

# STATE OF ALASKA

**DEPT. OF HEALTH AND SOCIAL SERVICES**  
**OFFICE OF THE COMMISSIONER**

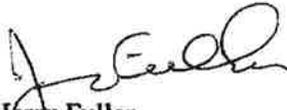
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February 8, 2008

I, Jerry Fuller, Medicaid Director, Department of Health and Social Services, State of Alaska, do hereby certify that the attached or enclosed documents are the materials under the State's control that are relevant and responsive to the January 16, 2008 information request of the House of Representatives, Committee on Oversight and Government Reform.

Sincerely,



Jerry Fuller  
Medicaid Director  
Department of Health & Social Service

## **Response to House Committee on Oversight and Government Reform**

Alaska Department of Health and Social Services is responding to your January 16<sup>th</sup> request for information on state specific impacts of the several recent Medicaid regulations proposed by the Centers for Medicare and Medicaid Services (CMS). Thank you for asking about these impacts as it appears CMS has not been seriously considering comments received as a result of the several Notice of Proposed Rulemaking (NPRM) published in the Federal Registry on these regulations.

Attachments included with this response are the actual comments that Alaska submitted to CMS on each of the NPRM. In addition paper copies will be sent to the House majority and minority staffs as directed in your letter. Note the material on GME was not submitted to CMS.

### **General comments about the regulations under review:**

- Most of the proposed regulations appear to have tenuous or have no basis in statute.
- All of the proposed regulations are a direct cost shift to state funds.
- Most of the regulations are written in vague and/or confusing language. It will be the future guidance issued by CMS that will determine the true meaning of the regulations and the true fiscal and human impacts.
- Most of the proposed regulations create new significant and expensive administrative burdens for both providers and the state.
- None of the proposed regulations will improve or enhance services for the Medicaid eligible population.

**1) Cost limit for public providers:** Estimate \$2.5 million Total Fund increase (\$1.25 million Federal) each year this regulation is in effect to meet these new administrative requirements. Changing from our current prospective cost based reimbursement methodologies to retrospective cost settlements can be expected to increase litigation and overall increase

program costs, but we cannot determine the magnitude of such changes. We know we don't reimburse any provider more than cost so there will not be any savings from implementing these new requirements. We expect some of the small public providers, such as schools, who have minimal to no experience with cost reporting, will simply cease being Medicaid providers and will choose to provide services to Medicaid IDEA eligible students without Medicaid funds. Service provision for this population is already tenuous given the remoteness, minimal population density for most of Alaska and a paucity of health care professionals in most remote areas.

The proposed regulation appears to be completely ignorant of the reimbursement methodology used by OMB and the IHS for reimbursing tribally operated facilities. Tribal health corporations complete a version of a Medicare cost report and that provides the basis for the daily hospital inpatient rate and the outpatient encounter rate. This regulation would appear to require states to overlay a different cost methodology for some or all tribally provided services.

**2) Payment for Graduate Medical Education:** This prohibition of GME would cost shift to the state a bit over \$400,000 in SFY 2009 and 2010, and about \$800,000 for each of the following three years. Alaska currently has 10 primary care residency slots at one hospital. Contrary to the CMS analysis for this proposed regulation there is a tremendous physician shortage in Alaska, as well as in much of the country. From the 2008 state legislative session funding was provided to increase the number of residents to 20, thus the potential doubling of GME. A state report indicates Alaska needs 50 new physicians yearly to meet the growing need, thus our future physician needs will require an increase in funding, not less, to support this additional training expense. For thirty to forty years states have used GME to support their training programs. It is certainly unusual that now CMS decides GME is not supported by statute, while it has always been left to state discretion to determine what costs to include or not in reimbursement methodologies.

**3) Payment for hospital outpatient and private clinic services:** This regulation would determine a new Federal Upper Limit (FUL) for private clinic services based on Medicare reimbursement. Some amount of primary care is delivered through clinic services. Alaska Medicaid delivers most of our outpatient behavioral health services (mental health and substance abuse services) through Community Mental Health Clinics (CMHC). These are

generally local private and/or public non-profit agencies. They are reimbursed on a fee for service basis using a combination of CPT and HCPCS coding. CPT codes in Alaska are reimbursed based on the RBRVS system that CMS adopted for Medicare reimbursement, except the conversion factor used by Alaska Medicaid is a third higher than the one used by Medicare. Thus our reimbursement is about a third higher than Medicare. If we understand this proposed regulation correctly Alaska would, at a minimum, need to reduce our CPT coded reimbursement to no more than what Medicare reimburses for the same codes. Therein lies the problem. Medicare reimbursement in Alaska is not high enough to attract and hold a sufficient number of primary care physicians to serve those with Medicare coverage. Our Medicare population cannot now find a physician that accepts new Medicare insured patients. Many practitioners have stopped accepting Medicare and require cash from existing patients. Primary care access for Medicare beneficiaries has become public clinics and the emergency rooms. Requiring Alaska to reduce rates for private clinics to no more than Medicare guarantees some of these clinics will close, others will reduce services or not see Medicaid eligible patients and patients will get services in the more expensive emergency rooms(ER) and hospitals. Yes, there would be some immediate programs saving due to reimbursement reductions to stay within the new FUL, but there will be significant program increases as untreated Medicaid eligible persons show up in ERs or needing inpatient level of care. Penny wise and pound foolish comes to mind to describe this. In addition there will be an increased administrative burden on the state to update reimbursement to this new FUL every year. While there is no way to objectively evaluate the dollar impacts, the immediate cost saving due to compliance with the FUL will be more than offset by future increases in hospital and ER costs.

The language describing the new Federal Upper payment Limit for outpatient hospitals is very confusing and open to many interpretations. It seems to be saying that to be efficient and economical and meet the new FUL the outpatient service array that is considered in the calculation of the FUL must be the same service array as covered under Medicare. That inherently makes no sense since a big service both in frequency and cost in Medicaid is maternity and well child services. So the new FUL doesn't include the cost of these major Medicaid services. In one place the regulation says the FUL must be calculated on a code by code basis. Elsewhere it indicated aggregate methods are acceptable.

This regulation doesn't even mention tribally operated hospital outpatient and clinic services that in Alaska are reimbursed on an encounter basis. The encounter rate is calculated by the IHS and OMB and updated annually and published in the Federal Registry. This proposed regulation appears to be contradictory and in direct conflict to the regulations behind the IHS/OMB encounter rate methodology, not to mention in direct conflict with numerous CMS guidance letters and other publications on this topic.

If Alaska were to follow our understanding of this regulation there would be some amount of immediate program cost savings as we reduce our reimbursement to no more than Medicare pays. Any immediate savings would be quickly eliminated as access decreases and Medicaid eligible patients find access in the emergency rooms and inpatient setting as they get sicker before seeking care. It is estimated we would need about 7 additional accountants, auditors and researchers to implement and maintain this process every year at a new total fund cost of over \$750,000, half federal, half state funds.

**4) Provider taxes:** Alaska has no provider taxes.

**5) Coverage of Rehabilitative Services:** The proposed regulation uses many undefined terms and vague descriptions such that the true rule making will occur later in CMS guidance letters, the state plan approval or disapproval process and disallowance proceeding, all outside Administrative Procedures Act requirements. As was stated by a CMS official in a November conference discussing this proposed regulation, mention was made of an "evolving policy". The vagueness of the language does suggest that CMS doesn't quite know what it wants the policy to be for rehabilitation services, other than the current broad language that provides flexibility to states to devise services that work appears to no longer be acceptable and that saving over \$2 billion federal funds with a significant cost shift to the state is acceptable. It is extremely difficult, if not impossible, for states to reconfigure programs to an 'evolving policy'.

The second CMS stated purpose of this regulation, "ensure fiscal integrity" through limitations between Medicaid and all other federal, state or locally funded programs (intrinsic to another program) fails because there is no statutory basis for such a limitation and Congress has expressly rejected such a policy. This policy would save significant Medicaid federal funds by cost shifting to state and local funds. CMS also appears to be stretching Medicaid

Third Party Liability statute and meaning to be inclusive of “intrinsic elements of programs other than Medicaid,” even if those other programs are dollar capped or intended for those citizens without access to care. The net result of this new rule will be that Medicaid-eligible individuals will be denied federally funded services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Since the services are necessary it will be state funds that support the continued services, though perhaps at a reduced level.

More precisely this proposed language could also be used to deny FFP for children in the care of juvenile justice, even though not in inmate status, and fully eligible for Medicaid and EPSDT. The tenor of this proposed regulation could indicate the same for children in foster care, whether eligible for IV-E or not.

The regulation also applies the Institution for Mental Disease (IMD) 16 bed limit to all other community residential treatment facilities, except those meeting the PRTF requirements, and has the potential to limit, if not eliminate critical services needed to either keep children out of inpatient care or PRTF level of care, or negatively impact the ability to transition children from inpatient care to community setting. The impact of this regulation package will be fewer available services under rehabilitation; residential services pushed toward PRTF or inpatient level of care since community based residential services will be significantly reduced

CMS has already been applying their new thinking and the intent of this regulation for the past two years to rehabilitation state plan amendments that we have submitted. We have withdrawn one and have another in abeyance hoping for Congressional relief from this redefinition of rehabilitative services.

