsy, to get rehabilitation services. As advocates for one group – people with mental illness – we do not support the exclusion of any other group on the basis of their disability.

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

Conclusion:

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

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

We ask that you revise these regulations to make it clear that the federal government encourages any state system to do all they can to provide effective treatments to people with serious mental illnesses. We are all non-profit agencies doing the best we can with ever changing administrative rules and guidelines that have nothing to do with recovery and serving individual's in need. Please stop the nonsense and let us do what we do best.

Thank you, Cynthia C. McKeough

Cynthia C. McKeough
Quality Improvement at Development Centers, Inc.
17421 Telegraph Rd
Detroit, MI 48219

248 - 770 - 6782

CMS-2261-P

Dear DHHS Staff:

I am writing to oppose proposed rule changes that would eliminate Medicaid funding for habilitative services for persons with mental retardation and other related developmental conditions. In the state of North Carolina there are inadequate resources available to meet the needs of persons with developmental disabilities. Elimination of this funding source will make access to adequate services more difficult for all persons with developmental disabilities.

I am the mother of Diamond who has Cerebral palsy, hearing disability, and a disabled leg, also limited hand motor skills. My daughter receives case management services and schooling at a Developmental Center also my daughter has Medicaid funding which helps pay for speech therapy, occupational therapy, and physical therapy services. With the help of these therapies, my daughter is making progress with learning to walk and learning to use sign language to talk. We also have found our case manager to be very helpful with being sure our daughter gets the services she needs. If you eliminate Medicaid funding for habilitative services to persons with developmental

CENTERS FOR MEDICAID AND MEDICARE SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTENTION:CMS-2261-P
PO BOX 8018
BALTIMORE MD 21244-8018

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DEAR DHHS STAFF
I AM WRITING TO OPPOSE PROPOSED RULE CHANGES THAT WOULD ELIMINATE MEDICAID FUNDING FOR HABILITATIVE SERVICES FOR PERSONS WITH MENTAL RETARDATION AND OTHER RELATED DEVELOPMENTAL CONDITIONS. IN THE STATE ON NORTH CAROLINA THERE ARE INADEQUATE RESOURCES AVAILABLE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES. ELIMINATION OF THIS FUNDING SOURCEWILL MAKE ACCESS TO ADEQUATE MORE DIFFICULT FOR ALL PERSONSWITH DEVELOPMENTAL DISABILITIES.

I AM THE PARENT OF A CHILD WHO HAS CEREBRAL PALSYWITH SEVERAL DISABILITIES. MY DAUGHTER RECEIVES CASE MANAGEMENT SERVICES AND SCHOOLING AT A DEVELOPMENTAL CENTER. MY FAMILY DOES NOT RECEIVE ANY MEDICAID FUNDED SERVICES, HOWEVER, I AM CONCERED THAT THERE WILL NOT BE ENOUGH FUNDS AVAILABLE FOR CASE MANAGEMENT TO CONTINUE WITH SERVICES FOR MY CHILD. I AM A SINGLE MOM AND NEED THIS SERVICE VERY BADLY. IF YOU ELIMINATE MEDICAID FUNDING FOR HABILITATIVE SERVICES TO PERSONSWITH DEVELOPMENTALDISABILITIES, CHILDREN LIKE MY SON WILL NOT BE ABLE TO GET THE SERVICES SHE SO IS IN NEED OF.

SINCERELY;
HOPE AUSTIN SINGLE MOM OF THEREE, ONE WITH A DISABILITY.

2917 DIXON HOWE RD
GASTONA NC 28056
704-913-1679
704-867-6955

Hope Austin

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Richard Ingle
105 Beech LN
Kings Mountain
28086

Date: 9-24-07

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

To Whom It May Concern:

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

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens. Some of the rule changes seem to specifically target people living with mental illness and attempt to reduce their access to needed services, these service include but are not limited to: peer and social support, prevocational activities, experiential programming that focuses on building confidence and preventing relapse. These supports are both preventative and helps individuals to maintain their mental health. Some of these services have been working effectively and supported by CMS approved Medicaid funding for more than ten years.

Overburdening community mental health programs with bureaucratic and administrative processes without additional or alternative funding causes reduction in direct services and develops inefficencies in an already crippled mental health system. This system change results in a substantial services cut for people who are underserved and at risk of institutionalization in our prison system..

A NAMI 2007 publication states that "Medicaid has increasingly funded mental health services , and its share of the mental health funding by states has increased substantially over the years to become the largest source of public mental health spending. In addition the Urban Institute analyzed 2004 Medicaid data and concluded that 73% of Medicaid beneficiaries receiving rehabilitative services had mental health treatment needs, and these beneficiaries are responsible for 79% of rehabilitation services spending. the dramatic shift of mental health funding to Medicaid has diminished the flexibility of providing needed community services to people with severe mental illnesses. For these reasons, these regulations will have a critical effect on individuals with serious mental illness."

We are against the narrow redefinition of the term "rehabilitative services". Narrowing this definition will develop a gap of service provision to many of our valuable citizens. Many people will not fit functional definitions to qualify for Medicaid services; others who are in the process of recovery will be excluded from community supports because they are "functioning at normal levels". These gaps will result in people regressing to lower levels of functioning before needed services can be obtained. Mental health services will ultimately become more expensive and be less effective.

The concept of "person centered" services and rehabilitation plans cannot be effectively manged by using Medicaid as the major source of funding. Other funding streams are needed that can provide the innovation and flexibility to allow people to recovery and maintain this recovery. Funding for services such as education, employment, housing and pre-vocational services are critical to provide "person centered care". Many of the changes being proposed will reduce the number of people who will be able to access any type of mental health services.

The proposed rule changes should not be implemented until the State and Local government has a plan to actively provide the necessary recovery focused services that would no longer be "covered" by Medicaid. People with mental illnesses should not have to bear the burden of Medicaid funding cuts. Thousands of people with mental illnesses depend on services that are provided by ICCD Certified Clubhouses. These programs have demonstrated a rich history of service provision that resulted in long term reduction of services for people with mental illnesses. The strength of the ICCD

Clubhouse is that its services are always available to participants and can easily reduce the impact and cost of a persons relapse.. It is a mistake to re-organize funding for long approved services in an effort to reduce short term spending. A poorly developed strategy will result unnecessary and more costly and emergency spending in the long run. More importantly though it will cost the lives and futures of those insensitively denied the comparatively inexpensive services they currently have.

Sincerely, Richard L. Dyck

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Jane Goodridge
3929 Nottaway Road
Durham, NC 27707
919-403-9646
Cell – 919-210-4355
GGOODRIDGE@nc.rr.com

October 1, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

I am a board member of Threshold, a Clubhouse for severely mentally ill adults in Durham, NC. Threshold has been in business as a Non-Profit Organization for over 20 years, relying on Medicaid and state funding to provide needed services in our community. As a citizen of Durham, as well as a mother whose son died of a mental illness eight years ago, I am deeply concerned about the welfare of the mentally ill who are so vulnerable and so unable to plead for themselves. Furthermore, their condition has no glamour – no one to tout the need to care for HIV-AIDS children or raise awareness about breast cancer. Society, as a whole, just wishes mentally ill people would disappear – which certainly seems to be reflected in the Proposed Rule to amend the definition of Medicaid Rehabilitative Services as published in the Federal Register, August 13, 2007 (Volume 72, Number 155).

It is clear from the published "Summary" of this proposed Rule, that its intent is to severely restrict rehabilitative services to Medicaid eligible individuals with long term Mental Illness, through increased documentation requirements for already overburdened Providers and through extremely restrictive service definitions. Threshold Members rely on Medicaid as their only health insurance and are threatened by the degree to which their coverage could be reduced by the proposed Rule change.

Threshold is the life-blood for its members. It is what brings focus to lives that are scary, fragmented, and very, very difficult. It also has been proved to keep them out of the hospital. To remove this support from them will only increase Medicaid costs in the long run with more expensive psychiatric hospitalizations. Some members, with Threshold's support, have been able to hold jobs, be more involved with their families, and essentially have some sort of normal life. Again, without Threshold, that is likely to disappear.

Please do not enact this Proposed Rule. Please think deeply about the mentally ill and how BEST we can help them. Not throw them to the wolves and hope they disappear. They won't.

Sincerely,

Jane Goodridge

Jane Goodridge

cc:
Mike Leavitt, U. S. Secretary of the Department of Human Services
Mike Easley, North Carolina Governor
U.S. Senator Richard Burr
U.S. Senator Elizabeth Dole
Senator Nesbitt, Co-Chair of the N. C. Legislative Oversight Committee
Rep. Verla Insko, Co-Chair of the N. C. Legislative Oversight Committee
Dempsey Benton, N.C, Secretary of the Department of Human Services
Mike Mosley, Director of the N.C. Division of Mental Health
Leza Wainwright, Deputy Director of the N.C. Division of Mental Health
William Lawrence, Jr., Director of the N.C. Division of Medical Assistance
Tara Larson, N.C. Division of Medical Assistance
Jo Perkins, N.C. Division of Vocational Rehabilitation
Carl Britton-Watkins, Chair of the N.C. Consumer Family Advisory Committee
Debra Dihoff, Director, NC-Alliance for the Mentally Ill
John Tote, Director, Mental Health Association of NC
Yvonne Copeland, NC Council of Community Programs
Tisha Gamboa, Director, N.C. Mental Health Consumer Organization
Joel Corcoran, Director, International Center for Clubhouse Development

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October 1, 2007

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

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

Dear Sir or Madam,

I am writing to state my concern that the CMS proposed rules on Medicaid Rehabilitation Services will be very detrimental to individuals with mental illnesses. I am particularly worried that these rules will hurt the ability of states to fund such services as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. Research confirms that such rehabilitation services help people with serious mental illness to achieve better outcomes such as: having stable housing and employment, undergoing less hospitalization, and having less involvement with the criminal justice system.

Even now these services are hard to come by. It is certain that things will become much worse if the proposed rules are adopted, eliminating 2.2 billion dollars from the already under-resourced service system.

Again I urge you to forgo the implementation of your currently Proposed Regulations on Coverage for Rehabilitative Services. Thank you for considering my viewpoint.

Sincerely,

Gerald M. Rubin

Gerald M. Rubin

NAMI
MINNESOTA
National Alliance on Mental Illness

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October 1, 2007

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

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

Dear Sir or Madam:

The National Alliance on Mental Illness of Minnesota (NAMI-MN) appreciates the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program. With 22 local affiliates, NAMI Minnesota is the state's largest grassroots organization representing children and adults with mental illness and their families. Many of our members have personally experienced the effectiveness of rehabilitation services and have been able to live, work and participate in their communities as a direct result of these services.

Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better outcomes, such as stable housing and employment. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses and their families.

NAMI Minnesota knows that without access to treatment and community supports children have poor educational outcomes and end up in out-of-home placements or the juvenile justice system. We know that adults with mental illness end up homeless, in the criminal justice system, unemployed or living with a very poor quality of life. For this reason, we are particularly concerned that any new regulations governing rehabilitation services facilitate the provision of these services and in no way discourage systems and providers from increasing the availability of these critical services. Many of our members are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars from an already under-resourced service system.

NAMI is very appreciative of the effort in the proposed rules to encourage states to use rehabilitative services to meet the goals of the New Freedom Commission. We particularly agree with the quote from the Commission referenced in the preamble to the rules, "[m]ore individuals would recover from even the most serious mental illnesses and emotional

disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs."

We believe that the emphasis on recovery and person-centered planning and the inclusion of the individual, their families and other individuals in treatment planning is a very positive development that will further improve access to treatment. However, other sections of the proposed regulations have the potential to frustrate the ability to engage individuals in the process of recovery and provide evidence based and tailored services. We are particularly concerned about the prohibition on billing for services that may maintain a person's functioning and the broad exclusion of services that are "intrinsic" to other programs. We will describe these concerns in greater detail below.

Overall, NAMI believes that a system of rehabilitative services must follow these principles:

- Services should attain a high degree of accessibility and effectiveness in engaging and retaining persons in care.
- The effects of these services shall be sustained rather than solely crisis-oriented or short-lived.
- Services must be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery.
- Whenever possible, services should be provided within the person's home and/or community, using the person's natural supports.

Specific comments on sections of the preamble and regulations follow:

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

Section 440.130(d)(1)(iii) – Definition of qualified providers of rehabilitative services

This section provides general requirements for providers of rehabilitative services. While NAMI fully supports choice for consumers of services, we request clarification that schools and other systems could be reimbursed under Medicaid for services provided by employees of that system who meet Medicaid provider requirements. For example, it is often most efficient for schools to hire a therapist or behavioral aide rather than contract with an outside provider. This also allows for proper training and accountability.

Our members report great barriers to coordinating their services and supports so we would like to ensure that the burden is not shifted to consumers and their families to find service providers who will accept Medicaid because other systems such as education are no longer providing someone to give the service. Nothing in the current regulations prohibits schools and other systems from using their own employees, but CMS should clarify in the preamble that such

practices are permissible as long as individuals are informed of their choice to seek another Medicaid provider if they wish to do so.

Section 440.130(d)(1)(v) Definition of Rehabilitation Plan

NAMI commends CMS for the emphasis on a person-centered planning process including the individual, the individual's family and others of the individual's choosing. The active participation of the individual is an essential part of the recovery process. In addition, research indicates that recovery is greatly facilitated by support from an individual's family.

NAMI also applauds the requirement that the plan include goals for the rehabilitation services, the services to be provided, and a timeline for assessment of the effectiveness of the provided services. It is important that individuals and their families have clear information about the services that are being made available so they can ensure that the services are actually received. It is also necessary for a treatment plan to have clear goals and for providers and the individual to periodically review whether goals and services need to be altered.

Several of our members have raised concerns, however, about the relationship between a rehabilitation plan and other service plans. CMS should clarify that plans produced by other entities, such as an individualized education plan or provider treatment plan, can be the rehabilitation plan as long as they meet the requirements of Section 440.130(d)(3).

Recommendation:

Add: **The requirement for a rehabilitation plan may be met by a treatment plan, individualized educational plan or other plan if the written document meets the requirements in Section 440(d)(3).**

Section 440.130(d)(vi) Definition of Restorative Services:

The proposed regulation and the preamble indicate that services that provide assistance in maintaining functioning may only be reimbursed as a rehabilitative service when necessary to help an individual achieve a rehabilitative goal. They further clarify that rehabilitative goals must be designed to assist with the regaining or restoration of functional loss. We have received overwhelming feedback from our members regarding their concern with the exclusive emphasis on restoring functioning rather than maintaining functioning. Many of our members describe their personal recovery process as varied, with periods of maintenance as well as periods of restoration. As one NAMI member stated, "recovery is not a linear process trending upward." Instead, consumers and family members describe their illnesses as up, down and stable depending on the period of time. In addition, many times these fluctuations did not depend on

the rehabilitation services, but rather on outside events, changes in the course of the illness, or changes in medication effectiveness.

Moreover, our members noted that a person's history and severity of illness could be such that a period where the person is not regressing is meeting a rehabilitative goal. For example, an individual with schizophrenia who has experienced multiple hospitalizations and contacts with law enforcement and who has gained sufficient living skills to maintain stable housing may need services to continue those skills. Withdrawing services as soon as the person's living skills were sufficiently restored to allow him or her to live in home for a brief period is inadvisable because the person's history and severity of illness indicate that he or she is likely to regress without further support.

Requiring that a person deteriorate before services can be provided is not cost effective. For individuals with serious mental illnesses, a break in services and support can lead to a downward spiral and long period of acute illness. Thus, NAMI recommends that the proposed rule be amended to allow provision of rehabilitative services if the rehabilitation plan documents that based on the individual's history and severity of illness, such services are needed to prevent regression. The provider would be required to periodically review whether the history and severity of illness continue to merit rehabilitative services to prevent regression as part of the review of the rehabilitation plan.

Moreover, NAMI recognizes the value of consumer run services such as clubhouses and peer support services. Many of our members find these services to be instrumental in their recovery. These programs also recognize that progress is not always linear and prohibiting services to prevent regression can be a barrier to their ability to serve people in need of services.

CMS has full authority to allow rehabilitation services which will prevent regression or deterioration. Section 1901 of the Medicaid Act clearly authorizes expenditures for rehabilitation and other services to help families and individuals "attain and **retain** capability for independence and self-care."(emphasis added).

In addition, NAMI commends CMS for specifying that rehabilitative services enable an individual to perform a function, but the individual is not required to demonstrate that they actually performed the function in the past. This is particularly true for children, who will not necessarily have had the ability to perform a function in the past due to their level of development and acquisition of age appropriate skills. It would be helpful for CMS to further clarify that rehabilitation services may be provided to children to achieve age appropriate skills and development.

Medicaid is a critical funding source for evidence based practices for children with serious mental illnesses. For example, multi-systemic therapy has been funded under Medicaid and has

been proven in multiple clinical trials to produce good outcomes for children, including reduced psychiatric symptoms, decreased substance use and abuse, decreased hospitalizations and out of home placements, less contact with law enforcement, and increased school attendance. However, NAMI hears from many of our members regarding their inability to access MST and other services. The proposed regulations should encourage the further dissemination of evidence based services for children by clarifying that rehabilitative services are available to allow children to gain age appropriate skills and development.

Recommendation:

Amend the language of restorative services to add: In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary **to prevent regression based on a documented history and severity of illness** or to help an individual achieve a rehabilitation goal defined in the rehabilitation plan.

Secondly, amend the language to add bolded language: Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. **For children, this can include services to achieve age appropriate skills and development.**

Section 440(d)(1)(vii) Definition of Medical Services

The proposed regulations provide that medical services are those required for the diagnosis, treatment or care of a physical or mental disorder. It would be helpful to clarify that rehabilitation services include a functional assessment of the individual. It is critical for a provider to attain the correct diagnosis, but our members experiences indicate that individuals with the same diagnosis may have very different rehabilitative goals and services based on their current functional level and their stage of recovery from the illness. Accordingly, we recommend that CMS amend this section to specifically include functional assessment or to indicate in the preamble that such an assessment is part of the meaning of diagnosis. This would provide consistency with later requirements in the proposed regulation for a rehabilitation plan which must be "based on a comprehensive assessment… including diagnosis and presence of a functional impairment in daily living."

Recommendation:

Add bolded language: services that are required for the "diagnosis**, assessment**, treatment or care of a physical or mental disorder…"

Section 440.140(d)(3) Definition of Written Rehabilitation Plan

NAMI commends CMS for requiring a written rehabilitation plan to guide treatment. We support the inclusion of the individual and the individual's family in the development of the rehabilitation plan.

However, NAMI strongly urges additional language to provide needed flexibility to address the nature of mental illness and the current practices in mental health service delivery.

For example, as indicated in our prior comments on restorative services, NAMI encourages language which allows the reevaluation process to determine whether services were effective in preventing regression or deterioration as well as achieving reduction of disability and restoration of functional ability.

We further note that while individuals should always be encouraged to actively participate in treatment planning, rehabilitative services are often required to assist an individual in acquiring the skills necessary to understand the benefits of treatment and begin a recovery process. Assertive community treatment teams (ACT) for example, is an evidence based practice based on an outreach model and a team approach to providing services to individuals with serious mental illness who also have a history of multiple hospitalizations and/or involvement with law enforcement. ACT teams report that they often will need to provide services for a period of time before an individual is ready to sign a treatment plan. However, they can develop the plan and provide services with the goal of developing social and living skills such that the individual is able to more actively participate and sign a treatment plan.

Moreover, the mental health service delivery system is not always coordinated and individuals with serious mental illnesses can move into new communities. It is not uncommon for an individual with serious mental illness to lack sufficient linkages to the community provider system. An individual with a serious mental illness who has been released from jail or the hospital without continuity of care or someone who has recently moved to a new community may experience a crisis and require rehabilitation services such as mobile crisis services. At the point of service, the provider of mobile crisis may not have a treatment plan signed by the individual on file, particularly if that individual was not a previous resident of that community. In addition, an individual in a psychiatric crisis may not be able to actively participate in a treatment plan at that time. If the individual has Medicaid coverage, they should be able to get coverage for this intervention regardless of the fact that these requirements for a written treatment plan could not be met. The proposed regulations should have sufficient flexibility to allow Medicaid financing for crisis stabilization services.

Of course, it is preferable to have a planning process and a crisis plan included in the rehabilitation plan. However, the regulations should have sufficient flexibility to recognize that this will not always be possible.

In addition, a mental health provider does not always have knowledge of alternate providers of the same service and it may be confusing to the individual being served if the provider attempts to give this information. However, the rehabilitation plan should indicate that the person has been given information about any available resource listing alternative providers. We suggest adding language that clarifies this obligation and recognizes that in some circumstances, such as an emergency intervention, it may not be feasible to do so.

Recommendation:

Amend the proposed rule to add bolded language:

(xi) indicate the anticipated provider(s) of the service and **when feasible document that the individual was informed of any available resource for identifying alternate providers of the same service.**

(xiv) ... if it is determined that there has been no measurable reduction of disability, **prevention of regression**, or restoration of functional level, any new plan...

(xv) document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan **or document the exigent circumstances which prevented such participation in the development of the plan, signing of the plan and/or receipt of a copy of the plan. Such circumstances may include, but are not limited to, the need to provide services to allow an individual to begin the planning process or to receive services in the event of an emergency or crisis.**

Section 440.130(d)(4) Impairments to be Addressed

The regulation states that services "may address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs." NAMI appreciates the express inclusion of mental health and substance-related treatment needs. However, NAMI is concerned about the explicit omission of developmental disabilities from the list of impairments to be addressed in this section and in other parts of the rule and preamble. NAMI believes that a categorical exclusion of a particular disability is disability-based discrimination and should not be included in the proposed regulations. We urge CMS to allow all individuals regardless of disability to be eligible to receive rehabilitative services if the requirements for provision of the service are met.

Recommendation:

Amend to add bolded language: may address the individual's physical **or mental** impairments, mental health impairments, and/or substance-related disorder treatment needs."

Section 440.130(d)(5) Settings

This section of the regulation can be very helpful in reinforcing that rehabilitative services may be provided in natural settings and build upon natural supports. However, NAMI urges CMS to revise the preamble language which gives states the authority to determine the setting for the service. Rehabilitation services should be available in whatever setting will yield the best results and the appropriate setting should be determined as part of the rehabilitation planning process with input from the individual with mental illness and his or her family.

We also recommend adding to the settings listed in the proposed regulations to clarify that rehabilitative services can be provided in setting such as schools, workplaces and in the community. Assertive community treatment and mobile crisis, for example, often take place in the community and outside of a home or facility. The preamble includes some of these settings, but it would be helpful to also have them in the regulation itself.

Recommendation:
Delete section of the preamble granting states the authority to determine the setting.

Add to the list of settings: ... **school, workplace, foster home, group home, mobile crisis vehicle, community mental health center, substance abuse treatment setting, community setting** and other settings.

Section 441.45 Rehabilitative Services

Section 441.45(a)(1) – Assurance of compliance with other federal regulations

NAMI appreciates the specific inclusion of these regulatory requirements. However, it would be helpful to also include the regulatory and statutory requirements of Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), which mandate that Medicaid beneficiaries under the age of 21 must receive all medically necessary services to ameliorate or correct a physical or mental condition regardless of whether the services are included in a state's Medicaid plan. 42 U.S.C. Section 1396d(r)(5) and 42 C.F.R. Section 440.40(b).

EPSDT is a critical requirement for children with mental illness who require rehabilitative services to facilitate their recovery and full participation in their schools and communities. States should be required to ensure that nothing in their implementation of these regulations will compromise the mandate in the EPSDT provisions.

Recommendation:

Add bolded language: **and 440.40(b)** of this chapter and **42 U.S.C. Sections 1396(d)(r)(5) and 1396a(a)(43).**

Section 441.45(a)(5)(iii) Specifies the methodology under which rehabilitation providers are paid.

Each state will be required to submit a state plan amendment on rehabilitation services. NAMI strongly urges CMS to allow states maximum flexibility in payment methodology to support evidence based practices. As the preamble notes, the President's New Freedom Commission determined that more adults and children with serious mental illnesses would recover if they had access to evidence based treatment. NAMI's research indicates that there are critical shortages of these services in all states. CMS should ensure that its policies facilitate providing more access to effective services such as Assertive Community Treatment, Multi- Systemic Therapy and Therapeutic Foster Care.

Many states find it administratively efficient to combine services provided in these evidence based treatment programs, a practice commonly known as "bundling." Services can be bundled into a case rate, daily rate or similar arrangement. This allows a provider to predict revenue and facilitates its ability to hire the extensive teams of individuals required to provide these services with fidelity to the model. ACT services, for example, will often be provided by a 10 member team, including nurses, a psychiatrist, a peer specialist, a substance abuse specialist and others. Numerous research studies have confirmed that good outcomes are dependent on fidelity to the model, including the active participation of a full team. States should be given the flexibility to choose the method that they believe will best allow them to ensure fidelity to the evidence based practice and replication throughout the state.

While CMS's goal of ensuring that Medicaid is not paying for non-rehabilitative services is laudable, this objective can be achieved by examining the services that are combined in the bundled rates. States should be required to explain their rate setting methodology, but they should not be arbitrarily prohibited from using bundling methodologies that are efficient and essential to significant expansion of the availability of the evidence based services. CMS allows managed care arrangements that use similar methodologies and should be consistent in its review of state rehabilitation plan amendments.

Recommendation:

In reviewing state plan amendments, CMS should allow states flexibility in rate setting methodologies. If there are concerns about the services that are provided within a bundled rate methodology, CMS should review the state's documentation of the specific services they intend to provide within the combined rate.

