JUDGE DAVID L.
BAZELON
CENTER
FOR MENTAL HEALTH LAW

June 30, 2023 *Via electronic submission to www.regulations.gov*

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator for the Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Docket Number CMS-2442-P, RIN 0938-AU68, Ensuring Access to Medicaid Services

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS), on its Notice of Proposed Rulemaking on "Ensuring Access to Medicaid Services" under the Medicaid Program (proposed Access Rule). The undersigned individuals and organizations offer the following comments.

While we are pleased to see Medicaid propose new rules to promote access, we are concerned that many provisions in the proposed Access Rule intended to improve access to and the quality of home- and community-based services (HCBS) will not apply to Medicaid State plan mental health rehabilitative services.[1] The protections in these provisions relate to: person-centered planning requirements, grievance systems, incident management systems, payment adequacy, reporting requirements, transparency regarding waiting lists for services, and quality measures and assurance systems.

State plan mental health rehabilitative services are how most Medicaid enrollees receive community mental health services—and most Medicaid beneficiaries receiving mental health

[1] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27960, 27964–65 (proposed May 3, 2023).

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rehabilitative services are people with mental and behavioral health-related disabilities.[2] Accordingly, to exclude Medicaid State plan rehabilitative services from the proposed Access Rule amounts to excluding people with mental health and behavioral health disabilities from the proposed Access Rule's added protections.

The protections afforded by the proposed Access Rule should apply to State plan mental health rehabilitative services as they do to services provided under the HCBS waiver authorities. Mental health rehabilitative services serve the same functions as HCBS waiver services, including to help states increase community living options for people with disabilities, as Congress and CMS acknowledged only two years ago with respect to the American Rescue Plan Act.[3] These home- and community-based services are critical to the civil rights of people with disabilities to live in the community, as required by Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C. (Lois Curtis)*.[4]

I. Mental Health Rehabilitative Services Are Home- and Community-Based Services

The proposed Access Rule's requirements, safeguards, and benefits should extend to mental health rehabilitative services, because rehabilitative services are home- and community- based services.

The American Rescue Plan Act (ARP) recognized this reality. It included mental health rehabilitative services as defined by section 1905(a),[5] as part of the array of "home and community-based services" for which the Act provides increased federal medical assistance percentage (FMAP).[6]

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[2] The Medicaid rehabilitation option represents the "single largest source of behavioral health expenditures in the Medicaid program." STAN DORN, ET AL., U.S. DEP'T OF HEALTH AND HUM. SER., THE USE OF 1915(I) MEDICAID PLAN OPTION FOR INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS (2016); *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., PUB. NO. SMA-13-4773, MEDICAID HANDBOOK: INTERFACE WITH BEHAVIORAL HEALTH SERVICES 5 (2013) ("[in] 2004, 73 percent of Medicaid beneficiaries receiving rehabilitation services were individuals with mental health needs, and these beneficiaries were responsible for 79 percent of rehabilitation spending under the option").

[3] American Rescue Plan Act of 2021, Pub. L. 117–2, § 9817(a)(2)(B) (2021); U.S. Dep't of Health and Hum. Ser., Ctr. for Medicare & Medicaid Serv., State Medicaid Director's Letter, 1 (May 13, 2021).

[4] *Olmstead v. L.C.*, 527 U.S. 581, 599–02 (1999).

[5] Section 1905(a)(13) of the Social Security Act defines rehabilitative services as: "any medical or remedial services … recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." Social Security Act, 42 U.S.C. § 1396d(a)(13) (2019).

[6] American Rescue Plan Act of 2021, Pub. L. 117–2 § 9817(a)(2)(B)(iv), (vi) ("The term 'home and community-based services' means…Home and community-based services authorized under subsections (b), (c), (i), (j), and (k)

Consistent with Congress' recognition in the Act that mental health rehabilitative services are home- and community-based services, the protections afforded by the proposed Access Rule should extend to such services. Critically important mental health rehabilitation services include services that have been shown to help people with mental health disabilities live successfully in their own homes and communities and avoid unnecessary institutionalization.[7] These services include Assertive Community Treatment (ACT), mobile crisis services, intensive case management, peer support services, supported employment, and services to help individuals secure and maintain housing.[8] States finance these services using Medicaid rehabilitative services option dollars.[9]