We are also currently under going a CMS financial management review of bundled rates, which seems to have evolved into CMS collecting data of all Medicaid services provided to children involved with Juvenile Justice. More than once the CMS auditors have stated Medicaid services for these children are not eligible for FFP. The same auditors have stated more than once that multiple community residential homes with a common affiliation are in aggregate IMDs and thus FFP is not available for these children services. From our perspective CMS is already enforcing their new regulation even

though we believe there is no statutory basis for the regulation or CMS statements from the auditors that they say as fact.

There will be a huge human impact. In 2004-5 Alaska was sending about 700 children a year to the Lower 48 states for residential psychiatric treatment services not available in Alaska. That was seen as unacceptable. The state and others provided funds to build additional residential beds in Alaska. The number of out of state children has been reduced to about 250. While some of the new beds were at the PRTF level of care, many more are at the Behavioral Rehabilitation Service (BRS) level, a step-down in care from PRTF, and covered in the Medicaid state plan under rehabilitative services. These are the beds that the CMS regulations and on site CMS auditors say are now IMDs and FFP is not available for even children, even though FFP is available for children in IMDs and PRTFs, the higher level more expensive service. If FFP is not available for lower level, less expensive community residential placements, our options are clear. We will return some number of children to available treatment sources in the Lower 48 at an increased cost, but with FFP available. The legislature might appropriate additional general funds to maintain some children in state. Bottom line a cost effective system is totally disrupted and more children will end up in higher level treatment thousands of miles from home.

Fiscal estimates for the elimination of only the BRS portion of our rehabilitation services is \$9 million federal funds in 2008 dollars and that will reoccur annually thereafter. The rehabilitative services state plan that is in abeyance by endless CMS questioning is costing about \$15 million federal funds annually. We fully expect there will be additional costs to the state (saving to the federal government), but it must be noted that it is extremely difficult to estimate the impacts of this regulation given the confusing language, given the confusing messages given by onsite auditors, and not being able to guess what we must do to refigure our behavioral health system to meet the evolving CMS standards. The numbers presented here are considered conservative estimates.

**6) Payments for school administrative costs:** This will reduce federal funds to Alaska by at least \$8 million annually. In addition CMS has already deferred school administrative funds in Alaska for several past quarters, about \$8 million federal funds, based on a long struggle for Alaska to meet the current CMS expectations for the claiming process.

Some history. In the mid to late 1990s CMS published multiple letters of guidance touting the virtues of Medicaid outreach in the school settings. Most states took up the offer and collaborated with schools to develop this outreach. Alaska and many other states also worked with regional CMS offices to figure out the reimbursement and claiming side of this process. A few states and contractors developed claiming methodologies that were reviewed by GAO and OIG and found to be problematic. As a result CMS issued several versions of guidance that culminated in the final version in 2003. Alaska was slow to change its' methodology to comport to the CMS guidance, but when we did we just borrowed another state's CMS approved methodology and tools thinking it would be easily approved by CMS. It took over 16 months of conversation with CMS to finally get approval and the approved plan is different in many aspects from their published guidance. This is the basis of the current deferred funds and we continue to work with CMS to get the funds released.

We do not tell the schools how they must use the funds they have earned from the Medicaid outreach they have done. We can't say with precision what the school funding issues will be if administrative claiming ceases. It is likely at least some of the funds are used to support the requirement of IDEA, since that federal program has never been adequately funded. What will be certain is schools will likely minimize or stop performing Medicaid outreach activities.

Alaska has not claimed for school based transportation and is not affected by that portion of the regulation.

**7) Targeted Case Management:** The biggest impact of the TCM regulation is the significantly increased administrative burden for certain providers. Our Infant Learning Program (ILP), part C of the IDEA, just began billing for TCM. This current year they might be reimbursed up to \$.5 million federal funds for TCM services. The current Medicaid state plan amendment for this TCM program uses billing at a statewide monthly rate for the TCM services. The rate was developed based on cost reports for these providers. Per the regulations we must now change the claiming to 15 minute increments. This change greatly increases the administrative burden for these, small, remote providers. In addition there is other increased documentation requirements. At this point it is not clear if it will be cost effective for these providers to comport to the new regulations. It may be

the increased administrative costs are not worth the funds gained from Medicaid reimbursement.

Our Juvenile Justice agency just started claiming for TCM in July 2007. With all of the negative words from CMS about TCM, other states dealing with CMS questions and oversight, and the future proposed regulations they only claimed TCM for two months and then stopped. This created a \$600,000 hole in their budget that now must be made up in some other manner.

The State of Alaska has been working with the Alaska tribal health corporations to make changes to Medicaid to make it more sustainable. A big part of the tribal work centers on case management as a means of disease prevention and disease management to reduce future costs. Like the ILP program mentioned above it remains to be seen if the new administrative requirements and billing in 15 minute increments will be barriers that effectively end the program before it begins.

## **Graduate Medical Education comments**

It is incredulous that after many, many years CMS decides that because GME is not listed as an explicit Medicaid service in 1905 that FFP is no longer available for GME. This is certainly a new and novel reinterpretation of statutory intent. And this appears to be partially based on the false CMS assertion that in the 50s and 60s there was a need for additional physicians, but that need was met by the 80s. That flies in the face of reality and the findings of Congress in S.896, the Physician Shortage Elimination Act of 2007, a bill under consideration in the current legislative session. The Congressional findings stated in that bill are:

Congress finds the following:

- (1) The average life expectancy in the United States has increased to 80 years of age, causing an ever-increasing demand for medical care.
- (2) Medical school enrollment numbers have been virtually stagnant for the last 25 years.
- (3) During the last 20 years, median tuition and fees at medical schools have increased by 229 percent (122 percent adjusted for inflation) in private schools and by 479 percent (256 percent adjusted for inflation) in public schools.
- (4) The Association of American Medical Colleges, in its Statement on the Physician Workforce, dated June, 2006, called for an increase of 1,500 National Health Service Corps program awards per year to help meet the need for physicians caring for underserved populations and to help address rising medical student indebtedness.
- (5) The National Health Service Corps program has a proven record of supplying physicians to underserved areas, and has played an important role in expanding access for underserved populations in rural and inner city communities.
- (6) Continued expansion of the National Health Service Corps program is strongly recommended.
- (7) The growing debt incurred by graduating medical students is likely to increase the interest and willingness of graduates of United States medical schools to apply for National Health Service Corps program funding and awards.
- (8) One-third (250,000) of active physicians are over the age of 55 and are likely to retire in the next ten years, while the population will have increased by 24 percent. These demographic changes will cause the population-to-physician ratio to peak by the year 2020.

(9) In 2005, the Council on Graduate Medical Education stated in a report to Congress that there will be a shortage of not fewer than 90,000 full-time physicians by 2020.

(10) A decrease in Federal spending to carry out programs authorized by title VII of the Public Health Service Act threatens the viability of programs used to solve the problem of inadequate access to health care.

(11) A continuing decline in the number of primary care physicians will lead to increased shortages of health care access in rural America.

(12) There is a declining ability to recruit qualified medical students from rural and underserved areas, coupled with greater difficulty on the part of community health centers and other clinics to attract adequate personnel.

(13) Individuals in many geographic areas, especially rural areas, lack adequate access to high quality preventive, primary and specialty health care, contributing to significant health disparities that impair America's public health and economic productivity.

(14) Barriers to adequate access most acutely affect community-based health care safety-net providers, including Community and Migrant Health Centers, Native American health centers, Rural Health Clinics, Critical Access Hospitals, public health departments, and their patients.

(15) Area Health Education Centers and Health Education Training Centers provide a national network of community-based and governed entities, linked to community resources and academic centers, that provide an infrastructure to facilitate and implement partnerships and programs that successfully address each of these barriers, respond to the health needs of underserved communities and populations, and use educational interventions to reduce health disparities.

(16) A collaborative process is needed between hospitals and non-hospital settings to maximize the potential of non-hospital health care training.

Regardless of why this is being done, the impact will be felt on state budgets as this is a direct cost shift to states. While CMS may state there is no legal obligation for state funding of GME, reality says states will step up to insure continued medical training capacity for physician. Also, how will states assure future access to physician services if there is a lack of physicians. Logic suggests state Medicaid agencies will be forced to reimburse at higher rates to gain physician access in a more competitive market.

What Congress provided in the DRA through state flexibility to achieve savings and not just cost shifts to states, CMS takes away by constricting state

flexibility and cost shifting to states. In the current state fiscal year this regulation will eliminate about \$400,000 federal funds from GME payments Alaska makes to a local non-profit hospital to support the primary care residency program.