Section 441.45(b)(1) Services that are excluded from rehabilitation, including those that are intrinsic elements of other programs

NAMI strongly urges CMS to strike this section of the regulation because these provisions create an ambiguous standard that states and beneficiaries will be unable to apply. The preamble and the regulation give no guidance on how to determine if a service is an intrinsic element of programs other than Medicaid. Individuals with mental illnesses, their families, and state policymakers will not be able to determine what is intrinsic to other programs and this lack of clarity undermines the integrity of the Medicaid program.

Moreover, the ambiguity of the proposed regulations places states in an untenable position. They can either forego federal funds that they may be entitled to or they can bill Medicaid and risk an audit and the eventual loss of state dollars. For Medicaid to operate successfully as a state-federal program, the terms and conditions of the relationship and what can be provided must be clear and readily applied by states.

Furthermore, the current language in the proposed rule can be read to disallow rehabilitative services that are furnished through a non-medical program as either a benefit or an administrative activity, including those that are intrinsic elements of other programs. However, under the Medicaid statute, a Medicaid eligible individual who resides in a state that has chosen the rehabilitation option is entitled to rehabilitative services paid for by Medicaid regardless of their participation in another program. The proposed language in Section (b) (1)(i) regarding therapeutic foster care acknowledges this distinction and provides an exception for "medically necessary rehabilitation services for an eligible child." This language should be included in Section (b)(1) to clarify the agency's intent.

Clarifying language is particularly important for children, who are entitled to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). As previously noted, this mandate requires that children receive all necessary services to correct or ameliorate a physical or mental condition, regardless of whether the service is covered under the state Medicaid plan. *See* 42 U.S.C. Section 1396d(r)(5). Thus, Medicaid eligible children are entitled to all rehabilitative services necessary to ameliorate a physical or mental condition such as mental illness. This clear mandate also applies regardless of whether the rehabilitative service is intrinsic to another program or is furnished as a benefit or administrative activity of another program.

Finally, third party liability rules under Medicaid have recognized that states have an obligation to determine if another entity is legally liable for payment of the services. If CMS is unwilling to strike the language, the proposed regulations should be clarified such that services are only excluded if the other program has a specific legal obligation to pay for services to a specific Medicaid recipient. Programs that are financed by capped or discretionary appropriations from state or local entities should be specifically excluded from these provisions.

NAMI believes that if this language is unchanged, it will have a devastating effect on the ability and willingness of other programs to provide quality treatment to adults and children with serious mental illnesses. These other programs are often operating with little resources and growing need. If they are denied Medicaid resources to pay for the treatment for individuals with mental illnesses, some are likely to fail to provide needed services and others may refuse to serve individuals with mental illnesses.

Moreover, the ambiguity inherent in the language of the proposed rule will discourage the dissemination of evidence based practices in these other programs. NAMI is just beginning to see child welfare, juvenile justice and corrections programs that serve large numbers of adults and children with serious mental illnesses recognize the value of these mental health interventions and coordinate with the mental health system to adopt such practices. Research clearly shows that this coordination leads to better outcomes. The proposed rule should facilitate and not impede such progress.

Finally, the President's New Freedom Commission report decried a fragmented service system that denied hope and opportunity to adults and children with serious mental illnesses. They wrote:

The promise of the New Freedom Initiative-a life in the community for everyone-can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic-the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

NAMI strongly urges CMS to reconsider the current language in this section of the proposed rule which furthers fragmentation by discouraging other systems from offering treatment to individuals with serious mental illnesses. NAMI is deeply concerned that this provision will move us in the wrong direction at a time when states are showing progress in moving toward systems' coordination.

Recommendation:
Strike Section 441.45(b)(1).

If CMS is unwilling to strike this section, add:

"including services that are intrinsic elements of programs other than Medicaid [list of programs], **except for services which are medically necessary rehabilitation services for an eligible individual.**

And add: **This exclusion will only apply if the programs other than Medicaid are legally liable to provide the services to a specific Medicaid eligible individual. Discretionary appropriations do not constitute legal liability to a specific individual.**

Sections 445(b)(i) and (ii) Exclusion of Therapeutic Foster Care Services

Therapeutic foster care, also known as treatment foster care (TFC), has a strong evidence base supporting its effectiveness for children with serious mental illness. Trained parent/providers work with youth in the treatment home to provide a structured and therapeutic environment while enabling the youth to live in a family setting. These services are effectively used to avoid out of home placement and more trauma to the child and family. Moreover, this intervention has been proven in multiple clinical trials to improve functional behavior, reduce contact with law enforcement, and decrease hospitalization and out of home placements.

As part of the President's Executive Order on Community Based Alternatives for People with Disabilities, the President ordered federal agencies to review their policies and regulations "to improve the availability of community-based services for qualified individuals with disabilities" and promote the integration of adults and children with disabilities in their local communities. The proposed language in these sections should be altered to facilitate the provision of treatment foster care so children with mental illnesses can continue to live in the community, rather than in more costly residential and hospital settings.

The preamble to the regulation indicates that CMS is promulgating this regulation because some states have packaged services within therapeutic foster care which are not medically necessary rehabilitative services. CMS should clarify in the regulation that states may only provide medically necessary rehabilitative services as part of any bundling of services, but should allow states to use a case rate, daily rate or other arrangement as long as the services included in that rate are medically necessary rehabilitation services.

Recommendation:

Revise these sections to read:

(i) **Services that are packaged as part of therapeutic foster care services which are not medically necessary rehabilitation services for an eligible child. States are permitted to package medically necessary rehabilitation services to provide therapeutic foster care to an eligible individual child.**

Section 445(b)(1)(iv): Exclusion for Teacher Aides

NAMI urges CMS to clarify that the language regarding school services does not apply to behavioral health aides and other mental health providers who address a child's functional impairments which interfere with his or her ability to learn. Mental health providers in the schools play an essential role in allowing children to develop into productive, independent adults and the proposed regulations should encourage the provision of these services. The New Freedom Commission called for schools to play a far greater role in effectively addressing the mental health needs of students and NAMI recommends amending this provision to ensure consistency with that call to action.

Recommendation:

Add: Routine supervision and non-medical support services provided by teacher aides in school setting (sometimes referred to as "classroom aides" and "recess aides"), **however this exception shall not apply to behavior aides and other related service providers in the classroom that are designated to address a specific child's functional impairments and to provide rehabilitative services for that child**.

Section 445(b)(2): Exclusion of habilitation services

As previously noted, NAMI is concerned about policies that exclude a particular disability or group of disabilities from eligibility for a Medicaid service. Individuals with mental retardation and related conditions, such as cerebral palsy, appear to be categorically excluded in this proposed regulation from rehabilitation services.

In addition, in Section 6411(g) of the Omnibus Reconciliation Act of 1989 (OBRA 89), Congress required that a final regulation specify the type of habilitation services to be covered. This Congressional directive does not contemplate complete exclusion of the services from coverage under the rehabilitation option.

Recommendation:

Delete the categorical exclusion for habilitation services. Additionally, delete the categorical exclusion of people with mental retardation and related conditions from eligibility for rehabilitation services.

Section 445(b)(3): Exclusion for recreation or social activities that are not focused on rehabilitation.

NAMI applauds CMS's statements in the preamble that specifically note that "for an individual with a mental illness, what may appear to be a social activity may in fact be addressing the rehabilitative goal of social skills development as identified in the rehabilitation plan." We also

appreciate earlier clarification that an activity that may appear to be recreational may be rehabilitative if it is addressing a particular impairment and functional loss. NAMI urges CMS to include this clarifying language in the regulation itself in addition to the discussion in the preamble.

We also urge CMS to clarify that personal care services that are performed to teach the individual some independent living skills are coverable services. For individuals with mental illness, modeling and cuing are often used to teach these skills and personal care services may be provided as part of the process in furtherance of the rehabilitation goal. The purpose of the service is to achieve a rehabilitative goal, rather than to provide personal care to the individual. The preamble recognizes this distinction by specifying that teaching an individual to cook a meal to re-establish the use of her or his hands or to restore living skills may be a coverable rehabilitation service. It would be helpful to provide that clarification in the regulation as well.

NAMI further urges CMS to clarify that supportive services furnished to address rehabilitative goals may be provided in community settings, including employment and academic settings or in the context of preparing to enter employment or academic settings as long as the primary purpose of the services is to achieve a rehabilitative goal rather than to assist the person with gaining employment or education. Employment and education settings or contexts can be therapeutic because the individual must interact or prepare to interact with others and manage symptoms in an increasingly challenging environment. As long as the service is directed at achieving the rehabilitative goal rather than retaining a job or furthering an education, the services should be reimbursable as rehabilitation services.

Recommendation:

Add: **Recreational and social activities that are addressing a particular impairment or functional need, such as social activities addressing a goal of social skills development, are reimbursable as rehabilitation services.**

Add: **Services, however, that are directed at achieving a rehabilitative goal may be provided in the context or setting for work or education if the purpose of the service is to address a functional impairment rather than to assist with employment or academic enhancement.**

Add bolded language: Personal care services, **except for those which are furnished to teach a skill in furtherance of a rehabilitative goal.**

Section 441.45(b)(4): Exclusion of services provided by public institutions.

This section of the proposed rules restates current law with respect to public institutions. NAMI appreciates the language stating that "rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement..."

The language, however, also states that such community services cannot be "part of the public institution system." NAMI strongly urges CMS to strike the word "system" to be clear that community services which are rehabilitative are reimbursable regardless of whether a child or adult remains part of the juvenile justice or correctional system. This is particularly important for rehabilitation services that are provided in the community while the youth or adult with mental illness is still under the auspices of the correctional system, such as mental health services in a group home for children who are under juvenile court jurisdiction or forensic assertive community treatment for adults who are still in the corrections system. This clarification is very important given the large numbers of youth and adults with mental illnesses who come under the jurisdiction of these systems. It is consistent with other sections of the preamble and regulation which recognize that involvement in other programs does not affect Medicaid eligibility for services.

NAMI also strongly urges deletion of language indicating that community services can only be reimbursable if they are not used in the administration of other non-medical programs. This language is ambiguous and the preamble gives no guidance to determine whether services are used in the administration of a non-medical program. NAMI believes that a Medicaid eligible individual should receive rehabilitative services if medically necessary to address a functional impairment regardless of any involvement in another program. This point is included in the preamble language noting "enrollment in these non-Medicaid programs does not affect eligibility for Title XIX services." NAMI seeks similar language in the final regulation.

Recommendation:
Strike the following language: ... that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

Section 441.45(b)(8): Exclusion of services that are not provided to a specific individual.

NAMI applauds the discussion in the preamble recognizing that "effective rehabilitation of eligible individuals may require some contact with non-eligible individuals." The preamble further explains that counseling sessions for the treatment of the child may include the parents or other non-eligible family members and concludes that "contacts with family members for the purpose of treating the Medicaid eligible individual may be covered under Medicaid."

NAMI appreciates this recognition of the importance of family relationships in supporting recovery. Recent research studies have confirmed that family support leads to better outcomes from treatment. NAMI urges CMS to amend the rule to add language from the preamble to be clear on this point.

Recommendation:

Add: **Contacts with and services to family members and other non-eligible individuals for the purpose of treating the Medicaid eligible individual may be covered as a rehabilitative service.**

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

Sincerely,

Sue Abderholden
Executive Director

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October 2, 2007

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

To Whom It May Concern:

The Council of Agency Directors of Cuyahoga County, Cleveland, Ohio would like to make the following comments on the proposed CMS rule for the Medicaid Program: Coverage for Rehabilitative Services:

While the proposed rule on balance is reasonable and consistent with the way behavioral health care providers in Ohio conduct their business, there are several issues that warrant further attention.

1) "Intrinsic Elements" need further definition. It is proposed "in Sec. 441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid." We appreciate that Medicaid rehabilitative services are based on medical necessity and are to be "coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals." However, this is a slippery slope. Individuals receiving treatment need a holistic approach to their care and issues under the medical necessity umbrella may at times warrant discussion about an individual's housing, vocational or educational needs. The mere mention of these needs or services should not give cause for CMS to reject wholesale Medicaid billing reimbursements for legitimate rehabilitative services where the focus is, indeed, on treatment.

2) Behavioral health care providers are often told by state and county authorities that they need to use evidence based practices more prolifically. Ironically, those same evidence based practices often do not conform to revenue reimbursement requirements. While we appreciate that CMS proposes to do away with so-called "bundled services," we would be negligent in not commenting that by doing so, CMS is turning away from proven evidence-based practices such as Therapeutic Foster Care, Assertive Community Treatment Teams, Intensive Home and Community Based Services and Multi-Systemic Therapy. These may be "models of care" and not "medically necessary services defined under Title XIX of the Act," but research has proven their effectiveness for children with serious emotional disturbance and adults with mental illness.

An Association of Community Mental Health Agencies of Cuyahoga County
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3) While CMS makes clear the difference between habilitative and rehabilitative services, what is unclear is the application of rehabilitative services for children and adolescents with serious emotional disturbance. Young people are passing through developmental life stages and continuously learning new skills. "Restoration of functioning," as a concept applied to children, is confusing. Further definition here would be helpful. For adults with chronic mental illness, we are encouraged that CMS recognizes "that rehabilitation goals are often contingent on the individuals' maintenance of a current level of functioning." But we need further clarity when CMS says, "In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan." We are hopeful that such rehabilitation goals, based on medical necessity, would include such things as compliance with medications, maintenance of stability in the community, etc.

4) Further clarity is needed on CMS' proposal to "exclude payment for services that are provided to residents of an institution for mental disease (IMD), including residents of a community residential treatment facility of over 16 beds." First, please define an "institution." While certainly, room and board at a children's residential treatment facility may not be billed to Medicaid, it is unclear why other medically necessary behavioral health interventions would be disallowed.

Thank you for this opportunity to provide feedback. Please feel free to add us to any forthcoming response list you may compile. We appreciate your consideration of these comments.

Sincerely,

John Nosek
President

JUDGE DAVID L.
BAZELON
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FOR
MENTAL
HEALTH
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Civil Rights and Human Dignity

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October, 1, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

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

OVERVIEW (PREAMBLE)

There is an incorrect statement in the preamble with respect to the availability of FFP for a Medicaid-covered service furnished to a child that is included in the child's special education program under IDEA. Under the statute, Section 1903(c), Medicaid is not prohibited or restricted from paying for services that are included in the child's individualized education program.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

440.130(d)(1)(v), Definition of Rehabilitation Plan

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. We applaud CMS for including requirements that are designed to ensure the individual's participation in this process, but believe the wording could be improved. There is a real difference between an individual providing "input" and an individual having "active participation." By including both terms in different places, the regulation confuses this issue. Further, by requiring the plan to be developed by the provider significantly diminishes the role of the individual. In mental health service delivery, it is a better and far more common practice to have a service planning team working with the active participation of the individual than to have a single provider develop the plan.

In the preamble, CMS recommends the use of a person-centered planning process. There is, however, no reference to person-centered planning in the regulation itself.

Providers should also be encouraged to be flexible in response to the individual's needs. Serious mental illness is often a cyclical disorder and, in the course of their recovery, individuals may suddenly deteriorate, requiring a change in services. Service planning and goal setting should anticipate this need and crisis plans need to be developed as part of the rehabilitation plan.

Rehabilitation providers should also be encouraged to inform individuals that they have the right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated. All Medicaid providers are required under federal law to inform individuals about advance directives, although state law governs how those directives are to be developed and implemented.

Recommendation:

Revise the language under paragraph (v) so as to require the plan to be developed by a team that is led by a qualified provider working within the State scope of practice act, with the active participation of the individual (unless it is documented that the individual is unable to actively participate due to their medical condition), the individual's family (if a minor or as the individual desires), individual's authorized decision maker and/or of the individual's choosing and following the guidance of the individual (or authorized decision-maker), in the development, review and modification of the goals and services.

This change should also be made to section 440.130(d)(3)(ii) and (xiii).

Add language to Section 440.130(d)(1)(v) to the effect that CMS encourages the use of person-centered planning processes.

Encourage providers to take into account the possibility of relapse, and incorporate within individuals' rehabilitation plans provisions for how they will respond should crises arise.

When developing a rehabilitation plan with the individual, providers should inform the person of their right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated.

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

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

have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Recommendation:

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

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

440.130(d)(1)(vii) Definition of medical services

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person's functional capacity – clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

This definition also includes the word "care" after treatment, but that term is nowhere else defined. Does it mean clinical care? The word rehabilitation should be inserted here to make

clear the term "medical services" includes rehabilitation. This is important because the term "medically necessary" is used in this regulation to indicate necessary rehabilitation services.

Recommendation:

Add to section (vii) the word "assessment" before the word "diagnosis" and replace the word "care" with the word "rehabilitation."

440.130(d)(1)(viii)(2)Scope of Services

The definition of scope of services is limited to medical or remedial services. However, the term restorative services is also used in this regulation to describe covered rehabilitation services.

Language is included in the preamble to the effect that services are to be provided at the least intrusive level to sustain health. Coupled with states' obligations to furnish care in the least restrictive setting, this wording can encourage providers to focus on delivery of the most effective community services that can improve the individual's functioning within a reasonable time frame and discourage provision of restrictive levels of care that are unacceptable to the individual.

Recommendation:

Insert the word "restorative" after "medical" in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

Insert into this section a requirement that rehabilitation services be delivered in a coordinated manner.

The preamble phrase "services are to be provided at the least intrusive level to sustain health and ensure the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level" should be added to the definition of the scope of services, and additionally, services should also be required to be provided in the most integrated, appropriate setting.

440.130(viii)(3) Written Rehabilitation Plan

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, we do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed.

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for

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

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

Finally, there should be documentation that the provider has provided the individual with information on advance directives.

Recommendations:

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

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan.
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- certification that the individual has been informed about their rights regarding advance directives;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has

received this information (to the extent the service planning team is aware of all existing providers.

CMS should also encourage a single treatment and rehabilitation plan and a single planning team and service planning meetings.

440.130(4) Impairments to be addressed

The regulation states that services may address an individual's physical impairments, mental health impairments and/or substance-related disorder treatment needs. In describing this section in the preamble, the agency also states that because rehabilitative services are an optional service for adults, states have the flexibility to determine whether they will be limited to certain services for specific populations.

Limiting services to only one group, based on diagnosis or disability violates Medicaid's requirement that services be furnished in sufficient amount, duration and scope to reasonably achieve their purpose. Excluding coverage of rehabilitative services needed by individuals with mental illnesses would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:

Section 440.130(4) should be changed to delete "/or" after the word "and" in this sentence.

440.130(5) Settings

In addition to the settings cited in the regulation, it would be helpful to add some of the settings where other sections of the regulation limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add in the regulation settings described in the preamble.

Recommendation:

Add to the list of appropriate settings for rehabilitation services "schools, therapeutic foster care homes, and mobile crisis vehicles."

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

furnished to retain or maintain functioning (see comments above).

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state

Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396?? (1396d(r)). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

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

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

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

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

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on

Mental Health from the U.S. Surgeon General). The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

If states are not able to create a package of covered services as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs.

The regulation makes no acknowledgment that therapeutic foster care is a mental health service, provided through mental health systems to children with serious mental disorders who need to be removed from their home environment for a temporary period and furnished intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system; it is not a service exclusively for children in the foster care system.

Recommendation:

Therapeutic foster care should be listed as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, states should be given the discretion to define therapeutic foster care as a single service and pay through a case rate, daily rate or other appropriate mechanism.

Language should also be included in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care.

441.45(b)(2)

The proposed regulation makes it explicit that habilitation services are not coverable as rehabilitation services. This section is based on a premise that individuals with developmental disabilities never can require, or be eligible for, rehabilitation services.

This section in problematic, especially for persons dually-diagnosed with developmental disability and mental health disorder.

Recommendation:

Revise this section to clarify that individuals with a mental disorder are eligible for medically-necessary rehabilitation services regardless of whether they also have another diagnosis, such as mental retardation or other developmental disability.

441.45(b)(3)

The Preamble includes examples of when recreational or social activities may be covered services due to a focus on skill building or other rehabilitative needs. However, the regulation does not include any examples or any specific language explaining when these activities are covered services. This is a serious omission, as the regulation alone may be interpreted in the field as denying any recreational or social activities no matter how therapeutic and how focused they are on restoring functioning.

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are covered rehabilitative services. It would be helpful if CMS would clarify this and also explain to providers how they document that a service was personal care skill building, even though the provider may have had to demonstrate (and therefore provide) personal care in the process.

Recommendations:

Language that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation services should be included in the regulation at section 441.45(b)(3).

The regulation should clarify how personal care furnished as an integral part of personal care skills training is covered and how it is to be documented.

Individuals in Secure Custody and Residing in Public Institutions

The addition of the phrase "in secure custody of" law enforcement is unnecessary as the regulation also requires that the individual be residing in a public institution. The law only stipulates that FFP not be available for individuals in a public institution, and does not reference secure custody.

Recommendation:

Delete the phrase "in secure custody."

441.45(b)(7) Services for individuals who are not Medicaid eligible

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered. In the preamble (page 45207) there is an explanation of how services that are furnished through contacts with non-eligible individuals, but which are exclusively for the treatment of Medicaid-eligible individuals, are covered. No such explanation, however, is included in this section.

Recommendation

The language in the preamble explaining when services may be furnished through contacts with relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services should be included in the regulation.

OTHER ISSUES

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services through 15-minute increments and the denial of payment through daily rates, case rates and similar arrangements are supported by language in the regulation, at least by inference.

These new shifts in rate setting methodology are not efficient and are moreover extremely detrimental to the provision of evidence-based mental health services which are more and more frequently being offered as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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

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

Recommendation:

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

EPSDT Mandate

The regulation appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. In several places, the regulation needs to be amended to reflect the EPSDT provision.

Recommendation:

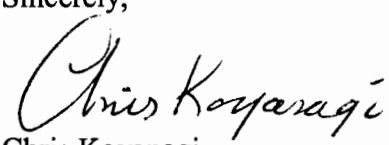
Section 441.45(a), insert a new paragraph clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

Section 441.45(a)(5) should clarify that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically-necessary.

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

Sincerely,



Chris Koyanagi
Policy Director

CMS-2261-P

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September 27, 2007

Dear Sirs,

Re: Proposed Medicaid change for Rehabilitation Services

I am chairman of the Board of Directors of Piedmont Pioneer House, Inc. (PPH). I am writing in response to the recent announcement from Medicaid of the possibility that psychosocial rehabilitation services may no longer receive funding. We are quite concerned.

Piedmont Pioneer House is a daytime "fraternity" located behind the old orthopedic hospital on South New Hope Road, Gastonia, NC. For five days a week people with severe mental illness commune with their peers. This builds self-esteem and helps with their rehabilitation.

If this "no funding" change occurs, PPH, Inc. will have to possibly close its doors unless another funding source can be found. PPH has been in operation since 1977 and has provided excellent services for people who have a mental illness in Gaston and Lincoln counties. If this program closes because of non-funding from Medicaid, then there will be many people in our community in crisis situations, therefore, causing our community to be in a crisis situation.

Many with mental illness will have to be hospitalized or incarcerated. This will cost tax payers more money, not to mention the toll on human lives and even deaths that could be prevented. A one night stay in a psychiatric hospital can cost up to $2000. Therefore a 10 night stay would cost Medicaid around $20,000 and a person can receive two years of psychosocial rehabilitation for that price. So if a person had three to four hospitalizations per year, that would amount to three to four times the cost of psychosocial rehabilitation. Clubhouses certified by the International Center for Clubhouse Development (I.C.C.D.) such as, Piedmont Pioneer House have proved to reduce hospitalization rates by up to 85% in the severe and persistent mentally ill population.

I.C.C.D. clubhouses also assist their members in finding employment and to pursue educational goals. PPH currently has two members attending college courses and two members working on their GED's. PPH has successfully helped several people return to work and therefore no longer require Social Security Disability benefits.

In closing, I ask that you please take into considerations how this proposed change would affect the mental health population. I assure you the outcome would not be good. If you had a family member with mental illness, would you not want him functioning at his highest potential in the least restrictive environment with friends and a support system?

Thank you for your consideration of this very important matter.

Sincerely,

Jonathan App

Jonathan App
Piedmont Pioneer House Board Chair

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September 29, 2007

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

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

I am very troubled by the estimate in the rule that would save the federal government 2.2 billion dollars. Creating barriers to services will not save money in the long run. Rather, it will increase the costs from hospitalization, incarceration and other bad outcomes that result from a failure to get needed treatment. I am the mother of a mentally ill son in prison, resulting largely from lack of services and a member of NAMI for many years. His having been in prison nearly half his life without meaningful treatment only exacerbates the problem. But the system all too often handles it this way.

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

There are good points, such as family participation and encouragement of communication between providers, the individual and family members. However, these changes are recommended.

Recommended changes:

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

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

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

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

Recommendation:

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

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

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

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

Recommendation:

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

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

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

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

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

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

Recommendation:

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

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

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

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

Recommendation:

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

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

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

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

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

Recommendation:

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

Linda Quinet
American living in France
Voting state: Connecticut
lquinet@earthlink.net
Mailing address:
41 Morena, Irvine, CA 92612

193

Lugene Hunt
1008 Avon Ave. Apt. I
Burlington NC 27215

October 2, 2007

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

To whom it may concern:

Reference: File code CMS-2261-P

I'm writing you concerning a proposal that was made at one of your CMS meetings. I understand this proposal consists of cutting the funds and this may affect the Psychosocial Services in which I am a client. I must say the program has helped me tremendously through out the years. Coping with mental illness has not been easy but with this program I have come along way. It also has kept me out of the hospital; and that's a good thing.