Thanks to CMS' extension to spring 2025,[10] states can continue to use ARP funding to enhance and expand the home- and community-based services identified in the Act, including rehabilitative services, for millions of people with disabilities and aging Americans. As explained by CMS Administrator Brooks-LaSure, the extension of time for states to use ARP funds "will help people with Medicaid to live and thrive in the setting of their choice."[11]

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of section 1915 of such Act (42 U.S.C. 1396u-7) [and] Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of such Act (42 U.S.C. 1396d(a)(13))"). CMS has requested that states include in their initial and quarterly reports an explanation of how they intend to sustain ARP-funded activities beyond the availability of ARP funding. State Medicaid Director's Letter, *supra* note 3 at 15. The Transformed Medicaid Statistical Information System (T-MSIS) also includes rehabilitative services as part of its definition of HCBS. *See* Victoria Peebles and Alex Bohl, U.S. Dep't of Health and Hum. Ser., Ctr. for Medicare & Medicaid Serv. and Mathematica Pol'y Rch., Medicaid Policy Brief: The HCBS Taxonomy: A New Language for Classifying Home- and Community-Based Services, 4 (Aug. 2013) (listing "psychosocial rehabilitation" among HCBS taxonomy categories and services); *and* Victoria Peebles and Alex Bohl, The HCBS Taxonomy: A New Language for Classifying Home- and Community-Based Services, 4 Medicare Medicaid Res Rev. 1, E1 (Sept. 2014) (same).

[7] LEGAL DEFENSE FUND & JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, COMMUNITY-BASED SERVICES FOR BLACK PEOPLE WITH MENTAL ILLNESS: ADVANCING AN ALTERNATIVE TO POLICE, 18 n. 163 (2023) https://www.bazelon.org/wp-content/uploads/2023/01/Community-Based-Services-for-Black-People-With-Mental-Illness.pdf.

[8] American Rescue Plan Act of 2021, Pub. L. 117–2, § 1947(b) (codified as amended at 42 U.S.C. § 1396w-6); JOHN O'BRIEN, SAN FRANCISCO DEP'T OF PUB. HEALTH, HUM. SERV. RSCH. INST., THE MEDICAID REHABILITATIVE SERVICES OPTION (June 2017); SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2.

[9] DORN, *supra* note 2; *see also Medicaid Benefits: Rehabilitation Services- Mental Health and Substance Use*, KAISER FAMILY FOUNDATION, (2018) https://www.kff.org/medicaid/state-indicator/rehabilitation-services-mental-health-and-substance-use/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; *and* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2 at 3–4 ("Nearly all states offer some rehabilitative mental health services").

[10] U.S. DEP'T OF HEALTH AND HUM. SER., CTR. FOR MEDICARE & MEDICAID SERV., HHS EXTENDS AMERICAN RESCUE PLAN SPENDING DEADLINE FOR STATES TO EXPAND AND ENHANCE HOME- AND COMMUNITY-BASED SERVICES FOR PEOPLE WITH MEDICAID (June 3, 2022).

[11] *Id.*

The recognition that mental health rehabilitative services are home- and community-based services should be ongoing and not end when states spend down American Rescue Plan funds. CMS should apply to these critical services the added protections of the proposed Access Rule.

II. Like Other Home- and Community-Based Services, Mental Health Rehabilitative Services Are Critical to Community Integration

As recognized in the proposed Access Rule,[12] home- and community-based services are essential to achieving compliance with the Supreme Court's *Olmstead v. L.C.* decision and to preventing the needless segregation of people with disabilities.[13] Under *Olmstead*, the failure to provide services to people with disabilities in the most integrated setting appropriate—for virtually all people with mental health disabilities, in their own homes and communities—is disability-based discrimination that violates the ADA.

