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October 9, 2007

Acting Administrator Kerry Weems
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Comments on the Medicaid Rehabilitation Services Option (CMS-2261-P) from the Brain Injury Association of America

Dear Acting Administrator Weems:

These comments are submitted on behalf of the Brain Injury Association of America (“BIAA”). Founded in 1980, BIAA is the leading national organization serving and representing individuals, families and professionals who are touched by a life-altering, often devastating, traumatic brain injury (TBI). Together with its network of more than 40 chartered state affiliates, as well as hundreds of local chapters and support groups across the country, BIAA provides information, education and support to assist the 5.3 million Americans currently living with traumatic brain injury and their families. BIAA strongly supports policies that ensure access to rehabilitative care so that individuals with disability, injuries or chronic conditions - including those with traumatic brain injury (TBI) – may regain and/or maintain their maximum level of independent function and community participation.

On August 13, 2007, the Centers for Medicare and Medicaid (CMS) issued a Notice of Proposed Rule Making (NPRM) that would save \$2.2 billion over five years by restricting access to services provided under the Medicaid Rehabilitative Services Option. BIAA strongly opposes this NPRM because it will restrict the ability of state Medicaid programs to provide important community rehabilitative services which many Medicaid recipients with traumatic brain injury rely on to improve and maintain their health and ability to function as independently as possible. **BIAA strongly urges CMS to withdraw the proposed rule.**

Despite the NPRM’s stated intent in the preamble – to ensure provision of services in the “best interests” of the recipients – these proposed changes will dramatically decrease access to community-based rehabilitation services for individuals with traumatic brain injury, and, ultimately, result in decreased access to home- and community-based living. This harmful proposal stands in stark contrast to goals associated with President Bush’s New Freedom Initiative, the Americans with Disabilities Act and its Olmstead Supreme Court decision,

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Medicaid's Money Follows the Person grants, and other government initiatives aimed at improving independent, community living outcomes.

BIAA opposed a similar proposal in 2005 as legislative language sent from the Secretary of the Department of Health and Human Services (HHS) to Congress. HHS offered this legislative proposal as a potential means of achieving savings in the Deficit Reduction Act of 2005 (DRA). However, the proposal was ultimately rejected by Congress due to serious concerns regarding its impact on access to community living for individuals with disabilities and the financial strains it would place on state and local governments. BIAA remains unclear as to why CMS continues to push these harmful changes when there is such widespread concern regarding their impact from Members of Congress, states, providers, clinicians, and advocates. If changes to this benefit are needed, the legislative process is the appropriate process and BIAA therefore requests that CMS withdraw this proposed rule to make substantial changes to the Medicaid Rehabilitative Services Option without Congressional directive.

BIAA would like to provide the following comments on specific provisions within the NPRM:

Written Rehabilitation Plan(§440.130 (d)(3))

The NRPM would require a written rehabilitation plan to be developed for each individual receiving services under the Rehabilitative Services Option. This section states that the rehabilitation plan would establish a basis for evaluating the effectiveness of care offered in meeting the stated goals, provide a process to involve the beneficiary and other stakeholders in the management of the rehabilitation care, and document that the services are allowable under the regulations. The rehabilitation plan would include a timeline based on anticipated rehabilitative "progress" to be reevaluated yearly and if no progress is determined upon evaluation, it appears that a new plan would have to be drafted.

BIAA does not oppose the implementation of a written rehabilitation plan and supports the NPRM's requirement that virtually all stakeholders be involved in the process of establishing the written plan including the individual receiving services and their family and/or guardian. However, BIAA is concerned that the written plan could be used as a basis for termination of services when sufficient "progress" is not achieved according to the plan, leading to exacerbation of the individual's condition and requiring a higher level of support.

Given the variability of mental illness, developmental disabilities and cognitive impairments – including those caused by a traumatic brain injury - it would be difficult for many providers, clinicians, consumers and other stakeholders to develop written rehabilitation plans that accurately predict the functional progress to be made by most individuals with these disabilities. In addition, some of these conditions are episodic in nature and change dramatically

over time. We encourage CMS to ensure that determinations of appropriate rehabilitative “progress” (and any termination of services based on these determinations) are made on a case-by-case basis by qualified experts.

Requirements and Limitations for Rehabilitative Services – Limitations for Rehabilitation Services

The Intrinsic Element Standard (§441.45 (b)(1)):

The NPRM would disallow Federal Financial Participation (FFP) for services under the rehabilitative services option that are considered an “intrinsic element” of another federal, state or local program. *Section V “Regulatory Impact Analysis,” Subsection C “Alternatives Considered,”* of the NPRM states that, in drafting this regulation, the agency considered “not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs.” However, the rule also states that the absence of this provision would result in a “less efficient use of Medicaid funding because... increased Medicaid funding would have simply replaced other sources of funding.” BIAA strongly disagrees with these assumptions.

Implementation of the intrinsic element standard would essentially remove the Medicaid safety net, a defining characteristic of this entitlement program. Medicaid coverage is already subject to third party liability – a standard which establishes Medicaid as the “payor of last resort” without harming the beneficiary. BIAA feels that this proposed “intrinsic element” standard is not only unnecessary in light of third-party liability standards already in place, but will have the unfortunate impact of reducing access to vital rehabilitative services for many individuals with traumatic brain injury currently receiving them under this option. Without these rehabilitative services, many individuals with TBI are at grave risk of ‘falling through the cracks’ and/or will eventually require higher level, less community integrated and far more costly levels of care, including emergency room over utilization, skilled nursing facilities, psychiatric settings, incarceration and homelessness.