## CMS -2213-P Payment for Outpatient and Private Clinics

Our analysis of the proposed regulation regarding private clinic services, if we understand the letter and intent correctly, will have a profound and negative impact upon our ability to provide mental health and substance abuse services to Medicaid eligible Alaskans. It is conceivable there will also be a negative impact upon private physician clinics.

Alaska Medicaid provides much of our behavioral health services (mental health and substance abuse services) through Community Mental Health Clinics (CMHC). These are generally local private and sometimes public non-profit agencies. They are reimbursed on a fee for service basis using a combination of CPT and HCPCS coding. CPT codes in Alaska are reimbursed based on the RBRVS system that CMS adopted for Medicare reimbursement, except the conversion factor used by Alaska Medicaid is higher than the one used by Medicare. If we understand this proposed regulation correctly Alaska would, at a minimum, need to reduce our CPT coding reimbursement to no more than what Medicare reimburses for the same codes. There in lies the problem.

Medicare reimbursement in Alaska is not high enough to attract a sufficient number of primary care physicians to serve those with Medicare coverage. The newspaper has been replete with articles about the great lengths that Medicare eligible folks have taken to be seen for primary care issues. Some have noted they take trips to the Lower 48 to see physicians there. The majority of Alaska primary physicians have opted out of Medicare. Others who continue to accept Medicare are taking no new patients. Public funded clinics and the emergency rooms appear to be the access points for these people. Setting a Medicaid private clinic UPL based on Medicare reimbursement is expected to have similar dire consequences, at least in relation to clinics providing rehabilitation services and potentially some physician directed clinics that focus on behavioral health services.

Requiring the Alaska Medicaid program to adhere to this new proposed private clinic UPL for the non-profit private clinics that provide behavioral health rehabilitation services and physician services will effectively raise access issues under 447.204, thus creating a perfect Catch 22. The proposed regulation appears to bind us to a new UPL no greater than Medicare, yet Medicare rates in Alaska are so low in proportion to the high cost of health care that primary care access through private providers is almost non-existent. Yet we would be required to adopt this lower rate for the bulk of the services provided by CMHCs, effectively ending their participation as Medicaid providers and ending behavioral health rehabilitation services. The consequence of this is more Medicaid eligible folks seeking mental health and substance abuse treatment in public clinics, already swamped serving Medicare eligibles; using higher cost settings, emergency rooms; or foregoing treatment until inpatient hospital or IMD treatment is necessary. The alternative settings for this treatment will cost much more than any savings due to the UPL. Another consequence is certain legal challenges under 447.204, which will certainly include CMS as a defendant, since the state cannot raise rates above the new UPL to address the access issues.

Hopefully I have misunderstood the requirements imposed by the proposed regulation and my concerns are not real. However, if I have a correct understanding then there will be very serious and probably unintended consequences that will require further CMS involvement to resolve. The state will be stymied by the Catch 22 created in Alaska by this new private clinic UPL regulation.

***State of Alaska, Department of Health and Social Services comments regarding the CMS Proposed Rule (CMS 2258-P):  
Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership***

***SCHIP Providers***

The preamble (at FR/Vol. 72, No. 11, pages 2236 and 2240) states that “...SCHIP providers are not subject to the cost limit provisions of this regulation”. Correspondingly, the proposed regulation at 457.628 (a) does not apply the proposed cost limit provisions at section 447.206 to the state’s SCHIP programs.

The proposed regulations do not define; what is an SCHIP provider. Alaska implemented Title XXI (SCHIP) as a Medicaid program expansion. Providers are not uniquely enrolled to provide services to the SCHIP population as differentiated from the Medicaid population. Additionally, provider payment rates for services provided the SCHIP and Medicaid populations are exactly the same. Are those states which selected the option to implement the SCHIP as a Medicaid expansion being retroactively penalized for not implementing the SCHIP as a stand alone program in their state?

What is a SCHIP provider? Given the SCHIP program implementation options included by Congress in the statute; these proposed regulations must clearly define the criteria and characteristics of what is; and, what is not an SCHIP provider for application of the regulation’s provisions; especially the cost limit provisions.

If Alaska’s Medicaid providers are considered to be SCHIP providers are they exempt from the cost limit provisions of 447.206 for that unit of government or governmental health provider?

If Alaska’s Medicaid providers are not considered to be SCHIP providers and are required to meet the cost limit provisions of 447.206 for that unit of government or governmental health provider; will CMS allow the Medicaid Agency to exclude SCHIP costs and reimbursements when making the Medicaid cost limit and overpayment determination? If CMS does not allow exclusion of the SCHIP costs and reimbursements in the cost limit determination the result will be a cost shift from the Federal government to the state Medicaid Agency for the difference between the states’ regular FMAP and the enhanced SCHIP FMAP.

***Secretary’s Responsibilities***

The proposed regulations at 447.206 (c)(2) states that “Reasonable methods of identifying and allocating costs to Medicaid will be determined by the Secretary in accordance with sections 1902, 1903, and 1905 of the Act, as well as 45 CFR 92.22 and Medicare cost principles when applicable.” Will the Secretary prospectively establish the “reasonable methods” to identify and allocate Medicaid costs?

447.206(c)(4) requires the Secretary to approve the form of auditable documentation consistent with 433.51(b)(1-4) which must be used to support non-hospital and non-nursing facility services. Will the Secretary prospectively provide the form(s) of auditable documentation to support the non-hospital and non-nursing facility services; or, will the states have to develop the form(s) and hope that their form(s) will meet with the Secretary's retrospective approval? The latter unfairly affords CMS the opportunity to reinterpret these regulations over and over as states submit their documentation.

One of the most difficult problems faced by any Medicaid program is client access to medical services. Many variables impact client access to medical services including payment rates, services restrictions, client demeanor, local economics, and administrative requirements. A cursory review of the state's Medicaid Management Information System (MMIS) provider file identified a number of providers which may be units of government or governmental health providers providing other than hospital or nursing home services such as case management or personal care. Of course these providers are in the less populated areas of the state, which have fewer medical services available to their Medicaid clients thereby exacerbating the already poor provider access. Requiring these smaller units of government or governmental health providers to prepare and file cost reports may result in their discontinuing provision of these services for Medicaid eligibles. CMS should acknowledge the true impact of these proposed regulations on the smaller units of government or governmental health providers and provide some floor criteria below which the regulations do not apply. Suggestions for floor criteria include the number of facility beds, Medicaid eligible population in some mile radius, number of Medicaid clients served by the unit of government or governmental health provider and population base in the unit of government's area.

#### ***433.50(a)(1) Applicable Taxing Authority***

The proposed regulations require a unit of government to have applicable taxing authority or, if a governmental health provider, to be able to access funding as an integral part of a governmental unit with applicable taxing authority. The language of the Social Security Act especially Section 1903 which CMS references in the preamble does not once mention or refer to "taxing authority", so we question CMS's statutory basis for such a requirement.

There is no known Congressional direction to the Executive Branch to define "public agency" let alone as narrowly as CMS proposes to do. CMS is attempting to define public agencies exclusively as governmental entities with "applicable taxing authority." What is "applicable" taxing authority? CMS neither defines "applicable" in the regulatory language; nor discusses it in the preamble. Without definition of this term or criteria with which to make a determination, CMS will arbitrarily decide whether or not each of the individual taxes in each of the nation's thousands of units of government or governmental health providers may be "applicable" and therefore eligible as the state portion of match through IGTs or CPEs. CMS is clearly stating that the federal government's interests outweighs the state's interests in the federal-state partnership. States would be required to

meet an undefined and unsupported standard; one at constant risk of arbitrary interpretation and reinterpretation by CMS.

Although people commonly think of governments as raising revenue through taxes, this is by no means the only source of revenue to governments. Governments raise money through user fees, sale or lease of public resources (minerals, timber, land), fines, legal settlements, etc. In fact, the federal government assists states in the funding of education and care of the mentally ill through land grants. For example, in Alaska we have a public entity, the Alaska Mental Health Trust that is a government body funded entirely by legal settlements and the revenue derived from the use and sale of land. As established, it happens to reside in the Executive Branch; but it could also be a quasi-independent body.

In addition, the proposed regulation overlooks the potential for intermediate units of government between the taxing authority and the provider. These units of government may be funded by revenue sharing (again, not all revenue may be tax revenue). Consider the case of an independent school district that receives funds from the state foundation formula and local governments. The school district might not be an integral part of any single governmental unit with applicable taxing authority. This proposed regulation will increase the burden on states to find alternative funding to replace match currently provided by schools. In many cases, for many states, this will effectively end schools' ability to bill Medicaid because the increase in general fund expenditures cannot be supported.