The U.S. Department of Justice—the federal agency responsible for enforcing the ADA and *Olmstead*—has acknowledged through its settlement agreements that the community-based mental health services that states must provide to comply with *Olmstead* are typically financed

[12] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. at 27964–65 (HCBS "are part of a larger framework of progress toward community integration of older adults and people with disabilities," and "play an important role in States' efforts to achieve compliance with…the Supreme Court's decision in *Olmstead v. L.C.*, in which the Court held that unjustified segregation of persons with disabilities is a form of unlawful discrimination under the [Americans with Disabilities Act (ADA)] and States must ensure that persons with disabilities are served in the most integrated setting appropriate to their needs."); *see also Olmstead v. L.C.*, 527 U.S. at 600–1 (finding that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life…and institutional confinement severely diminishes the everyday life activities of individuals," holding that unnecessary segregation is disability-based discrimination, and mandating that states and local governments provide services to people with disabilities in the most integrated setting appropriate).

[13] LEGAL DEFENSE FUND & JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, *supra* note 7 (citing KEVIN MARTONE, ET AL., TECH ASSISTANCE COLLABORATIVE, OLMSTEAD AT 20: USING THE VISION OF OLMSTEAD TO DECRIMINALIZE MENTAL ILLNESS 5 (Sept. 2019) https://www.tacinc.org/resource/olmstead-at-20/ (noting these services "have been proven successful in reducing arrest and incarceration as well as other forms of institutionalization"); ROBERT BERNSTEIN, IRA BURNIM, & MARK J. MURPHY, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, DIVERSION NOT DISCRIMINATION: HOW IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT CAN HELP REDUCE THE NUMBER OF PEOPLE WITH MENTAL ILLNESS IN JAILS 18 (July 2017) https://www.bazelon.org/wp-content/uploads/2018/07/MacArthur-White-Paper-re-Diversion-and-ADA.pdf (noting these services' success in preventing needless institutionalization and pointing out that their availability increases jurisdictions' compliance with the Americans with Disabilities Act); JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, DIVERSION TO WHAT? EVIDENCE-BASED MENTAL HEALTH SERVICES THAT PREVENT NEEDLESS INCARCERATION 7–8 (Sept. 2019) https://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (describing these services and the evidence of their success in preventing incarceration)).

through the Medicaid rehabilitative services option. The Department's settlements require states to increase their capacity to provide the services[14] that have been shown to be effective in helping people with disabilities live in the community: Assertive Community Treatment (ACT),[15] mobile crisis services,[16] intensive case management,[17] peer support services,[18] supported employment,[19] and supported housing.[20]

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[14] U.S. DEP'T OF JUST., SETTLEMENT AGREEMENT WITH THE STATE OF NORTH CAROLINA, III.C (Aug. 23, 2012) https://www.justice.gov/iso/opa/resources/172012823125624712136.pdf; U.S. DEP'T OF JUST., SETTLEMENT AGREEMENT WITH THE STATE OF GEORGIA, III.A.2 (Oct. 19, 2010) https://archive.ada.gov/olmstead/documents/georgia_settle.pdf; U.S. DEP'T OF JUST., SETTLEMENT AGREEMENT WITH THE STATE OF NEW HAMPSHIRE, V (Dec. 19, 2013) https://www.justice.gov/sites/default/files/crt/legacy/2013/12/30/nhada_propsettlement_12-19-13.pdf.

[15] Assertive Community Treatment (ACT) is an individualized package of services and supports effective in meeting the day-to-day needs of people with serious mental illness living in the community. An ACT team is available 24 hours per day and is composed of a multi-disciplinary group of professionals that provide intensive case management, assessments, psychiatric services, substance use disorder services, housing assistance, and supported employment. *See* DIVERSION TO WHAT, *supra* note 13 at 3–4; *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2 at 3–4 ("More intensive nonhospital services, such as…Assertive Community Treatment (ACT), are often covered under the rehab option"); *see also* SETTLEMENT AGREEMENT WITH THE STATE OF NORTH CAROLINA, *supra* note 14 at III.C.4 (noting that the state will rely on community mental health services such as ACT teams, case management services, peer support services, and psychosocial rehabilitative services to satisfy the requirements of the agreement).

[16] Mobile crisis services provide rapid response and are typically provided by teams of mental health professionals trained to de-escalate individuals in mental health crisis. Mobile crisis teams should include at least one peer specialist and one on-call psychiatrist. *See* DIVERSION TO WHAT, *supra* note 13 at 7–8.

[17] *See* SETTLEMENT AGREEMENT WITH THE STATE OF NORTH CAROLINA, *supra* note 14 at III.C.4 (noting that the state will rely on community mental health services such as ACT teams, case management services, peer support services, and psychosocial rehabilitative services to satisfy the requirements of the agreement).