As written, the new policy appears to exempt federal Medicaid from covering its share of the cost of rehabilitative services that may be *allowable* under vocational, prevocational, educational, substance-abuse, mental health, foster care, and assisted living programs. However, the rule does not indicate that the services *must* be provided by these other programs or received by the beneficiary in order for Medicaid to withhold FFP. As a result, the onus is taken off Medicaid to ensure access to these services and placed instead on the Medicaid recipient who, in cases where traumatic brain injury results in significant cognitive impairment, will often be unable to navigate the bureaucracy that limits access to rehabilitation.

Denial of FFP does not simply render important Medicaid rehabilitative services unnecessary. State and local governments may attempt to help ensure that individuals maintain access to these services at substantial costs to their governments. However, state and local governments face significant, and sometimes severe, budgetary constraints. The ability of these governments to absorb this cost-shift will vary widely and significant access problems will result. While there indeed may be discretionary federal, state, and local programs that allow provision of rehabilitative services similar to those currently being provided under Medicaid, there is no indication that these other programs will be able to provide such services to a large influx of Medicaid recipients. This disruption in the continuum of care for some of that nation's most vulnerable individuals, including those with traumatic brain injury, will ultimately lead to greater institutionalization and less independent living, likely costing Medicaid more in the long-term. More clarity is needed regarding implementation of this new language; however, it appears to establish a very dangerous standard.

Exclusion of Habilitative Services (§441.45 (b)(2)):

The NPRM also proposes to exclude FFP for all rehabilitative services that assist individuals in attaining and/or maintaining function (as opposed to *regaining* function) under section 1905(a)(9) or 1905(a)(13) of the Social Security Act. CMS refers to such services as “habilitative” and proposes to include services provided to individuals with “mental retardation or related conditions” in this habilitation exclusion.

BIAA is very concerned that CMS is trying to force a medical model onto a benefit clearly designed to provide psychosocial rehabilitation services to individuals with complex disabilities, such as those caused by traumatic brain injury. A narrowed focus on short-term medical rehabilitation, which one might complete initially following an injury or accident and likely involves time-limited services, leaves out the important concept of post-acute rehabilitation, which is a critical aspect of the continuum of care for individuals with traumatic brain injury. For such individuals, maintenance and attainment of function years after the initial injury is as important as – and often contributes to – the regaining of function.

For example, multiple studies have documented demonstrated functional gains in individuals who have participated in Community Integrated Rehabilitation (CIR) programs, delivered in the post-acute phase of recovery, (i.e. many years following the initial injury).¹ In particular, one study found that participation in a Comprehensive Holistic Day Treatment CIR

¹ Trudel, T.M., Nidiffer, F.D. & Barth, J.T. (in press). Community integrated brain injury rehabilitation: Treatment models and challenges for civilian, military and veteran populations. *Journal of Rehabilitation Research and Development*.

program significantly improved societal participation and social functioning even among individuals with a long history of limited participation after brain injury.²

The regulation points out that while habilitation services may not be allowable under the rehabilitative services option, Medicaid will cover such services in two ways - in an ICF/MR or under the home-and-community-based services (HCBS) waiver/HCBS option. CMS seems to imply in the proposed rule that this habilitation provision will not deny access to such services, but, rather, simply shift services from coverage under one benefit to another. However, BIAA does not believe that solely providing habilitation services under these alternatives benefits will reach all of the individuals in need of such care. Clearly, if this were the case, there would be no budgetary savings associated with this provision.

For example, an ICF/MR would not be an appropriate setting for many individuals to receive habilitative services, specifically when such habilitative services may prevent them from reaching the institutional level of care required by the ICF/MR benefit.

Additionally, the HCBS waiver has much stricter eligibility requirements than the Medicaid Rehabilitative Services Option (as does the new HCBS option, although regulations implementing this option have yet to be published). BIAA urges CMS to refrain from pushing states onto waivers to provide appropriate rehabilitation services when, for many years, states have been successful in using the flexibility currently allowed by the Rehabilitative Services Option to best serve the needs of their populations, including individuals with traumatic brain injury.

Several states currently provide important habilitation services to Medicaid recipients with disabilities through adult day habilitation programs. Section 6411(g) of the Omnibus Budget and Reconciliation Act of 1989 (OBRA 89) placed a moratorium on elimination of coverage of day habilitation services for people with mental retardation/developmental disabilities, including persons who sustained traumatic brain injuries prior to age 18, in states that included such services in their state Medicaid plan prior to enactment. The statute states that CMS may issue a proposed rule outlining the specific types of day habilitation and related services that a state may cover under the rehabilitative services option and CMS contends that the NPRM issued on August 13, 2007 serves as the NPRM referenced by OBRA 89. However, BIAA argues that the terms set forth in this proposed rule would completely *eliminate* day habilitation services from coverage under the Medicaid rehabilitative services option and, thus, are inconsistent with the terms set out in OBRA 89 which explicitly permit CMS to specify the *types* of day habilitation and related services covered under this option.

² Malec, J. "Impact of comprehensive day treatment on societal participation for persons with acquired brain injury." *Archives of Physical Medicine and Rehabilitation*, Vol. 82, July 2001.

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Conclusion

In conclusion, BIAA strongly supports increased utilization of community rehabilitative services, not only for the millions of civilians who live with the life-long effects of TBI, but also the thousands of brave men and women who sustain traumatic brain injuries while serving in Iraq and Afghanistan. Our nation has moved beyond institutionalization as an acceptable standard of care and efforts to slow or block the shift to community-based care, as is the case with this NRPM, represent poor public policy. **BIAA strongly urges CMS to withdraw the proposed rule.**

Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Susan H. Connors". The signature is written in a cursive, flowing style.

Susan H. Connors
President/CEO