The proposed "Form CMS-10176 Governmental Status of Health Care Provider" developed by CMS provides little more than yes/no responses to the points of the regulation language and therefore, does not lead one to an obvious conclusion. For example; "2) Does the unit of government that operates the health care provider have generally applicable taxing authority?" Check the yes or no box. "If no, move to number 7. If yes: Describe type of taxing authority. Describe source(s) of tax revenue." CMS offers no practical direction for the preparation and submission of the form to assist the state, or themselves in analyzing the complex financial and organization relationships which exist in the many and varied units of government in each of the 50 states. Frustratingly, CMS proposes to only support the 50 state medicaid programs with an archaic paper exchange system for determination and authorization of units of government or governmental health providers. Further, CMS fails to identify any processing or review standards (other than the form itself) or timeframes within which to complete its reviews of a state's request and the approval or denial of that request. CMS should amend the proposed regulations to offer an electronic process (perhaps part of NPI) to request and approve/deny state requests including applicable and appropriate timeframes and standards for their processing and review.

In the preamble and the proposed "Form CMS-1076", CMS places great weight on the consolidated annual financial report of the governmental unit as the information source necessary to complete the form. It is incongruous that CMS fails to make references in either the preamble or the body of the regulatory changes to the Governmental Accounting Standards Board statements or pronouncements as the basis upon which the

determinations that a unit of government or governmental health provider is eligible to provide IGTs or CPEs will be made. CMS's failure to provide objective criteria and standards with which a state can prospectively evaluate whether a public agency is a unit of government or a governmental health provider before submitting the form to CMS for its determination will only result in unnecessary and protracted litigation of CMS's apparently arbitrary determinations. The delays and inefficiencies to program administration will result in diminished access to and quality of recipient care.

Real life examples of the absence of common criteria and standards are: What is the definition of a "component unit" on the consolidated annual financial report referenced in the preamble at page 2240? Would an "Enterprise Fund" entry on the consolidated annual financial report qualify? In this example, would a contract between the entities support or eliminate this relationship as a unit of government or a governmental health provider? What about the situation where a city owns a hospital facility and contracts for the management and operation of the hospital? Is that a unit of government or a governmental health provider? Another example would be a city through its health department contracting for the provision of speech or physical therapy services. What is the status of such entities under this proposed rule?

#### ***433.50(a)(1) Indian Tribes***

The proposed regulations require Indian tribes to have generally applicable taxing authority to be considered a unit of government or a governmental health provider. This requirement clearly flies in the face of over 100 years of treaties, statutes, executive orders, and court decisions recognizing and cementing the unique government-to-government relationship the United States has with Tribal governments. Some Indian tribes have, and some of those exercise their taxing authority; but Alaska Native tribes and tribal organizations neither have, nor exercise taxing authority. Identifying only those Indian tribes exercising their generally applicable taxing authority (which remains undefined) as a unit of government or as a governmental health provider for purposes of the Medicaid program is both morally wrong and quite possibly not legal. This is especially troubling when CMS in 433.51(c) allows federal funds authorized by federal law to be used as match for the Medicaid program. Federal funds received under the Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law 93-638 are specifically allowed to match other federal funds.

Even more troubling is that it appears CMS has failed to act in "good faith" with the state Medicaid agencies and the Indian tribes in those states. CMS issued State Medicaid Director Letter #05-004 (SMDL) October 18, 2005 to respond to questions about using expenditures certified by Tribal organizations to fulfill the state matching requirements for activities under the Medicaid program. The letter described CMS's policy regarding the conditions and criteria under which tribal organizations can certify expenditures as the non-federal share of Medicaid expenditures for administrative functions. It also described the Tribes and Tribal Organizations which could participate pursuant to ISDEAA. Just over 7 months later in response to state and tribal comments CMS and IHS jointly issued SMDL #06-014 on June 9, 2006 to clarify the conclusion stated in footnote 1 of SMDL #05-004. SMDL #06-014 clarified that federal funds awarded under

ISDEAA may be used to meet matching requirements. And just 6 months after that, January 18, 2007 CMS reversed itself by publishing these proposed regulations which would only allow this federal matching if the tribe has generally applicable taxing authority. This could be interpreted that CMS purposefully and willfully misdirected the states and the Indian tribes; while simultaneously developing and working these regulations through the Executive Branch's internal regulation clearance processes; which took much longer than the 6 months between June 2006 and January 2007 to complete. These regulations appear to redefine for the Medicaid program only, the government to government relationship between the United States and Indian Tribes and Tribal Organization. In terms of this redefinition and the development of these regulations, when during the processes did the Tribal Consultation required of CMS in its own Tribal Consultation Policy (December 2005) occur? What were the results of that Tribal Consultation? Did CMS only consult with the Tribe through the Tribal Technical Advisory Group (TTAG) until a month after these proposed regulations were published?

Under (ISDEAA) PL 96-638, Tribes and Tribal organizations are clearly afforded governmental functions and responsibilities and receive substantial amounts of funds to do so through contracting or compacting with the federal government. Has CMS determined that consistent with their policy articulated in the State Medicaid Director Letters that for purposes of these regulations Indian Tribes and Tribal Organizations are units of government or governmental health providers because they are a part of the federal government which has taxing authority and contracts or compacts for the provision of federally funded health services to tribal beneficiaries? And therefore, the federal government has the legal obligation to fund the expenses, liabilities and deficits of the tribal health care delivery system through the Indian Health Service and the annual Congressional appropriations? If so, the proposed rule does not reflect this decision.

CMS should rewrite the proposed regulations with separate paragraphs as necessary to affirm their existing policy regarding Indian Tribes and Tribal Organizations as expressed in the SMDL #05-004 and #06-014. The rewrite would remove the requirement that to be considered a unit of government or a governmental health provider, Indian Tribes must have taxing authority (generally applicable or otherwise); or the rewrite should specifically acknowledge the unique nature and circumstances of Indian Tribes and Tribal Organizations such that they are deemed to have met the taxing authority requirement.

#### ***Section 447 Payments for Services***

##### ***447.206 Cost limits for providers operated by units of government.***

This paragraph requires annual cost reporting by all units of government and governmental health providers for all Medicaid services it provided during the year; the state Medicaid Agency's review and retrospective determinations of whether the Medicaid payments to that unit of government or governmental health provider exceeded its costs to deliver the Medicaid service(s); and if so, refund of the overpayment to CMS.

CMS's sudden development of a double standard between the Medicare and Medicaid programs is an especially troubling aspect of this proposed regulation. Medicare pays for services based on prospectively determined rates. Historically, CMS has aggressively pushed state Medicaid Agencies to prospectively set payment rates to end retroactive provider settlement. CMS is now reversing course to require states to implement interim rate methodologies with retrospective determination of whether the payments exceeded the provider's cost to provide the services. Development and implementation of these processes for units of government, governmental health providers and state Medicaid Agencies will result in significantly increased administrative and auditing workloads.

In this context, the State of Alaska is faced with a unique problem in terms of services provided to Medicaid clients by units of government and governmental health providers. While most states have some cross-border purchasing of Medicaid services in neighboring states, it is generally limited in scope and duration to the same providers in the neighboring state(s). Alaska does not share a border with any other state and as a frontier state lacks the full range of medical services infrastructure available in-state as compared with what is available in most of the other states. This situation results in a broad range and volume of Medicaid services necessarily being purchased out-of-state (in the lower 48 states) and this regulation will create a dramatic new workload.

Each authorization for out-of-state service will have to be evaluated to determine if the service will be/was provided by a unit of government or a governmental health provider in the other state. In addition, for those out-of-state services provided by a unit of government or governmental health provider the state Medicaid agency will have to retrospectively, after the provider's fiscal year:

- 1) request and receive a copy of the provider's annual financial report covering the dates of service,
- 2) review the financial report,
- 3) make the subsequent retrospective determination whether Medicaid payments to the unit of government or governmental health provider exceeded its cost to provide the Medicaid service(s),
- 4) make overpayment collection and
- 5) transmittal to CMS if indicated, and
- 6) periodically audit the out-of-state unit of government or governmental health provider.

Even if Alaska accepted the servicing state's Medicaid payment rate(s) for that unit of government or governmental health provider; the proposed regulations would require Alaska to either make the cost limit determination through an audit of the unit of government or governmental health provider; or monitor and accept the servicing state's cost limit determination and make the retrospectively calculated refund of any overpayments to CMS. In either case, additional administrative mechanisms will be needed to provide the monitoring and tracking necessary to support the regulatory processes.

CMS's proposed regulations uniquely penalize Alaska for its lack of the medical infrastructure routinely available in the other states. Its small population base, vast geographic distances, comparatively small Medicaid/SCHIP programs and state budget combine to require a disproportionate administrative response by Alaska to meet the requirements imposed by the proposed regulations, resulting in a corresponding disproportionate increase in program costs to both the state and federal governments.

The proposed 447.206(d)(2) states "Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending period in which interim payment rates were made." Please clarify that this section is applicable only in a retrospective cost reimbursement methodology and does not apply to a prospective cost reimbursement methodology. Without this clarification, health providers could construe that states are required to pay full costs, rather than that payments are limited to cost, in a prospective cost reimbursement methodology. In those situations where payments were less than cost, the providers would argue an additional Medicaid payment including federal funds at the FMAP would be due the provider. "

The proposed 447.206(d)(3) states "Final reconciliation must be performed annually by reconciling any interim payments to the finalized cost report for the spending year in which any interim payment rates were made." Please clarify that the "finalized cost report" may be prepared by the Medicaid agency rather than requiring the Medicaid agency to wait for a Medicare intermediary to finalize the cost report. The Medicaid agency should not have to either wait for an Intermediary generated final, which could change again, or accept the Medicare intermediary's determination of Medicaid costs.