[18] Peer support services includes a number of services designed to support people with mental illness. Peer support services are provided by trained specialists with "lived experience" in the mental health service system, who use that experience to build relationships of trust with people and provide needed support. They may perform a variety of tasks, including helping individuals transition from a corrections or other institutional setting to the community, stay connected to treatment providers, build confidence, maintain or develop social relationships, and participate in community activities. *See* DIVERSION TO WHAT, *supra* note 13 at 11–12; *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2 at 3–5 ("rehabilitative services…might include…peer support and counseling") (citing Medicaid Program; Coverage for Rehabilitative Services, 72 Fed. Reg. 45147, 45201–13 (Aug. 13, 2007) (codified at 42 C.F.R. 440, 441)); *see also* SETTLEMENT AGREEMENT WITH THE STATE OF NORTH CAROLINA, *supra* note 14 at III.C.4 (noting that the state will rely on community mental health services such as ACT teams, case management services, peer support services, and psychosocial rehabilitative services to satisfy the requirements of the agreement).

[19] Supported employment is a package of services and supports aimed at helping people get and keep a job in the mainstream workforce. Supports are not time-limited and are focused on the individual's vocational goals and preferences. *See* DIVERSION TO WHAT, *supra* note 13 at 9–10; *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2 at 3–5, 2013 ("rehabilitative services…might include…supported employment") (citing Medicaid Program; Coverage for Rehabilitative Services, 72 Fed. Reg. at 45201–13).

[20] Supported housing is a comprehensive set of services including a housing subsidy and voluntary social support for being a successful tenant. It enables people with mental health disabilities to obtain and maintain housing security in their own apartments and homes within their community. *See* DIVERSION TO WHAT, *supra* note 13 at 5–6.

Mental health rehabilitative services are as critical as HCBS waiver services to achieve community integration and implementation of the *Olmstead* decision, which acknowledges that deinstitutionalization is critical to protect civil rights. Indeed, increased use of rehabilitative services "is due, in large part, to the movement toward deinstitutionalization of individuals with serious mental illness (SMI) as states seek a flexible option for providing these services in the community or home."[21]

CMS has recognized this important relationship between Medicaid and the objectives of *Olmstead* before, and has strongly encouraged states to use ARP funds to "increase access to HCBS for all Medicaid beneficiaries including…people with behavioral health conditions," and to "offer a broader range of community-based services, particularly for people with behavioral health conditions."[22] As CMS has acknowledged, the availability of mental health rehabilitative services is critical for helping Medicaid beneficiaries live successfully in the community.[23]

III. CMS' Reasons for Excluding Mental Health Rehabilitation Services from the Proposed Access Rule's Protections Are Insufficient

A. States Already Have Data Collection and Reporting Capabilities for Mental Health Rehabilitative Services, and CMS Should Expand Them Through the Proposed Access Rule

One of CMS' stated reasons for not applying the new requirements to section 1905(a) Medicaid State plan services was "based on State feedback that States do not have the same data collection and reporting capabilities for these services as they do for other HCBS."[24] CMS has raised this concern with respect to proposed Access Rule HCBS provisions regarding person-centered

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[21] SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2.

[22] Medicaid.gov, Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html.

[23] HHS EXTENDS AMERICAN RESCUE PLAN SPENDING DEADLINE, *supra* note 10.

[24] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. at 27972–75; *See also id.* at 27990–92, 28072.

planning,[25] grievance systems,[26] incident management systems,[27] payment adequacy,[28] and reporting requirements.[29]

We disagree with this rationale for not extending these provisions to services provided through a state's Medicaid plan. As a general matter, states have many of the data collection and reporting capabilities that justify extending proposed Access Rule requirements to mental health rehabilitative services. CMS has been requiring states to submit quarterly reports on ARP spending related to all of the home- and community-based services identified in that legislation, including mental health rehabilitative services, for years.[30] To the extent needed, CMS can add additional requirements for states to build necessary capacity.