The program provides other services such as; .Transitional employment; independent living and educational classes for Academic Skill (GED).

As you see this program is very vital to me and others. Please reconsider your proposal that this program may stand. Thank you for your time.

Sincerely yours,

Lugene Hunt

Lugene Hunt

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Bryan D. Eaker
112 Dunes Drive
Kings Mountain, NC 28086

September 25, 2007

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

To Whom It May Concern:

I am a Rehabilitation Specialist for Adventure House, a Psychosocial Rehabilitation Program that follows ICCD standards for the "Clubhouse" model. This model started in New York City in the 1950's. This successful rehabilitation model now serves those with mental illnesses, not only in the United States but throughout the world. Clubhouse utilizes the "word ordered day" rehabilitation process and guarantees its members: the right to a place to come; the right to meaningful relationships; the right to meaningful work; and the guaranteed right to a place to return.

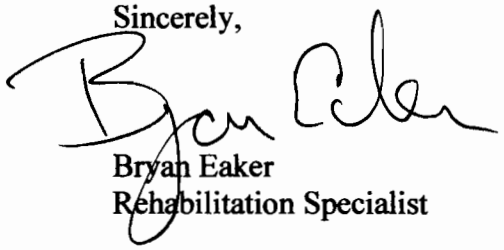
I would like to respond to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services. I would specifically like to give my opinion on Definition of Restorative Services: 440.130(d)(1)(vi).

This definition includes appropriate rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for those with mental illnesses, continuation of rehabilitative services is at times essential to *retain* their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services. Without a place "to come to each day, build meaningful relationships, be able to work, and be welcomed back no matter how long you're absent" our members would surely find themselves on the psychiatric floor of a hospital, in jail, or possibly homeless … as many of our members were before joining Adventure House. Section 1901 of the statute specifically

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

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

Sincerely,



Bryan Eaker
Rehabilitation Specialist

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September 20, 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

Dear Sir or Madam:

I am writing to urge you to fully implement the recommendations of the National Alliance for the Mentally Ill regarding the proposed regulations on coverage for Medicaid Rehabilitative Services. Those recommendations represent the wisdom of those who are challenged by mental illnesses and their families, who know very well what rehabilitation services are necessary to the process of recovery from mental illnesses.

Thank you,

Dave Falkenberg
Elgin, IL

CMS-2261-P

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September 27, 2007

Rebecca B. Edwards, MA, QSAP, QP
809 North Lafayette Street, Suite H
Cleveland Psychosocial Services, Inc.
Shelby, North Carolina. 28043

Centers for Medicare and Medicaid
Department of Health and Human Services
Baltimore, MD, 21244-8018

To whom it may concern:

I have worked with both substance abuse, mental health, and those with dual diagnosis, since 1999. I have seen some substance abuse clients get better and others who could not hold on to their sobriety. I have never seen a mental health client "recover" from their mental illness. Those clients that I have on my case load are severe and persistent mentally ill. Many of my clients also have chronic health problems as well. They have few resources and sometimes no support. It is currently very hard to find almost non-existent resources for Medicaid clients and almost impossible to obtain resources for those who do not have entitlements. The proposed Medicaid changes will endanger those clients. The changes seem to indicate that if the "illness" is not caught early, then the chronically mental ill will be left on their own. The American Medical Association states that substance abuse is a disease. Those with severe and persistent mental illness is by definition an illness and chronic. Some may get to a level of functioning that is better but most will not. Do we tell someone that has had a stroke or a heart attack that they will not get better and so no rehabilitation will be had because they are chronic? We are first to do no harm to our clients. Doctors, clinicians, and community support are supposed to do no harm. How much harm will your new proposal do in undermining our already fragile clients and the strained and fragile mental health system? Most of my clients are on the lowest part of Maslow's Hierarchy with trying to get their basic needs met. How can they improve their life on a time table when they are seeking to get basic needs and safety issues met? Many times community support is the life line to help them get their basic needs and safety issues met; however, we have to earn their trust and that takes time as most have been hurt many times in their life. We are not supposed to be their support system, but many times there is no one else they can depend on.

Rebecca B. Edwards

Rebecca B. Edwards, MA, QSAC, QP

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DATE: 9-26-07

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

To Whom It May Concern:

Reference: File code CMS-2261-P

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

Adult and Child Mental Health Center is a Indiana state certified Joint Commission on Accreditation of Healthcare Organizations accredited community mental health center primarily serving seriously emotionally disturbed children and seriously mentally ill adults residing in Indianapolis, Indiana and Johnson County Indiana. Our organization provides recovery oriented behavioral health services to approximately four thousand three hundred (4300) registered clients each year. Our services include "evidence based treatments" such as Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Supported Employment and Illness Management and Recovery. Our continuum of services include access to inpatient psychiatric care, residential treatment, therapeutic foster care, partial hospitalization, intensive outpatient therapy, home based counseling, and case management. Because our organization primarily serves a low income disabled population, Medicaid Rehab Option funding is our primary funding source supplemented by Division of Mental Health and Addiction funding, and Indiana Department of Child Services funding.

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

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

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

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

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will not be eligible for services. This serves no one's interest.

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

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

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

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

Additionally, The preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss.

Recommendation:

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

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

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? The guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

Is it allowable for a service planning team to create a single plan of services that address both treatment issues and rehabilitation issues? Frequently in mental health service delivery clinical issues (such as medication and therapy) are planned in conjunction with rehabilitation needs (skill building, etc.). Requiring two separate planning processes and two separate planning documents is burdensome not only on providers but also on the individual consumer. Clearly,

multiple service plans do not facilitate coordination or accountability. The regulation does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

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

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

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

Recommendations:

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

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

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

management services).

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

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

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

Recommendation:

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

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

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

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be

coordinated with services furnished by other programs. The regulation should include this language.

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

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

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

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

Sincerely,

Dana Frantz, LCSW
Adult and Child Center
8320 Madison Ave.
Indianapolis, IN 46227

CC: Indiana State Congressional Caucus

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Mr. David T. Walsh, MA
718 N. Laurel Street
Lincolnton, NC 28092

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 440 and 441 [CMS 2261-P] RIN 0938-A081
Medicaid Program; Coverage for Rehabilitative Services
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Proposed rule.

Brief History of my qualifications: I have a Master's degree in Counseling and have worked in the field of Human Services ever since graduating with my Masters in 1975. I've worked with both children and adults in various setting and in various capacities. Most recently I have been working with adults who have been diagnosed with severe and persistent mental illnesses, so my commits are primarily directed to how I foresee the proposed rule changes would affect this population. The majority of the individuals who are currently receiving services have been diagnosed as having schizophrenia.

D. Impairments to be Addressed

The Commission noted in its report that, ``**[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs.**"

- My concern centers around the use of the word "recovery" that is used not only in the above passage, but through out the document on the proposed rule changes. Individuals, who stand to be impacted by these proposed rule changes, will never "recover" from their mental illness. At best, their only hope is that with adequate support provided through the various community based programs that they will be able to maintain a certain level of stability that will allow them to remain in their community and not have to be hospitalized. However, even with this support, there is no guarantee that individuals who have schizophrenia will not have to be hospitalized at various times throughout the course of their life-long battle with their mental illness.

F. Requirements and Limitations for Rehabilitative Services
At Sec. 441.45(a)(2), we propose to require that the State ensure that **rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.**

- The implication here is that once these individuals have reached a certain level of functioning, that services can be terminated. This would imply that the supports that allowed the individual to attain this "functional level" are no longer needed. This may be true for a very short period of time, but most individuals that fall into

the category of "severe and persistent mental illness" this is not the case. Usually they will have periods of time where they are capable of managing their illness with minimum support. If all supports are stopped, it will only be a matter of time before their ability to "manage" their symptoms and their illness will results in major decompensation and most likely having to be hospitalized. With each "psychotic break-down", research has shown that the individual's ability to regain their prior "level of functioning" is greatly reduced and the likelihood of their getting back to where they were before the break-down is poor. If services are stopped and then they have to be reinstated once the individual gets out of the hospital, this just creates another barrier that these individuals have to overcome.

2. Limitations for Rehabilitative Services

Medicaid rehabilitative services must be coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals and are available as part of other services or programs.

- I understand that part of the problem in the current system is that there has been some "duplication" of services and that some type of controls need to be put into place regarding this issue. However, it Medicaid funding is stopped in these instances here in North Carolina, then the question is how will the individuals affected receive the mental health services that they so badly need in order to maintain or achieve a better "level of functioning." Many of the service institutions to which are referred to here, do not have the funding to pay for specialized mental health services, nor do they have "qualified professionals" to provide these services.

Summary:

In light of recent events that have had a major impact on our national mental health delivery system, it would appear that the proposed rule changes would only set our current system back instead of reforming it. Here in North Carolina we have been experiencing "mental health reform" for the past year and things really have not improved that much. NAMI (National Alliance on Mental Illness) has been doing national "report cards" on the states mental health services. Last year, North Carolina received an overall grade of "D+". NAMI identified North Carolina's "urgent needs" to include: funding, to build more crisis services and alternatives to hospitalization, and to have more "safety net" resources. Current Medicaid rules are making it difficult for our state to provide adequate services and the proposed rule changes appear to only "tighten the noose" that is around the necks of our citizens who suffer from chronic and severe mental illness.

David T. Walsh, MA
Thursday, September 27, 2007

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September 17, 2007

Donna W. Miller, MA, LPC
809 N. Lafayette St, Suite G
Cleveland Psychosocial Services, Inc.
Shelby, NC 28150

Centers for Medicare and Medicaid
Department of Health and Human Services
Baltimore, MD 21244-8018

To whom it may concern:

As a taxpayer, I applaud the Department of Health and Human Services, Centers for Medicare and Medicaid Programs for searching for a way to be fiscally responsible and to serve the maximum number of people with limited funds. However, in my opinion as a Licensed Professional Counselor working with chronically mentally ill adults, I feel that the proposed Rule Changes to Medicaid Program Coverage for Rehabilitative Services would likely result in negative impacts on an already fragile Mental Health/SA system.

The basis/foundation of rehabilitation services for Mental Health/Substance Abuse is to restore the individual consumer to his/her best functional level under the direction of a medical practitioner and delivered by qualified practitioners for the nature and scope of the services provided. Only those services considered "medically necessary" to the recovery and rehabilitation of an individual may be authorized and provided.

If the proposed changes to the Federally Funded Program are adopted as written, there will be no "beneficiary protections" for persons with chronic mental health and substance abuse disabilities. Consumers will be forced into a "cookie cutter" approach to mental health and substance abuse recovery to maximize the "time-limited" approach to growth and recovery. If consumers do not progress according to a federal/state mandated time limit, the consumers will either be forced out of the system to fend for themselves or given access to so few supports that they cannot possibly achieve "recovery." This withdrawal of system supports will not "reduce the duration and intensity of medical care to the least intrusive level possible which sustains health" but rather increase usage of already overloaded doctors, emergency rooms and hospital beds. This would negate any proposed monetary savings on a Federal and State level.

The time-limited approach to recovery would result in a scattered approach to services where every consumer in the system would be considered appropriate for every rehabilitative service available in the hopes that something would help, rather than being goal directed and fiscally responsible. Skills and recovery are built over time and in a progressive manner. You cannot "teach" self esteem skill building for maximum functioning to an individual who is worried about safety, security and bill paying on a

daily basis. Community Support Services focuses on lower level skill building before beginning to work on skills for higher level functioning.

The Plan as written allows for the Medicaid program to abdicate any responsibility for the rehabilitation, health, and welfare of individuals suffering from chronic mental disorders. Because these individuals do not fall under the proposed "early access" clause and because their disabilities are chronic in nature, therefore their recovery would just take too long and therefore not be considered appropriate for rehabilitation services. I guess they just go home and wait for a relapse to occur so they can come into the system again. The proposed rule changes place an emphasis, not on rehabilitation for persons with mental health and substance abuse disabilities, but rather on the creative writing skills of the person developing the person-centered plan.

At issue is national mental health reform and having access to quality services across the nation. If the plan is adopted as written, the states will have to provide funding and administration of services which will lead to disparity in services. States with limited funding sources will see a drastic reduction in quality of services provided and as opposed to services provided in more affluent states.

Donna W. miller, MA, LPC
Donna W. Miller, MA, LPC

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REHABILITATION SERVICES

BRIDGEWAY

ADMINISTRATION
& PACT TRAINING AND
TECHNICAL ASSISTANCE
CENTER

PARTIAL CARE

UNION COUNTY
SUPPORTIVE HOUSING
& HOMELESS OUTREACH

HUNTERDON COUNTY
SUPPORTIVE HOUSING

PACT TEAM 1

PACT TEAM 2

PACT TEAM 3

PACT TEAM 4

PACT TEAM 5

PACT TEAM 6

CRIMINAL JUSTICE
& JAIL DIVERSION

RISE

September 28, 2007

Centers for Medicare & Medicaid Services

Dept of Health and Human Services

Attention: CMS-2261-P

P.O. Box 8018

Baltimore, MD 21244-8018

To Whom It May Concern:

Reference: File code CMS-2261-P

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

Bridgeway is a not for profit, community based psychiatric rehabilitation agency serving New Jersey residents who have serious mental illnesses. We operate six PACT teams, Supportive Housing services, PATH (homeless outreach) Supported Employment and Recovery Oriented Partial Care. We serve over 1000 people annually and they frequently have co-occurring substance abuse and chronic health problems. Most persons served are in the very low income category and have extensive mental health service histories.

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

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

Recommendation:

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

440.130(viii)(3) Written Rehabilitation Plan

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

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

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

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

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

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

Recommendations:

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

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

X that the plan use person first language as defined by the USPRA guidelines

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

Insert additional language into 441.45(a)(2) to describe when services may be furnished with the

goal of retaining or maintaining functioning.

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

441.45(b) Non-covered services

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

There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an intrinsic element of another program. We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service B in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

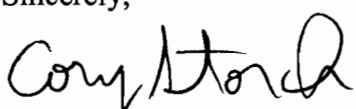
Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for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

Recommendation:

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

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

Sincerely,



Cory Storch, Executive Director
Bridgeway Rehabilitation Services

CC: Members of the State Congressional Caucus
The Honorable Jon Corzine, Governor of the state of New Jersey

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September 21, 2007

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

As an advocate for children and adults with disabilities and as a United States citizen I am very concerned with the possibility that the state of Arkansas may no longer be able to provide day habilitation services to children and adults in need as covered by Medicaid.

The day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. I have seen children make amazing progress; even when Doctors have given up on them. I have witnessed children increase their readiness for kindergarten. I have seen adults function in society leading productive and fulfilling lives while earning a paycheck and having pride in the work they do. I have seen families finding a social support group that they otherwise may have never had, allowing their child to remain in the home instead of having to be placed in a residential setting.

Without these services being available to persons with developmental disabilities, the cost will be significant and many people will not be able to reach their own potentials. The United States government must be stopped from making day habilitation services disappear in Arkansas. Please do NOT eliminate this critical service.

Sincerely,

Alice J. Robison

Concerned Citizen
Franklin County Learning Center, Inc.

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September 26, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services

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

To Whom It May Concern:

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

I believe that the proposed rule changes published on August 13, 2007, will have a dramatic effect on the Clubhouse Community and all persons with severe and persistent mental illness. Here we help to rebuild lives of individuals whom at no fault of their own have been diagnosed with a mental illness. We help by working side by side in the daily operation in every aspect of the Clubhouse. Building relationships, reestablishing self-esteem and self-worth is an essential part of a person's rehabilitation. Some people have been told by doctors, that they would never be able to work again. Through our help, we have been successful in increasing functioning levels through individuals working on the computer to input billing data. Assist in meal preparations for a group of seventy. Successful in operating banking transactions in our member bank. Helping with transitional employment, by gathering all needed information to help prepare people to go back into the workforce. These are only a few areas that help to prepare a person to sustain their illness with fewer hospitalizations. Another example, we have Supported Living Housing and members who never thought it would be possible to ever live independently, now live on their own. We just celebrated an 18 year anniversary for one of our residents. Just having a place to come to occupy time, you wouldn't believe the benefits: decreased depression, having a family orientated environment, where meaningful work is accomplished. We are not an Arts and Craft Day Program. We are so much more; we are their family and their hope to live as normally as you and I…..

Sincerely,

Charity Hector, BAOP

Centers for Medicare & Medicaid Services (263)
Department of Health & Human Services
PO Box 8018
Baltimore MD. 21244-8018 Attn: CMS-2261-P

My name is Ricky & I'll 48 yrs. old.
I've been suffering with depression & mental Illness
my whole adult life. I was suicidal until
I got on medication and then I still stayed
isolated from people until I was recommended
to Adventure House. Once I started Adventure
House it was like getting my life back.
It gives me a place to go and the feeling of
belonging, and a reason to keep living.
With my medication and the help of Adventure
House I'm living a much fuller life.
Yours Truly.

Ricky Dean Ramsey
833 Charles Rd.
Apt-A-2
Shelby, NC 28152

Wanda Burson
708 Park Ave Terrace
Shelby N.C. 28150
Sept 28/2007

Centers for Micaide & Medicar
Serves
Health and Human Serves
Attention CMS-2261-P
P.O. Box 8018,
Baltimore, MD. 21244-8018

Dear, Sir
I Wanda Burson
Came to Adventure,
Adventure in the 1980's
When I came into the doors
I was impessed, as It means
a lot to me I did not understand
How worked. I learned many
things throught years. There are opportu
nese hear. It made me
feel I can important here And
I learned many skill
I've many frein friends
this place it's all I
ever liked. for many years
sign Wanda B

Centers for Medicare + Medicaid Services 225
Department of Health + Human Services
PO Box 8018
Baltimore, MD 21244-8018 Attn: CMS-2261-P

Dear Sirs,

I would like for Adventure House to stay open, because when I started the ClubHouse one of my sons had just deceased. I withdrew from public and didn't want to see or be around anybody. I was informed by my case manager that Adventure House might be helpful to me. Every since I started I came out of my shell, and really enjoyed coming to Adventure House. I came every day ~~ever after~~ I had my pace maker put in. Now I have the gout, which slows me down, but I still attend even after 20 years.

If I hadn't came here, than I wouldn't have been able to interact with people at all. Now I can function better ~~and~~ because of Adventure House.

Mattie L. Lathem
825 Fredrick St.
Shelby NC 28150

Byran Dorsey
422 Monroe Drive
Shelby, NC 28150

September 27, 2007

Centers for Medicare + Medicaid Services
Department of Health + Human Services
Attn: CMS-2261-P
PO Box 8018
Baltimore MD. 21244-8018

Dear Sir:

I have been a member of Adventure House for ten years. When I first started to Adventure House I was very sick with mental illness. Adventure House has helped me a lot, I can function better since I have been at Adventure House. I have fun with my friends and I have learned how to do many other things. I would like for Adventure House to stay open so I will have some place to go everyday where people understands me.

Byran Dorsey

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September 28, 2007

Centers for Medicare & Medicaid Services
Attention : CMS-2261-P
P.O. Box 8018
Balimore, MD 21244-8018

To Whom It May Concern,

Reference: File code CMS-2261-P

The Clubhouse means a lot to me. I have found it to be very important to my well being. I like coming to Adventure House everyday Monday through Friday. It is a place where I feel I belong. I have relationships with my friends and staff. I stay busy while at the Clubhouse and do not worry or think about my problems.

I know when I didn't have a job the TEP program found one for me. God answers prayers. I hope you reconsider the recommendations that are being proposed so that Adventure House will be able to remain open for a long time.

Sincerely Yours,

Arneshia Blackmon

Mrs. Arneshia Blackmon
1833 Stony Point Road
Waco, N.C. 28159
704-435-8044

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn. CMS-2261-P
P.O Box 8018
Baltimore, MD. 21244-801

Betty D. McBrayer
9/26/2007

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To whom it May Concern,

I like Adventure House means so much to me. I felt so welcome when I first came. Everybody works together in each department. The head workers are always making a worker feel like you are doing a good job. A lot of people will be lost if it was closed down. I would be very upset if it were no longer in existence. I look forward to coming every day if I couldn't it would be lost in accomplishments to do.

Betty McBrayer
1332 East Stagecoach Trail
Lawndale North Carolina
28090

704-538-9677

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Grace Keyser
196 Diane Avenue
Hatboro, PA 19040
grace_keyser2004@yahoo.com

September 24, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007, submitted by Grace Keyser, 196 Diane Avenue, Hatboro, PA 19040.

OVERVIEW (PREAMBLE)

There is an incorrect statement in the preamble with respect to the availability of FFP for a Medicaid-covered service furnished to a child that is included in the child=s special education program under IDEA. Under the statute, Section 1903(c), Medicaid is not prohibited or restricted from paying for services that are included in the child=s individualized education program.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

440.130(d)(1)(v), Definition of Rehabilitation Plan

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. I applaud CMS for including requirements that are designed to ensure the individual's participation in this process, but believe the wording could be improved. There is a real difference between an individual providing "input" and an individual having "active" participation. By including both terms in different places, the regulation confuses this issue. Further, by requiring the plan to be developed by the provider significantly diminishes the role of the individual. In mental health service delivery, it is a better and far more common practice to have a service planning team working with the active participation of the individual than to have a single provider develop the plan.

In the preamble, CMS recommends the use of a person-centered planning process. There is, however, no reference to person-centered planning in the regulation itself.

Providers should also be encouraged to be flexible in response to the individual's needs. Serious mental illness is often a cyclical disorder and, in the course of their recovery, individuals may suddenly deteriorate, requiring a change in services. Service planning and goal setting should anticipate this need and crisis plans need to be developed as part of the rehabilitation plan.

Rehabilitation providers should also be encouraged to inform individuals that they have the right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated. All Medicaid providers are required under federal law to inform individuals about advance directives, although state law governs how those directives are to be developed and implemented.

Recommendation:

Revise the language under paragraph (v) so as to require the plan to be developed by a team that is led by a qualified provider working within the State scope of practice act, with the active participation of the individual (unless it is documented that the individual is unable to actively participate due to their medical condition), the individual's family (if a minor or as the individual desires), individual's authorized decision maker and/or of the individuals choosing and following the guidance of the individual (or authorized decision-maker), in the development, review and modification of the goals and services.

This change should also be made to section 440.130(d)(3)(ii) and (xiii).

Add language to Section 440.130(d)(1)(v) to the effect that CMS encourages the use of person-centered planning processes.

Encourage providers to take into account the possibility of relapse, and incorporate within individuals' rehabilitation plans provisions for how they will respond should crises arise.

When developing a rehabilitation plan with the individual, providers should inform the person of their right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated.

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

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

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. I am concerned that states

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and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Recommendation:

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

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

440.130(d)(1)(vii) Definition of medical services

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person's functional capacity. Clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

This definition also includes the word "care" after treatment, but that term is nowhere else defined. Does it mean clinical care? The word "rehabilitation" should be inserted here to make clear the term "medical services" includes rehabilitation. This is important because the term "medically necessary" is used in this regulation to indicate necessary rehabilitation services.

Recommendation:

Add to section (vii) the word "assessment" before the word "diagnosis" and replace the word "care" with the word "rehabilitation".

440.130(d)(1)(viii)(2)Scope of Services

The definition of scope of services is limited to medical or remedial services. However, the term "restorative services" is also used in this regulation to describe covered rehabilitation services.

Language is included in the preamble to the effect that services are to be provided at the least intrusive level to sustain health. Coupled with states' obligations to furnish care in the least restrictive setting, this wording can encourage providers to focus on delivery of the most

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effective community services that can improve the individual's functioning within a reasonable time frame and discourage provision of restrictive levels of care that are unacceptable to the individual.

Recommendation:

Insert the word "restorative" after medical in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

Insert into this section a requirement that rehabilitation services be delivered in a coordinated manner.

The preamble phrase "services are to be provided at the least intrusive level to sustain health and ensure the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level" should be added to the definition of the scope of services, and additionally, services should also be required to be provided in the most integrated, appropriate setting.

440.130(viii)(3) Written Rehabilitation Plan

The inclusion of this section is to be commended, and generally I agree with the intention as well as the specific language. However, I urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed.

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

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

Finally, there should be documentation that the provider has provided the individual with information on advance directives.

Recommendations:

I recommend inclusion of the following requirements regarding the written rehabilitation plan:

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- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan.
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- certification that the individual has been informed about their rights regarding advance directives;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers.

CMS should also encourage a single treatment and rehabilitation plan and a single planning team and service planning meetings.

440.130(4) Impairments to be addressed

The regulation states that services may address an individual's physical impairments, mental health impairments and/or substance-related disorder treatment needs. In describing this section in the preamble, the agency also states that because rehabilitative services are an optional service for adults, states have the flexibility to determine whether they will be limited to certain services for specific populations.

Limiting services to only one group, based on diagnosis or disability violates Medicaid's requirement that services be furnished in sufficient amount, duration and scope to reasonably achieve their purpose. Excluding coverage of rehabilitative services needed by individuals with mental illnesses would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:

Section 440.130(4) should be changed to delete "/or" after the word "and" in this sentence.

440.130(5) Settings

In addition to the settings cited in the regulation, it would be helpful to add some of the settings where other sections of the regulation limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add in the regulation settings described in the preamble.

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Recommendation:

Add to the list of appropriate settings for rehabilitation services "schools, therapeutic foster care homes, and mobile crisis vehicles."

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

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targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

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

Recommendation:

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

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

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

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

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

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

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on

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Mental Health from the U.S. Surgeon General). The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

If states are not able to create a package of covered services as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs.

