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Advancing the rights of Californians with disabilities

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Via Fed-Ex and e-mail: <http://www.cms.hhs.gov/eRulemaking/>  
(One original and two copies)

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

Reference: File Code CMS 2261-P  
Medicaid Program; Coverage for Rehabilitative Services;  
proposed regulations

To Whom It May Concern:

Protection & Advocacy, Inc. (PAI) is the federally-mandated protection and advocacy agency for the State of California. As such, PAI represents individuals with disabilities in a wide range of matters, including assistance in obtaining rehabilitative health care and services under the Medicaid program.

PAI concurs with the comments and recommendations made by the Bazelon Center for Mental Health Law, and the National Health Law Program. PAI submits the following additional comments directed to specific provisions of the proposed regulations.

**Section 440.130(d)(1)(i)(A) – Definition of “Recommended by a physician or other practitioner of the healing arts”**

Section 440.130(d)(1)(i)(A) adds a definition of “Recommended by a physician or other practitioner of the healing arts” that provides that the physician or other practitioner has determined that receipt of services “would result” in reduction of the individual’s disability and restoration to the individual’s best possible functional level.

It is unlikely that any practitioner could state that any provision of medical care or services “would result” in anything. That degree of certainty is impossible.

The proposed regulation should be amended to read: “is expected to result.”

**Section 440.130(d)(1)(iii) – Definition of “Qualified providers of rehabilitative services**

The regulations should specify that peer providers can be qualified providers of rehabilitative services.

**Section 440.130(d)(1)(v) – Definition of “Rehabilitation plan”**

The first sentence of this section defines “rehabilitation plan.” The following sentences set forth requirements for the plan. The additional sentences following the definition in the first sentence appear to be unnecessary because the standards for rehabilitation plans contained in those additional sentences are also set out in Section 440.130(d)(3). In addition, the sentences following the definition contain slightly different terminology than the plan requirements in Section 440.130(d)(3). Although the requirements overlap, they are not the same in all respects. Therefore, the portion of section 440.130(d)(1)(v) following the definition in the first sentence is redundant and potentially confusing and should be eliminated.

The second sentence refers to providers working within the “State scope of practice act.” This is different from the terminology generally used in the

Medicaid statute and regulations. In order to avoid confusion, this provision should be changed to: “acting within the scope of the provider’s practice under state law.” The same change should also be made wherever “State scope of practice act” terminology appears in the proposed regulations.

**Section 440.130(d)(1)(vi) – Definition of “Restorative services”**

The definition of “restorative services” correctly points out that the emphasis in covering rehabilitation services is on ability to perform a function rather than actually having performed the function in the past. The definition also points out that rehabilitation goals are often contingent on an individual’s maintenance of a current level of functioning. However, while the regulations state that assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan, the regulations do not make it clear that, at times, the rehabilitation goal may not be immediately obtainable.

The mental health recovery model, referenced in the regulations, Section 440.130(d)(3)(iv), recognizes that recovery may be a long-term, even lifelong process that may involve periods of time when there is a plateau in recovery or even deterioration in functioning. The regulations should be amended to acknowledge this so that they are not interpreted as requiring unrealistic goals, or goals at variance with the recovery model. The regulations should be amended to require states to provide the specific rehabilitation services described in Section 1905(a)(13) of the Social Security Act, 42 U.S.C. § 1396d(a)(13)<sup>1</sup> for the purposes of carrying out the broad and overarching rehabilitation goals of the Medicaid

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<sup>1</sup> “...other diagnostic, screening, preventive, and rehabilitative 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 within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level...”

program contained in Section 1901 of the Social Security Act, 42 U.S.C. 1396.<sup>2</sup> This is necessary in order to carry out the purposes of the entire Medicaid statute as expressed in both of the above-referenced sections.

The regulation should specify that rehabilitation services are available to an individual who can be expected to benefit from the services because the services are directed at maximum reduction of disability and restoration of best possible functional level, that the rehabilitation goals must be directed toward helping the individual “attain or retain capability for independence or self-care,” that attainment or retention of independence and self-care may be a long-term, or even a lifelong process, and that rehabilitation goals should not impose unreasonable time limits on the attainment or retention of independence and self-care, or unreasonable expectations as to what represents independence and self-care.

The regulations should also be amended to provide that for individuals eligible for EPSDT services, Medicaid rehabilitative services must be provided that are necessary to “correct or ameliorate” a physical or mental condition, and that the scope of Medicaid rehabilitative services that a State offers to individuals under age 21 (or 22 in some cases) must be as broad as is allowed under the federal Medicaid program.

**Section 440.130(d)(2) – Scope of Medicaid rehabilitation services**

“Within the scope of his practice under State law” should be changed to “within the scope of the provider’s practice under State law.”

The regulations should also be amended to provide that for individuals eligible for EPSDT services, Medicaid rehabilitative services must be provided that are necessary to “correct or ameliorate” a physical or mental condition, and that the scope of Medicaid rehabilitative services that a State offers to individuals under

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<sup>2</sup> “...rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care....”

age 21 (or 22 in some cases) must be as broad as is allowed under the federal Medicaid program.