Even if there is a need to increase states' data collection and reporting capabilities, CMS should require states to do so, and give states additional time as appropriate to implement these systems. The proposed Access Rule creates numerous new and expanded data collection and reporting requirements[31] and this is no reason to exclude the critical services provided to people with mental health disabilities from the Rule's important requirements and safeguards. To the extent states require flexibility on this point, the proposed Access Rule already includes flexibilities relating to data collection and reporting. There are flexible timelines for implementing various elements of home- and community-based service systems under the Rule, including two years for grievance system requirements,[32] three years for person-centered service plan requirements,[33] and four years for payment adequacy requirements.[34] Similar flexibility could be shown for data collection and reporting requirements for mental health rehabilitation services. The need to expand data collection and reporting capabilities is an insufficient rationale to exclude altogether Medicaid State plan mental health rehabilitation services from the proposed Access Rule.

[25] *Id.* at 27972–75, 28072.

[26] *Id.* at 28072.

[27] *Id.* at 27978–81, 28072.

[28] *Id.* at 27982–86, 28072.

[29] *Id.* at 27990–92.

[30] State Medicaid Director's Letter, *supra* note 3; *see also* DEP'T OF THE TREASURY, PROJECT AND EXPENDITURE REPORT USER GUIDE, 10 (2022); DEP'T OF THE TREASURY, COMPLIANCE AND REPORTING GUIDANCE, 17 (2023).

[31] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. at 27981–91.

[32] *Id.* at 27975–78.

[33] *Id.* at 27972–75.

[34] *Id.* at 27982–86.

B. Mental Health Rehabilitative Services Are Person-Centered

The proposed Access Rule provisions regarding person-centered planning[35] and grievance systems[36] do not apply to Medicaid State plan rehabilitative services because, according to CMS, "the person-centered planning and service plan requirements for section 1905(a) services are substantially different from those for section 1915(c), (i), (j), and (k) services."[37]

This rationale is inconsistent with our understanding of service planning required by regulations governing Medicaid State plan services. Mental health rehabilitative services authorized under section 1905(a) of the Act and incorporated into the definition of HCBS under section 9817 of the ARP are person-centered by design[38] and should therefore be included in CMS service and accountability requirements.

Though section 1905(a) of the Social Security Act does not explicitly discuss person-centered service requirements as sections 1915(i), (j), and (k) do,[39] the service plan elements of section 1905(a) services are not substantially different from those for 1915(c), (i), (j), and (k) services. Section 1905(a) services allow states, programs, and consumers to tailor service plans to each consumer's needs, strengths, and preferences for services, settings, and providers.[40] To the extent section 1905(a) services do not yet have explicit requirements to ensure person-centered service plans are developed and used, we agree with CMS' recommendation "that States implement person-centered planning process[es] for all HCBS,"[41] including rehabilitative services, and recommend CMS establish such requirements for section 1905(a) services.

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[35] *Id.* at 27972–75.

[36] *Id.* at 27975–78.

[37] *Id.* at 27972–75; *see also id.* at 27990–92.

[38] CMS and leadership have recognized the impact and importance of ARP section 9817 services, such as rehabilitative services, to delivering person-centered services for people with Medicaid. *See* Medicaid.gov, *supra* note 22; *see also* U.S. DEP'T OF HEALTH AND HUM. SER., CTR. FOR MEDICARE & MEDICAID SERV., CMS ISSUES GUIDANCE ON AMERICAN RESCUE PLAN FUNDING FOR MEDICAID HOME AND COMMUNITY BASED SERVICES (May 13, 2021); HHS EXTENDS AMERICAN RESCUE PLAN SPENDING DEADLINE, *supra* note 10.

[39] Section 1915(c), similar to section 1905(a), does not explicitly mention person-centered planning or service plan requirements. *See* Social Security Act, 42 U.S.C. § 1396n (2018); Social Security Act, 42 U.S.C. § 1396d (2019).

[40] SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2 at 3–5, 2013 (rehabilitative services can be delivered in a variety of settings, including the consumer's own home; by a variety of providers, including peers; and can be used to attain life skills such as through peer support, skills training, and supported employment).

[41] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. at 27972–75.

