



Summary and Analysis of CMS Proposed Rule Regarding Medicaid Rehabilitative Services

PLEASE SEND ADDITIONAL
COMMENTS & CONCERNS TO:
Laura Weidner
Child Welfare League of America
Government Affairs Associate, Health
lweidner@cwla.org; 703/412.3168

Importance of Rehabilitative Services for Children in Foster Care

In FFY 2004, there were 509,662 children in foster care and during that same year, approximately 800,000 children spent at least some time in a foster care setting.¹ Children that enter the foster care system are at an extremely high risk for both physical and mental health issues as a result of biological factors and the maltreatment they were exposed to at home. Separation from familial ties and the continued instability that often ensues only exacerbate this vulnerability. Numerous studies have documented that children in foster care have medical, developmental and mental health needs that far surpass those of other children, even those living in poverty. For instance, one study found that 60% of children in care have a chronic medical condition and one-quarter have three or more chronic health problems.² Dental problems afflict many of these children, with one-third to one-half of them reported to have dental decay.³ Frequent developmental delays are found in regards to language and cognition⁴ and up to 80% of children in out-of-home care meet the clinical criteria for behavioral problems or psychiatric diagnosis.⁵

When children are removed from their home base and placed in state custody, child welfare agencies are responsible for meeting their health and mental health needs, and virtually all children in foster care are eligible for and obtain health care services through Medicaid. Medicaid is a joint federal-state partnership that allows states to create individual and unique programs tailored to their needs. Federal guidelines outline a set of mandatory beneficiaries and required core services that states must provide Medicaid services for, but once states meet those obligations, they have the option to expand the scope and types of services offered and to provide services for individuals who exceed the income guidelines—

as long as their plans are specifically approved by the Centers for Medicare and Medicaid Services (CMS).

For example, many states choose to provide rehabilitative services to children in foster care, with “rehabilitative services” currently defined as:

“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.” [Social Security Act, Section 1905(a)(13)]

Rehabilitative services have been increasingly used by states recently—especially for individuals with mental illness—for a couple of reasons. The increase was prompted in part by the recommendations from the President’s New Freedom Commission on Mental Health, issued in 2003, to improve the nation’s mental health system. A strong and continuous goal of the Commission’s report is to ensure consumer- and family-driven services and treatment that focuses on recovery.⁶ Recovery, in the Commission’s view, is a fairly fluid concept that helps individuals to “live, work, and learn, and participate fully in their communities” and “live a fulfilling and productive life despite a disability.”⁷ Rehabilitative services are a means to that end. They are especially useful for children in foster care, as well as other populations, because they permit services to be provided in the least restrictive setting and over a period of time, to properly and thoroughly address health needs.

The Freedom Commission also stressed the need for research that promotes recovery and resilience and the implementation thereafter of evidence-based practices. We know the situation for children in foster care is dire and they are quite vulnerable, since many have been through great physical and/or mental turmoil. We also know that early intervention and reduction of physical and/or mental disability are keys to increasing children’s chance for success. In an extensive survey of adults regarding seven categories of adverse childhood experiences, including psychological, physical, or sexual abuse, having located an extremely high correlation between the breadth of early exposure to abuse or household dysfunction and health risk factors later in life, researchers learned the negative consequences of inaction and lack of proper care.⁸ Adults who had experienced four or more categories of childhood exposure, compared to those who had none, had four- to twelve-fold increased health risks for alcoholism, drug abuse, depression and attempted suicide. There was also a graded relationship to presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fracture, and lung disease.

Rehabilitative services offer a realistic opportunity to, in the least restrictive setting possible, reduce the physical and/or mental disabilities that many children in foster care have, thereby decreasing such lingering and long-term negative impacts, restoring the child’s functioning level, and ultimately reducing any cost on society.