The regulation makes no acknowledgment that therapeutic foster care is a mental health service, provided through mental health systems to children with serious mental disorders who need to be removed from their home environment for a temporary period and furnished intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system; it is not a service exclusively for children in the foster care system.

Recommendation:

Therapeutic foster care should be listed as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, states should be given the discretion to define therapeutic foster care as a single service and pay through a case rate, daily rate or other appropriate mechanism.

Language should also be included in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care.

441.45(b)(3)

The Preamble includes examples of when recreational or social activities may be covered services due to a focus on skill building or other rehabilitative needs. However, the regulation does not include any examples or any specific language explaining when these activities are covered services. This is a serious omission, as the regulation alone may be interpreted in the field as denying any recreational or social activities no matter how therapeutic and how focused they are on restoring functioning.

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are covered rehabilitative services. It would be helpful if CMS would clarify this and also explain to providers how they document that a service is personal care skill building, even though the provider may have had to demonstrate (and therefore provide) personal care in the process.

Recommendations:

Language that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation services should be included in the regulation at section 441.45(b)(3).

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The regulation should clarify how personal care furnished as an integral part of personal care skills training is covered and how it is to be documented.

Individuals in Secure Custody and Residing in Public Institutions

The addition of the phrase "in secure custody" of law enforcement is unnecessary as the regulation also requires that the individual be residing in a public institution. The law only stipulates that FFP not be available for individuals in a public institution, and does not reference secure custody.

Recommendation:

Delete the phrase "in secure custody."

441.45(b)(7) Services for individuals who are not Medicaid eligible

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered. In the preamble (page 45207) there is an explanation of how services that are furnished through contacts with non-eligible individuals, but which are exclusively for the treatment of Medicaid-eligible individuals, are covered. No such explanation, however, is included in this section.

Recommendation

The language in the preamble explaining when services may be furnished through contacts with relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services should be included in the regulation.

OTHER ISSUES

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services through 15-minute increments and the denial of payment through daily rates, case rates and similar arrangements are supported by language in the regulation, at least by inference.

These new shifts in rate setting methodology are not efficient and are moreover extremely detrimental to the provision of evidence-based mental health services which are more and more frequently being offered as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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

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

Recommendation:

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

EPSDT Mandate

The regulation appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. In several places, the regulation needs to be amended to reflect the EPSDT provision.

Recommendation:

Section 441.45(a), insert a new paragraph clearly stating 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.

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

Section 441.45(a)(5) should clarify that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically-necessary.

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

Sincerely,

Grace Keyser

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September 20, 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

Dear Sir or Madam:

I am writing to urge you to fully implement the recommendations of the National Alliance for the Mentally Ill regarding the proposed regulations on coverage for Medicaid Rehabilitative Services. Those recommendations represent the wisdom of those who are challenged by mental illnesses and their families, who know very well what rehabilitation services are necessary to the process of recovery from mental illnesses.

Thank you,

Doreen Joyce

Doreen Joyce
Elgin, IL

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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 being submitted on behalf of the National Disability Rights Network (NDRN). NDRN is the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) systems and the Client Assistance Programs (CAP). The P&A/CAP network operates in every state and territory and provides free legally-based advocacy to ensure the rights of children and adults with disabilities. NDRN strongly urges you to reconsider numerous provisions of the proposed rules which appear to violate EPSDT requirements and overstep CMS's rulemaking authority.

Medicaid has long been recognized -- on a bipartisan basis -- as the driving force behind the availability of individualized, community-based supports and services that enable people with disabilities of all ages to lead fuller, healthier, and more productive lives. Medicaid's structure is critical to future progress toward community integration. For years, CMS has recognized the great opportunity and role it has to identify new avenues for Medicaid coverage of community supports and services. These efforts have been consistent with the Presidents New Freedom Initiative and Executive Order 13217 issued on June 18, 2001 announcing an effort among all federal entities to remove barriers to community living for people of all ages with disabilities. For example, CMS has issued numerous "state Medicaid Director letters" that demonstrate to Medicaid Directors how long-standing or recently issued Medicaid policies can be used to assist individuals with disabilities to move from institutions to the community with appropriate Medicaid supports.

NDRN is concerned that the proposed rehabilitation rules will scale back the rehabilitative services available to children and adults with disabilities and create new barriers to full participation in the community. In many such cases, loss of these vital rehabilitation services will

likely lead to deterioration in abilities (resulting in a need for higher cost medical treatment) and loss of independence, community and family involvement. In addition, NDRN is concerned that unwanted institutionalization will end up being the only option available to receive critical services. Numerous studies have shown institutional costs to be higher than the cost of providing comparative services in the community (See: Stancliffe and Lakin, 1998; and Moss, D., & Foss, A. 2000). Yet, additional costs from treating more involved medical needs, and increased institutionalization were not taken into account in the CBO score of savings from the proposed rule.

The comments submitted to CMS by the Coalition of Citizens with Disabilities (CCD) go into detail regarding our concerns. NDRN is in full support of CCD's comments and the accompanying recommendations. As a legal services organization we feel it important to highlight those portions of the comments reflecting our belief that the proposed rule contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.

I. The Intrinsic Element Test Oversteps CMS Rulemaking Authority

The proposed rule would deny Federal financial participation (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.

In addition, the reference to services "that are intrinsic elements of programs other than Medicaid is not properly defined and this lack of definition is likely to lead to uncertainty for beneficiaries, their families, and health care providers as states grapple with figuring out what can and cannot be covered under this vague test. This uncertainty is sure to mean fewer states seeking to implement the multi-program coordination that has been identified by CMS as a promising practice leading to improved coordination between programs and intensive community supports. There are already mechanisms states use to ensure that Medicaid does not pay for services that are the responsibility of other programs, such as pursuing a fraud and abuse action. 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).

Another unintended consequence of the proposed rule may be denial of necessary EPSDT services for children. When EPSDT is at issue, even if a third party is liable, 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. The proposed rule adds yet another layer of administrative cost and likely confusion and may have a chilling effect on a states willingness to attempt multi-program coordination.

II. 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.

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

We suggest an overall restatement of the EPSDT requirement in the regulations, consistent with the recommendation in the comments of the Judge David L. Bazelon Center for Mental Health Law:

> Insert a new paragraph in § 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when necessary to correct or ameliorate a physical or mental illness or condition.
>
> Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct a physical or mental illness or condition.
>
> Amend § 441.45(b)(4), to refer to the EPSDT requirement and instruct states to comply with it.

III. The proposed rule will lead to unnecessary institutionalization of individuals with disabilities.

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. The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. NDRN is concerned that the proposed rules will have a negative impact on the ability of states to pay for these services.

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 unnecessary institutionalization. As we explained earlier in our comments, unnecessary institutionalization usually costs more than equivalent community services and these costs were not reflected in the CBO score for the proposed rule. Much more important, is knowing that the proposed rule will deny the civil right of and individual to receive services in the most integrated setting appropriate as required by the Americans with Disabilities Act (28 C.F.R. § 35.130(d)).

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

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.

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).

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."*

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.

V. Transitioning Rehab Option Services into Waiver Services Does Not Provide an Equal Service

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

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

NDRN is already concerned that 1915(c) and 1915(i) waiver programs often have long waiting lists, on which individuals needing community services can languish for years. When a state provides these services under the rehabilitation option waiting lists are not permitted. It seems in

direct conflict with the ADA integration mandate (28 C.F.R. § 35.130(d).) and the new Freedom Initiative to restrict access to rehabilitation services, knowing that there is no ready alternative source of these services – except for unwanted, inappropriate and often more costly institutionalization. NDRN strongly recommends that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

VI. Discriminatory Definition of Rehabilitation Services

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

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

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. CMS must comply with all civil rights laws and this policy appears to violate the ADA's prohibition of discrimination on the basis of disability (see: 28 C.F.R. § 35.130(d). We urge the Secretary to rescind this constraint on rehab option services.

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

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

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

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

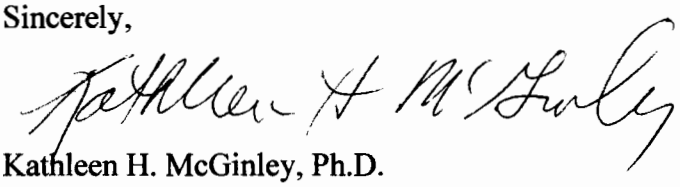
Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitation services in school settings, new requirements of this rule could be disruptive to schools and could make it more difficult to use the school environment to assure that children with disabilities receive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

programs to use school settings to provide essential rehabilitation 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.

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 rehabilitation services, consistent with Title XIX of the Social Security Act. Thank you for the opportunity to comment on the proposed rule. If you have any questions, please let me know (Kathy.mcginley@ndrn.org)

Sincerely,



Kathleen H. McGinley, Ph.D.
Deputy Executive Director for Public Policy

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Andrea Holland
11 Corticelli Street
Florence, MA 01062

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:

I am writing about the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services, published in the Federal Register on August 13, 2007. I have been working at Riverside Industries, Inc. in Easthampton, MA for more than 10 years. I am committed to our mission of serving people with disabilities. This non-profit organization has been a driving force behind client-driven services that ensure clinical consults for communication augmentation, direct therapies such as physical therapy, occupational therapy, and alternative therapies, as well as behavioral and emotional learning. I am writing to urge you to oppose the provisions related to excluded federal financial participation (FFP) for habilitation services and I urge you to withdraw this proposed rule.

The proposed rule would eliminate established programs that provide day habilitation services and it would impose discriminatory exclusion with regard to rehabilitation services for people with mental retardation and other related conditions.

States should have flexibility to continue operating habilitation programs under the longstanding state plan options. This option was intended to give states added flexibility, not to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities. 1915 (c) waiver programs are known for having long and large waiting lists. The NPRM is likely to have the same problems. I urge you to oppose implementing the proposed exclusion of FFP for habilitation services under the clinic and rehab options.

Finally, I strongly oppose the proposed rule's definitions of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." This exclusion violates a fundamental principle of Medicaid: that medical assistance be 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].

I urge the Secretary to rescind the constraint on rehab options that is so blatantly stigmatizing and discriminatory to people with developmental disabilities. Thank you for your attention to this gravely important matter.

Andrea Holland

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ARKANSAS MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

Division of Behavioral Health Services
4313 West Markham
Little Rock, Arkansas 72205-4096
Telephone (501) 683-0312 *FAX* (501) 686-9182 *TDD* (501) 686-9176
E-Mail joyce.soularie@arkansas.gov

September 25, 2007 *via e-mail*

Mr. David Campbell, Chief
Permits and Technical Assessment Branch
Mailcode 3AP11
U.S. Environmental Protection Agency, Region III
1650 Arch Street
Philadelphia, PA 19103

RE: Docket ID # EPA-R03-OAR-2006-0060

Dear Mr. Campbell:

On behalf of the Arkansas Mental Health Planning and Advisory Council (AMHPAC), I am writing to inform you of the potential impact of the Centers for Medicare and Medicaid Services' (CMS) proposed changes to rehabilitative services for the consumers and families of Arkansas who depend on Medicaid reimbursement for community-based behavioral health services.

As listed in the *Federal Register*, under the new rules, CMS would no longer pay for habilitation services through the Medicaid rehabilitation program. Habilitation services are defined as helping individuals acquire new functional abilities, while rehabilitation is defined as helping individuals reacquire lost functional abilities. If this new language is adopted into Medicaid regulations, many Arkansas children and their families will lose rehabilitation services. These children have been dealing with brain disorders from a very young age. They are receiving services that help them achieve abilities that their peers develop naturally. Yet our children need community-based behavioral health services to achieve such abilities. Without these needed services the number of children who will go into juvenile justice and residential treatment placements will increase dramatically.

The *Federal Register* also discussed not allowing Medicaid reimbursement for maintenance of individual level of functioning. Many of the adult consumers in our public system are in need of many habilitation services to successfully be maintained in the community setting. Without these services these individuals will end up in institutional settings - and the cost for their care will be transferred to the prison system, nursing homes and state- or federally-run residential facilities (state hospitals, V.A. facilities, and residential care facilities [RCF]). The state hospitals have decreased bed capacity dramatically over the last thirty years since deinstitutionalization; if these proposed regulations are implemented we will return to dependency on bed-based institutions like we did in the sixties and seventies. This dependency on such institutions will cost more than community-based care.

We are pleased, however, with the proposed intent to embrace recovery- and person-centered planning principles.

AMHPAC respectfully writes this letter asking that the thousands of Arkansas consumers and their families be allowed to keep the services that allow them to live in their own communities.

Sincerely,

Joyce Soularie
State Chairperson

cc: The Honorable Arkansas State Governor Mike Beebe
The Honorable United States Senator Blanche Lincoln
The Honorable United States Senator Mark Pryor
The Honorable United States Representative Marion Berry
The Honorable United States Representative John Boozman
The Honorable United States Representative Mike Ross
The Honorable United States Representative Vic Snyder

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DISABILITY POLICY COLLABORATION

A Partnership of The Arc & United Cerebral Palsy

October 10, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

The following comments are submitted on behalf of The Arc of the United States and United Cerebral Palsy. The Arc is the oldest and largest advocacy organization for people with intellectual and developmental disabilities and their families United Cerebral Palsy (UCP) is one of the largest charities in America and works, through its affiliate network, to advance the independence, productivity and full citizenship of people with disabilities.

We believe that the proposed rule is unjustified and unnecessary, and that 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.

In addition, we believe that the proposed rule does not fully comply with the Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate for children and would have a serious impact on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that the proposed rule complies with Medicaid's 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.

Most importantly we believe that 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 rehabilitative 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." (Report of the House Budget Committee, "Explanation of the Commerce and Ways and Means Committees Affecting Medicare-Medicaid Programs," Sept. 20, 1989) It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

In contradiction to the plain language of Section 6411(g) of OBRA '89, the proposed rule **does not** specify which day habilitation services that a state may cover. Instead, the proposed regulation would prohibit the 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 coverage for habilitation services as a component of the clinic and rehabilitative 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 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 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 rehabilitative 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 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 aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the 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, something that is not permitted for clinic or rehab option services. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006). Shifting habilitation services to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable.

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

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

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

Very truly yours,

Marty Ford

Marty Ford
Director of Legal Advocacy
The Arc and United Cerebral Palsy Disability Policy Collaboration

215

Amanda Texeira
116 Mazarin Street
Springfield, MA 01151

To Whom It May Concern:

I am writing as part of a movement on behalf of myself, my colleagues, and the individuals we serve here at Riverside Industries, Inc. and other day hab programs throughout our state and our nation.

It is clear that the passing of the proposed rulemaking (NPRM) regarding Medicaid coverage of rehabilitative services, would have detrimental effects on the individuals we would serve in Day Hab Programming in the future.

This plan offers no answers for the individuals or their team members. What is to happen to those who would be turned away when the cap is reached? These Day Programs have proven to be critical in the lives of the individuals we serve. How can you legally regulate and measure quality of life?

The options currently in place allow for flexibility when running habilitation programs. This model has proven to be incredibly successful in comparison to those states which have already

adopted the plan of including Day Habilitation services under more restrictive rehab and clinic options.

Without oversimplifying the situation, it appears to make little sense to me (and I'm sure, to others who serve as team members of those individuals who would be affected by this ruling), why you would pass a ruling so uniquely backwards in terms of progression of our movement. I strongly oppose this ruling, and I hope that our voice is loud enough to help our legislators make the right decision.

Sincerest thanks,

Amanda Texeira

Amanda Texeira,
Developmental Specialist
Riverside Industries, Inc.

CHARLES A. WILSON
6TH DISTRICT, OHIO

FINANCIAL SERVICES

SUBCOMMITTEE ON FINANCIAL INSTITUTIONS & CONSUMER CREDIT

SUBCOMMITTEE ON HOUSING & COMMUNITY OPPORTUNITY

SUBCOMMITTEE ON DOMESTIC & INTERNATIONAL MONETARY POLICY, TRADE & TECHNOLOGY

SCIENCE & TECHNOLOGY

SUBCOMMITTEE ON TECHNOLOGY & INNOVATION

RURAL CAUCUS

SPORTSMEN'S CAUCUS

STEEL CAUCUS
EXECUTIVE BOARD

Congress of the United States
House of Representatives
Washington, D.C. 20515-3506

October 12, 2007

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

Re: CMS-2261-P/Provisions of Proposed Regulations for Medicaid's Rehabilitative Services Option

To Whom It May Concern:

I am writing today regarding the proposed regulations for Medicaid's mental health rehabilitative services. I appreciate the opportunity to comment on this important issue. With Medicaid serving as the primary public funding source for mental health services, many under the Medicaid's rehabilitation option, it is essential that any proposed regulations are carefully considered.

I support the proposed regulations that would require a written rehabilitation plan outlining the services that will be provided; and support the involvement of both the beneficiary and their family. I believe the creation of a rehabilitation plan is necessary to measure accountability and success of a program.

While I fully support a beneficiary's involvement in developing a plan, I encourage some flexibility within the rules to allow providers to conduct outreach to individuals who may not be ready to be part of a formal treatment planning process. Therefore, I encourage Centers for Medicaid and Medicare Services (CMS) to include language within Section 440.130(d)(3) that recognizes the need for the use of early engagement services.

Psychiatric rehabilitation plays a key role in helping individuals; which is why I was pleased to see that CMS recognized psychosocial rehabilitation services as an integral component of metal health services. As you know, psychiatric rehabilitation focuses on helping individuals to access the resources they need to increase their capacity in order to have a successful living, working, learning and social environments; and is essential in ensuring an individuals rehabilitation success.

Additionally, I support the proposed regulations that allow for flexibility in how rehabilitation services are paid. Allowing states flexibility will ensure the continuation of many highly effective programs. If executed correctly, these services would focus on the improvement of the disability and achievement of specific rehabilitation goals, and not duplicate services intrinsic to programs outside of Medicaid.

226 CANNON HOUSE OFFICE BUILDING	800 MAIN ST.	4137 BOARDMAN-CANFIELD RD.	1200 MAIN ST.	258 FRONT ST.	202 PARK AVE., SUITE C
WASHINGTON, DC 20515-3506	BRIDGEPORT, OH 43912	CANFIELD, OH 44406	WELLSVILLE, OH 43968	MARIETTA, OH 45750	IRONTON, OH 45638
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TOLL FREE (888) 706-1833 • WWW.CHARLIEWILSON.HOUSE.GOV • PRINTED ON RECYCLED PAPER

Again, thank you for the opportunity to comment on this important issue. If you have any additional comments or concerns, please contact my aide, Melissa Benish, at (202) 225-5705.

Sincerely,

Charlie A. Wilson

Charlie Wilson
Member of Congress

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September 21, 2007

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

As an advocate for children and adults with disabilities and as a United States citizen I am very concerned with the possibility that the state of Arkansas may no longer be able to provide day habilitation services to children and adults in need as covered by Medicaid.

The day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. I have seen children make amazing progress; even when Doctors have given up on them. I have witnessed children increase their readiness for kindergarten. I have seen adults function in society leading productive and fulfilling lives while earning a paycheck and having pride in the work they do. I have seen families finding a social support group that they otherwise may have never had, allowing their child to remain in the home instead of having to be placed in a residential setting.

Without these services being available to persons with developmental disabilities, the cost will be significant and many people will not be able to reach their own potentials. The United States government must be stopped from making day habilitation services disappear in Arkansas. Please do NOT eliminate this critical service.

Sincerely,

Anita L. Peters

Concerned Citizen
Franklin County Learning Center, Inc.,
Stepping Stone School
and all therapy services
Crawford County, Arkansas,

218

530 Kent St.
Chestertown, MD 21620
October 10, 2007

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

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

Dear Sir or Madam:

I am pleased to have the opportunity, as a parent of an adult son (one of four sons) who suffers from serious mental illnesses (having a dual diagnosis), to comment on the proposed rule regarding coverage for rehabilitative services under the Medicaid program.

Although there may also be more, a couple of old sayings, or proverbs, immediately came to mind as applicable when reading about the proposed changes:

"Penny-wise and pound-foolish" and
"For want of a nail, the horse was lost."

With appropriate community rehabilitative services, those with mental illnesses often can improve and function re daily tasks and life in the community. Without such services, what are the alternatives? Expensive hospitalizations, expensive custodial care, homelessness, inability to live to one's potential, jail incarcerations, or worse. Didn't we all learn something from the recent Cho shootings at Virginia Tech about what happens when appropriate community services are not provided or provided for?

I wish to speak mainly to Section 440.130(d)(1) Rehabilitation and Restorative Services, though there also others that are presently problematic as well; they also could and should be improved. Under the proposed regulations and the preamble, rehabilitative goals have to be targeted at progress. They can't be used to maintain stability unless that is linked to another goal where they are still working on improvement. But mental illness does not work in a straight line upward. For many with mental illness (including our son), the path to recovery is not straight up or down. It is often a process with periods of progress and periods where symptoms may have to be closely managed to prevent deterioration. The changing course of serious mental illness must be factored into the proposed regulations governing rehabilitative services.

For some who have been hospitalized or in jail, "merely" staying stable is not easy and is an achievement. It also requires services so they do not deteriorate and get worse. This is especially true in our son's case. He was recently dismissed from a community day program, evidently because he was not considered by somebody to be making adequate progress, whatever that was considered to be (never defined, and he will appeal). He was told to find another, more appropriate program, but that is a crock--this is a rural area and there is no other program at all, appropriate or otherwise. In his case, just getting himself to the program and participating to the extent he can keeps him stable, prevents further deterioration, and avoids hospitalization (which likely wouldn't do him much good anyway, partly because hospitals discharge too soon). What has he been doing most of the time since discharged from the program? He feels hopeless and spends most of his time in bed. I hope your agency will adjust its regulations to take into account the nature of mental illnesses and allow services to prevent deterioration.

Sincerely,

Margaret Q. Fallaw

Margaret Q. Fallaw

cc: Congressman Wayne Gilchrest

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James and Carol Howe
7401 Willow Rd.
Frederick, MD 21702

October 8, 2007

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, Md. 2144-8018

Dear Sir or Madam:

We are parents of two persons with schizophrenia. For nearly fifty years we have watched their courageous struggle against this disease. We have seen them refuse to accept medications and other services for their illness and watched the inevitable deterioration in their health and consequent costly hospitalizations. Then we have seen them accept their mental illness and the treatments that would restore their path to mental health. We have watched this expensive, destructive cycle repeat itself. Happily those days are over. After many years of repeating this cycle, they have got the message that they do have a brain disorder and that the treatments and supports that they receive do help them achieve normal lives.

The proposed changes that you propose may, as you predict, "save" more than 2 billion dollars in the budget that you are responsible for. However, we know from painful experience that what you save will be small in comparison with the increased costs in expensive hospitalizations, increased expenses in jails and prisons, in costs for police and other emergency services.

History records eons of human experience in which "madness" of a substantial fraction of humans was the common experience. The only response was confinement in jails, prisons, and hospitals with unspeakable cruelty. Finally, this generation of humans has discovered that the cause of these painful conditions lies in our physical brains. It is discovering treatments that restore victims to normal productive lives. This has opened the promise of putting the unspeakably painful past behind us. Science has made this is possible- but only if state of the art treatment and supports are available. Now such treatment and support are only available for a minority of mentally ill persons. It would make economic and humane sense to bring state of the art treatment and supports to all persons with these brain disorders as science continues to search for breakthroughs that will end the scourge of mental illnesses.

Given the unique promise that science has brought to the human family, it is indescribably distressful to learn that you are searching for ways to protect your budget at the inevitable cost to the budgets of other parts of government and to the lives of those millions of Americans who suffer from these no fault mental illnesses.

Please reconsider the changes that you are proposing in your budget in the light of the impact that such a course would have on the budgets of other parts of the government and on the millions of Americans whom fate has singled out for mental illness.

Sincerely,

James W. Howe

Carol W. Howe

Carol W. Howe

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October 10, 2007

To whom it may concern,

I am strongly against the Proposed Rulemaking (NPRM) The Proposed Rule is a step back in the progress we have made in our Great State of Massachusetts. I work for Riverside Industries Inc in Easthampton and I am committed to our mission of serving people with Disabilities. By passing this proposed Rulemaking (NPRM), you would be selecting a form of Exclusion and Discriminate against people with Developmental Disabilities and Mental Retardation. Please make sure you do not stimatize or Discriminate against the people that I serve.

Sincerely,

Robin Brokos

4 Tarleton Court
Northport, NY 11768

221

October 11, 2007

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

RE: File Code CMS-2261-P

To Whom It May Concern:

As parents of a son with Autism, we are writing to express our strong opposition to regulations proposed by the Center for Medicare and Medicaid Services (CMS) which would drastically eliminate many clinical services currently provided to individuals with developmental disabilities. These proposed regulations would change the definitions of "habilitation" thereby resulting in excluding necessary speech therapy, occupational therapy and physical therapy from allowable services in Medicaid clinics for individuals with autism and other developmental disabilities.

It is estimated that in 2006, nationwide approximately 52,000 people with autism and other developmental disabilities received necessary habilitation services through the clinic and rehabilitation options that are being eliminated by these proposed regulations.

As a result, we strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services and urge that this proposed rule be withdrawn. The proposed rule would severely harm people with autism and other developmental disabilities in two major ways:

(1) It eliminates longstanding programs for providing habilitation services to people with autism and other developmental disabilities
(2) It imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with autism, mental retardation and other developmental disabilities.

