



October 12, 2007

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

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

Dear Mr. Weems:

The American Public Human Services Association and its affiliates, the National Association of State Medicaid Directors and the National Association of Public Child Welfare Administrators, respectfully submit this comment letter on the coverage for rehabilitative services regulation published in the August 13, 2007, *Federal Register* (72 FR 45201) for the Centers for Medicare and Medicaid Services.

Please be assured that NASMD and NAPCWA share your strong commitment to protecting the fiscal integrity of the Medicaid program. We appreciate the opportunity to work with CMS to develop proposals and guidance that will provide consistency and stability to the Medicaid program while serving those in need. However, we submit that the agency's proposed rule creates some additional challenges for states to achieve this goal.

The proposed rule appears grounded in the assumption that rehabilitation services serve as "intrinsic elements" within a series of other federally funded programs, and that states are thereby duplicating their funding streams in seeking support from Medicaid for these services. This is, in fact, misleading. In many of these programs, including IV-E Foster Care Services included under the rehabilitative service option, are not eligible for a federal match. In the case of Title IV-B Child and Family Services funding, there are no federal matching funds available to states, since this is a capped program. If rehabilitative services were to be disallowed by Medicaid, states would lose necessary federal funding and place particularly vulnerable populations at risk of

losing needed rehabilitative services.

States utilize a variety of medical models of care in serving the varied needs of their population. The proposed rule would reduce state flexibility in packaging rehabilitative services with other community-based service networks and limit state ability to craft effective systems of care.

The major areas of concern identified by states include:

- The inability of states to provide rehabilitative services based on the erroneous assumption that they are “intrinsic elements” within other federal match rate programs;
- The increased financial burdens the proposed rule would place on states by decreasing available funding streams; and
- The loss of flexibility for states in providing rehabilitative services to their Medicaid populations.

We appreciate the opportunity to provide you with the following comments.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

440.130(d)(1)(ii): Other Licensed Practitioner of the Healing Arts

The term licensure is not broad enough to cover all the practitioners of the healing arts that a state may deem as allowable providers of rehabilitative services. Under the scope of practice defined in state law, states may also allow practitioners who are credentialed and accredited to practice their healing art. States should be allowed the flexibility to determine their own definitions of allowable practitioners within state law.

440.130(d)(1)(iii): Qualified providers of rehabilitative services

Under the proposed definition of “qualified providers,” states are concerned that qualified therapeutic foster parents will not be explicitly identified by newly approved state plans as qualified providers of rehabilitative services. We urge CMS to continue to recognize qualified therapeutic foster parents as legitimate providers of rehabilitative services.

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

This definition of the rehabilitation plan calls for developing a treatment plan focused on achieving identified goals. Individuals who suffer from chronic mental illness experience extreme shifts in their levels of recovery and rehabilitation, complicating the process of goal setting and achievement. Evidence supports that Assertive Community Treatment is the most cost-effective and beneficial means of continually supporting severely mentally ill patients within community treatment settings. States urge CMS to allow for increased flexibility in developing rehabilitation plans that will enable crisis and stabilization planning.

The plan's definition also calls for the central involvement of an "authorized decision maker" in setting goals and identifying services. This figure may prove problematic for children in foster care, since multiple individuals in their lives may take on this role. States ask CMS to clarify this language so that it may not be misconstrued within the child welfare system.

440.130(d)(1)(vi): Restorative Services

CMS defines restorative services as those services provided to a person to regain a level of functioning that has been lost. Children present an exception to this definition, because a previously appropriate level of functioning may not have been developmentally possible. In these instances, children who are striving to gain an age-appropriate level of functioning, often in line with their peers in the general population, are considered recipients of rehabilitative services. States urge CMS to clarify the meaning of restorative services to encompass children and their rehabilitation needs.

States also recognize that the distinction between habilitation and rehabilitation is not always clearly drawn. For example, a child with a Severe Emotional Disturbance may rely on medication for behavioral regulation; however, if this medication regimen is disrupted, the child's condition may escalate. The absence of a regulated medication schedule—typically considered habilitative services—will disrupt the child's treatment, requiring additional services to restore that child to a prior level of functioning. These additional services will then fall under the definition of rehabilitative services. Allowing a flexible and reasonable understanding of rehabilitative services would extend continuous treatment services to the child, barring the occurrence of an episode of decompensation. Such episodes will compromise a child's stability, disrupting family functioning, school attendance, and, in the case of foster children, permanent placements.