History

CWLA believes that there is a shared mission between Medicaid and child welfare services to provide not only for the basic safety of children in foster care, but also to improve their overall well-being, including close attention to both physical and mental health care outcomes. To do this, it is essential that the federal government continue to allow and adequately fund the use of Medicaid rehabilitative services so that the health care needs of children in foster care are properly addressed.

Unfortunately, in recent years, federal Medicaid policy has been moving in the opposite direction, to the detriment of roughly 800,000 children who spend time in the foster care system each year. In 2005, the Bush Administration proposed to severely restrict Medicaid coverage for certain services. When deliberating and finalizing the Deficit Reduction Act of 2005, Congress did enact third party liability rules in regards to another important Medicaid option for children in foster care—targeted case management—but explicitly rejected adopting the Administration’s suggested “intrinsic element” test for the Medicaid rehabilitative services option. In doing so, Congress expressed its desire for the rehabilitative services option to remain a strong and available stream of care. The Administration’s efforts to limit the use of Medicaid’s rehabilitation option to provide rehabilitative services to children in foster care and others were again reflected in the President’s FY 2007 and FY 2008 budget proposals.

On August 13, 2007, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the Federal Register, CMS 2261-P/72 Fed. Reg. 45201, that seeks to “clarify the broad general language of the current regulation.” The proposed regulation may be viewed in its entirety at:

<http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2261P.pdf>. The following is a summary of the proposed rule, with focus on its potential impact on children in foster care, and CWLA’s corresponding initial analysis and concerns.

CMS Proposed Rehabilitative Services Rule and Corresponding Concerns

In proposed rule 2261-P/72 Fed. Reg. 45201, CMS proposes to amend 42 CFR chapter IV as follows:

Clarification of the Definition of and Proper Settings for Rehabilitative Services:

The basic definition of “rehabilitative services” is retained as: “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 an individual to the best possible functional level.”

- **CONCERN:** Little to no clarification as to what “maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level” means. The term “maximum reduction...and restoration” is especially confusing when it comes to children, considering their ever-changing developmental stages. Are developmental stages taken into account?
- **CONCERN:** While the majority of the philosophy behind the proposed regulation is commendable and it is estimated that such changes should reduce Federal Medicaid

spending by approximately \$2.2 billion over five years, it does not address the numerous administrative and financial burdens it creates, especially at the state and local level. Without proper infrastructure and assistance for program administrators up front, access to services will most certainly be restricted as a result.

Rehabilitative services may be provided in a facility, home, or other setting. [Proposed Section 440.130(d)(5)] The proposed rule explicitly clarifies that rehabilitative services are not an inpatient benefit and therefore do not include room and board in an institutional or community setting. [Proposed Section 440.130(d)(2)]

- **IMPROVEMENT:** In line with the President's New Freedom Commission on Mental Health's recommendations, the proposed regulation is a person- and family-centered approach that is focused on early intervention and front-ended recovery in the least restrictive setting possible.

Defining "Qualified Providers of Rehabilitative Services": Individuals providing rehabilitative services would have to meet the provider qualification requirements applicable to the same services when furnished under other benefit categories. Such provider qualifications can take various forms including for instance, education, work experience, and/or supervision and licensing, but the qualifications must be reasonable, stated in the Medicaid state plan, and applied in a uniform manner to ensure freedom of choice for the consumer. [Proposed Section 440.130(d)(1)(iii)]

In the "Provisions of Proposed Regulations" background section, CMS clarifies 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. [p. 25] This presumably means that therapeutic foster parents would have to meet provider qualifications as detailed in the corresponding state plan.

- **IMPROVEMENT:** Some states have already begun to move in this direction to ensure that providers of rehabilitative services, including some therapeutic foster parents, are qualified and properly suited for the job.
- **CONCERN:** Requiring *all* therapeutic foster parents to meet high standards will surely reduce availability of services.