Developmental Disabilities Institute (DDI) is one of the largest not for profit providers of services to individuals with autism and other developmental disabilities on Long Island, and our son receives these essential services from Developmental Disabilities Institute. Over 3,000 clinic visits a year would be eliminated by these proposed regulations at our clinics alone. I believe that States should have the flexibility to continue operating these very necessary habilitation services to individuals with autism and other developmental disabilities. We urge the Secretary to rescind these proposed regulations.

Thank you.

Very truly yours,

Virginia R. Kacin / William L. Kacin

William L. Kacin
Virginal R. Kacin

222

Heather Petrowicz
155 Holyoke st.
Easthampton MA
01027

Center 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,

I am writing in regards to the proposed rulemaking (NPRM) Medicaid Coverage of rehab Services [file Code CMS-2261-P] published in the federal Register on August 13, 2007. I have been employed with Riverside Industries Inc. for about 3 yrs. We are a non-profit organization that is committed to Serving people with disabilities. I am writing to urge the opposition and withdrawl of the proposed rule related to the excluded federal financial participation (FFP).

If the proposed rule goes into effect it will dissolve Services to people who have yet to receive Services due to age and/or Not eligable yet. It would also cut aide to the people we Serve by making amount of ratios to increase. the care we give is important and should stay the way it is.

I urge again the opposition and withdrawl

of this current proposal.

Sincerely,
Heather E. Petrowicz

Heather E. Petrowicz

223 10-9-07

Centers for Medicare and Medicaid Services
Attention: CMS-2261-P
PO Box 8018
Baltimore, MD 21244-8018

To Whom it May Concern,

I beg of you not to cut funding for Mentally ill patients! My daughter is 25 years old and has suffered from shizophrenia ~~for~~ since age 15. She attends a Clubhouse model facility in Durham, NC. Called Threshold. It's the only uplifting thing that has happened to her in recent years. She lives to attend this facility daily! PLEASE don't take Her only reason for getting out of the bed in the morning away. Even the threat of losing Threshold has my daughter in tears. She says 'what will happen to me if I lose Threshold'.

The changes you are proposing will hurt the group of people in this society who ~~cannot~~ are the most powerless. Mentally ill people are considered "throw-aways".

Don't throw away the only hope they have!

Sincerely,
Cindy Knapp
Durham, NC

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Places for People, Inc.

4130 Lindell Boulevard St. Louis, Missouri 63108 (314) 535-5600

E-mail: contact@placesforpeople.org www.placesforpeople.org

October 9, 2007

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

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

Dear Sir or Madam:

Thank you for allowing the opportunity for the mental health community to comment on the proposed rule changes for rehabilitative services. As a provider of substance abuse services within a community mental health agency, I see first hand the value of rehabilitative services for individuals in quadrant four (severe mental illness and severe substance abuse). Our agency provides ACT services to these individuals on a time unlimited basis. We have consumers who make great strides year to year and advance greatly in their ability to function as a part of the community, eventually having little need for our ongoing services. Unfortunately this is not the norm for us, or other providers who serve those with sever co-occurring disorders.

The face of our average consumer has evolved over the years. Being one of the first community mental health agencies available after deinstitutionalization, our "original" consumer population were those clients who were held in hospitals. When they were released, they lacked the necessary skills to living in an independent setting. Places for People was then available to provide skills training to those clients who needed to learn how to resume functioning in the greater society. These consumers continue to receive services from our agency on an ongoing basis to maintain or increase their ability to live in the least restrictive setting possible.

The new face of the consumers we serve is much younger. These individuals need assistance with both their ongoing mental health concerns and their increasingly common co-occurring substance abuse disorders. Having never been institutionalized, this new client population needs a different type of rehabilitation, often focused on rebuilding the

bridges that were damaged during the course of their two destructive no-fault illnesses. Both mental illness and substance abuse disorders are chronic relapsing conditions. Both follow a cycle that will lead the person to make great strides and cataclysmic setbacks.

Due to the cycle that I see daily in the lives of the consumers I serve, I would like to illustrate several concerns that I have with the new proposed regulations for individuals living with mental illness and substance abuse disorders.

Although I understand the need to curb spending, I am troubled by the figure that the new rules will save the federal government 2.2 billion dollars in spending. To this mental health provider, it is very disconcerting that a system that has been illustrated as so fragmented by the President's New Freedom Commission is going to have considerably less money to rebuild itself. This lack of funding for vital services will lead to an increase in hospitalization, incarceration, and other negative outcomes that are not only bad for the individuals involved, but pushing people into these more involved systems of care will increase overall government spending for this population.

As a social worker for an agency whose core population is acquired through assertive outreach, I have great concern about the wording under **Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan** which excludes provisions for outreach and crisis services. An entire team in our agency is devoted to bringing in new clientele who are currently homeless. This team, called the ACTION team, follows a process of referral, engagement, assessment, treatment planning, and then goal directed service provision. I am concerned that the engagement, assessment, and pre-treatment planning process will not be covered under the wording of these new regulations. It is impossible for our agency to continue to provide service to the population we assist without funding for these outreach services. **I would ask that this section include a provision for payment for outreach and emergency services.**

As noted above, the disorders that our consumer's live with are chronic relapsing conditions. Even with access to the best medication, treatment, and support available, individuals with mental illness and substance abuse disorders are prone to relapse. Unlike those who have contact with the best supports, the consumers we serve have limited access to costly medications and treatments, and often lack connections with family, leaving their social support squarely on the shoulders of agencies like ours. It is because of this volatility that I advocate for a revision to **Section 440.130(d)(1) Rehabilitation and Restorative Services** to include services that allows **payment for rehabilitative services to prevent deterioration as well as to restore functioning.** This addition will better accommodate the nature of the illnesses CMS seeks to serve with these proposed rules.

Section 441.45(b) Exclusion of services, including those that are an "intrinsic element" of other programs expresses a limitation to the coverage provided under the new Medicaid rules. This section indicates that services that are "intrinsic" to other systems of care will not be covered. This language and provision erects a barrier to adequate service provision for this group of people through its reference to "other

programs". It is not appropriate to require individuals, family members, and state policymakers to determine what is intrinsic to other programs. This ambiguity places states in an untenable position. They can either forego federal funds that they may be entitled to or they can bill Medicaid and risk an audit and the eventual loss of state dollars. It is my desire that this entire section be removed from the regulations. This cumbersome rule requires individuals with mental illness, families, and other providers to speculate about the services provided under other systems of care.

As the regulations read currently, individuals in need of habilitation services are markedly absent from the new rules. **Section 445(b)(2) Exclusion of habilitation services** expressly neglects individuals with mental retardation and related conditions. This is discriminatory and limits the benefit available through a system of care that assists people in great need. Please consider removing this section which categorically excludes people with mental retardation from accessing rehabilitation services.

To address **Section 445(b)(3) Exclusion of recreation or social activities that are not focused on rehabilitation**, I would first like to congratulated CMS on its inclusion of social and recreational services which are focused on rehabilitation. In community mental health, a portion of our time is spent in social settings with consumers, modeling and in-vivo teaching the consumers how to engage in the community. Due to the great importance of this kind of rehabilitation, it is essential that services be provided to address specific functional impairments which may be done in the context of work or educational settings.

I would, again, like to express my gratitude for the opportunity provided by CMS to the mental health community, allowing us to speak out about changes to the rehabilitation regulations before they finalized is a benefit that is greatly appreciated. Please carefully consider the recommendation put forth in this and the other letters you receive. Remember that individuals with mental illness and substance abuse disorders rely on the services for the hope of a better quality of life. The rehabilitative services provided under Medicaid allow people to live more fulfilling and independent lives. Thank you for allowing this forum to ensure that those most involved in the services provided have a voice.

Sincerely,

Kim Warden, MSW, ITC

Kimberly Probst Warden, MSW
Integrated Treatment Coordinator
Places for People
4130 Lindell Boulevard
St. Louis, Missouri 63108
(314) 535-5600

225

PATH Treatment Foster Care and Family-Based Services
National Support Center

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www.pathinc.org

October 10, 2007

Center for Medicare and Medicaid Services
Department of Health and Welfare
Attn CMS-2261-P - PO Box 8118
Baltimore, Maryland 21244-8018

RE: CMS 2261-P Comments on Proposed Rule on Medicaid Program; Coverage for Rehabilitation Services, 72 FR 45201

I serve as chief administrator of a private child welfare agency that provides services in Minnesota, North Dakota, and Wisconsin. These services include therapeutic foster care and home based mental health services. I am submitting this comment letter on coverage for rehabilitation services published in the August 13, 2007 Federal Register (72FR 45201) for the Center for Medicare and Medicaid Services.

Our agency has two primary concerns and several specific comments.

The first concern is that the proposed rule appears to be based on the assumption that some rehabilitative services are intrinsic to services such as foster care and therefore are paid through other programs. It is our experience that this is not the case. The two most likely alternative funding sources are IV-E Foster Care and Title IV-B Child and Family Services Funding. In the states in which we work, these funds are very limited and have been shifted away from funding mental health rehabilitation. While we agree the services should be bundled, our fear is that the proposed rule will lead to an end of the services, rather than inclusion elsewhere.

The second concern is the possibility that the proposed language might limit the delivery of services only to direct work with Medicaid eligible individuals. We know from our work in foster care and home-based programming that the involvement of family is extremely important in achieving desired outcomes. We believe there must be room for states to choose to provide supports to families and foster families as part of an overall rehabilitation plan.

In addition to the above general comments, we have comments on several specific areas.

440.130(d)(1)(iii): Qualified providers of rehabilitative services
This section might limit the ability of states to identify qualified and licensed therapeutic foster parents as providers of services. While the states we work with have different views of the role of foster parents, we believe states should have the option of identifying them as providers.

440.130(d)(1)(v): Rehabilitation Plan
This section calls for the central involvement of an authorized decision maker in planning and approving services. Children in foster care have many people involved in their lives, and are often parts of different family and individual plans. The identification of a single decision maker may create barriers in obtaining necessary services for the child. We believe instead that the plans should be developed and authorized by a mental health professional, who is involved in overseeing the delivery of services.

440.130(d)(1)(vi): Restorative Services
The definition of restorative services seems to complicate our efforts to develop appropriate children's mental health programs. While it makes sense to focus adult services on regaining a level of functioning which has been lost, this does not fit for children. Instead we should be considering how to help children achieve a level of functioning which is age-appropriate in relation to their peers in the general population. This is especially significant in foster care where the trauma of previous abuse and neglect, coupled with placement, often delays children's development. We believe that services should include the concept of overcoming delays when there are serious identified mental health problems and significant gaps in development.

441.45(b)(1)(i-iii) Therapeutic Foster Care
The research provides evidence that therapeutic foster care is the best treatment option for many children. Without funding for therapeutic foster care, case managers may be forced to use more expensive and less effective residential treatment services, in order to obtain funding. Rehabilitative services should include therapeutic foster care as a service option.

The proposed rule appears to be based on the assumption that therapeutic foster care includes rehabilitation services which are funded by other programs. We agree that an overall program of therapeutic foster care does include rehabilitative services, but they are not being adequately funded. We believe that states should have the option of coupling Medicaid funding with other funding sources to support therapeutic foster care.

Thank you for the opportunity to comment on the proposed regulation. Please feel free to contact me, if you have any additional questions. I can be contacted at 612-259-1601 or mpeterson@pathinc.org.

Sincerely,

PATH Inc.

Mike Peterson

Michael Peterson MSW, LICSW
Interim Chief Executive Officer

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PATH
Treatment Foster Care and Family-Based Services
North Dakota, Inc.

Great Challenges Make Great Kids.

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ACCREDITED
COUNCIL ON ACCREDITATION OF SERVICES FOR FAMILIES AND CHILDREN, INC
MEMBER OF
FOSTER FAMILY-BASED TREATMENT ASSOCIATION

October 3, 2007

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

I'm writing this letter to comment on the proposed Medicaid rule for coverage of rehabilitative services. This comment applies to those costs related to medical services only, not to the non medical foster maintenance (board and room) costs.

As Chief Executive Officer of North Dakota's largest Therapeutic Foster Care provider, I am concerned with the movement of medical assistance support and funding away from the children we serve. The 300 plus children in our care are diagnosed with serious mental health issues and have at least one Axis I Diagnosis. Our services are medically indicated and recommended individually for each child. As such, Therapeutic Foster Care at this level clearly qualifies as a rehabilitation service.

The effort to unbundle and the creation of increasingly inflexible criteria and barriers for Medicaid services will push children even further toward more costly, more restrictive services. This result from your proposal will occur in spite of the reality that the populations of Therapeutic Foster Care and more costly restrictive programs are typically the same children in terms of functional disability.

A recent study of Minot State University looked at the assessed levels of severity of symptoms across levels of care in North Dakota. The children with the most severe symptoms were those children found treated in Therapeutic Foster Care. These children's psychiatric symptoms were more severe than those of children in Psychiatric Residential Treatment Facilities. [1]

Children with psychiatric need and severe symptoms have been clearly shown to improve with less cost expended while treated in Therapeutic Foster Care compared to costs incurred in more restrictive Psychiatric Residential Facilities. As such, I believe Therapeutic Foster Care clearly qualifies as an important rehabilitation service.

It would appear that the Medicaid program is willing to increase cost in order to achieve arbitrary criteria. The rule proposal reaffirms the goal to "reduce duration and intensity of medical care to the least intrusive level possible, which sustains health." In spite of this the more flexible, successful concepts of community based, bundling, least restrictive and Therapeutic Foster Care are restricted in the proposal.

Therapeutic Foster Cares services are woven into a treatment context. A "whole", contextual, therapeutic, coordinated, integrated approach that creates our dramatic service success. These same concepts of integrated, bundled services are allowed in more costly settings. In this proposal the less restrictive services are challenged, disallowed and impeded in the very service areas that accomplish Medicaid's stated goals.

Medicaid appears to view foster care as child welfare (IV E, IVB) and duplicative without the acknowledgement that Therapeutic Foster Care is also treatment service that serves children with severe, psychiatric symptoms and disabilities with evidence based, less restrictive and less costly approach. It is further noted that under federal law and regulation federal IV E funding is prohibited from paying for treatment services.

The proposed rule as written will increase our cost and practice complexity by the infusion of barriers and burdens not placed on the more restrictive and more costly medical centers and Psychiatric Residential Facilities. In addition, these barriers compete with the very goals stated in your document.

I strongly recommend that Therapeutic Foster Care be covered as a rehabilitation service alternative for children with severe Psychiatric problems with funding appropriately available through a bundled, case rated service as allowed in the more restrictive settings.

Our organization has a long and positive relationship with the Medical Assistance Program in North Dakota in our efforts to serve children with serious psychiatric symptoms.

I thank you for the opportunity to comment and your time and consideration.

Sincerely,

William A. Metcalfe, CEO
PATH ND, Inc.

---

[1] North Dakota Foster Care Child Placement: Assessing Appropriate Level of Care.
By: Vicki J. Michels, Ph.D. and Deborah J. Olson, Ph.D

cc: Byron Dorgen
Kent Conrad
Earl Pomeroy
Maggie Anderson

bcc: Dale Twedt
Mike Peterson

227

STATE OF ALABAMA

DEPARTMENT DYS SERVICES

BOB RILEY
GOVERNOR

POST OFFICE BOX 66
MT. MEIGS, ALABAMA 36057

J. WALTER WOOD, JR.
EXECUTIVE DIRECTOR

October 5, 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:

This letter is to express to you the Alabama Department of Youth Services' concern regarding the proposed Centers for Medicare and Medicaid Services (CMS) rule changes for rehabilitative services. The proposed rule changes from the CMS regarding coverage for Rehabilitative Services would virtually eliminate all rehabilitative services provided through the Department of Youth Services. Annually, DYS provides rehabilitative services to approximately 420 youth. The proposed changes would not only effect clients in the Department's custody, who are placed in community residential programs, but there would also be a loss of service for those clients throughout the state in non-custodial programs who receive rehabilitative services. The annual financial impact of the proposed rule changes would be over eight millions dollars for DYS. Without the availability of Medicaid Rehabilitative Services, these clients will not have the best opportunity to improve their quality of life and become the productive citizens that we all desire.

In summary, the Department of Youth Services strongly disagrees with the proposed rule change. Any assistance that you and the Medicaid agency can provide would be greatly appreciated.

Sincerely,

J. Walter Wood, Jr.
Executive Director

JWW/gb

Kim Nguyen

From: Amy Smith [asmith@mhacolorado.org]

Sent: Monday, October 08, 2007 1:27 PM

To: 2succeed; CHARG ; Chinook Clubhouse; Community Connections; Cortez Kiva; Dr Knight Recovery Center; Friendly Harbor; frontier.house@northrange.org; Leta Holly; Hopeful Heart; Kim Nguyen; New Beginnings; New Horizons; Oasis Clubhouse; Open Arms ; Rainbow Center; Rainbow House; Spirit Crossing; STAR Reach; Summit Center; Wishing Well; Alicia Nix (E-mail); Allen Overton; Angie Darrow (E-mail); anne lowe; Anne Wahlborg (E-mail); ladyatlast@gmail.com; bethefeltman@hotmail.com; C. Margaret Gibson; crlrynlds@aol.com; Carol Jean Foos Garner (E-mail); cjb62984na@yahoo.com; Carolyn Hall; Chad Morris (E-mail); Christine Allison; Claire Ohman (E-mail); David Burgess (E-mail); David Lockert (E-mail); Delshaun Gamble (E-mail); Jgcgull@aol.com; Diane Milne; Keyyou2@Hotmail.com; Donna Lay (E-mail); Dorothy Anderson; Edward.Knight@ValueOptions.com; Ellis Miller; ERic Wagers; FrankTR1962@yahoo.com; gloria_anderson@bhiinc.org; ganderson@midwestmhc.org; Hernando Liebmann (E-mail); james purfield; jane mountain; Janice Curtis (E-mail); Jay Borgman; Jenifer Koberstein (E-mail); Jessie Hummel; Jim Terito; Juan Chapel; Julie Albright; paris.kat@juno.com; Kim Payne; Kimberly Plante; Leeanne Merrifield (E-mail); angelslovewolfs@yahoo.com; Lucy Hausner (E-mail); Margaret French (E-mail); Mary Van Pelt (E-mail); Nancy Contizano (E-mail); RA Smith; Russell Corwin (E-mail); ruth and zim olson; Sandy Boenfoeft; muffen13@msn.com; Shelly Kennaday; sherri green; Theanne Keffeler; Tonita Koontz; Tonya Wheeler; WE CAN Board; Wendy Trachta; yvonne baughman

Subject: FW: Action needed on Rehab changes

From: Lacey Berumen [mailto:lberumen@nami.org]
Sent: Monday, October 08, 2007 12:14 PM
To: walt Oppenheim; Tamara Chambless; Tammy Snow; susan bailey; Sue Labate; Sandy Kuark; Patti Marqui Hilker; Pat Echtermeyer; nita brown; Nita Bradford; Mickey Shayne; Luisa Lumbano; Laura Michaels; Kevin Fehringer; Kathy Redman; Kat Lovato; Kathryn Chaney; Julie Reiskin; julie Hymen-Johnson; Janice Curtis; janet wood; Janet Companion; Jane Mountain; Fran N. Coleman; Eileen Doherty; Deborah Amesbury; David Burgess; Christine Hall; Christopher Habgood; Cheri Bishop; Char Irvine; Catherine Benavidez Clayton; Burger Tom; bill rohlman; Barbara Hancock; Barbara Dausch; Amy Smith; Lynette Loken; Carroll Watkins Ali; Anne Coughlin; Harry Courtney; dennis Hofts; joanne kelly; phoebe norton; anne weiher; sandra lemming; rita stoddard; jackie howe; Duane wahlborg; Graham Witherspoon; Warren Taylor; Shirley Brownlee; Patti Marqui Hilker; Pam Haynes; Norm Bertelsen; Nola Lange; Laurie Behring; Jennifer Fehringer; Chuck Taylor; Catherine Lambert; Caprice Tuff; Bernie Bliss; Angie Vrame
Subject: Action needed on Rehab changes

PROPOSED MEDICAID RULE THREATENS SERVICES FOR PEOPLE WITH MENTAL ILLNESS – YOUR ADVOCACY IS URGENTLY NEEDED!

The Centers for Medicare and Medicaid have issued proposed rules on the Medicaid Rehabilitation Services option. The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community

treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. NAMI is concerned that the proposed rules may have a negative impact on the ability of states to pay for these services. For a copy of the proposed rules click here .

It will be very important to generate many comments from NAMI state and local affiliates and individual advocates about the proposed rules. To help with this process, NAMI National has drafted two sets of comments. The first is a technical, comprehensive set of comments. To review these comments, click here .

The second document is a shorter version that is designed specifically to be of use to grassroots advocates in developing their comments. To review, click here.

NAMI members and state and local organizations are encouraged to send comments and to include information about their own experiences and how these regulations will affect their local communities. You should feel free to use information from either of these documents or to cut and paste from both. Comments are due by October 12th. For instructions on sending comments, click here.

2291

October 11, 2007

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

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

To Whom It May Concern:

My name is David Dickey. I receive services from Pikes Peak Mental Health in Colorado Springs, CO. I benefit greatly from the services I get through Medicaid, Medicare, SSI, and SSDI. I ask that you please not cut the funding for these critical and essential services.

Sincerely yours,

David L. Dickey
P.O. Box 2004
Woodland Park, CO 80866

Where Coping Skills, problem solving, also medatation are important
a regemend of right medication were being (overdosed)
it is very important to find
Support between peer, staff, Community

After Basics we need to be
tort Boundrays also Communication skill

95 percent of Life is self talk!
we are looking irritated from how
life treats us (We are Victims of life)

After decomposing for 10 year
I failed out of College

We Need real teachers for

State School High

Taking us into Finishing work (College)

Taking it away is observent

we want our funds being used properly
Not ~~schooled~~
Schodered interally

like ADI surposed to be NON profitt
the Bossses in getting all the money
when Clients show ability they should
get extra money in talents

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October 11, 2007

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

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

To Whom It May Concern:

I receive services for the mentally ill and have made progress in my daily living skills. The center of PPMHC is the only outside activity that I participate in. It has helped with learning to be with other people and groups. The clubhouse is a place where we do things that are encouraging my growth. On limited budget the clubhouse offers food + drink for a small fee and for some people this is their only meal - like go on outings that help prepare us for the community.

Sincerely yours,

Lynda Riehl (LYNDA RIEHL)

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October 11, 2007

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

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

To Whom It May Concern:

Please do not cut the budget that may interfer with services I receive at the Pikes Peak Mental Health Center. I got out of the state hospital a few months ago. I then began coming to the groups and clubhouse. It has been extremely instrumental to my well being and recovery and is a very vital part of my life. I benefit from so many groups here. I am finding a sense of meaning, purpose and a sense of belonging. I am learning all variety of skills from ways to cope, social skills, vocational (such as learning the computer, peer specialist training, community involvement, self expression through art and writing, just to name a few. I feel the services I receive are very instrumental in helping me learn and prepare to be able to continue to recovery and also eventually achieve long term goals such as being able to work again and becoming more active in my life and in the community.

Sincerely yours,

Jeanie Cowan

October 11, 2007

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

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

To Whom It May Concern:

I am disabled and I have problems finding things to do. Please do not cut the budget any more. We need the Clubhouse. It makes me feel wanted when I got a nice place to do things and people to talk to.

Sincerely yours,

Joyce I.

October 11, 2007

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

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

To Whom It May Concern:

We are recipients of Pikes Peak Mental Health in Colorado Springs, CO. Some of us have been receiving services for almost 20 years. We are highly disappointed that these Rehabilitative Services such as Medicare, & Medicaid and Therapeutic Interventions are being considered for reduction. We would lose critical and essential services necessary for our overall wellness. There will be less money for services such as health care, medication, groups, and community resources. If you must cut back spending, how about areas like military spending, and high government salaries Please reconsider cutting the funding for these programs.

Sincerely yours,

The Recipients of Pikes Peak Mental Health
875 W. Moreno Ave.
Colorado Springs, CO 80905

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October 11, 2007

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

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

To Whom It May Concern:

My name is Russell Freed I am an Client of PPMH Cole Spr. from a bullet wound through my Knee.

It is ~~easy~~ easy to blame the clients for. Not getting Better, taking away our services

These services our important for Support Learning Basic problem solving except we need to improve our Communication skills to be appropriate Not throw Violent outburst from out of control Confusion.

The trouble is internal mis mangement of Copident staff not Clients

Big Bussnes like ADI take money from their front the money or Services drip down from top

We Need to be Educated less medicated. I working on getting out of mental Health I flank out of Collage, Need Better Time magement prudent information Not Games

Sincerely yours,

236

October 11, 2007

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

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

To Whom It May Concern:

Please do not cut our funding for serivces for the cubhouse and other Services that we count on so much!

Sincerely yours,

Curtis E. MARDIS

Curtis E. Mardis

237

October 11, 2007

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

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

To Whom It May Concern:

I would miss out on my talks with my Therapist AND groups AT the mental Health center
Please continue to Fund us AT at the Center and For groups.

Sincerely yours,

Glenn Grenich

238

October 11, 2007

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

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

To Whom It May Concern:

PLEASE don't cut the Funding you have IN FRONT ~~$~~ of the ~~cut~~ cut block. If their any way could FLip some other funding because we're going to add more to your homeless Family, so please think it over.

Sincerely yours,

Michael Thomas
2631 W Pikes Peak Ave #5
Colorado Springs, CO 80904

October 11, 2007

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

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

To Whom It May Concern:

Why are the poor and/or mentally ill picked on when Budget cuts are sought. The monies saved by such cuts, will cause hardships on the poor and/or mentally ill. The poor and/or mentally ill benefit from the monies for: housing; food stamps; S.M.I.B. and G.M.I.B.; not to mention the mental health centers in the states of the United States of America. I for one do not want to see such cuts go through to effect the poor and/or mentally ill. If this goes through I will be forced to vote in the opposition of the current party in office.

