



To: State CEOs State Medicaid Directors and State Child Welfare Administrators
From: Jerry Friedman
Date: August 15, 2007
Subject: Notice of Proposed Rule Making: Coverage for Rehabilitative Services 42 CFR Parts 440 and 441

On August 13, 2007, the Centers for Medicare & Medicaid Services (CMS) published a notice of proposed rule making (NPRM) on the Coverage for Rehabilitative Services in the *Federal Register* (72 FR 45201). The NPRM reflects the administrative proposal included in the president's budget plan for fiscal year (FY) 2008 and is similar to language the administration has proposed in previous years.

The text of the NPRM can be found at: http://www.cms.hhs.gov/MedicaidGenInfo/08_Medicaidregulations.asp. Comments will be accepted through 5:00 p.m. on October 12, 2007. APHSA plans to submit comments on behalf of states. In addition, I encourage individual states to submit a letter documenting the specific impact on your state.

APHSA Position

Over the past several years, APHSA has been in contact with various federal officials and agencies within the U.S. Department of Health and Human Services and the White House to discuss changes to the definition of the rehabilitation option that were under consideration. APHSA has repeatedly represented states' concerns to the administration and Congress regarding the policy direction under discussion, specifically the potential change to the definition of the rehabilitation option and CMS audits denying some services under the rehabilitation option.

NPRM Summary

In recent years, federal officials have cited at least two major concerns with the rehabilitation services option. First, the administration has repeatedly challenged the appropriateness of certain services. In addition, officials have cited that the Medicaid program should be the payer of last resort, and that the program has inappropriately reimbursed for claims under the rehabilitative services option that they assert should have been paid for using funds from other federal or state programs. CMS proposes amending Medicaid Rehabilitative Services to address these issues and ensure that rehabilitative services are provided in a coordinated manner, in the best interest of the individuals, are limited to rehabilitative purposes, and are furnished by qualified providers.

The proposed rule seeks to clarify the services definition and specifically address that Medicaid Rehabilitative Services do not include services furnished by other programs that are focused on social or educational development goals. These services and programs include, but are not limited to, foster care, child welfare, education, child care, pre-vocational and vocational services, housing, parole and probation, juvenile justice, public guardianship and any other non-Medicaid services from federal, state, or local programs. CMS specifically states that the Medicaid Rehabilitative Services benefit should *not* be used for services already included in the provision of foster care, such as case planning, and for juvenile justice services such as wilderness camps.

Proposed Changes

Listed below are other major provisions in the NPRM that would have a cross-cutting impact on states' health and human services programs. The proposed rule 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. The provider qualifications in the state plan may include education, work experience, training, credentialing, supervision, and licensing.
- Require that covered rehabilitative services for each individual be identified under a written rehabilitation plan, which includes specific treatment goals and is re-evaluated at least yearly. The rehabilitation plan must include a comprehensive assessment of the individual’s needs, be developed by qualified providers, specify the individual’s rehabilitation goals, identify the methods, frequency, and duration of service delivery, and contain the beneficiary’s signature. Additional requirements are specified in the NPRM.
- Require that the provider document 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. CMS has proposed an annual evaluation of the rehabilitation plan. This would require that a rehabilitation plan be revised if it does not demonstrate effectiveness in restoring the beneficiary's functional level or reducing their disability within a year.
- Maintain that therapeutic foster care is not considered a medically necessary service under Title XIX of the Social Security Act. As a result, the rule would prohibit reimbursement for this service under the Medicaid Rehabilitative Services benefit. Elements of therapeutic foster care that would not qualify as reimbursable under Medicaid include provider recruitment, foster parent training, and other foster care services.
- Exclude FFP for expenditures for “habilitation services,” including those provided to individuals with mental retardation or related conditions. The rule clarifies that habilitation services help individuals acquire new functional abilities rather than focus

on restoring any lost function. CMS indicated that the agency plans to work with states with existing habilitation programs under the clinic services or rehabilitative services benefits in their state plans to make the transition to appropriate Medicaid coverage authorities. This is consistent with the agency's efforts over the past several months to encourage the use of 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, (P.L. 107-171).

- Only permit recreational and social activities that are specifically focused on the improvement of physical or mental health impairment and achievement of a defined rehabilitation goal specified in the rehabilitation plan.
- Prohibit payment under the rehabilitative services option for expenditures for room and board in an institutional, community, or home setting. In addition, in-patient psychiatric services would not be covered.
- Clarify Medicaid reimbursement rules to allow coverage of non-Medicaid eligible parents and other individuals involved in a Medicaid beneficiary's treatment plan, e.g., for family counseling purposes.

Fiscal Impact

CMS anticipates that the proposed rule would reduce federal Medicaid spending for rehabilitative services by approximately \$180 million in FY 2008. Over the five-year period FY 2008 to 2012, CMS estimates that federal spending would be reduced by \$2.2 billion.

Legislative Update on the Rehabilitative Services Option

In anticipation of the administration's proposal and in conjunction with efforts to reauthorize the State Children's Health Insurance Program (SCHIP), there has been renewed congressional interest in this issue. On July 13, Senator Debbie Stabenow (D-MI) sent a request to Democrats on the Senate Finance Committee seeking their support on a letter to be sent to HHS Secretary Leavitt regarding CMS administrative actions and Office of Inspector General (OIG) state audits relating to the Medicaid rehabilitative services and targeted case management options. The letter expressed concern that administrative actions by CMS and OIG relative to these options sometimes contradict prior CMS policy or guidance to states, reverse precedent in the Medicaid program, or conflict with federal law.

On August 1, the House approved an SCHIP reauthorization measure, H.R. 3162, which includes language to place a one-year moratorium on changes to the rehabilitative services option in Medicaid. Specifically, upon enactment, the provision (Section 814) would prohibit CMS from taking any action that would restrict coverage or payment for services covered under the Medicaid rehabilitative services option that are more restrictive than the policies in place as of July 1, 2007. Although similar language was considered in the Senate, the Senate-approved measure, S. Amdt. 2530 to H.R. 976, does not include the moratorium language.

During Congress' month-long August recess and into at least September, congressional staff will continue their negotiations to develop a compromise version of their respective SCHIP

measures. At this time, it is unclear if and when an agreement will be reached and whether that agreement will retain the House language. The outlook for enacting a SCHIP reauthorization measure is further complicated by the unyielding opposition from the Bush Administration to both the House and Senate bills.

For additional information, please feel free to contact Martha Roherty, APHSA/NASMD at mroherty@aphsa.org or Rachel Demma, APHSA/NAPCWA at rdemma@aphsa.org should you have any questions or concerns.

APHSA will be hosting an all-state call on this issue. Please join us on Thursday, August 23, 2007, at 1:30 p.m. EST.

Conference Number 1-877-271-1828

Passcode: 19343817#