### ***Collection of Information Requirements and Financial Impacts***

CMS's impact estimate of 10-60 hours on the part of each governmental provider to complete the approved form(s) to be submitted with a CPE is nothing short of fantasy. CMS estimates that it will only take the provider 10-60 hours to prepare and submit the cost report information and an additional 10-60 hours for the state Medicaid Agency to review and verify the cost report information submitted. However, even more extraordinary is CMS's intentional failure to acknowledge the increased Medicaid agency audit activity specifically required by these proposed regulations at 433.51(b)(4), 447.206(c)(4) and 457.220(b)(4).

As of November 2006 there were 18,058 providers on the state's MMIS provider file. Sorting the file by the state listed for the provider's pay-to address identified 7,434 out-of-state providers and 10,624 in-state providers. The present MMIS provider file and provider type table do not capture designations such as unit of government or governmental health providers. As a work around to estimate the impact of these regulations the in-state and the out-of-state provider lists were sorted to identify those providers with one of the following words in the provider's "pay-to" name: state, city, county or borough. These sorts resulted in identification of 123 out-of-state providers and 162 in-state providers with those words in the provider name. Undoubtedly, this methodology understated the numbers of units of government and governmental health providers on the MMIS provider file.

The present MMIS provider file and provider type table does not capture unit of government or governmental health providers as a particular or unique type(s) of provider. Consequently the Department has neither a quick nor efficient methodology to identify unit of government or governmental health providers as a subset of all the Medicaid providers on the MMIS Provider file. To effectively identify the units of government or governmental health providers on the file will be a manual and thus very staff intensive process, ultimately requiring direct contact with each individual provider to determine whether or not the provider is a unit of government or governmental health provider. Alaska's Medicaid provider enrollment application and processes will have to be changed to capture and verify the provider's governmental status.

We estimate that the review of the MMIS Provider File and the subsequent direct contact with providers will require at least 4 FTEs (state or contractor) for 6 months, with a one time cost of \$135.8. The activities of at least one of these positions will require a professional level position to interpret the regulations and determine if providers meet the criteria as a unit of government or a governmental health provider, assuming these criteria ever become known.

The MMIS provider file needs reprogramming to record the provider's governmental status. If the Department determines that it will need to make payments at different rates or rates determined by different methodologies then there would be additional programming necessary to the MMIS to accommodate the payment differences to the governmental and non-governmental providers for the same services. To be in compliance with the proposed regulations all of these activities will have to be completed

by December 31, 2007. Any programming to the MMIS and the Medicaid agency's data warehouse to capture the unit of government or governmental health provider status would be in addition to the above estimate. Given that this data element would not be required for claims processing the programming to capture the data element on the file and to pass it to, and record it on the data warehouse is estimated to between \$50.0 to \$100.0 total cost. This cost will be much more if unique unit of government and governmental health provider payment rate methodologies need to be developed, integrated and implemented in the MMIS. This cost could easily exceed \$1,000.0.

### ***Cost Reporting and Auditing***

The workload on state Medicaid agencies imposed by these regulations is both new and substantial. To successfully meet these regulatory requirements processes will have to be developed and implemented which identify and record units of government and governmental health providers, monitor and contact those providers for their cost reports and their annual financial reports, review, analysis and determination of provider's cost limit, schedule and conduct the audits, coordinate refund of identified overpayments to CMS, coordinate and resolve any appeals of the audits or subsequent litigation.

Assuming 30 units of government or governmental health providers are identified out of the 162 potentially identified and an audit cycle in which once every 3 years each entity is audited, the Medicaid agency estimates it will have to add 4 new staff to support that workload. \$435.9 is the projected annual cost of the additional staff necessary to perform this workload including travel and the other support costs.

If the Alaska Medicaid Agency is precluded from accepting the Medicaid payment rate and cost limit determination of the other state for those services purchased outside of Alaska; the Medicaid agency estimates that out of the 123 providers, an additional 23 units of government or governmental health providers would be added to the workload. The Medicaid Agency's cost estimate would increase by an additional \$224.4 to \$658.3.

## Targeted Case Management

Overview: The proposed regulation goes far beyond the original statutory language and that amended by the Deficit Reduction Act. The proposed regulations do not provide clarity to the statute, but in fact offer confusion instead. The guidance provided by the Background section of the NPRM clearly indicates that future guidance on case management will be little more than a significant cost shift to the states that represents an Unfunded Mandate.

Background page 68081 paragraph that begins “Our proposed Exclusion of FFP...” describes that Medicaid case management could be reimbursed for Medicaid eligible individuals in other public, non-institutional programs “when the services are identified due to a medical condition targeted under the State Plan and are not used in the administration of the other non-medical programs’. That seems to be a clear statement that appears to be contradicted by the actual regulation and other language in Section F. Please clarify in regulation the precise availability of FFP for plan, waiver and administrative case management in other programs.

Further confusion is added by the above statement. A new requirement, not supported by statute is that case management, to be eligible for FFP, must be tied to a medical condition targeted under the state plan. There is no statutory requirement that ties case management to a certain specified medical condition. This statement seems to turn TCM into only medical case management, a much narrower view than cited elsewhere in statute and regulations. What is the true intent of this linkage of case management to a stated medical condition?

441.18 (8)(vi) The requirement to bill in 15 minute increments is not supported by history, the DRA and other federal statutes. Your proposed regulation says using methods other than 15 minute billing is not efficient and economical to administer, yet such methodologies are efficient and economical for RHCs, FQHCs, hospitals and nursing homes. Just as it makes no sense to require piecemeal billing for these provider types, it makes no sense and is not efficient and economical to require TCM to be reimbursed in this manner. If CMS has issues about a case rate, daily or monthly rate then similar cost principles that govern FQHCs and RHCs can be applied to TCM. It is not very difficult for a state to develop a cost basis that supports a daily or monthly rate, and it is equally simple for CMS to validate such methodologies. It is administratively burdensome and expensive for some provider types to bill in time increments and it is administratively expensive and burdensome for state oversight functions. States used to have flexibility to determine methods and rates within broad statutory and regulatory frameworks. This regulation and other recent proposed regulations appear as attempts by CMS to end the state-federal partnership and to operate and control Medicaid in a fashion similar to Medicare. If that is the intent, then get statutory authority and do it. If that is not the intent, then continue to let states determine the reimbursement methodologies that work for them, provide guidance into the methodologies just as has occurred with FQHCs and RHCs over the years.

441.18 (9) (c) (2) The title of this is Medicaid Program; Optional State Plan Case Management. The body of the proposed regulation then proceeds to totally confuse state plan case management with waiver case management and administrative case management. This regulation takes the clear language from the CMS State Medicaid Manual, language that has been in place since at least 1994, and then creates problems where none had existed before. With funding only available for one case manager (state plan, waiver, administration) per recipient, and the chosen case manager not able to direct services or act as a gatekeeper, this regulation insures cost savings to the federal government at state expense, as other federal statutes and regulations require these administrative functions and now FFP is not available for them. There is no legal basis for such a program change and the resulting cost shift. This proposal needs to be evaluated in terms of Unfunded Mandates as states must continue to perform these administrative functions and now FFP is not available when a state provides TCM for the same recipient.

441.18 and Background: This proposed regulation ignores the cost allocation language in the DRA in regard to TCM and makes an executive decision to eliminate Medicaid case management (plan, waiver or administrative) from other programs that receive federal funding (or for that matter any local, state or federal funded program) on the grounds that case management is somehow “intrinsic to another program.” The premise that the other program must cover all case management costs is outlandish and not supported by statute. The DRA language directed the use of a cost allocation methodology found in OMB A-87 as the means to separate costs between programs and not have duplicate payments. After years of requiring states to adhere to the cost allocation principles in OMB A-87, the CMS regulation takes that a giant leap forward toward eliminating cost allocation altogether by invoking the oft stated, but never found in statute “intrinsic to another program” and denying FFP whenever costs are associated with more than one program. If this doctrine were invoked when Medicaid was begun, there would have never been a viable Medicaid program; some pre-existing state or local program would have overlapped with Medicaid and HCFA would have withheld FFP. If cost allocation is not acceptable for case management, then why is it acceptable in facility rate setting, funding of public assistance case work or any one of the dozens of areas of Medicaid it is routinely applied. No clear basis of differentiation is supplied by CMS. If this is not the intent of this proposal then the regulations must be rewritten to make clear the intent.