In addition, the Supreme Court decision in *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999), protects individuals from inappropriate institutionalization when they may be successfully treated and maintained in a less-restrictive environment. Rehabilitative services directly support this aim in the case of individuals who require services to continually restore their level of functioning.

440.130(3)(xi) Written Rehabilitation Plan

Section 440.130(3)(xi) would require plans to include alternate providers of the same service as options for recipients. For children in foster care, particularly those in residential treatment facilities of 16 beds or fewer, there are limited treatment options based on access to and the availability of qualified service providers. States ask that CMS recognize these limitations and amend this requirement to offer states greater flexibility, given these circumstances.

441.45(b)(1)(i-iii) Therapeutic Foster Care, Adoption Services, Family Preservation, and Family Reunification Services

Rehabilitative services are fundamental to maintaining the safety, permanence, and well-being of children involved in the child welfare system. For children with serious mental disorders, therapeutic foster care is the least restrictive out-of-home placement option. Therapeutic foster

care is a widely recognized evidence-based practice that demonstrates successful outcomes for children in care. Without the services provided under the rehabilitative option, many of these children would require institutional placement in residential treatment programs or hospital settings that carry significantly higher monetary costs for Medicaid, as well as immeasurable emotional costs for children and their families.

According to Section 441.45(1)(i), rehabilitative services provided within the context of therapeutic foster care are considered an intrinsic element of IV-E federally funded foster care. States challenge CMS' narrow interpretation of IV-E reimbursement as a duplicative cost based on Medicaid's coverage of rehabilitative services provided via therapeutic foster care. Packaged therapeutic foster care services covered under this Medicaid option are not billable under Title IV-E, as stated by the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20: "Title IV-E foster care is to cover the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel for a child's visitation with family or other caretakers." The congressional mandate that all children under Title IV-E receive Medicaid coverage speaks to the expectation that federal child welfare funding streams not be used to address the physical and mental health needs of children in this system.

The proposed restrictions on allowable therapeutic foster care services supported to date by Medicaid's rehabilitative option will exclude this vulnerable population of children from needed mental health services. States have consistently conducted time studies and cost reports that extrapolate rehabilitative costs from Title IV-E billable services. If CMS removes the Medicaid coverage option by enacting this rule, costs for these services will pass to currently constrained state budgets. States urge CMS to amend the proposed rule by striking 441.45(1)(i) and (ii).

Although adoption services, family preservation, and family reunification are federally funded by Title IV-B, this is a capped program. CMS includes it as a federal financial participation-eligible program in Section 441.45(1)(iii). As a capped funding source, Title IV-B does not serve as a reliable funding stream for states in paying for rehabilitative services within the continuum of child welfare. States urge CMS to amend the proposed rule by striking 441.45(1)(iii).

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

The language in this section does not correspond with the language in the proposed rule on page 45207, which states, "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."

Children in foster care may have an array of individuals in their life who are key participants in their rehabilitative treatment. These individuals could include biological family members, foster family members, kin, and other caring adults such as teachers or mentors. States request that CMS clarify this inconsistency by stating that individuals who are not Medicaid eligible, but are integral to the treatment of a Medicaid recipient, are covered by the rehabilitative service option.

In addition, during the APHSA conference call on August 23, 2007, CMS officials stated that when a child is in an institution, federal financial participation under the rehabilitative option can be used for the training provided to the parent in preparation for the child's return home. This statement is negated in Section 441.45(b)(7), and states urge CMS to amend the section to include flexibility in service provision to individuals who are not Medicaid eligible.

Thank you for the opportunity to comment on the proposed regulation. If you have any additional questions, please contact Martha Roherty, NASMD Director, or Anita Light, NAPCWA Director, at (202) 682-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jerry Friedman". The signature is written in black ink on a white background.

Jerry Friedman
Executive Director