C. A Large Number of Medicaid Beneficiaries Receive Mental Health Rehabilitative Services

As the proposed Access Rule identifies, large numbers of Medicaid beneficiaries with mental health needs receive mental health rehabilitative services under section 1905(a) State plan authorities.[42] CMS stated as a reason for excluding mental health rehabilitative services from the proposed Access Rule's requirements relating to person-centered planning,[43] grievance system,[44] incident management system,[45] payment adequacy,[46] and reporting,[47] that "only a small percentage of HCBS nationally is delivered under section 1905(a) State plan authorities." Although technically correct, this statement fails to account for the large numbers of beneficiaries who receive mental health rehabilitative services, which are home- and community-based services under the broader definition enacted by Congress in the American Rescue Plan Act. Indeed, mental health rehabilitative services are how a majority of the millions of Medicaid enrollees receive community mental health services.[48]

CMS' proposed Access Rule must extend these significant protections to mental health rehabilitative services—to exclude these services would be to exclude people with mental and behavioral health disabilities from improved service access, quality, and safeguards critical to community integration.

Conclusion

We thank you for the opportunity to comment on this important proposed Access Rule and encourage the administration to finalize this rule, with the changes proposed in these comments. Please contact Monica Porter (monicap@bazelon.org) with any questions, or for additional information.

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[42] *Id*.
[43] *Id*.
[44] *Id*. at 27975–78.
[45] *Id*. at 27978–81.
[46] *Id.* at 27982–86.
[47] *Id.* at 27990–92.
[48] The Medicaid rehabilitation option represents the "single largest source of behavioral health expenditures in the Medicaid program." DORN, *supra* note 2; *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 2 ("[in] 2004, 73 percent of Medicaid beneficiaries receiving rehabilitation services were individuals with mental health needs, and these beneficiaries were responsible for 79 percent of rehabilitation spending under the option").

Sincerely,

Bazelon Center for Mental Health Law

Access Living

Activating Change

Alabama Disabilities Advocacy Program

American Association for Marriage and Family Therapy

American Association for Psychoanalysis in Clinical Social Work

American Association of People with Disabilities

American Association on Health and Disability

Anxiety and Depression Association of America

Autistic Self Advocacy Network

Black and Brown United in Action

William Brooks, Executive Director, Center for Justice, Civil Rights, and Liberties

Cal Voices

California Association of Mental Health Peer-Run Organizations (CAMHPRO)

Center for Public Representation

The Honorable Tony Coelho

The Coelho Center for Disability Law, Policy and Innovation

Laurie Coker, Director, GreenTree Peer Support Program, Winston-Salem, NC

Connecticut Legal Rights Project, Inc.

Disabilities Law Program - Community Legal Aid Society, Inc.

Disability Law Center, Inc.

Disability Law Center of Alaska

Disability Law Center of Utah

Disability Rights Advocates

Disability Rights Arkansas

Disability Rights California

Disability Rights Center - NH

Disability Rights Connecticut

Disability Rights Education & Defense Fund

Disability Rights Florida

DisAbility Rights Idaho

Disability Rights Iowa

Disability Rights Louisiana

Disability Rights Michigan

Disability Rights Oregon

Disability Rights Texas

Disability Rights Vermont

Disability Rights of West Virginia

Disability Rights Wisconsin

Family Voices

Kathleen M. Flaherty

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Eve Hill, Partner, Brown Goldstein & Levy

Indiana Disability Rights

Keep the Promise Coalition

Bruny Kenou, Founder and Director, Lay Mental Health Advocates

Kiva Centers

Philip Kumin

Lakeshore Foundation

The Leadership Conference on Civil and Human Rights

Meaningful Minds United, Inc.

Mental Health Connecticut

National Association for Rights Protection and Advocacy

National Association for Rural Mental Health

National Association of Councils on Developmental Disabilities

National Association of County Behavioral Health and Developmental Disability Directors

National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)

National Council on Independent Living

National Disability Rights Network (NDRN)

National Mental Health Consumers' Self-Help Clearinghouse

Native American Disability Law Center

New York Association of Psychiatric Rehabilitation Services

North Dakota Protection & Advocacy

Oklahoma Disability Law Center, Inc.

Parents Available to Help (PATH)

Peer Voice North Carolina

Psychotherapy Action Network

Quality Trust for Individuals with Disabilities

RI International

Lauren Spiro, Managing Director, Spiro and Associates LLC

Technical Assistance Collaborative

Tennessee Mental Health Consumers' Association

Laura Van Tosh, Mental Health Policy Roundtable