Written Rehabilitation Plan Requirement: To ensure that the services "are designed and coordinated to lead to the goals set forth in state and regulation" and to ensure transparency, covered rehabilitative services would have to be identified under a written rehabilitation plan that is reasonable and based on the individual's condition and standards of practice. The section enumerates seventeen specific requirements that the written plan would have to meet including: be based on a comprehensive assessment; be developed by a qualified provider; specify individual's rehabilitation goals; indicate frequency, amount, and duration of services; specify a timeline for reevaluation of the plan to occur within a year; and review whether goals are being met. [Proposed Section 440.130(d)(3)]

- **IMPROVEMENT:** Written rehabilitative plan requirement will help ensure state accountability and required corresponding re-evaluation of the written plan will ensure that progress is being made or appropriate changes are put in place.
- **CONCERN:** While the requirement for the written rehab plan that will guide the services to be delivered makes sense, it does not take into account that the child/adult potentially has other existing plans. It does not discuss if and how the written rehab plan would be coordinated—and therefore does not realize the importance of coordinating it—with other existing plans so that the child’s needs may be appropriately and efficiently addressed. It would presumably create additional burdens on all concerned.

Another of the seventeen requirements for the written rehab plan is it be developed, reviewed, and modified not only with input from the individual, but the individual’s family, health care decision maker, and/or persons of the individual’s choosing. [Proposed Sections 440.130(d)(ii)-(iii) and 440.130(d)(xiii)]

- **IMPROVEMENT:** By requiring input from the individual, the individual’s family, the individual’s authorized health care decision maker and/or persons of the individual’s choosing up front, everyone’s voice is heard and a true person- and family-centered approach is achieved.
- **CONCERN:** Freedom of Choice and involving the beneficiary’s family are noteworthy concepts, but for a child in foster care, under state custody receiving rehabilitative services, who has the authority to choose and who should be involved in the decisionmaking process?
- **CONCERN:** What happens when the family is not accessible or chooses not to participate? What is the standard that providers will be held to?—will documented *reasonable attempts* to involve listed persons fulfill the requirement?

The written rehab plan is also to include the individual’s relevant history and current medical findings as needed to achieve the rehabilitation goals. [Proposed Section 440.130(d)(xvii)]

- **CONCERN:** Many children in care arrive for services without prior, up-to-date medical records or information about previous health care providers, making locating a comprehensive medical history very difficult. Some children may not have even had a primary care physician.

In the “Provisions of Proposed Regulations” background section, CMS clarifies that services that provide assistance in *maintaining* functioning (as opposed to reducing or restoring) would only be considered rehabilitative if necessary to help the individual achieve a rehabilitation goal that is defined in the rehabilitation plan. Therefore, services aimed at maintaining functioning that are not explicitly stated as a rehab goal in the written rehab plan would not be eligible for federal financial participation (FFP). [Pages 15-16 of proposed reg]

Case Record Requirement: To “establish an audit trail,” providers of rehabilitative services would have to maintain case records that include such items as the following: a

copy of the rehabilitation plan; name of individual; date of rehabilitative services provided; progress made. [Proposed Sections 441.45(a)(3)-(4)]

- **CONCERN:** Extremely difficult, as the physical location changes for children in state custody.

Adoption of an “Intrinsic To” Test: This section explicitly states that rehabilitation does *not* include services “furnished through a non medical program as either a benefit or administrative activity including services that are intrinsic to elements of programs other than Medicaid, such as foster care, child welfare, education, child care...juvenile justice.” [Proposed Section 441.45(b)(1)] While no definition or guidance is offered as to what “intrinsic to” means, whatever services that are deemed “intrinsic to” programs other than Medicaid would simply *not* be eligible for payment under Medicaid. Individuals in other programs, such as foster care, would still be technically eligible to receive rehabilitative services, but without federal financial participation from Medicaid, access to such services would surely be impacted. To be covered as a rehabilitative service, the proposed rule’s test appears to be one based on proper jurisdiction of programs, medical necessity, and clearly distinct services.