To point out another example of this regulation as another Unfunded Mandate CMS seems to operate under the belief that all children in the care and custody of the state under Title IV-E are receiving IV-E funding. Due to Welfare Reform in 1996 the income eligibility for IV-E eligibility is frozen at the 1996 standard. Each year fewer and fewer children in the states' care and custody or eligible for funding under IV-E, yet the federal requirements apply and states have an increasing General Fund burden. Eliminating Medicaid as a funding source for case management of Medicaid services required by these children, services required by federal law, is a direct cost shift to the states and an Unfunded Mandate. Please also note that case management of medical services is not a function of, nor is payment available under, Title IV-E. The budget note for this regulation indicated an increase of Title IV-E funds to backfill this Medicaid fund loss,

however Congress would have to appropriate those funds and, more likely in the current federal budget process, the funding won't be appropriated, thus a direct Unfunded Mandate to the states.

In theory, a single case manager makes sense. The same could be said for only having a single physician. But what works in theory often fails in the real world. If this one case manager standard is legitimate to apply, then the same logic must be applied to physician and other practitioner services. Yet no rational support could be found for such a position.

Sec 441.18 (7). Documentation requirements are found in preexisting regulation and it is not necessary to add different or new requirements in this section. Documentation must be the same or very similar regardless of the type of service or provider.

Summary: The proposed regulation, rather than furnishing clarity, provides only additional confusion. The proposed regulation goes well beyond statutory language and Congressional intent. What is clear is that this regulation represents a significant cost shift to state, another Unfunded Mandate. This proposal should be withdrawn.

# STATE OF ALASKA

**DEPT. OF HEALTH AND SOCIAL SERVICES**  
OFFICE OF THE COMMISSIONER

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November 6, 2007

Secretary Michael O. Leavitt  
Centers of Medicare and Medicaid Services  
Dept. of Health and Human Services  
Attention: CMS-2287-P  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Alaska Dept. of Health and Social Services Comments on Proposed Rule 2287-P.

Dear Secretary Leavitt,

The Alaska Department of Health and Social Services is in complete opposition to the funding reductions contained in CMS' proposed Rule 2287-P, which seeks to cut Medicaid reimbursement for legitimate and necessary school-based services in direct contravention of existing federal law and Congressional intent. Although the state of Alaska agrees that CMS must address inappropriate claiming on the part of service providers, singling out children and school districts is an arbitrary application of the "efficiency and economy" tenets central to Medicaid law and the administration of the state plan within it.

Rather than eliminate federal financial participation for costs of effective activities that serve Medicaid-eligible students in schools where they and their families can be reached most efficiently, we urge CMS to examine thoroughly and report on the current effects of policies implemented through its 2003 Administrative Claiming Guide. CMS applies the clear guidance, criteria and limitations from this Guide to other types of Administrative Claiming in states, which shows that it has full confidence in these policies since it has applied them throughout the Medicaid program. Without fully analyzing this policy's impact CMS is proposing to overturn nearly 20 years of consistent policy that encouraged schools to perform the administrative activities that support each state's Medicaid plan by eliminating the funding entirely. Alaska cannot support this drastic reduction in funding without the data to prove there is a problem since the 2003 Guide was published. The state does, however, welcome the opportunity to continue working with CMS to ensure appropriate claiming throughout its Medicaid program.

In the preamble to this proposed rule, CMS cites examples of claiming errors without admitting that these situations occurred before the policies in the 2003 Administrative

Claiming Guide were implemented. If CMS eliminates funding for every type of service, activity or delivery system where it identifies inappropriate or even abusive claiming practices by some providers, funds would no longer be available for any benefits under the Medicaid program today. After having carefully scrutinized **current** claims for school-based services, CMS would be in a better position to establish regulations that ensure proper claiming and support the key role schools play in identifying Medicaid-eligible children, promoting access to Medicaid services available in their communities and arranging or delivering needed care.

Historically, Congress and the federal government have encouraged Medicaid to share in schools' costs for meeting the medical needs of students with disabilities.<sup>1</sup> As indicated by bills and amendments before the last and current Congress,<sup>2</sup> it is vital that Medicaid also share in schools' costs to assist the growing numbers of uninsured and underserved school-age children whose lack of access to basic health care significantly impedes learning.

Limiting claimable administrative activities to state employees ignores previous federal court decisions prohibiting CMS from denying funding based on the type of State employee conducting the activity. CMS is attempting to exceed the limits of its authority by trying to legislate how a state divides its authority for its functions and responsibilities to residents.<sup>3</sup> Further, eliminating the ability for school personnel to claim their allowable administrative costs for federal financial participation decreases the efficiency and economy of the overall program and unduly burdens both schools, who must provide medical services (whether or not they bill Medicaid) under IDEA, and state agency staff. It is a well recognized fact that early delivery of health care and preventive services saves us from the longer term costs of illness.

For this reason, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for Medicaid recipients ages 0-21 years requires states to perform EPSDT outreach and informing, as well as help Medicaid-eligible children and their families access EPSDT services through transportation. As CMS is well aware, its *State Medicaid Manual* not only encourages state Medicaid agencies to coordinate EPSDT administrative activities with "school health programs of State and local education agencies," but also states that, "Federal financial participation (FFP) is available to cover the costs to public agencies of providing direct support to the Medicaid agency in administering the EPSDT program."<sup>4</sup>

Federal financial participation in the costs of outreach, informing, and care coordination is available to all public entities performing such activities on behalf of the Medicaid program. The Medicare Catastrophic Coverage Act of 1988 expressly allows Medicaid to

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<sup>1</sup> Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), *Medicaid and School Health: A Technical Assistance Guide, August 1997* (CMS, 1997), and *Medicaid School-Based Administrative Claiming Guide* (CMS 2003).

<sup>2</sup> Protecting Children's Health in Schools Act of 2006 (SB3705, HR5834) and 2007 (SB578, HR 1017).

<sup>3</sup> *Massachusetts v. Sec'y of Health & Human Svcs.*, 816 F.2d 796,798 (1<sup>st</sup> Cir.1987)

<sup>4</sup> Centers for Medicare and Medicaid Services, *State Medicaid Manual*, Section 5230 and 5230.2.A.

reimburse school districts for state plan covered services, including transportation, that schools provide pursuant to the Individualized Education Programs of Medicaid-eligible children with disabilities. A rule to prohibit schools from claiming administrative and transportation expenses would not only contradict existing law but also circumvent Congressional intent.

Contrary to the current HHS Secretary's statement "that general school-based administrative activities are not necessary for the proper and efficient administration of the State plan," extensive state and national studies on the subject reveal data that such activities routinely result in increased Medicaid coverage of uninsured children; a stated priority for this administration.<sup>5</sup> Sadly, the current Secretary offers no data or argument to support his contention that these services are no longer necessary. After nearly 20 years, why are these administrative activities suddenly not needed?

In the 2003 Medicaid School-based Administrative Claiming Guide, CMS confirmed that "the school setting provides a unique opportunity to enroll... and to assist" Medicaid-eligible children to "access the benefits available to them." In the introduction to the Guide CMS acknowledges, "Contemporary schools are engaged in a variety of activities" to carry out their mission to "help ensure that students come to school healthy...ready to learn [and ready to] benefit from instructional services." Schools and communities across the U.S. are highly invested in helping students achieve to their fullest potential and the Medicaid program is an essential component of that mission.

Alaska urges the Centers for Medicare and Medicaid Services to abandon this proposed rule in order to avoid further conflicts with existing statutes and policies and to continue investing federal matching funds in efficient and effective school-based Medicaid administrative activities and state plan-covered transportation services while working with states to ensure appropriate claims are made.

Respectfully submitted,

Jerry Fuller,  
Medicaid Director  
Alaska Department of Health and Social Services

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<sup>5</sup> *Financing Mental Health for Children, Youth and their Families*, National Center for Children in Poverty, Columbia University, (October 2007)

**Submitted on behalf of the Alaska Department of Health and Social Services, Medicaid and Health Care Policy**  
**Jerry Fuller, Medicaid Director**

## **General Comments**

The summary of the proposed rule indicates two purposes. One “in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records”, and two “ensure fiscal integrity.....must be coordinated with but do not include services furnished by other programs.....” The proposed regulation fails to meet either purpose. In fact the proposed regulation uses many undefined terms and vague descriptions such that it will be the standard that subsequent CMS guidance through letters, state plan discussions and denials, disallowances etc. will actually determine the meaning of this regulation. Given the \$2.3 billion estimated federal fund savings it is easy to deduce the direction of future guidance.

Beneficiary protection fails as the impact of this regulation package will be fewer available services under rehabilitation; residential services pushed toward PRTF or inpatient level of care since community based residential services will be significantly reduced, in potential violation of the Supreme Court Olmstead decision; and the added administrative burden will drive up costs and remove funds from service provision. The current broad definition of rehabilitation services make it possible for Medicaid beneficiaries to live in the community while averting institutional placements in nursing facilities and state psychiatric hospitals. The current rehabilitation definitions do permit a cost effective service array and does avoid beneficiaries being placed in higher cost, more restrictive service settings.