The regulations should also specify that peer services are included in the scope of services.

**Section 440.130(d)(3)(ii) – Development of rehabilitation plan**

Subsection (ii) provides standards for development of the plan while Subsection (iii) provides standards for development, review and modification of plan goals and services.

It is difficult to see a distinction between development of a plan and development of plan goals and services. These things seem to be inseparable. The functional difference between the two provisions in the proposed regulations seems to be that the individual receiving services provides “input” into the development of the plan, but “actively participates” in development, review, and modification of plan goals and services. Again, there seems to be no distinction between these two activities that would lead to this functional difference.

An individual should be able to actively participate in every aspect of the development of the plan. This does not mean that all decisions regarding the plan are made by the individual or that the individual is present during all discussions about the plan. For example, the individual would not necessarily decide how much the services cost and would not necessarily be present when a provider is asked if the provider would be available or willing to provide services. However, the individual should actively participate in development of all aspects of the plan if the individual’s participation can make a difference in the outcome to the individual. This participation goes well beyond development, modification or review of the plan goals and services.

Also, if the individual has provided written instructions in an advance directive, these instructions should be considered in the development of the plan and in the development, review, and modification of plan goals and services.

In addition, the section provides that the plan should be developed with input from various individuals. Input from individuals such as family members can be helpful in developing a plan. However, the requirement as written can easily be interpreted as requiring that the provider seek out and obtain input from various individuals in preparing the plan. In order to avoid this interpretation, the regulation should be changed to provide that input “received” by the provider is considered.

Finally, some individuals may not be authorized to provide input, such as an attorney who has not been authorized to disclose confidential information. The section should be amended to provide that only authorized persons may provide input.

Subsection (iii) should be deleted and Subsection (ii) should be amended to read:

Be developed by a qualified provider(s), within the scope of the provider(s) practice under State law, with the active participation of the individual, in accordance with instructions in the individual’s advance health care directive, and/or with the active participation of persons of the individual’s choosing, which may include members of the individual’s family and the individual’s authorized health care decision maker. In developing the plan the provider(s) shall consider input received from persons of the individual’s choosing and/or other individuals authorized to provide input. This may include members of the individual’s family.

“Working within the State scope of practice act” in Subsection (ii) should be changed to “acting within the scope of the provider’s practice under State law.”

#### **Section 440.130(d)(3)(xiv) – Reevaluation of rehabilitation plan**

Subsection (xiv) provides that if there is no measurable reduction in disability and restoration of functional level there would have to be a different rehabilitation strategy. This appears to be inconsistent with the mental health recovery model under which there may not be measurable reduction in disability or restoration of

functional level for periods of time. It also appears to be inconsistent with the regulation that provides that services directed at maintaining functioning may be appropriate. See discussion of Section 440.130(d)(1)(vi), above.

The purpose of this subsection could be carried out by referring to the goals of the plan being met rather than requiring “measurable” reduction and restoration. If the goals are directed at reduction and restoration over time but this cannot be achieved during the course of the plan, services should not be denied. Therefore, the clause: “If it is determined that there has been no measurable reduction of disability and restoration of functional level...” should be replaced with:

If it is determined that the goals set forth in the plan are not being met, or that there is no progress in meeting the goals....

**Section 441.45(b)(1) – Services furnished through a non-medical program**

This section provides that FFP is not available for covered Medicaid rehabilitation services that would otherwise be reimbursed if the individual is receiving the services under a non-medical care program such as foster care, and the services are an “intrinsic element” of the program.

This provision violates comparability provisions of the Medicaid Act because it denies Medicaid-covered services to a class of individuals who are otherwise eligible to receive the covered services. This is because the denial is based on the individual being enrolled in a particular non-medical program rather than on receipt of the otherwise-covered services from that program. The requirement places Medicaid beneficiaries in the position of not receiving the covered Medicaid rehabilitation services at all if the State chooses not to provide the same service under the non-medical care program. This is because the proposed regulation prohibits otherwise-covered Medicaid rehabilitation services from being provided to individuals enrolled in certain categories of non-medical programs regardless of the services that are actually provided under those programs.

States have considerable leeway in structuring their programs and should receive FFP for Medicaid-covered services if the State chooses to cover the services under the State Medicaid program rather than under another program. The other portions of the regulations requiring that services be provided by qualified providers in accordance with a comprehensive written rehabilitation plan, as well as other Medicaid quality assurance requirements contained in the proposed regulations and other Medicaid regulations, should be sufficient to insure that Medicaid programs do not pay for services that are not covered by Medicaid. Moreover, the “intrinsic elements” requirement is not defined in the regulations, is found nowhere in the Medicaid Act and has been rejected by Congress. This should counsel restraint in adopting the standard.