Sincerely yours,

Jack H. Ceder Sr.
3615 E. Uintah St. #203
Colorado Springs, Colo. 80909-4227

240

October 11, 2007

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

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

To Whom It May Concern:

The cut in the money is not too bad. For us, though the necessary choice was made, and I/we hope it turns out well and good. Our hopes are in you and He will abide. May your choice for this be the right one, and God Bless you.

Sincerely yours,

Heidi Rutledge, M.

Heidi Rutledge, M.

241

October 11, 2007

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

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

To Whom It May Concern:

I do not want budget cuts to be cut on mental health services. I have a mental illness. I depend on my local Pikes Peak Mental Health Center to help me live a normal life with treatment medicine, housing and other programs for mentally ill people.

I need psychiatric hospitals to stay open for many mentally ill patients. Many mentally ill people need housing help to stay off the streets.

I need psychiatric hospitals and other mental institutions to stay open. I am disabled, and depend heavily on Medicare and Medicaid to treat my mental illness. Please do not cut 2.2 billion dollars for the mentally ill.

Sincerely yours,

Thanh Nguyen

242

October 11, 2007

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

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

To Whom It May Concern:

I'm concerned about the gov. cutting back on services I receive. I am in housing I can afford. I have therapy once a week something I really need to keep stable I receive help in attending club house activities and groups. Without this I would not have interaction and support from any where else I hope the funding will not be stopped from these services

Sincerely yours,

Doris Kaminski

243

October 11, 2007

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

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

To Whom It May Concern:

Would you give your daughter a son a snake. We need this club House ~~house~~ Clubhouse I can feel free, to do what is right with my mind and mood with my body.

If you remove the funding, you will be slowing down the enjoy health. When I come here I with my friends. I need to feel free if your cut funds you will be keeping that life.

Sincerely yours,

Ellen King

244

October 11, 2007

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

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

To Whom It May Concern:

I do not understand why your cuting our benefits. I come to Pikes Peak mental Health Center for services in Colorado Springs, Colorado. I come to groups and therapy there and would not benefit from ony mental health cuts.

Sincerely yours,

[illegible]

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October 11, 2007

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

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

To Whom It May Concern:

IF IT WASN'T FOR THE BENEFITS SUCH AS AOI FOOD STAMPS AND OTHER BENEFITS I WOULD BE HOMELESS. I HAVE BEEN HOMELESS AND I HAVE HAD PIKES PEAK MENTAL HEALTH PICKED ME UP AND PUT ME BACK ON MY FEET WITH THERAPY GROUPS AND OTHER GROUPS THAT LET YOU KNOW YOUR NOT ALONE. TO CUT THE FUNDS WILL AFFECT ME AND OTHERS THAT HAVE TROUBLE FUNCTIONING WITHOUT MEDICATIONS AND THERAPY

Sincerely yours,

RAYMOND LAPP

246

October 11, 2007

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

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

To Whom It May Concern:

Please Consider us poor that need these Services, we don't want to Lose these Services they help so many people, think of the people Should come frist. Lets all pray about it.

Michael D. Ondi

Sincerely yours,

Michael Dean Ondie

Michael D. Ondie

247

October 11, 2007

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

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

To Whom It May Concern:

To the United States of America
Dear Mr President You Don't Know
who I Am But this My Concern
the [illegible] Country Well Being [illegible]
would To Be If You Don't Know
what I Mean You Are Cutting
2.2 Billion Dollars of
people who need this agency
& other agencies To Survive
who [illegible] [illegible] Food For Children
DHS Welfare Social Security
SSI Disability & [illegible] [illegible]
[illegible] Hard Work in the [illegible]
[illegible] work & [illegible] Taxes
which I [illegible] To [illegible]
towards these people of [illegible] [illegible]
& Social Disability & with to [illegible] [illegible]
of [illegible] Constitutional [illegible]
[illegible] [illegible] to support
Self [illegible] Company
[illegible] [illegible] [illegible] which
& [illegible] Tax [illegible]
Billions of Dollars a Month
To [illegible]
the Nation
[illegible] Destroy

Sincerely yours,

[illegible]

To Whom It May Concern:

I am currently working as a Qualified Professional. Medicaid is the primary funding source for our nonprofit agency. I have been through all required trainings and workshops for developing person centered plans and have a few issues and concerns with current and proposed changes. It is my interpretation that Medicaid will, over time, cut services for individuals with chronic mental illness. I don't understand how this is viable since individuals with severe and persistent mental illness is by definition, an illness and chronic. Cutting services for a person with a chronic condition is not acceptable practice in the medical field thus would not happen and with mental health parity this should not happen as well.

Communtiy Support is the catch all, do all for individuals with a variety of issues and with the proposed cut in funding, many providers would not be able to financial survive. Providers who are playing by the rules are the one's to suffer. The current service definitions make it difficult to help an individual to met unforeseen needs that might not be covered in the initial PCP thus requiring a review to add a goal or intervention before a need can be met. Point being is that Person Centered Planning is great on paper but in conjunction with Medicaid and the vulnerability of being audited, the limitations far outweigh the benefits for the consumer. By tightening the definitions and limiting services to a chronically ill person will only provide detrimental outcomes that the state will have to address at a later time.

As a taxpayer I would have to question the manner in which the DHHS and CMS are cutting up services for this population. Although I understand the need to be more fiscally responsible, the manner of achieving this goal has to be responsible as well. Since the new service definitions came into effect 18 months ago it seems that changes and new rules are made up as we go along. LME's have different interpretations of the definitions and ultimately have caused some providers to close down. I feel that services that are provided and paid for by Medicaid should truly have the consumer's best interest in mind and policies and services definitions need to reflect this. Unfortunatley I see a long road of additions and audits that ultimately determine that the current system is not viable and result in another expensive MH, DD and SA overhaul.

9-28-07

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

Robert Curry
831 Charles Rd
Apt. D
Shelby, NC 28152

This letter is in response to the proposed Medicaid Funding Change.

My name is Robert & I have been coming to the Adventure House program which is a day Rehabilitation Clubhouse model program. I started attending Adventure House in 1986. I am a charter member. Before I came to the program I was in and out of Broughton and Kings Mountain Hospitals. My medicine was not working good. It also had a lot of side effects. I rode in an ambulance twice a day for having panic attacks. I now recieve disability. My insurance is Medicaid. Medicaid pays for my medicine, and for me to ride the TACC Vans and for me to attend the program.

Since I started coming to Adventure House,

10/09/2007 250

Centers for Medicare and Medicaid Services

To Whom It May Concern,

I am writing you to express my opposition to the regulations on CMS-2261-P.

I am in full support of day habitation services for all people that will benefit.

Most important is that these services provide a support system needed by many individuals and their families.

These services allow for families to keep their adult children in a home living environment and will reduce the need to return to an institutional model setting. Thank you for considering this most important issue.

Sincerely,

Diane C. O'Keefe

2261-P

CMS-[redacted]

Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School

Submitter : **Mrs. Dawn Conway** **Date & Time: 10/12/2007**

Organization : **Livingston County Special Services**

Category : **Academic**

Issue Areas/Comments

GENERAL

see attachment

October 10, 2007

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

Dear Sir(s) or Madam(s):

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

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

Major Issues and Concerns

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) DAY HABILITATION AND RELATED SERVICES-

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

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

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

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

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

(B) any requirements respecting such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,
Dawn E. Conway
Executive Director
Livingston County Special Services
Pontiac, IL 61764
815-844-7115

22618

CMS-[redacted]

Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School

Submitter : **Dr. Sheri Piercy** **Date & Time:** **10/12/2007**

Organization : **Tri-County Special Education Association**

Category : **Academic**

Issue Areas/Comments

GENERAL

See attachment

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. I have been a member of CEC since 1980, when I began teaching students with multiple disabilities in Illinois' public schools. Today, I am the Executive Director of a joint agreement that assists 15 public school districts in central Illinois with the provision of special education and related services to students with disabilities. In this role, I closely supervise the services of a variety of service providers: occupational and physical therapists, speech-language pathologists, psychologists, social workers, administrators, and support staff. Districts supervise the services provided by teachers, counselors, speech-language pathologists, administrators, support staff, and many others. 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. Medicaid reimbursement is very important for the students served by the professionals employed by this cooperative and its member districts.

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

Major Issues and Concerns

CEC has major issues with the proposed rule. We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by

the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

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

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

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

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

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

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

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

We are troubled that the proposed rule could interfere with states' ability to deliver preventive services, authorized by section 1905(a)(13) of the Social Security Act, as defined by 42 C.F.R. § 440.130(c). Although the proposed rule ostensibly amends only

42 C.F.R. § 440.130(d), it creates the clear impression that numerous preventive services would be prohibited under section 1905(a)(13), even if they could be covered as preventive services.

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

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

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

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

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

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

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

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

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health

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

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

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

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

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

(g) DAY HABILITATION AND RELATED SERVICES-

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

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

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

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

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

(B) any requirements respecting such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sheri Wernsing Piercy, Ed.D.
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2261-P

CMS-~~2287-P-277~~

Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School

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

Organization : **LPVEC**

Category : **Academic**

Issue Areas/Comments

GENERAL

"See Attachment"

In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

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

Summary:

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

Preliminary Comments:

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

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

services are covered for adults[2].

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

Regulatory Impact Analysis: Overall Impact

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

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

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

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

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

Overview:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] Id.

[13] 72 Fed. Reg. 45209

Overarching Issue - Conflict with EPSDT

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

Recommendations:

We recommend the following:

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

Recommendations

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

In the alternative:

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

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

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

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

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

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

Proposed Elimination of Transportation Services

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

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

Non-covered services: 441.45(b)

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

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

participation for the Medicaid-covered individual?

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

Recommendations:

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

Summary:

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

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

our most vulnerable citizens.

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

2261-P

CMS-~~2287-P-276~~

Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School

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

Organization : **LPVEC**

Category : **Academic**

Issue Areas/Comments

GENERAL

See attachment

In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

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

Summary:

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

Preliminary Comments:

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

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

services are covered for adults[2].

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

Regulatory Impact Analysis: Overall Impact

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

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

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[3] 42 U.S.C. § 1396 (emphasis added)
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they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the requirements of Executive Order 13132.

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

Overview:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] Id.

[13] 72 Fed. Reg. 45209

Overarching Issue - Conflict with EPSDT

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

Recommendations:

We recommend the following:

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

Recommendations

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

In the alternative:

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

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

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

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

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

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

Proposed Elimination of Transportation Services

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

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

Non-covered services: 441.45(b)

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

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

participation for the Medicaid-covered individual?

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

Recommendations:

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

Summary:

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

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

our most vulnerable citizens.

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

255 [redacted]

10/12/07

To Whom It May Concern –

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

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

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

It is time Now that our individuals with autism get equal assistance and opportunities. They have been neglected for 30+ years. – my 36 year old son sits home everyday. He desperately requires programming + therapies applicable to his needs. Thank you for your consideration.

Sincerely,

Mrs. Lynn Burke Asher

Address: 4941 Stephanie Way
Pipersville PA 18947

✓ Parent

____Professional

____Other ____________________

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BOBBY J. EDMONDS
Union County Judge

UNION COUNTY OF ARKANSAS

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Re: File Code 2261-P
Medicaid Program; Coverage for Rehabilitative Services
Day Habilitation

To Whom It May Concern:

While serving as County Judge for the past ten years, after retiring from the Accounting Department at Murphy Oil Corporation, I have had the opportunity to support community-based options for individuals with developmental disabilities and their families. The benefits to the individuals and families are obvious. When they can remain in the community near their families and natural supports and never have to depart for the large state institutions as in the past. While working with consumers, parents, providers and other stakeholders I learned that community-based services were desired by a large percentage of those needing services. We e joined hands with the State and Federal Governments in a partnership to provide to provide community-based options. Day Habilitation which is the core service included in the Developmental Day Treatment Clinic Services (DDTCS) option we added to our state Medicaid Plan in the early 80's, has provided day treatment to many who moved from state-operated institutions to community settings. I see many of them functioning well in our community. Currently we have over 200 individuals and families benefiting from this service option.

Through information in my role as County Judge, with the county government providing local support funding to meet unfunded items, and my involvement with community non-profit boards, I find DDTCS Day Habilitation to be a very cost-effective service. The Proposed Rules published in the August 13, 2007 Federal Register anticipates that States will transition to Medicaid waiver services, and in a separate section cost savings and reduction in spending is addressed. It does not seem feasible that a service model with a one-on-one client/staff ratio would result in savings unless a large number of individuals get fewer hours of services or perhaps none at all. Our experience to date with waiver services in this State has been that people spend long periods of time, sometime years, on waiting lists. If there are in fact federal savings, they come at a "high price" to one of our most vulnerable populations. I encourage you to reconsider and withdraw the proposal for elimination of day habilitation services. It has proven to be a cost-effective model that consumers and parents choose to meet their needs for community-based care.

Sincerely,

Bobby Edmonds
Union County Judge

101 North Washington, Room 101 • El Dorado, Arkansas 71730
Telephone 870•864•1900 • Fax 870•864•1902

ONE VERY IMPORTANT THING I WANT TO SAY BEFORE I CLOSE THIS LETTER IS THE FACT THAT SINCE I HAVE BEEN COMING TO THE "ADVENTURE HOUSE" I HAVE'NT BEING HOSPITALIZED. I DO TAKE MEDICINES BUT I HAVE FRIENDS HERE, I STAY BUSY I WATER PLANTS AND SEVERAL OTHER CHORES. "ADVENTURE HOUSE" IS MY HOME AND I AM VERY PROUD TO BE PART OF IT!!!

SINCERLY YOURS

Elizabeth Griggs
811 SUGAR HILL RD.
LAWNDALE, N.C.
704-538-5034 28090

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Texas Council of Community
Mental Health & Mental Retardation Centers, Inc.

October 22, 2007

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

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

Dear Sir or Madam:

I am the Associate Director of Behavioral Health for the Texas Council of Community MHMR Centers and am grateful for the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program.

We are a the umbrella organization for the 39 Community Mental Health Centers in Texas that provide comprehensive community based services to individuals living with serious mental illnesses and their families. Many of our clients have personally experienced the effectiveness of rehabilitation services and have been able to live, work and participate in their communities as a direct result of these services.

Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better outcomes, such as stable housing and employment. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses and their families.

I am writing to express the concern of my organization about regulatory changes being developed by the Centers for Medicare and Medicaid Services (CMS) that are likely to narrow the scope of rehabilitation services covered by Medicaid.

This letter will supplement the formal response filed by the National Council of Community Behavioral Health Care of which this center is a member.

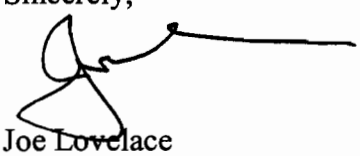
Westpark Building 3, Suite 240 | 8140 N. Mopac Expressway | Austin, TX 78759
512.794.9268 | fax 512.794.8280 | office@txcouncil.com

The rehab option in the Medicaid program is widely used by Texas to fund community-based mental health services. In fact, this option is most commonly used to underwrite mental health services including community-living skills training, medication management, crisis services, day programs and employment related services.

For this reason, we are particularly concerned that any new regulations governing rehabilitation services facilitate the provision of these services and in no way discourage systems and providers from increasing the availability of these critical services. Many of my peers are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars from an already under-resourced service system.

I urge you to refrain from any regulatory activity that either narrows the definition of reimbursable services under the rehabilitation option or lessens Medicaid reimbursement for rehabilitation services.

Sincerely,



Joe Lovelace
Associate Director of Behavioral Health
Texas Council of Community MHMR Centers

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Educational Services & Products, LLC

19 Dove Street · Suite #104 · Albany, NY 12210-1346 · (518) 445-3840 · FAX (518) 445-3841 · www.espllc.com

October 12, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Comments Concerning CMS-2261-P

Dear Acting Administrator Weems:

I am writing on behalf of the +/- 1,200 School Districts for which Educational Service & Products, LLC (ESP) provides Medicaid billing services – and on behalf of the +/- 3,000,000 Medicaid-eligible Special Education students in the United States – to request that the Centers for Medicare and Medicaid Services (CMS) rescind its proposed rule concerning Medicaid Rehabilitative Services (i.e., CMS 2261-P), which was published in the *Federal Register* on January 18, 2007. In this regard, I am making this request for the following reasons:

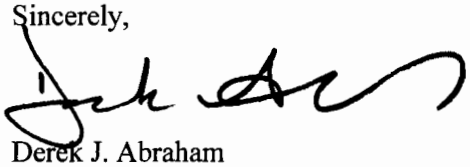
- Per the *Individuals with Disabilities in Education Act (IDEA)*, School Districts are mandated to provide a variety of health-related services – and related services – to all of their Special Education students;
- Although the Federal government originally promised to pay for forty percent (40%) of the total cost of *IDEA*-mandated services, it has never provided that level of funding to States/School Districts (Note: At the present time, the Federal government pays for approximately 18% of the total costs that States and School Districts incur in conjunction with *IDEA* mandates);
- Since 1988, School Districts have been allowed to seek Medicaid reimbursement with respect to the claimable health services and related services that they provide to Medicaid-eligible Special Education students – and their Medicaid outreach-related costs (Note: This type of Medicaid claiming requires States to file "State Plan Amendments" (SPAs) to their respective "Title XIX/Medicaid State Plans";
- Several States have based their SPAs concerning School-based Health Services on the Medicaid program's Rehabilitative Services Option;
- Other States have structured their SPAs concerning School-based Health Services on the Medicaid program's Early Periodic Screening, Diagnostic and Treatment (EPSTD) component – which mandates that all Medicaid-eligible individuals under the age of 21 be provided whatever health-related services they need to correct or eliminate their physical and/or mental illnesses and conditions, regardless of whether those services are included in their States' "Title XIX/Medicaid State Plans"; and

- The proposed rule would *de facto* make it impossible for School Districts to claim Medicaid reimbursement for many of the health services – and related services – that they are required to provide to Special Education students.

Given the fact that the Federal government has never lived up to its stated intent to pay for 40% of the costs that States and School Districts incur with respect to *IDEA*-related services – and given the fact that Congress explicitly authorized States and School Districts to seek Medicaid reimbursement with respect to the claimable health-related services that they provide to Medicaid-eligible Special Education students – it is simply inconceivable that CMS would attempt to increase the financial burden of States and School Districts by implementing the proposed rule. In this regard, the proposed rule is neither "compassionate" nor "conservative" – and its enactment would only increase the financial burden of all States and School Districts.

Please feel free to contact me if you have any questions and/or if I can provide you with any further information concerning this matter.

Sincerely,



Derek J. Abraham
Managing Partner

SUMMARY: EPA proposes to approve the State Implementation Plan (SIP) revision submitted by the Commonwealth of Virginia for the purpose of establishing a variance for the International Paper, Franklin Paper Mill facility located in Franklin, Virginia. The variance provides regulatory relief from compliance with state regulations governing new source review for the implementation of the International Paper, Franklin Paper Mill innovation project. In lieu of compliance with these regulatory requirements, the variance requires the facility to comply with site-wide emission caps. In the Final Rules section of this **Federal Register**, EPA is approving the Commonwealth's SIP submittal as a direct final rule without prior proposal because the Agency views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this action, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time.

DATES: Comments must be received in writing by September 12, 2007.

ADDRESSES: Submit your comments, identified by Docket ID Number EPA–R03–OAR–2006–0060 by one of the following methods:

A. *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.

B. *E-mail: campbell.dave@epa.gov.*

C. *Mail:* EPA–R03–OAR–2006–0060, David Campbell, Chief, Permits and Technical Assessment Branch, Mailcode 3AP11, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103.

D. *Hand Delivery:* At the previously-listed EPA Region III address. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–R03–OAR–2006–0060. EPA's policy is that all comments received will be included in the public docket without change, and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an anonymous access system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov index.* Although listed in the index, some information is not publicly available, *i.e.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Virginia Department of Environmental Quality, 629 East Main Street, Richmond, Virginia, 23219.

FOR FURTHER INFORMATION CONTACT: Sharon McCauley, (215) 814–3376, or by e-mail at *mccauley.sharon@epa.gov.*

SUPPLEMENTARY INFORMATION: For further information, please see the information provided in the direct final action, with the same title, that is located in the Rules and Regulations section of this **Federal Register** publication. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not subject of an adverse comment.

Dated: July 31, 2007.

William T. Wisniewski,

Acting Regional Administrator, Region III.

[FR Doc. E7–15585 Filed 8–10–07; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 440 and 441

[CMS 2261–P]

RIN 0938–A081

Medicaid Program; Coverage for Rehabilitative Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the definition of Medicaid rehabilitative services in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services and programs include, but are not limited to, foster care, child welfare, education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and any other non-Medicaid services from Federal, State, or local programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 12, 2007.

ADDRESSES: In commenting, please refer to file code CMS–2261–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Submit electronic

comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2261–P, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2261–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–3685 in advance to schedule your arrival with one of our staff members.

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or

7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Maria Reed, (410) 786–2255 or Shawn Terrell, (410) 786–0672.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2261–P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable (for example, names, addresses, social security numbers, and medical diagnoses) or confidential business information (including proprietary information) that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

A. Overview

Section 1905(a)(13) of the Social Security Act (the Act) includes rehabilitative services as an optional Medicaid State plan benefit. Current Medicaid regulations at 42 CFR 440.130(d) provide a broad definition of rehabilitative services. Rehabilitative services are defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." The broad general language in this regulatory definition has afforded States considerable flexibility under their State plans to meet the needs of their State's Medicaid population.

Over the years the scope of services States have provided under the rehabilitation benefit has expanded from physical rehabilitative services to also include mental health and substance abuse treatment rehabilitative services. For example, services currently provided by States under the rehabilitative benefit include services aimed at improving physical disabilities, including physical, occupational, and speech therapies; mental health services, such as individual and group therapy, psychosocial therapy services; and services for substance-related disorders (for example, substance use disorders and substance induced disorders). These Medicaid services may be delivered through various models of care and in a variety of settings.

The broad language of the current statutory and regulatory definition has, however, had some unintended consequences. It has also led to some confusion over whether otherwise applicable statutory or regulatory provider standards would apply under the rehabilitative services benefit.

As the number of States providing rehabilitative services has increased, some States have viewed the rehabilitation benefit as a "catch-all" category to cover services included in other Federal, State and local programs. For example, it appears some States have used Medicaid to fund services that are included in the provision of foster care and in the Individuals with Disabilities Education Improvement Act (IDEA). Our audit reviews have recently revealed that Medicaid funds have also been used to pay for behavioral treatment services in "wilderness camps," juvenile detention, and similar facilities where youth are involuntarily confined. These facilities are under the domain of the juvenile justice or youth systems in the State, rather than Medicaid, and there is no assurance that the claimed services reflect an independent evaluation of individual rehabilitative needs.

This proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers. This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused on social or educational development goals in programs other than Medicaid.

This proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are in fact rehabilitative out-patient services, are furnished by qualified providers, are

provided to Medicaid eligible individuals according to a goal-oriented rehabilitation plan, and are not for services that are included in programs with a focus other than that of Medicaid.

B. Habilitation Services

Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) prohibits us from taking adverse action against States with approved habilitation provisions pending the issuance of a regulation that "specifies types of day habilitation services that a State may cover under paragraphs (9) (clinic services) or (13) (rehabilitative services) of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions." We believe that issuance of a final rule based on this proposed rule will satisfy this condition. We intend to work with those States that have habilitation programs under the clinic services or rehabilitative services benefits in 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) of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 107–171), enacted on February 8, 2006.

II. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption "PROVISIONS OF THE PROPOSED REGULATIONS" at the beginning of your comments.]

A. Definitions

In 440.130(d)(1), we propose to define the terms used in this rule, as listed below:

- Recommended by a physician or other licensed practitioner of the healing arts.
- Other licensed practitioner of the healing arts.
- Qualified providers of rehabilitative services.
- Under the direction of.
- Written rehabilitation plan.
- Restorative services.
- Medical services.
- Remedial services.

In § 440.130(d)(1)(iii), we would define "qualified providers of rehabilitative services" to require that individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories. Further, the provider qualifications must be set forth in the Medicaid State plan. These qualifications may include education, work experience, training, credentialing, supervision and licensing, that are applied uniformly. Provider qualifications must be reasonable given the nature of the service provided and the population being served. We require uniform application of these qualifications to ensure the individual free choice of qualified providers, consistent with section 1902(a)(23) of the Act.

Under this proposed definition, if specific provider qualifications are set forth elsewhere in subpart A of part 440, those provider qualifications take precedence when those services are provided under the rehabilitation option. Thus, if a State chooses to provide the various therapies discussed at § 440.110 (physical therapy, occupational therapy, speech, language and hearing services) under § 440.130(d), the requirements of § 440.110 applicable to those services would apply. For example, speech therapy is addressed in regulation at § 440.110(c) with specific provider requirements for speech pathologists and audiologists that must be met. If a State offers speech therapy as a rehabilitative service, the specific provider requirements at § 440.110(c) must be met. It should be noted that the definition of Occupational Therapy in § 440.110 is not correct insofar as the following—Occupational Therapists must be certified through the National Board of Certification for Occupational Therapy, not the American Occupational Therapy Association.