- **CONCERN:** Congress explicitly rejected adopting an “intrinsic to” test in regards to Medicaid rehabilitative services when debating and finalizing the Deficit Reduction Act, so is there proper authority to do so now?
- **CONCERN:** While it is helpful to clarify what is covered by Medicaid and what is covered by other federal programs, the proposed regulation and its “intrinsic to” test does not properly consider the child welfare system. The child welfare system is required to ensure that the children in their care get the services they need, including medical (physical and dental) and mental health. Most children that come into the child welfare system have experienced some level of trauma, either through exposure to some type of violence (domestic, community, child abuse/neglect of siblings) or through the actual experience of the child abuse or neglect. These children have added trauma as a result of events surrounding their removal from the home. The research on trauma shows that these children have significant needs that require attentive services in order to recover. The results of the CFSR’s of the 50 states indicate that state child welfare agencies are already struggling to meet these needs largely because the mental health system as reported by the President’s New Freedom Commission is “fragmented and in disarray.”⁹ If the proposed “intrinsic to” test is put in place in regards to child welfare and Medicaid, this situation will only worsen. Both systems seek to and must ensure the provision of medically necessary services, but child welfare agencies should not be required to and certainly are unprepared and unable to shoulder the load alone. If Medicaid is not there to assist, what will be done to infuse greater dollars into the Mental Health system so that the services that are needed are being provided and available?

The section then provides a non-exhaustive list of examples of services that are “intrinsic to other programs” and not Medicaid coverable expenses such as:

- Therapeutic foster care services furnished by foster care providers to children, *except* for medically necessary rehabilitation services that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers (emphasis added). [Proposed Section 441.45(b)(1)(i)] The proposed rule provides further insight by stating that the following components of therapeutic foster care would be examples of non-Medicaid coverable expenses: “provider recruitment, foster parent training, and other such responsibility of the foster care system.” [p. 25-26]
- Packaged services furnished by foster care or child care institutions or 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 (emphasis added). [Proposed Section 441.45(b)(1)(ii)]
- Adoption services, family preservation, and family reunification services furnished by public or private social service agencies. [Proposed Section 441.45(b)(1)(iii)]
- **CONCERN:** In terms of therapeutic foster care, the proposed regulation excludes federal financial participation (FFP) for them, except for “medically necessary rehabilitation services that are clearly distinct from packaged therapeutic foster care services.” It is extremely difficult to unbundle therapeutic foster care services to meet these terms. Relegating assistance to arbitrary time-limited blocks produces undue administrative burdens, in turn taking much-needed attention away from children and lessening the positive impact of treatment. Such packaged services are evidence-based and proven effective, providing the comprehensive intensity of services which children suffering from physical and/or mental disability require. They are even recommended in the President’s New Freedom Commission Report. In addition, therapeutic foster care provides a higher level of care that is used by many different child and family serving systems to meet the specific needs of children. Children that require this level of care would presumably meet the eligibility test for rehab services, so it is not clear why therapeutic foster care services have been targeted nor what the difference is between Packaged TFC services and “medically necessary rehab services.”

Exclusion of Services Provided to Residents of an Institution for Mental Disease (IMD): The proposed rule would exclude federal financial participation (FFP) for 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. As such, services provided by accredited psychiatric residential treatment facilities (PRTFs) with over 16 beds to individuals under the age of 21 would not be considered rehabilitative services and would have to fall under another billing code. [Proposed Section 441.45(b)(5), pages 34-35]

Exclusion of Habilitation Services: The proposed rule would exclude federal financial participation (FFP) for habilitation services including those provided to individuals with mental retardation or “related conditions” as defined in the State Medicaid Manual Section

4398. The proposed rule clarifies that most physical impairments and mental health and/or substance abuse related disorders are *not* included in the scope of “related conditions” and therefore, would still be eligible as rehabilitative services.