The second purpose “ensure fiscal integrity” through limitations between Medicaid and all other federal, state or locally funded programs (intrinsic to) fails because there is no statutory basis for such a limitation and Congress has expressly rejected such a policy. This policy would save significant Medicaid federal funds by cost shifting to state and local funds, funds that are as limited as any other source. There would not be a cost shift to other federal funding sources as those programs are capped programs.

Section V Regulatory Impact Analysis states this is a major rule because it will save the federal government more than \$100 million annually, \$2.3 billion over 5 years, yet later in the same section it is quite clearly stated “we do not routinely collect data on spending for rehabilitation services” and at the time of this fiscal estimate “a comprehensive review of these rehabilitation services has not been conducted”. In spite of this lack of review and knowledge the proposed rule is expected to save the federal government over \$2 billion over 5 years. In one section it is stated “The rule would not directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to provisions of this rule”. Elsewhere it states “Since this rule would not impose any costs on state or local governments” and under a section labeled “FROM WHOM TO WHOM” it states “In this case costs previously paid for by the

Federal Government would be transferred to State Governments.” Given these conflicting and contradictory statements it must be questioned “Has CMS complied with the multiple reporting requirement that are necessary when regulations are promulgated?” There certainly isn’t any straight forward data and the narrative is contradictory and confusing. Based solely on statements within this NPRM, it seems quite clear that the Unfunded Mandates Reform Act and Executive Order 13132 do apply and must be addressed. It must also be mentioned that because the proposed regulations are so vague and lack in clarity the true rule making will occur later in CMS guidance letters, the state plan approval or disapproval process and disallowance proceeding, all outside Administrative Procedures Act requirements. The only thing clear is this regulation represents a major cost shift to states without any federal statutory basis.

### Specific Comments

Citation	Agree	Disagree	Comments
441.45(a)(2)		X	<p>Partially agree that Medicaid payments are made for only those rehab services that would likely attain the maximum reduction of the mental disability and restoration of the individual to the best possible functional level. However, this statement is too restrictive and ignores Sec. 1901.</p> <p>“SEC. 1901. [42 U.S.C. 1396] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (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. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.”</p> <p>The proposed regulation ignores (2) above, thus would not provide FFP for rehabilitation services that permit a beneficiary to “retain” capabilities.</p> <p>“For maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level” is new to Medicaid – but it is a well worn Medicare phrase. Medicare services will be provided until the patient stops making progress – then they stop. Of</p>

			<p>course Medicare has no responsibility for long term care services. Medicaid does and must determine and balance the service array to best meet the clients needs, both restorative and long term care needs.</p> <p>We are concerned about no FFP for a person with the Developmentally Delayed diagnosis to receive mental health rehabilitation services. The diagnostic realities do not afford this exact a line to be drawn. A majority of clients in behavioral health systems have co-occurring disorders – as many of 87%.</p> <p>The regulation appears to negate the option for rehabilitation for children who have not learned the skills in the first place. This could potentially make services for SED children severely limited – basically holding them to the clinical service package only, or higher cost, more restrictive settings. The current focus on “restoration” of previously learned skills does not take into account the developmental stages that children/youth may present and later grow into further skill sets.</p> <p>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. The regulation 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)).</p> <p>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.</p>
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441.45(a)(3) & 441.45(a)(4)		X	<p>(3) is another example of words without specific meaning. Which providers need to have a copy of this rehabilitation plan in their case records? Just those enrolled with Medicaid as rehabilitation providers or even the physician or clinic that may provide associated health care services?</p> <p>Alaska has been involved with a COSIG grant, resulting in the development of different and a more minimalist documentation requirement. The new emphasis of the Alaska effort has been to reduce the administrative burden, with a focus on outcomes based practice. The CMS emphasis on the specific details for a case record has not shown to be relevant to good practice, service delivery and outcomes. This level of proscription is counter productive and does not enhance beneficiary participation or protections, one of the major goals proclaimed in the introduction to this NPRM. It appears these proscriptive case planning requirements are being proposed without benefit of consultation and/or comprehension of best practices developed and promoted by SAMHSA and other leaders in the field of behavioral health treatments and outcomes.</p> <p>This requirement does not comport with “efficiency and economy” requirements in Title XIX. There will be significant added cost to comply with these extraordinary documentation requirement, cost that Medicaid providers will expect and rightly deserve to be compensated for doing, not to mention increased single state agency cost administrative costs to monitor.</p> <p>As an aside, if such a detailed and proscriptive approach is believed necessary for rehabilitation services then why is such an approach not being proposed for physician, therapies, hospitals etc. If this is being proposed for program integrity purposes it would seem it should be an equally effective tool across most all Medicaid services.</p>
441.45(b)(1)		X	<p>It is agreed there should not be duplicate payment for Medicaid services. And it is agreed that foster</p>

		<p>care, adoption assistance, family reunification etc. are not Medicaid reimbursable services. However, this rule introduces a much broader and very vague concept not found in statute and never before promulgated by CMS, other than a similar statutory concept proposed by CMS for the DRA, and rejected by Congress. The fact that statutory authority was sought earlier indicates that is necessary, and the fact that statutory authority was not granted indicates this section of regulation must be withdrawn; it is not valid or legal.</p> <p>The language in this section is very vague, which means CMS will provide meaning through guidance letters, state plan discussion and denials and disallowances. Intrinsic elements of another program, based on current CMS verbiage, could mean a state funded program for mental health could mean no FFP for Medicaid funded mental health programs. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has insurance with a legal obligation to pay. CMS appears to be stretching Medicaid Third Party Liability statute and meaning to be inclusive of “intrinsic elements of programs other than Medicaid,” even if those other programs are dollar capped or intended for those citizens without access to care. 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.</p> <p>The language of this regulation is broad enough to easily reach the above conclusions. This language could also be used to deny FFP for children in the care of juvenile justice, even though not in inmate status, and fully eligible for Medicaid and EPSDT.</p>
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		<p>The tenor of this proposed regulation could indicate the same for children in foster care, whether eligible for IV-E or not. CMS can take this much farther and interpret it more stringently, and use this rule to more dramatically to cut FFP.</p> <p>The language of this regulation indicates CMS does not understand that therapy of various types can be delivered in many different settings. Foster care is one such setting. Medicaid can not and does not pay for the maintenance of the child in foster care. That is other federal funding sources and state GF. However it is appropriate, and before this regulation, legal, to define and enroll into Medicaid foster parents that had special education or training in therapy techniques and to reimburse them for the therapy they provided to Medicaid eligible children in their care. This is a well established and cost effective model to provide therapy services to these most vulnerable children. This model is in sync with CMS stated community-based services preference.</p> <p>While we agree that foster care in and of itself should not be Medicaid reimbursable, we assert that foster parents who provide rehabilitative services and are employed and supervised through a mental health centers or clinics should be able to provide Medicaid reimbursable services. These services should be limited to children who have been assessed and determined to be in need of specific rehabilitation services provided by these specialized foster parents. To reiterate, we believe services are best delivered in the environment where the client lives.</p> <p>Alaska disagrees that providers of therapy in foster care should meet the same provider qualifications as those individuals who provide the same service outside of foster care because we believe this will severely limit the availability of Alaskan Native providers who are a valuable resource in keeping children in their communities. Research shows that</p>
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		<p>children are more effectively treated by providers whom they see as being similar to them. Also, properly trained and certified personnel can be as or more effective than higher level professional staff.</p> <p>Rehabilitation is defined separately in Title XIX of the Social Security act. There is no statutory basis for requiring different services to have the same provider qualifications. Determining the appropriate level of education, training, licensing and certification for providers has historically been the purview of states and there has not been any statutory change to require or permit this to change.</p> <p>Rehabilitation therapy can and should be delivered in many setting other than a clinical office. States have apparently erred by the labels used to describe their Medicaid services. In order to promote understanding perhaps this should be called therapy in a foster care setting, therapy while at a camp, therapy at or during recreation, etc. The important point is therapy can occur in most any setting and likely will be much more effective on a 24/7 basis compared to one hour session in an office. Of course the state plan must describe who is qualified to provide this therapy, what the therapy entails and the documentation to show it occurred and meet all other requirements.</p> <p>Rehabilitation services are most effective when they are delivered in the setting in which the problem behavior occurs. For example, we believe that a mental health associate out stationed in a school is more effective in resolving a child's inability to get along with his fellow students, than working with that student in a 'free standing" mental health clinic</p> <p>The current regulation adds to the silo programs and funding from HSS. HSS must find a way (perhaps through statutory changes) to coordinate across these programs to get global efficiency and the best outcomes, not each program only looking at their realm and ignoring all else.</p>
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			Alaska supports the concept of including vocational and prevocational activities as permitted services, but clarity is needed about when support for successful community living gets too close to prohibited vocational, pre-vocational, housing, and educational support services. We should be encouraging outcomes like successful community living (especially including employment, housing and education) with all state and federal programs.
441.45(b)(2)		X	Without doing research into OBRA 89, it appears from the language in the I) Background B. Habilitation Services that the proposed regulation ignores the Congressional direction in OBRA 89 to promulgate regulations that “specifies types of day habilitation services that a state may cover under paragraphs (9) (clinic services) or (13) (rehabilitation services) of Section 1905 (a) of the act...”. to maintain the CMS position of no FFP for habilitation services covered under the state plan option. Since this doesn’t comport with OBRA 89 and Congressional direction this should be withdrawn.
441.45(b)(3)	X	X	Agree with Medicaid not reimbursing social or recreational activities, but also believe that an activity that may be social or recreational can also be “rehabilitative” (in which case it would be identified in an assessment and treatment/rehab plan with an associated goal.)  However it must be recognized, and thus far is not, that rehabilitation services can be delivered during or in a social or recreational setting that are appropriate and directly related to the rehab plan and treatment goals. Think outside the box for a moment. Rehabilitation and therapies of various types can be delivered an office, home, moving vehicle, classroom, camping etc. As long as the service is documented and the reimbursement rate does not include costs associated with the setting or room and board that service should be a valid and reimbursable Medicaid rehabilitation service. A