We are proposing a definition of the term "under the direction of" because it is a key issue in the provision of therapy services through the rehabilitative services benefit. Therapy services may be furnished by or "under the direction of" a qualified provider under the provisions of § 440.110. We are proposing to clarify that the term means that the therapist providing direction is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuming professional responsibility for services provided, and ensuring that all services are medically necessary. The term "under the direction of" requires each of these elements; in particular, professional responsibility requires face-to-face contact by the therapist at least at the beginning of treatment and periodically thereafter. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.

B. Scope of Services

Consistent with the provision of section 1905(a)(13) of the Act, we have retained the current definition of rehabilitative services in § 440.130(d)(2) as including "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." We would, however, clarify that rehabilitative services do not include room and board in an institution, consistent with the longstanding CMS interpretation that section 1905(a) of the Act has specifically identified circumstances in which Medicaid would pay for coverage of room and board in an inpatient setting. This interpretation was upheld in *Texas* v. *U.S. Dep't Health and Human Servs.*, 61 F.3d 438 (5th Cir. 1995).

C. Written Rehabilitation Plan

We propose to add a new requirement, at § 440.130(d)(3), that covered rehabilitative services for each individual must be identified under a written rehabilitation plan. This rehabilitation plan would ensure that the services are designed and coordinated to lead to the goals set forth in statute and regulation (maximum reduction of physical or mental disability and restoration to the best possible functional level). It would ensure transparency of coverage and medical necessity determinations, so that the beneficiary, and family or other responsible individuals, would have a clear understanding of the services that are being made available to the beneficiary. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health. The Medicaid goal is to deliver and pay for the clinically-appropriate, Medicaid-covered services that would contribute to the treatment goal. It is our expectation that, for persons with mental illnesses and substance-related disorders, the rehabilitation plan would include recovery goals. The rehabilitation plan would establish a basis for evaluating the effectiveness of the care offered in meeting the stated goals. It would provide for a process to involve the beneficiary, and family or other responsible individuals, in the overall management of rehabilitative care. The rehabilitation plan would also

document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. It is our expectation that the reevaluation of the plan would involve the beneficiary, family, or other responsible individuals and would include a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods. It is important to note that this benefit is not a custodial care benefit for individuals with chronic conditions but should result in a change in status. The rehabilitation plan should identify the rehabilitation objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities. We recognize, however, that rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services.

It is our further expectation that the rehabilitation plan be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative services to an individual with the individual's condition(s). The rehabilitation plan is not intended to limit or restrict the State's ability to require prior authorization for services. The proposed requirements state that the written rehabilitation plan must:

- Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living;
- Be developed by qualified provider(s) working within the State scope of practice acts with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing;
- Ensure the active participation of the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review and modification of these goals and services;
- Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders;
- Specify the physical impairment, mental health and/or substance related disorder that is being addressed;
- Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder;
- Identify the methods that would be used to deliver services;
- Specify the anticipated outcomes;
- Indicate the frequency, amount and duration of the services;
- Be signed by the individual responsible for developing the rehabilitation plan;
- Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service;
- Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year;
- Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and
- Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

We believe that a written rehabilitation plan would ensure that services are provided within the scope of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. In order to determine whether a specific service is a covered rehabilitative benefit, it is helpful to scrutinize the purpose of the service as defined in the care plan.

For example, an activity that may appear to be a recreational activity may be rehabilitative if it is furnished with a focus on medical or remedial outcomes to address a particular impairment and functional loss. Such an activity, if provided by a Medicaid qualified provider, could address a physical or mental impairment that would help to increase motor skills in an individual who has suffered a stroke, or help to restore social functioning and personal interaction skills for a person with a mental illness.

We are proposing to require in § 440.130(d)(3)(iii) that the written rehabilitation plan include the active participation of the individual (or the individual's authorized health care decision maker) in the development, review, and reevaluation of the rehabilitation goals and services. We recommend the use of a person-centered planning process. Since the rehabilitation plan identifies recovery-oriented goals, the individual must be at the center of the planning process.

D. Impairments to be Addressed

We propose in § 440.130(d)(4) that rehabilitative services include services provided to an eligible individual to address the individual's physical needs, mental health needs, and/or substance-related disorder treatment needs. Because rehabilitative services are an optional service for adults, a State has flexibility to determine whether rehabilitative services would be limited to certain rehabilitative services (for example, only physical rehabilitative services) or will include rehabilitative treatment for mental health or substance-related disorders as well.

Provision of rehabilitative services to individuals with mental health or substance-related disorders is consistent with the recommendations of the New Freedom Commission on Mental Health. The Commission challenged States, among others, to expand access to quality mental health care and noted that States are at the very center of mental health system transformation. Thus, while States are not required to provide rehabilitative services for treatment of mental health and substance-related disorders, they are encouraged to do so. The Commission noted in its report that, "[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs."

Under existing provisions at § 440.230(a), States are required to provide in the State plan a detailed description of the services to be provided. In reviewing a State plan amendment that proposes rehabilitative services, we would consider whether the proposed services are consistent with the requirements in § 440.130(d) and section 1905(a)(13) of the Act. We would also consider whether the proposed scope of rehabilitative services

is "sufficient in amount, duration and scope to reasonably achieve its purpose" as required at § 440.230(b). For that analysis, we will review whether any assistive devices, supplies, and equipment necessary to the provision of those services are covered either under the rehabilitative services benefit or elsewhere under the plan.

E. Settings

In § 440.130(d)(5), consistent with the provisions of section 1905(a)(13) of the Act, we propose that rehabilitative services may be provided in a facility, home, or other setting. For example, rehabilitative services may be furnished in freestanding outpatient clinics and to supplement services otherwise available as an integral part of the services of facilities such as schools, community mental health centers, or substance abuse treatment centers. Other settings may include the office of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings. The State has the authority to determine in which settings a particular service may be provided. While services may be provided in a variety of settings, the rehabilitative services benefit is not an inpatient benefit. Rehabilitative services do not include room and board in an institutional, community or home setting.

F. Requirements and Limitations for Rehabilitative Services

1. Requirements for Rehabilitative Services

In § 441.45(a), we set forth the assurances required in a State plan amendment that provides for rehabilitative services in this proposed rule. In § 441.45(b) we set forth the expenditures for which Federal financial participation (FFP) would not be available.

As with most Medicaid services, rehabilitative services are subject to the requirements of section 1902(a) of the Act. These include statewideness at section 1902(a)(1) of the Act, comparability at section 1902(a)(10)(B), and freedom of choice of qualified providers at section 1902(a)(23) of the Act. Accordingly, at § 441.45(a)(1), we propose to require that States comport with the listed requirements.

At § 441.45(a)(2), we propose to require that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.

In § 441.45(a)(3) and (a)(4), we propose to require that providers of the rehabilitative services maintain case records that contain a copy of the rehabilitation plan. We also propose to require that the provider document the following for all individuals receiving rehabilitative services:

- The name of the individual;
- The date of the rehabilitative service or services provided;
- The nature, content, and units of rehabilitative services provided; and
- The progress made toward functional improvement and attainment of the individual's goals.

We believe this information is necessary to establish an audit trail for rehabilitative services provided, and to establish whether or not the services have achieved the maximum reduction of physical or mental disability, and to restore the individual to his or her best possible functional level.

A State that opts to provide rehabilitative services must do so by amending its State plan in accordance with proposed § 441.45(a)(5). The amendment must (1) describe the rehabilitative services proposed to be furnished, (2) specify the provider type and provider qualifications that are reasonably related to each of the rehabilitative services, and (3) specify the methodology under which rehabilitation providers would be paid.

2. Limitations for Rehabilitative Services

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

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

It should be noted however, that enrollment in these non-medical programs does not affect eligibility for Title XIX services. Rehabilitation services may be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. Medicaid rehabilitative services must be coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals and are available as part of other services or programs. Further, Medicaid rehabilitation services must be available for all participants based on an identified medical need and otherwise would have been provided to the individual outside of the foster care, juvenile justice, parole and probation systems and other non-Medicaid systems. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

For instance, therapeutic foster care is a model of care, not a medically necessary service defined under Title XIX of the Act. States have used it as an umbrella to package an array of services, some of which may be medically necessary services, some of which are not. In order for a service to be reimbursable by Medicaid, states must specifically define all of the services that are to be provided, provider qualifications, and payment methodology. It is important to note that provider qualifications for those who furnish care to children in foster care must be the same as provider qualifications for those who furnish the same care to children not in foster care. Examples of therapeutic foster care components that would not be Medicaid coverable services include provider recruitment, foster parent training and other such services that are the responsibility of the foster care system.

In § 441.45(b)(2), we propose to exclude FFP for expenditures for habilitation services including those provided to individuals with mental retardation or "related conditions" as defined in the State Medicaid Manual § 4398. Physical impairments and mental health and/or substance related disorder are not considered "related conditions" and are therefore medical conditions for which rehabilitation services may be appropriately provided. As a matter of general usage in the medical community, there is a distinction between the terms "habilitation" and "rehabilitation." Rehabilitation refers to measures used to restore individuals to their best functional levels. The emphasis in covering rehabilitation services is the restoration of a functional ability. Individuals receiving rehabilitation services must have had the capability to perform an activity in the past rather than to actually have performed the activity. For example, a person may not have needed to drive a car in the past, but may have had the capability to do so prior to having the disability.

Habilitation typically refers to services that are for the purpose of helping persons acquire new functional abilities. Current Medicaid policy explicitly covers habilitation services in two ways: (1) When provided in an intermediate care facility for persons with mental retardation (ICF/MR); or (2) when covered under sections 1915(c), (d), or (i) of the Act as a home and community-based service. Habilitation services may also be provided under some 1905(a) service authorities such as Physician services defined at 42 CFR 440.50, Therapy services defined at 42 CFR 440.110 (such as, Physical Therapy, Occupational Therapy, and Speech/Language/Audiology Therapy), and Medical or other remedial care provided by licensed practitioners, defined at 42 CFR 440.60. Habilitative services can also be provided under the 1915(i) State Plan Home and Community Based Services pursuant to the Deficit Reduction Act of 2005. In the late 1980s, the Congress responded to State concerns about disallowances for habilitation services provided under the State's rehabilitative services benefit by passing section 6411(g) of the OBRA 89. This provision prohibited us from taking adverse actions against States with approved habilitation provisions pending the issuance of a regulation that "specifies types of day habilitation services that a State may cover under paragraphs (9) [clinic services] or (13) [rehabilitative services] of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions." Accordingly, this regulation would specify that all such habilitation services would not be covered under sections 1905(a)(9) or 1905(a)(13) of the Act. If this regulation is issued in final form, the protections provided to certain States by section 6411(g) of OBRA 89 for day habilitation services will no longer be in force. We intend to provide for a delayed compliance date so that States will have a transition period of the lesser of 2 years or 1 year after the close of the first regular session of the State legislature that begins after this regulation becomes final before we will take enforcement action. This transition period will permit States an opportunity to transfer coverage of habilitation services from the rehabilitation option into another appropriate Medicaid authority. We are available to States as needed for technical assistance during this transition period.

In § 441.45(b)(3), we propose to provide that rehabilitative services would not include recreational and social activities that are not specifically focused on the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan, and provided by a Medicaid qualified provider recognized under State law. We would also specify in this provision that rehabilitative services would not include personal care services; transportation; vocational and prevocational services; or patient education not related to the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan. The first two of these services may be otherwise covered under the State plan. But these services are not primarily focused on rehabilitation, and thus do not meet the definition of medical or remedial services for rehabilitative purposes that would be contained in § 440.130(d)(1).

It is possible that some recreational or social activities are reimbursable as rehabilitative services if they are provided for the purpose allowed under the benefit and meet all the requirements governing rehabilitative services. For example, in one instance the activity of throwing a ball to an individual and having her/him throw it back, may be a recreational activity. In another instance, the activity may be part of a program of physical therapy that is provided by, or under the direction of, a qualified therapist for the purpose of restoring motor skills and balance in an individual who has suffered a stroke. Likewise, for an individual suffering from mental illness, what may appear to be a social activity may in fact be addressing the rehabilitation goal of social skills development as identified in the rehabilitation plan. The service would need to be specifically related to an identified rehabilitative goal as documented in the rehabilitation plan with specific time-limited treatment goals and outcomes. The rehabilitative service would further need to be provided by a qualified provider, be documented in the case record, and meet all requirements of this proposed regulation.

When personal care services are provided during the course of the provision of a rehabilitative service, they are an incidental activity and separate payment may not be made for the performance of the incidental activity. For example, an individual recovering from the effects of a stroke may receive occupational therapy services from a qualified occupational therapy provider under the rehabilitation option to regain the capacity to feed himself or herself. If during the course of those services the individual's clothing becomes soiled and the therapist assists the individual with changing his or her clothing, no separate payment may be made for assisting the individual with dressing under the rehabilitation option. However, FFP may be available for optional State plan personal care services under § 440.167 if provided by an enrolled, qualified personal care services provider.

Similarly, transportation is not within the scope of the definition of rehabilitative services proposed by this regulation since the transportation service itself does not result in the maximum reduction of a physical or mental disability and restoration of the individual to the best possible functional level. However, transportation is a Medicaid covered service and may be billed separately as a medical assistance service under § 440.170, if provided by an enrolled, qualified provider, or may be provided under the Medicaid program as an administrative activity necessary for the proper and efficient administration of the State's Medicaid program.

Generally, vocational services are those that teach specific skills required by an individual to perform tasks associated with performing a job. Prevocational services address underlying habilitative goals that are associated with performing compensated work. To the extent that the primary purpose of these services is to help individuals acquire a specific job skill, and are not provided for the purpose of reducing disability and restoring a person to a previous functional level, they would not be construed as covered rehabilitative services. For example, teaching an individual to cook a meal to train for a job as a chef would not be covered, whereas, teaching an individual to cook in order to re-establish the use of her or his hands or to restore living skills may be coverable. While it may be possible for Medicaid to cover prevocational services when provided under the section 1915(c) of the Act, home and community based services waiver programs, funding for vocational services rests with other, non-Medicaid Federal and State funding sources.

Similarly, the purpose of patient education is one important determinant to whether the activity is a rehabilitative activity covered under § 440.130(d). While taking classes in an academic setting may increase an individual's integration into the community and enable the individual to learn social skills, the primary purpose of this activity is academic enhancement.

Thus, patient education in an academic setting is not covered under the Medicaid rehabilitation option. On the other hand, some patient education directed towards a specific rehabilitative therapy service may be provided for the purpose of equipping the individual with specific skills that will decrease disability and restore the individual to a previous functioning level. For example, an individual with a mental disorder that manifests with behavioral difficulties may need anger management training to restore his or her ability to interact appropriately with others. These services may be covered under the rehabilitation option if all of the requirements of this regulation are met.

In § 441.45(b)(4), we propose to exclude payment for services, including services that are rehabilitative services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offense in, or confined involuntarily to, State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

We also propose to exclude payment for services that are provided to residents of an institution for mental disease (IMD), including residents of a community residential treatment facility of over 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illness, and that does not meet the requirements at § 440.160. It appears that in the past, certain States may have provided services under the rehabilitation option to these individuals. Our proposed exclusion of FFP for rehabilitative services provided to these populations is consistent with the statutory requirements in paragraphs (A) and (B) following section 1905(a)(28) of the Act. The statute indicates that "except as otherwise provided in paragraph (16), such term [medical assistance] does not include—(A) Any such payments with respect to care or services for any individual who is an inmate of a public institution; or (B) any such payments with respect to care or services for any individual who has not attained 65 years and who is a patient in an IMD." Section 1905(a)(16) of the Act defines as "medical assistance" "* * * inpatient psychiatric hospital services for individuals under age 21 * * *". The Secretary has defined the term "inpatient psychiatric hospital services for individuals under age 21" in regulations at § 440.160 to include "a psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State." Thus, the term "inpatient psychiatric hospital services for individuals under age 21" includes services furnished in accredited children's psychiatric residential treatment facilities that are not hospitals. The rehabilitative services that are provided by the psychiatric hospital or accredited psychiatric residential treatment facility (PRTF) providing inpatient psychiatric services for individuals under age 21 to its residents would be reimbursed under the benefit for inpatient psychiatric services for individuals under age 21 (often referred to as the "psych under 21" benefit), rather than under the rehabilitative services benefit.

In § 441.45(b)(6), we propose to exclude expenditures for room and board from payment under the rehabilitative services option. While rehabilitative services may be furnished in a residential setting that is not an IMD, the benefit provided by section 1905(a)(13) of the Act is primarily intended for community based services. Thus, when rehabilitative services are provided in a residential setting, such as in a residential substance abuse treatment facility of less than 17 beds, delivered by qualified providers, only the costs of the specific rehabilitative services will be covered.

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

The provision of rehabilitative services to non-Medicaid eligible individuals cannot be covered if it relates directly to the non-eligible individual's care and treatment. However, effective rehabilitation of eligible individuals may require some contact with non-eligible individuals. For instance, in developing the rehabilitation plan for a child with a mental illness, it may be appropriate to include the child's parents, who are not eligible for Medicaid, in the process. In addition, counseling sessions for the treatment of the child might include the parents and other non-eligible family members. In all cases, in order for a service to be a Medicaid coverable service, it must be provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.

Thus, contacts with family members for the purpose of treating the Medicaid eligible individual may be covered by Medicaid. If these other family members or other individuals also are Medicaid eligible and in need of the services covered under the State's rehabilitation plan, Medicaid could pay for the services furnished to them.

In § 441.45(b)(8), we propose that FFP would only be available for claims for services provided to a specific individual that are documented in an individual's case record.

We will work with States to implement this rule in a timely fashion using existing monitoring and compliance authority.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 440.130 Diagnostic, Screening, Preventative, and Rehabilitative Services

This section outlines the scope of service for rehabilitative services provided by States. The services discussed in this section must be provided under a written rehabilitation plan as defined in § 440.130(d)(1)(v). Specifically, § 440.130(d)(3) states that the written rehabilitation plan must meet the following requirements:

(i) Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing.

(iii) Ensure the active participation of the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review, and modification of these goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved including recovery goals for persons with mental illnesses or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder.

(vii) Identify the methods that will be used to deliver services.

(viii)Specify the anticipated outcomes.

(ix) Indicate the frequency and duration of the services.

(x) Be signed by the individual responsible for developing the rehabilitation plan.

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the beneficiary, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

The burden associated with the requirements in this section is the time and effort put forth by the provider to gather the information and develop a specific written rehabilitation plan. While these requirements are subject to the PRA, we believe they meet the exemption requirements for the PRA found at 5 CFR 1320.3(b)(2), and as such, the burden associated with these requirements is exempt.

Section 441.45 Rehabilitative Services

Section 441.45(a)(3) requires that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

The burden associated with these requirements is the time and effort put forth by the provider to maintain the case records. While these requirements are subject to the PRA, we believe they meet the exemption requirements for the PRA found at 5 CFR 1320.3(b)(2), and as such, the burden associated with these requirements is exempt.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: Melissa Musotto [CMS–2261–P], Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Katherine Astrich, CMS Desk Officer, [CMS–1321–P], *katherine_astrich@omb.eop.gov*. Fax (202) 395–6974.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a final document, we will respond to the comments in that document.

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This is a major rule because of the size of the anticipated reduction in Federal financial participation that is estimated to have an economically significant effect of more than $100 million in each of the Federal fiscal years 2008 through 2012.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6.5 million to $31.5 million in any 1 year. 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. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule. CMS is unable to determine the

percentage of providers of rehabilitative services that are considered small businesses according to the Small Business Administration's size standards with total revenues of $6.5 million to $31.5 million or less in any 1 year. Individuals and States are not included in the definition of a small entity. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 (proposed documents) of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicaid payment regulations and has fewer than 100 beds. The Secretary certifies that this major rule would not have a direct impact on small rural hospitals. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule.

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. Since this rule would not mandate spending in any 1 year of $120 million or more, the requirements of the UMRA are not applicable.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this rule would not impose any costs on State or local governments, preempt State law, or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

B. Anticipated Effects

FFP will be available for rehabilitative services for treatment of physical, mental health, or substance-related disorder rehabilitation treatment if the State elects to provide those services through the approved State plan. Individuals retain the right to select among qualified providers of rehabilitative services. However, because FFP 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 reduction in spending is expected to occur because FFP for rehabilitative services would no longer be paid to inappropriate other third parties or other Federal, State, or local programs.

The estimated impact on Federal Medicaid spending was calculated starting with an estimate of rehabilitative service spending that may be subject to this rule. This estimate was developed after consulting with several experts, as data for rehabilitative services, particularly as it would apply to this rule, is limited. Given this estimate, the actuaries discounted this amount to account for four factors: (1) The ability of CMS to effectively identify the rehabilitative services spending that would be subject to this proposal; (2) the effectiveness of CMS's efforts to implement this rule and the potential that some identified rehabilitative services spending may still be permissible under the rule; (3) the change in States' plans that may regain some of the lost Federal funding; and (4) the length of time for CMS to fully implement the rule and review all States' plans.

The actual impact to the Federal Medicaid program may be different than the estimate to the extent that the estimate of the amount of rehabilitative services spending subject to this rule is different than the actual amount and to the extent that the effectiveness of the rule is greater than or less than assumed. Because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services, particularly as it relates to this rule, there is a significantly wide range of possible impacts.

Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government agencies or geographic regions under Executive Order 12866. We invite public comment on the potential impact of the rule.

C. Alternatives Considered

This proposed rule would amend the definition of rehabilitative services to provide for important individual protections and to clarify that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. We believe this proposed rule is the best approach to clarifying the covered rehabilitative services, and also because all stakeholders will have the opportunity to comment on the proposed rule. These comments will then be considered before the final document is published.

In considering regulatory options, we considered requiring States to license all providers as an alternative to only requiring that providers to be qualified as defined by the State. However we believe that giving States the flexibility to determine how providers are credentialed allows for necessary flexibility to States to consider a wide range of provider types necessary to cover a variety of rehabilitation services. We believe this flexibility will result in decreases in administrative and service costs.

We also considered restricting the rule to only include participant protections but not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs. Had we not prohibited FFP for services that are intrinsic elements of other programs, States would continue to provide non-Medicaid services to participants, the result would have been a less efficient use of Medicaid funding because increased Medicaid spending would not result in any increase in services to beneficiaries. Instead, increased Medicaid funding would have simply replaced other sources of funding.

D. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in the table below, we have prepared an accounting statement showing the classification of the savings associated with the provisions of this proposed rule. This table provides our best estimate of the savings to the Federal Government as a result of the changes presented in this proposed rule that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.24 billion between FY 2008 and FY 2012. All savings are classified as transfers from the Federal Government to State Government. These transfers represent a reduction in the federal share of Medicaid spending once the rule goes into effect, as it would limit States from claiming Medicaid reimbursement for

rehabilitation services that could be covered through other programs.

ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED SAVINGS, FROM FY 2008 TO FY 2012

[In millions]

Category	Primary estimates	Year dollar	Units discount rate	Period covered
Federal Annualized Monetized ($millions/year)	443.4	2008	7%	2008–2012
	441.6	2008	3%	2008–2012
	448	2008	0%	2008–2012
From Whom to Whom?	Federal Government to State Government			

Column 1: Category—Contains the description of the different impacts of the rule; it could include monetized, quantitative but not monetized, or qualitative but not quantitative or monetized impacts; it also may contain unit of measurement (such as, dollars). In this case, the only impact is the Federal annualized monetized impact of the rule.

Column 2: Primary Estimate—Contains the quantitative or qualitative impact of the rule for the respective category of impact. Monetized amounts are generally shown in real dollar terms. In this case, the federalized annualized monetized primary estimate represents the equivalent amount that, if paid (saved) each year over the period covered, would result in the same net present value of the stream of costs (savings) estimated over the period covered.

Column 3: Year Dollar—Contains the year to which dollars are normalized; that is, the first year that dollars are discounted in the estimate.

Column 4: Unit Discount Rate—Contains the discount rate or rates used to estimate the annualized monetized impacts. In this case, three rates are used: 7 percent; 3 percent; 0 percent.

Column 5: Period Covered—Contains the years for which the estimate was made.

Rows: The rows contain the estimates associated with each specific impact and each discount rate used.

"From Whom to Whom?"—In the case of a transfer (as opposed to a change in aggregate social welfare as described in the OMB Circular), this section describes the parties involved in the transfer of costs. In this case, costs previously paid for by the Federal Government would be transferred to the State Governments. The table may also contain minimum and maximum estimates and sources cited. In this case, there is only a primary estimate and there are no additional sources for the estimate.

Estimated Savings—The following table shows the discounted costs (savings) for each discount rate and for each year over the period covered. "Total" represents the net present value of the impact in the year the rule takes effect. These numbers represent the anticipated annual reduction in Federal Medicaid spending under this rule.

ESTIMATED SAVINGS, FROM FY 2008 TO FY 2012

[In millions]

Discount rate (percent)	2008	2009	2010	2011	2012	Total
0	180	360	520	570	610	2,288
3	175	339	476	506	526	2,069
7	168	314	424	435	435	1,822

E. Conclusion

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services. Accordingly, there is a significantly wide range of possible impacts due to this rule. As indicated in the Estimated Savings table above, we project an estimated savings of $180 million in FY 2008, $360 million in FY 2009, $520 million in FY 2010, $570 million in FY 2011, and $610 million in FY 2012. This reflects a total estimated savings of $2.240 billion dollars for FY 2008 through FY 2012. We invite public comment on the potential impact of this rule.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 440

Grant programs—health, Medicaid.

42 CFR Part 441

Family planning, Grant programs—health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 440.130 is amended by revising paragraph (d) to read as follows:

§ 440.130 Diagnostic, screening, preventative, and rehabilitative services.