The proposed rule’s background information also attempts to clarify the often blurry difference between “rehabilitation” and “habilitation.” “Rehabilitative services” are measures that seek to *restore* individuals to their best functional levels, meaning the individual must have at some point had the capability to perform the activity. “Habilitation,” on the other hand, seeks to help individuals acquire *new* functional abilities.

Submission of Comments to CMS

CWLA continues to analyze the proposed regulation and would greatly appreciate your input. Please send any comments or concerns regarding the proposed regulation and the impact it would have on your agency and the children and families it serves to Laura Weidner, CWLA Government Affairs Associate at lweidner@cwla.org.

By law, CMS must provide a 60-day period during which the public may comment on this and other proposed regulations, CMS must consider the public comments that were received in a timely manner, and then CMS submits to the Office of Management and Budget (OMB) for review and approval. The deadline for submission of public comments is **October 12, 2007 at 5:00 p.m.** CWLA will be submitting comments on this proposed regulation to CMS and urges impacted parties—including agencies, organizations, families, and others—to do the same. The public may submit comments to CMS in one of the following ways:

1. **Electronically:** Submit comments in MS Word, WordPerfect, or Excel electronically at <http://www.cms.hhs.gov/eRulemaking>. Click on the link “Submit electronic comments on CMS regulations with an open comment period” and then on the Rehabilitation Services regulation, “CMS 2261-P.”
2. **By Regular Mail:** Submit comments by regular mail, including one original and two copies, to: Centers for Medicare and Medicaid Services, Department of Health and Human Services, Attn: CMS-2261-P, P.O. Box 8018, Baltimore, MD 21244-8018.
3. **By Express or Overnight Mail:** Submit comments by express or overnight mail, including one original and two copies, to: Centers for Medicare and Medicaid Services, Department of Health and Human Services, Attn: CMS-2261-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.
4. **By Hand or Courier:** Submit comments by hand or courier, including one original and two copies, at either a Washington, DC or Baltimore, MD address. If delivering to the Baltimore, MD address, first call (410) 786-3685 to schedule an appointment and then drop comments off at: 7500 Security Boulevard, Baltimore, MD 21244-1850. If delivering to the Washington, DC address, comments may be dropped off at: Room 445-G, Hubert H. Humphrey Building, 200 Independence Ave., SW, Washington, DC. Because security is restricted in the Hubert Humphrey Building, individuals are encouraged to leave comments in the CMS drop slots located in the main lobby.

- ¹ Child Welfare League of America (CWLA). (2006). Special tabulation of the Adoption and Foster Care Analysis and Reporting System (AFCARS). Washington, DC: Author.
- ² Simms, M.D., Dubowitz, H., & Szailagyi, M.A. (2000). Needs of children in the foster care system. *Pediatrics*, 106 (Supplement), 909-918.
- ³ Swire, M.R. & Kavalier, F. (1997). The health status of foster children. *Child Welfare*, 56(10), 635-653; Chernoff, R., Combs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care. *Pediatrics*, 93(4), 594-601.
- ⁴ Halfon, N., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care: The experience of the Center for the Vulnerable Child. *Archives of Pediatric and Adolescent Medicine*, 149, 386-392.
- ⁵ Clausen, J., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A.J. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7, 283-296; Halfon et al. (1995); Urquiza, A.J., Wirtz, S.J., Peterson, M.S., & Singer, V.A. (1994). Screening and evaluating abused and neglected children entering protective custody. *Child Welfare*, 123, 155-171.
- ⁶ President's New Freedom Commission on Mental Health. (2003). *Final Report, Achieving the Promise: Transforming Mental Health Care in America*. Available online at <http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>.
- ⁷ *Ibid.*
- ⁸ Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 14(4), 245-258.
- ⁹ President's New Freedom Commission on Mental Health. (2003). *Final Report, Achieving the Promise: Transforming Mental Health Care in America*. Available online at <http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>.