**Section 441.45(b)(1)(i) and (ii) –Therapeutic foster care services and “packaged” services**

These sections allow Medicaid rehabilitation services to be provided to eligible individuals who are receiving foster care services if the Medicaid rehabilitation services are “clearly distinct” from “packaged” foster care services. It is unclear from the regulations what “clearly distinct” and “packaged” mean. How distinct must the service be in order to be “clearly” distinct? What is clear to one auditor auditing payments to a particular provider (or Federal payments to a State) may not be clear to another auditor. Providers need clear standards in order to comply with regulatory requirements. The “clearly distinct” standard is not a clear standard. It allows auditors too much discretion to deny claims and will therefore make it difficult for beneficiaries to receive the services because providers will be reluctant to provide them.

In addition, the regulation does not make it clear that “packaged” services refers only to combining Medicaid and foster care services in such a way that it cannot be determined which services should be billed to Medicaid and which services should be billed to the foster care program. “Packaging” does not refer to the provision of services under the Medicaid rehabilitation service category alone.

States have considerable leeway in developing or not developing service sub-categories within the Medicaid rehabilitation service category. The regulations should make it clear that states can develop or not develop service subcategories that reduce administrative complexity so long as there is an appropriate audit trail that enables an auditor to determine that the services billed for are medically necessary rehabilitation services that have actually been provided.

The regulation is unnecessary for the same reason that the “intrinsic elements” regulation is unnecessary. The other portions of the regulations requiring that services be provided by qualified providers in accordance with a comprehensive written rehabilitation plan, as well as other Medicaid quality assurance requirements contained in the proposed regulations and other Medicaid regulations, should be sufficient to insure that Medicaid programs do not pay for services that are not covered by Medicaid.

#### **Section 441.45(b)(2) - Habilitation services exclusion**

This section proposes to eliminate habilitation services from coverage as a Medicaid rehabilitation service. CMS should not eliminate this service in the absence of Congressional authorization particularly since habilitation services have been provided under the rehabilitation option and Congress imposed a moratorium on denial of federal financial participation (FFP) for the service.

The moratorium on denial of FFP for habilitation services did not authorize CMS to eliminate the service. Section 6411(g)(2) of the Omnibus Budget Reconciliation Act of 1989 provides the following requirement for habilitation regulations:

- (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.

This statutory language does not permit CMS to eliminate habilitation services from the definition of rehabilitation services. Instead, it requires CMS to define the types of day habilitation and related services that are covered rehabilitation services.

While CMS refers to other sections of the Social Security Act that allow FFP for habilitation services, those sections provide for limits on the number of people eligible for services, caps on services and other exceptions to comparability requirements. Attempting to shift all habilitation services from the Medicaid rehabilitation service category to other service categories would violate comparability requirements because habilitation services fit within the broad definition of rehabilitation services.

Rehabilitation services, within the statutory definition, are not limited to services directed at “regaining” previous functioning that has been lost. As the regulations point out at 440.130(d)(i)(vi) (definition of “Restorative functioning”): “The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function.” Habilitation services, like other rehabilitation services, are directed at the ability to perform a function rather than actually having performed the function. There is no principled distinction between habilitation services and rehabilitation services.

Despite the proposed elimination of reimbursement for habilitation services under the rehabilitation category, the regulations seem to provide that individuals with mental retardation or related conditions are eligible to receive rehabilitation option services if they otherwise meet the criteria for receiving them. This result is required under the comparability requirements of the Medicaid Act.

Unfortunately, the proposed regulations are not clear and as currently worded could be interpreted to deny all rehabilitation services to individuals with mental retardation or related conditions. The regulations should clarify that individuals with mental retardation or related conditions are eligible for rehabilitation

services on the same basis as other Medicaid-eligible individuals by adding the following:

An individual with a diagnosis of mental retardation or a related condition is eligible to receive rehabilitation services under the state plan on the same basis as other Medicaid-eligible individuals when the rehabilitation services address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs.

**Sections 441.45(b)(4) and (5) – Public institution and IMD exclusions**

These subsections relating to the public institution and IMD (institutions for mental diseases) exclusions are unnecessary and have the potential for causing confusion. The subsections are unnecessary because these exclusions, which apply to the entire Medicaid program, are covered by other regulations that are general in scope. See, 42 C.C.R. §§ 435.1009, 435.1010, and 441.13. The subsections have the potential for creating confusion because their existence suggests that there are different or additional public institution or IMD exclusions that apply to the rehabilitation option apart from the public institution or IMD exclusions generally applicable to the Medicaid program.

If CMS chooses to emphasize that these exclusions apply to the rehabilitation option, as they do to the rest of the Medicaid program, CMS should cross reference the general regulations governing these exclusions here.<sup>3</sup>

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<sup>3</sup> However, CMS should not amend the general regulations related to public institutions or IMDs as part of this rule-making process because any amendment of those regulations would go beyond the scope of making changes to the rehabilitation option regulations.

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Thank you for this opportunity to comment.

Sincerely,

Daniel Brzovic

Associate Managing Attorney

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