* * * * *

(d) *Rehabilitative Services*—(1) *Definitions.* For purposes of this subpart, the following definitions apply:

(i) *Recommended by a physician or other licensed practitioner of the healing arts* means that a physician or other licensed practitioner of the healing arts, based on a comprehensive assessment of the individual, has—

(A) Determined that receipt of rehabilitative services would result in reduction of the individual's physical or mental disability and restoration to the best possible functional level of the individual; and

(B) Recommended the rehabilitative services to achieve specific individualized goals.

(ii) *Other licensed practitioner of the healing arts* means any health practitioner or practitioner of the healing arts who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.

(iii) *Qualified providers of rehabilitative services* means individuals who meet any applicable provider qualifications under Federal law that would be applicable to the same service when it is furnished under other Medicaid benefit categories, qualifications under applicable State scope of practice laws, and any additional qualifications set forth in the Medicaid State plan. These qualifications may include minimum age requirements, education, work experience, training, credentialing, supervision and licensing requirements that are applied uniformly. Provider qualifications must be documented in the State plan and be reasonable given the nature of the service provided and the population served. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

(iv) *Under the direction of* means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see § 440.110, "Inpatient hospital services, other than services in an institution for mental diseases") the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the supervision of services and ongoing involvement in the treatment. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.

(v) *Rehabilitation plan* means a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals. The plan is developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing and also ensures the active participation of the individual, individual's family, individual's authorized decision maker and/or of the individual's choosing in the development, review, and modification of the goals and services. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition. The plan must have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. The plan must be reasonable and based on the individual's condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individual's condition(s).

(vi) *Restorative services* means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past. For example, a person may not have needed to take public transportation in the past, but may have had the ability to do so prior to having the disability. Rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services.

(vii) *Medical services* means services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care of a physical or mental disorder and are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Medical services may include physical therapy, occupational therapy, speech therapy, and mental health and substance-related disorder rehabilitative services.

(viii) *Remedial services* means services that are intended to correct a physical or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.

(2) *Scope of services.* Except as otherwise provided under this subpart, rehabilitative services include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a individual to the best possible functional level. Rehabilitative services may include assistive devices, medical equipment and supplies, not otherwise covered under the plan, which are determined necessary to the achievement of the individual's rehabilitation goals. Rehabilitative services do not include room and board in an institution or community setting.

(3) *Written rehabilitation plan.* The written rehabilitation plan shall be reasonable and based on the individual's condition(s) and on the standards of practice for provision of rehabilitative services to an individual with the individual's condition(s). In addition, the written rehabilitation plan must meet the following requirements:

(i) Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care

decision maker and/or persons of the individual's choosing.

(iii) Follow guidance obtained through the active participation of the individual, and/or persons of the individual's choosing (which may include the individual's family and the individual's authorized health care decision maker), in the development, review, and modification of plan goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder.

(vii) Identify the methods that will be used to deliver services.

(viii) Specify the anticipated outcomes.

(ix) Indicate the frequency, amount and duration of the services.

(x) Be signed by the individual responsible for developing the rehabilitation plan.

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the individual, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

(xvii) Include the individual's relevant history, current medical findings, contraindications and identify the individual's care coordination needs, if any, as needed to achieve the rehabilitation goals.

(4) *Impairments to be addressed.* For purposes of this section, rehabilitative services include services provided to the Medicaid eligible individual to address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs.

(5) *Settings.* Rehabilitative services may be provided in a facility, home, or other setting.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

1. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—General Provisions

2. A new § 441.45 is added to subpart A to read as follows:

§ 441.45 Rehabilitative services.

(a) If a State covers rehabilitative services, as defined in § 440.130(d) of this chapter, the State must meet the following requirements:

(1) Ensure that services are provided in accordance with § 431.50, § 431.51, § 440.230, and § 440.240 of this chapter.

(2) Ensure that rehabilitative services are limited to services furnished for the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level.

(3) Require that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

(4) For all individuals receiving rehabilitative services, require that providers maintain case records that include the following:

(i) A copy of the rehabilitative plan.

(ii) The name of the individual.

(iii) The date of the rehabilitative services provided.

(iv) The nature, content, and units of the rehabilitative services.

(v) The progress made toward functional improvement and attainment of the individual's goals as identified in the rehabilitation plan and case record.

(5) Ensure the State plan for rehabilitative services includes the following requirements:

(i) Describes the rehabilitative services furnished.

(ii) Specifies provider qualifications that are reasonably related to the rehabilitative services proposed to be furnished.

(iii) Specifies the methodology under which rehabilitation providers are paid.

(b) Rehabilitation does not include, and FFP is not available in expenditures for, services defined in § 440.130(d) of this chapter if the following conditions exist:

(1) The services are furnished through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. Examples of services that are intrinsic elements of other programs and that would not be paid under Medicaid include, but are not limited to, the following:

(i) Therapeutic foster care services furnished by foster care providers to children, except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers.

(ii) Packaged services furnished by foster care or child care institutions for a foster child except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers.

(iii) Adoption services, family preservation, and family reunification services furnished by public or private social services agencies.

(iv) Routine supervision and non-medical support services provided by teacher aides in school settings (sometimes referred to as "classroom aides" and "recess aides").

(2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include "services provided to individuals" with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.)

(3) Recreational or social activities that are not focused on rehabilitation and not provided by a Medicaid qualified provider; personal care services; transportation; vocational and prevocational services; or patient education not related to reduction of physical or mental disability and the restoration of an individual to his or her best possible functional level.

(4) Services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offence in, or confined involuntarily to, public institutions such as State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit; or over which a governmental unit exercises administrative control. Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

(5) Services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of community residential treatment facilities with more than 16 beds that do not meet the requirements at § 440.160 of this chapter.

(6) Room and board.

(7) Services furnished for the treatment of an individual who is not Medicaid eligible.

(8) Services that are not provided to a specific individual as documented in an individual's case record.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: March 22, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 12, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–3925 Filed 8–8–07; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

National Park Service

43 CFR Part 10

Consultation and Dialogue On Regulations Regarding The Disposition Of Unclaimed Native American Human Remains, Funerary Objects, Sacred Objects, Or Objects Of Cultural Patrimony Excavated Or Discovered On Federal Or Tribal Lands After November 16, 1990, Pursuant To Provisions Of The Native American Graves Protection And Repatriation Act (NAGPRA)

AGENCY: National Park Service, Interior.

ACTION: Notice of consultation.

SUMMARY: This notice of consultation announces three consultation meetings and a facilitated dialogue session (recommended by the Review Committee) that will be held to obtain additional oral and written recommendations on regulations to be drafted regarding the disposition of unclaimed Native American human remains, funerary objects, sacred objects, or objects of cultural patrimony that are excavated or discovered on Federal or tribal lands after November 16, 1990. Previous consultation meetings were held November, 2005, and April, 2007.

DATES:

The four consultation/dialogue sessions are scheduled for October 14–16, 2007:

1. Tribal consultation: October 14, 2007, 8:30 a.m. to 10:30 a.m., Chaparral Suites Resort, 5001 North Scottsdale Rd., Scottsdale, AZ 85250. Authorized representatives of Indian tribes and Native Hawaiian organizations and traditional Native American religious leaders are invited to participate in this meeting. Tribal representatives wishing to make a public presentation at this session should submit a request to do so by October 8, 2007, including evidence that you are authorized to speak on behalf of an Indian tribe or Native Hawaiian organization.

2. Museum consultation: October 14, 2007, 10:45 a.m. to 12:45 p.m., Chaparral Suites Resort, 5001 North Scottsdale Rd., Scottsdale, AZ 85250. Authorized representatives of museums and national museum and scientific organizations are invited to participate in this meeting. Representatives wishing to make a public presentation at this session should submit a request to do so by October 8, 2007, including evidence that you are authorized to speak on behalf of a museum or national museum or scientific organization.

3. Museum-Tribal Dialogue: October 14, 2007, 2:30 p.m. to 5:00 p.m., Chaparral Suites Resort, 5001 North Scottsdale Rd., Scottsdale, AZ 85250. This facilitated discussion, recommended by the Review Committee, will provide the authorized representatives of Indian tribes, Native Hawaiian organizations, museums, and national museum and scientific organizations with a forum to identify points of agreement regarding the disposition of unclaimed Native American human remains, funerary objects, sacred objects, or objects of cultural patrimony. The results of the museum-tribal dialogue will be reported to the Review Committee at its October 15–16, 2007, meeting.

4. Review Committee consultation: October 15–16, 2007, 8:30 a.m. to 5:00 p.m., Heard Museum, 2301 North Central Ave., Phoenix, AZ 85004. Time will be scheduled during the Review Committee meeting for members of the public to provide oral and written recommendations. Members of the public wishing to make a public presentation at the Review Committee meeting should submit a request to do so by October 8, 2007.

Requests to make presentations or participate at any of the sessions should be faxed to (202) 371–5197 by October 8, 2007. Written comments should be postmarked or faxed to Sherry Hutt as indicated under **ADDRESSES** no later than December 1, 2007.

ADDRESSES: Written comments and requests for public presentations may be mailed to Sherry Hutt, Manager, National NAGPRA Program, National Park Service, 1849 C Street NW, Washington, DC 20240. Comments may also be faxed to Sherry Hutt at (202) 371–5197.

Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment - including your personal identifying information - may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

The consultation/dialogue sessions with Indian tribes, Native Hawaiian organizations, traditional Native American religious leaders, museums and national museum and scientific organizations on October 14, 2007 will be held at Chaparral Suites Resort, 5001 North Scottsdale Rd., Scottsdale, AZ

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North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

October 11, 2007

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-2261-P
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

Sent Via Overnight Express Mail

Dear Sir or Madam:

The North Carolina Department of Health and Human Services serves as the Single State Agency for the administration of the Medicaid Program in North Carolina. In addition, we are responsible for the delivery of services to individuals with mental illness, developmental disabilities and substance use disorders and also serve as the Single State Agency for the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant. We are also responsible for the administration of Social Services, including the administration of foster care in North Carolina. From that perspective, we believe we are uniquely qualified to comment upon the proposed rule posted for public comment by the Centers for Medicare and Medicaid Services as 42 CFR 440 and 441.

The proposed rules cause us significant concerns. They appear to reflect a belief that a person's rehabilitation from mental illness or substance use disorder follows a straight-line trajectory of continued improvement and that recovery can be achieved relatively quickly. In fact, we know that this is not the case. Individuals make progress and then experience relapse; thus, milestones along the road to recovery are sometimes measured in months or years. With some individuals, the appropriate service may be delivered for many months during which the maintenance of functioning is considered a hallmark of successful treatment. This misunderstanding of the nature of these illnesses is reflected in Section II.C. which explains the provisions of the rule. A sentence in that section states, "It is important to note that this benefit is not a custodial care benefit for individuals with chronic conditions..." In fact, mental illness and addictive diseases **are** chronic conditions; many people do achieve recovery with effective rehabilitation treatments, but they are never "cured" of the illness. We agree that Rehabilitation Option services should not be custodial; they should represent very active, clinical treatment and interventions, but the mere inclusion of this sentence seems indicative of the lack of understanding reflected throughout the proposed rules of the challenges faced by Medicaid recipients with mental illness and substance use disorders.

The President's New Freedom Commission Report, issued by this Administration, is a very forward-thinking document that provides a roadmap for how services to individuals with mental illness and substance use disorders can be improved in the United States. That report, issued just a few years ago, accurately cited the fragmented nature of the service delivery system. These proposed rules, including the assumption that these changes will reduce cost to the Medicaid Program for Rehabilitation Option services by $2.2 billion over a four year period, are moving in the opposite direction from the action agenda outlined in the New Freedom Commission Report. For these reasons, we urge CMS to withdraw these proposed rules and to engage state Medicaid and Mental Health and Substance Abuse Agencies in any future attempt at rule-making related to Rehabilitation Option services. By working through partnership, we feel we can reach an agreement to accomplish both programmatic and budgetary goals.

Our specific comments regarding individual components of the rules are as follows:

Sec. 440.130(i)(B)(v)
One of the best parts of the Notice of Proposed Rule Making is the discussion in the description of Provisions of the Proposed Rule around person-centered planning. The final two sentences of Section II. C. state "We recommend the use of a person-centered planning process. Since the rehabilitation plan identifies recovery-oriented goals, the individual must be at the center of the planning process." Despite these promising statements, it is disappointing to note that the proposed rule does not mention person-centered planning. Rather, this rule states that the rehabilitation plan is "developed by a qualified provider(s) working within the State scope of practice act, with input from the individual..." This seems to contradict the intent of the discussion and moves the approach back to a professional driven system. Without the reference in the rule, where is the authority to mandate this approach?

Sec. 440.130(d)(1)(vi)
We appreciate that the rule indicates that maintenance of a current level of functioning may be appropriate when paired with a rehabilitation goal. We have concerns about how this rule will be interpreted in individual consumers' plans. We also recommend that specific language referencing children should be added to focus on achievement of age appropriate functions rather than loss of a function the child might have had previously. These rules must be studied in relationship with EPSDT.

440.130(d)(2)
Though we recognize that Medicaid has for many years excluded payment of room and board in residential settings, it is important to note that this distinction continues the longstanding Medicaid bias toward institutional treatment settings, where room and board is recognized as a legitimate Medicaid cost, and would appear to run counter to the many initiatives that CMS has encouraged to "rebalance" the service delivery system in favor of more community-based services, including the current Money Follows the Person initiative. This incentivizes for coverage in facility based programs.

440.130(d)(3)(xiv)
We have concerns about how this section will be interpreted. In December 2005 in its approval of a State Plan Amendment for Rehabilitation Option services in NC, CMS limited the duration of services that a recipient could receive in several types of residential substance abuse services to no more than thirty (30) days in any given 12 month period. That causes us concerns that in the future that type of arbitrary timeframe may be applied to other services. Any mental health or substance abuse professional will attest that it is not reasonable to assume that consumers with severe and persistent or serious mental illness and/or substance use disorders will be able to demonstrate a "measurable reduction of disability and restoration of functional level" in a thirty (30) day period.

440.130(d)(5)
We believe that simply saying that services may be "provided in a facility, home, or other setting" provides too much room for individual interpretation by CMS Regional Offices. If CMS is going to restrict the services that can be delivered in certain settings as they have done in NC previously (see comments above for 440.130(d)(3)(xiv), those restrictions should be included in the rule.

441.45(a)(4) and (5)
We understand the critical importance of accurately documenting services delivered. However, the language in these two rules requiring inclusion of units of service could be interpreted to mean a progress note is needed for each unit of service delivered. Since many services are billed on a 15 minute unit basis, a single contact may represent four or more units of service. We hope that CMS will not increase the paperwork burden on providers by interpreting these two rules as requiring notes for each unit of service. We also believe that documentation of this nature does not drive quality care or administrative accountability. We would not begin to expect surgeons to document every 15 minutes for an activity or procedure.

We believe that these proposed rules will do significant harm to Medicaid recipients with mental illness and substance use disorders. NC has worked diligently over the past six years to improve our public system of services to these vulnerable populations. We believe that these proposed rules would cause irreparable damage to that system.

Miscellaneous Comments

It will be critical to the children of North Carolina for CMS to continue the practice of allowing habilitation and maintenance in the areas of Occupational Therapy, Physical Therapy and Speech Language Pathology. As stated in the CMS school guide "However, because occupational therapy, physical therapy and speech therapy do not have the same requirement to restore lost capabilities, habilitation services are not precluded from coverage under those service categories". Along with the school based guide, in a previous transmittal CMS recognized that the OBRA 89 legislation required maintenance to be provided to recipients under EPSDT. Clarification of the revised rehabilitation rules along with previous guidance for the specialized services will be required. Under the Individuals with Disabilities Education Act, Medicaid is the primary payer for medically necessary services provided to Medicaid students with an IEP. Congress and CMS have clearly demonstrated their intent that children be treated differently than adults when it comes to Specialized Therapies. To do any differently will have a devastating effect on a very vulnerable population.

We understand that rehabilitation services are to focus on the ability to perform a function, regardless of whether a child performed the function in the past. Although referenced for children, this is also critical for adults. As people receive services and achieve goals stated in their person centered plan, skills may be taught and achieved that the person may not have previously had due to the medical conditions. To limit a person's skill development due to such a narrow interpretation of rehabilitation would be counterproductive to a person's economic independence.

We support the use of various funding to cover the cost of care; Medicaid should not be the sole payor when other funding sources are available. However, we question the restrictiveness of the draft rules in regards to Therapeutic Foster Care. The two systems should be encouraged to work together to serve this most vulnerable population. The draft rules further fragment the systems. We encourage you to consider allowing states to establish the accountability of ensuring that funding is not mixed but does allow Medicaid to cover medical related expenses not covered by federal foster care funding. This includes specialized provider recruitment, caregiver training and other services that are part of the specialized care these children may require.

Sincerely,

Dempsey Benton

cc: N. C. Legislative Delegation
Senator Martin Nesbitt
Representative Verla Insko
William W. Lawrence, Jr., MD
Mike Moseley
Sherry Bradsher
NC Advocacy Community

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NATIONAL GOVERNORS ASSOCIATION
1908 - 2008

Tim Pawlenty
Governor of Minnesota
Chair

Edward G. Rendell
Governor of Pennsylvania
Vice Chair

Raymond C. Scheppach
Executive Director

October 10, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Mr. Weems:

On behalf of the nation's governors, we request that the Centers for Medicare and Medicaid Services (CMS) rescind the proposed rule regarding Medicaid rehabilitation services [CMS 2261-P], published in the *Federal Register* on August 13, 2007. Governors recognize the need to ensure that Medicaid reimburses for appropriate services and that enrollees are involved in developing and evaluating their plan of care. However, the proposed rule represents a significant departure from states' authority to provide necessary health-related services for Medicaid enrollees, and would unnecessarily shift costs to states by reducing federal Medicaid expenditures by $2.2 billion over five years without eliminating the need for such services.

The proposed rule would make significant changes to the definition and financing of Medicaid rehabilitation services. It seeks to create a firm distinction between rehabilitation services and habilitation services, which must be paid for by other programs. However, as proposed, this delineation does not adequately account for the complex nature and scope of these necessary services.

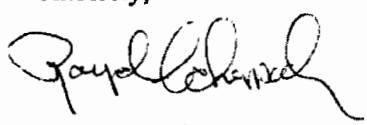
States have made tremendous progress in designing programs to address the needs of Medicaid enrollees. In addition, initiatives already are underway in many states to involve Medicaid enrollees in developing and reviewing their plan of care, when appropriate. Combined with other initiatives, these efforts are creating comprehensive and streamlined programs that can result in a seamless care delivery system for enrollees as well as improved quality and cost efficiencies. Rehabilitation services are an important component of such efforts.

In particular, mental health accounts for more than three-quarters of the services covered by Medicaid under existing rehabilitation plans. Implementing this rule may limit Medicaid coverage of these services and shift costs to already overburdened state mental health systems. Therefore, to avert any gaps in services resulting from the proposed changes in the definition and financing of rehabilitation services, CMS should preserve state authority to determine and cover the most appropriate services.

The proposed rule also addresses licensure and certification requirements for Medicaid providers delivering rehabilitation related services. We strongly urge you to defer to state standards and treat as final and binding determinations regarding the medical necessity of an item or service made by state- licensed or certified providers working in an educational program or setting.

In the past, governors have worked with the Administration and the Congress to develop important Medicaid reforms. The proposed policy by CMS (2261-P) was developed without sufficient outreach and could significantly restrict access to vital rehabilitative services for Medicaid-eligible individuals. The far-reaching nature of this rule and other recent regulations requires a more thoughtful, wide-ranging and collaborative effort. We recognize the complexities of these services and would welcome an opportunity to work collaboratively with CMS to establish clearer guidelines for coverage and reimbursement.

Sincerely,



Raymond C. Scheppach
Executive Director

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October 9, 2007

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

RE: File Code CMS-2261-P

To whom it may concern:

I am writing to express my strong opposition to regulations proposed by Center for Medicare and Medicaid Services (CMS) which would drastically eliminate many clinical services currently provided to individuals with developmental disabilities. These proposed regulations would change the definitions of "habilitation" thereby resulting in excluding necessary speech therapy, occupational therapy and physical therapy from allowable services in Medicaid clinics for individuals with autism and other developmental disabilities.

It is estimated that in 2006, nationwide approximately 52,000 people with autism and other developmental disabilities received necessary habilitation services through the clinic and rehabilitation options that are being eliminated by these proposed regulations.

As a result, I strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services and urge that this proposed rule be withdrawn. The proposed rule would severely harm people with autism and other developmental disabilities in two major ways:

(1) It eliminates longstanding programs for providing habilitation services to people with autism and other developmental disabilities
(2) It imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with autism, mental retardation and other developmental disabilities.

Developmental Disabilities Institute (DDI) is one of the largest not for profit providers of services to individuals with autism and other developmental disabilities on Long Island. Over 3,000 clinic visits a year would be eliminated by these proposed

regulations at our clinics alone. I believe that states should have the flexibility to continue operating these very necessary habilitation services to individuals with autism and other developmental disabilities. I urge the Secretary to rescind these proposed regulations. Thank-you.

Very truly yours,

Laurence Seth Cohen
30 Howe Street
Huntington Station, N.Y. 11746

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In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

This document is submitted on behalf of LEAnet, a California unincorporated association representing a national coalition of local education agencies in response to the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201

Summary:

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

Preliminary Comments:

We believe these proposed regulations would result in the denial of coverage for medically necessary services. This is especially a problem with regard to coverage of services for beneficiaries under 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those services are covered for adults[2].

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[1] Social Security Act, Section 1905(a)(13)]
[2] 42 U.S.C. § 1396d(r)(5)

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

Regulatory Impact Analysis: Overall Impact

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

To the contrary, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, most states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them, they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the

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

requirements of Executive Order 13132.

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

Overview:

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

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

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called "rehab option," which has been given broad and expansive administrative interpretation. This section says, inter alia, that medical assistance to be provided at state option includes "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level."

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[7] 72 Fed. Reg. at 45208 (Preamble, V.A.)
[8] 72 Fed. Reg. at 45206 (Preamble, II.F.2)
[9] See discussion of the DRA in Jeff Crowley and Molly O'Malley, Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues (Kaiser Commission on Medicaid and the Uninsured, August, 2007).

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

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

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

There have been previous attempts to curtail federal Medicaid contributions for covered benefits furnished to Medicaid-enrolled children who also are receiving services through public educational or social programs. The first such attempt occurred in 1988, when the Reagan Administration attempted to halt federal payments for medical assistance furnished as a related service under a child's special education plan. In response, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized

[10] (42 C.F.R. 440 130(d))

education plan[11]. The prohibition specifies as follows:

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

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

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

Overarching Issue - Conflict with EPSDT

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

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[11] 42 U.S.C. §1396b(c). Interestingly CMS concedes the existence of this statute in the school administration regulations but ironically, as justification for denying federal payments for administrative services. 72 Fed. Reg. 51398.
[12] Id.
[13] 72 Fed. Reg. 45209
[14] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5)

conflict or potentially conflict with the EPSDT requirements.

Recommendations:

We recommend the following:

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

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

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

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

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

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[15] 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A))
[16] Id. at 45203 (Preamble, II.C)
[17] Op. Cit.
[18] Id. at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi))
[19] Id. at 45204 (Preamble, II.C)

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

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

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

Recommendations:

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

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[20] 42 U.S.C. § 1396

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

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

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

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

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be provided.[22]" This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

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

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

[22] 72 Fed. Reg. at 45205 (Preamble, II.E)

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

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

Recommendations:

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

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

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

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included

[23] Dear State Medicaid Director, Peer Support Services – SMDL #07-011 (August 15, 2007)
[24] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))

under the IDEA[25]. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services[26]. Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . .[27]" Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party[28]. Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

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

It is difficult to understand what CMS means by the term "intrinsic." When the administration attempted to advance its "intrinsic" argument in 2005[29], it became evident that the concept reflected a fundamental misunderstanding of Medicaid's interaction with other programs serving children and the recommendation was rejected. Now the Administration seeks to do by regulation what Congress already has

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[25] 72 Fed. Reg. at 45202
[26] 42 U.S.C. § 1396b(c)
[27] 42 U.S.C. § 1396a(a)(25)(A)
[28] 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007).
[29] Medicaid's Rehabilitation Service Option, op. cit. p. 13

rejected by statute. The rehabilitation NPRM resuscitates the "intrinsic" exclusion once again, this time broadening it still further. As before, the Administration excludes payments for "intrinsic" elements while offering no definition of "intrinsic elements." But the NPRM also goes beyond the vagaries of the "intrinsic element" test to exclude payment for covered rehabilitation benefits in the case of children who are receiving services in the case of other specific programs. As a result, the rule adds a coverage condition not contemplated by the statute, which functions as the type of coverage exclusion common to commercial insurance[30]. In the proposed regulations, CMS states:

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

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

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

Recommendations:

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

In the alternative:

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

The responsibilities for states regarding third party payers, and the third party payers' own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

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

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

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

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

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental

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

health and/or substance related disorders can be appropriately treated with rehabilitation services[35]. However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

Recommendations:

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

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

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

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

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

We believe that an IEP developed in accordance with IDEA should satisfy CMS's stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student's physical or mental disability and restoration of the student to the best functional level. The IEP process

[35] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2))

includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Proposed Elimination of Transportation Services

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

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

Non-covered services: 441.45(b)

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

There appear to be only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service, in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or CMS is concerned that non-

medical programs are furnishing Medicaid-covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

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

Recommendations:

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

Summary:

As we have discussed above, we believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[37]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources

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

has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

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

- END -