			<p>fundamental principle of non-institutional services is that to help people recover or maintain you treat them in real world settings. Medicaid statute does not proscribe where psychiatrist may deliver services, nor does it proscribe where rehabilitation services may be provided.</p> <p>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.</p>
441.45(b)(4)	X	X	<p>Agree with excluding payment for rehab services provided to inmates in a secure setting, etc., but this is an exclusion that applies to all Medicaid services, thus should not be lumped into just the regulation about rehabilitation. It is appreciated that CMS has finally given some clarity to what is meant by ‘inmate in a public institution.’</p> <p>It is recommended that the terms be used consistently throughout. In the first paragraph it says “in the secure custody of law enforcement and residing in a public institution”. Later on this is shortened to public institution system. It must be explicit that all references in this section to public institutions only mean “in the secure custody of law enforcement residing in a public institution”. Otherwise at some future date different, more expansive meaning will be given to public institution and the intent will be unnecessarily confused.</p>
441.45(b)(5)		X	<p>This appears to be a new and novel approach to limiting a state’s ability to provide community services for children. Applying the IMD 16 bed limit to all other community residential treatment</p>

			<p>facilities, except those meeting the PRTF requirements, has the potential to limit, if not eliminate critical services needed to either keep children out of inpatient care or PRTF level of care, or negatively impact the ability to transition children from inpatient care to community setting. This regulation does not assist in beneficiary protections or enhance program integrity.</p> <p>Again, the guidance CMS provides will determine the magnitude of the negative impacts this section will have upon state programs. Again, there does not appear to be any program need for this regulation nor statutory basis to support its inclusion.</p>
441.45(b)(6)	X		<p>Agree with excluding payment for room and board as a rehab service, but again this restriction is much broader than just rehabilitation and should be elsewhere in the regulatory scheme.</p>
441.45(b)(7)	X		<p>Agree to exclude payment for rehab services provided to a non-eligible and strongly agree to the exception to this rule that allows providing family therapy (ineligibles) as long as it is in relation to the eligible family member's treatment goals.</p> <p>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.</p>
441.45(b)(8)	X		<p>Agree all services must be documented in the recipient's case record. Again this restriction is much broader than just rehabilitation and should be elsewhere in the regulatory scheme.</p>
440.130(d)		X	<p>It is common to refer to the benefit in Section 1905(a)(13) as the "rehab option," but the statutory language is broader, covering "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services . . . recommended by a physician or other licensed practitioner of the healing arts." The inclusion of "diagnostic, screening and preventive" services, the</p>

			<p>use of the expansive terms “other” and “any,” the description of “rehabilitative” as including both “medical” and “remedial” services, and the reference to “other licenses practitioner[s] of the healing arts” as well as physicians -- indicate the statute was intended to give States significant flexibility to define the benefit broadly to meet the service needs of the clients. The proposed regulation, through the use of vague terms and a lack of definition will result in stricture of flexibility, since the meaning of the terms will be defined through CMS guidance, the state plan process and disallowances.</p>
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440.130(d)(3)	X	X	<p>Agree in general with this section’s requirement that speaks to a treatment &amp; rehabilitation plan that comes from a comprehensive assessment, a plan (related to the assessment) that’s overseen by a qualified provider, that the client is involved in the planning process, that there are clear treatment goals and recommended services.</p> <p>Disagree with the fact that CMS micro manages the whole section about rehabilitation plans and the addition of “recovery goals”. This includes too much detail that should be left to state-level regulations. Example: CMS proposed rules includes the client signature as a requirement for the rehab plan. There are two problems with this: <u>First</u>, this is micro managing on the part of CMS. In most all other areas CMS policy is written in fairly “broad” language rather than this level of detail. This level of detail should be contained in state regulation not federal. <u>Second</u>, the recipient signature on a plan, especially for SMI adults, doesn’t really indicate any involvement in the planning process. The real desire from consumers and consumer advocacy groups is client “involvement” not client “signature.” The challenge of getting client “involvement” should be a responsibility of each state. If a patients signature has so much added value then why not require it of physicians, hospitals, etc? Why single out rehabilitation services for special treatment?</p> <p>We are often involved in cases in which a parent has harmed a child and the non offending parent is in denial. Demanding their input, when these parents may not be cooperative, and denying payment for services under these cases would not be in the child’s best interest.</p> <p>The emphasis on such detail in the clinical record and plan requiring client signature also confronts the reality of states developing a “electronic medical record”. This also has implications for telemedicine development, and face to face requirements. Disagree with the increased liability placed on the</p>
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		<p>supervising providers – who could potentially be held responsible for the actions of others providing the treatment that is in the treatment plan. This looks to make the individual who signs the treatment plan responsible for the actions of individuals providing the care. That is inappropriate.</p> <p>Regulations should allow for “professional responsibility” to be shared by agency and licensed professional overseeing patient care. The proposed language seems appropriate only in instances where the clinician is the enrolled provider.</p> <p>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? 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 audit purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.</p> <p>Make it permissible 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.). Do not require two separate planning processes and two separate planning documents. This is burdensome not only on providers but also on the individual consumer. Clearly, multiple service plans do not facilitate coordination or accountability. Please clarify that a single planning process and document is preferable.</p> <p>Including information on alternate providers of the same service in the plan is uncalled for and does not</p>
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		<p>serve any useful purpose. 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. In a metropolitan area how could providers be expected to even have this information. It is difficult enough for the single state agencies to keep this information current and accessible.</p> <p>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 a significant number of cases may be problematic.</p> <p>It is not uncommon for those with severe mental illness to believe they are not sick and not 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 no guarantee 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.</p> <p>Also, when children are removed from parental homes it is not uncommon for parents to be in a denial state and not cooperate with the care needed by the children. Signature does not translate to plan involvement.</p>
440.130(d) (v)		Clarify that a rehab plan may be part of a treatment plan. A separate/additional planning effort or

			<p>document would not be required for rehab services.</p> <p>Regulation should clearly require patient/family participation in plan development. However, there should be a provision to allow for service delivery w/o signatures as long as the rationale for no signature is documented. Note that in Alaska a child may be hundreds of miles from the parents home in order to receive services, thus no parent is available for signing. Documents may be mailed back and forth, but still no guarantee of obtaining a signature. The proposed must provide flexibility in obtaining signatures.</p> <p>The requirement to document that the services are “determined to be rehabilitative services consistent with the regulatory definition” appears to be administratively burdensome and requires clinical staff to perform compliance activities.</p>
440.130(d)(vi)		X	<p>The intent and meaning of this section is unclear. 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.</p> <p>The proposed rule raises more questions than it answers regarding services provided to children. While the preamble addresses the provision of services to persons with developmental disabilities, it is not clear how this narrow definition of rehabilitation would apply with respect to services provided to children, who may not have lost a functional ability but instead need services to assist them in achieving the developmental milestones appropriate for their age.</p>

			<p>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. Please refer to Sec 1901. This definition appears much more restrictive than permitted in statute. Rehabilitation services may be appropriate for people with chronic serious mental or emotional disabilities to permit retention of their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. The proposed regulation could be interpreted 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.</p> <p>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 and 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.</p>
440.130(d)(1)(vii)		X	<p>The definition of medical services should be explicit and make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service.</p>

## Conclusion

Many sections of the proposed regulation lack statutory basis. Congress explicitly rejected the ‘intrinsic to’ approach during the DRA process. Most sections use vague and/or undefined terms that will result in endless quibbling and legal challenges. As was stated by a CMS official in a recent conference discussing this proposed regulation, mention was made of an “evolving policy”. The vagueness of the language does suggest that CMS doesn’t quite know what it wants the policy to be for rehabilitation services, other than the current broad language that provides flexibility to states to devise services that work appears to no longer be acceptable and that saving over \$2 billion federal funds with a significant cost shift to the state is acceptable. It is extremely difficult, if not impossible, for states to reconfigure programs to an ‘evolving policy’. It is suggested this regulation be withdrawn until such time as CMS has a clear understanding of the policy intent and it has statutory authority for the regulation.

