

**Submitter :** Shirley Walker  
**Organization :** PA Assoc of Resources  
**Category :** Other Association

**Date:** 10/12/2007

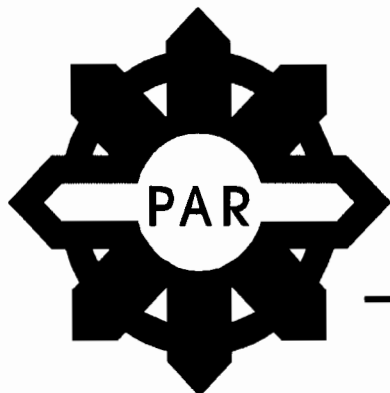
**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1091-Attach-1.DOC



Pennsylvania Association of Resources  
Autism • Intellectual Disabilities

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1007 North Front Street  
Harrisburg, PA 17102  
Phone 717-236-2374  
Fax 717-236-5625

October 12, 2007

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
P.O. Box 8018  
Baltimore, MD 21244-8018

**Re: File Code CMS-2261-P**

To Whom It May Concern:

The Pennsylvania Association of Resources for Autism and Intellectual Disabilities (PAR) is a 501(c)(3) nonprofit educational organization that supports over 45,000 individuals with intellectual disabilities including over 8,000 people living with autism who receive community services and supports through our member agencies in over 5,600 locations in the Commonwealth.

PAR thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to provide comments and recommendation on the August 13, 2007 *Federal Register* notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services. The services and supports provided by our members are primarily funded through the Medicaid program. We are therefore extremely concerned about the impact the proposed rules may have on the critical services provided to our most vulnerable citizens.

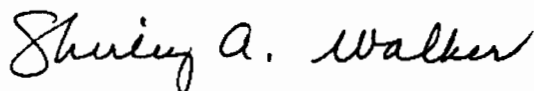
**PAR joins with our national association, the American Network of Community Options and Resources (ANCOR), in their request that the proposed rules be withdrawn, at least until various issues are clarified and satisfactorily addressed.**

The implications for people receiving services in Pennsylvania are not clear; questions have been raised as to whether the proposed rule would force Pennsylvania to restrict services, specifically wrap-around services to children with disabilities. These services are absolutely critical to the children served in our state, and the option to provide these services under the rehabilitation option must be preserved.

**Therefore, PAR respectfully requests that CMS withdraw the proposed rule; clarify various issues raised by stakeholders across the country; engage stakeholders in further public forums; and re-issue the rules as proposed for further public review and comment.**

Thank you for considering our comments and recommendations.

Sincerely,



Shirley A. Walker  
President and CEO





3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

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A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
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Baltimore, MD 21244-8018

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Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

#### GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

#### PROVISIONS OF THE PROPOSED RULE

##### 440.130(d)(1)(vi) Definition of Restorative Services

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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be

custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

#### 440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

#### Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

#### 441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.
5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.



Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**Submitter :** Pamela Braswell  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

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See Attachment

CMS-2261-P-1092-Attach-1.DOC



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A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
P.O. Box 8018  
Baltimore, MH 21244-8018

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Sincerely,

**Submitter :** Alden Briscoe  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

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Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

#### 440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

#### Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

#### 441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.
5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,



**Submitter :** Mr. John Buck  
**Organization :** Turning Point Community Programs  
**Category :** Health Care Provider/Association

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-1094-Attach-1.PDF



**TURNING POINT**  
COMMUNITY PROGRAMS  
a path to mental health

October 10, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

**Turning Point Community Programs** is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

Turning Point Community Programs began in Sacramento in 1976 with a unique vision about offering caring, hope, respect, and support on the path to recovery and mental health. From small beginnings as a non-profit mental health agency with only two full-time employees, Turning Point now employs more than 530 and is privileged to serve more than 4,000 mental health consumers each year. Our programs have expanded from Sacramento to Yolo, Merced, Stanislaus and will soon be in Nevada County.

Many of our employees include folks in recovery who are able to encourage and offer hope to others. Innovation and striving for excellence are hallmarks of Turning Point. Our staff is as diverse as the members we serve, and we never stop asking, "How can we improve?"

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas of the proposed rule:

#### 440.130(d)(1)(vi) Definition of Restorative Services

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. The regulation needs modification to make the meaning of this section clearer.

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. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and remission, and the long-term clinical course of these conditions is difficult to determine. As an illustration, *Mental Health: A Report of the Surgeon General*, notes that for people living with schizophrenia, "...a small percentage (10 percent or so) seem to remain severely ill over long periods of time (Jablensky et al., 1992; Gerbaldo et al., 1995). While these individuals can significantly improve, "most do not return to their prior state of mental function." (Mental Health: Report of the Surgeon General, 1999, pg. 274).

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation 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.

Section 1901 of the statute specifically authorizes funds for "rehabilitation and other services" to help individuals "retain" capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain an individual's functional level.

Similarly, CMS in the Medicare program explicitly acknowledges the importance of maintenance of current functioning as an acceptable goal:

For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."

Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

Additionally, 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 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.

Recommendation:

Further 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. Specifically, the language 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)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

Secondly, 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.

Clarify that pre-vocational services are allowable services when appropriately tied to a rehabilitation goal.

440.130(viii)(3) Written Rehabilitation Plan

We do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed. Without attention to our suggestions, this new requirement will add significantly to the administrative time and expense of agencies serving individuals in need of rehabilitative services.

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? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for every encounter will become a major burden, especially when services are delivered to a group.) 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 that this information is presented in a way that meaningfully demonstrates the

nature and course of services being provided.

Is it allowable 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.). Requiring two separate planning processes and two separate planning documents is burdensome not only on providers but also on the individual consumer. Clearly, multiple service plans do not facilitate coordination or accountability. The regulation does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

We are puzzled by the requirement that the plan include information on alternate providers of the same service. 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. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation.

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 some rare cases may be problematic. There are two factors to consider.

First, severe mental illness is episodic, and it is not always possible to determine when an exacerbation of the illness may occur. There may be instances in which a person, because of the symptoms of their illness, may not believe they are sick or 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 also no guarantee that 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.

#### Recommendations:

We recommended inclusion of the following requirements regarding the written rehabilitation plan:

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. 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.
- that the plan of services be based on a strengths-based assessment of needs;

- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers).

CMS should also clarify that a single treatment and rehabilitation plan is acceptable and encourage a single planning team and service planning meetings.

#### Section 441.45: Rehabilitative Services

##### 441.45(a)(2)

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level, as defined in the law. However, it would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

It would also be valuable to include the language in the preamble (page 45204) regarding how to determine whether a particular service is a rehabilitation service, based on its purpose.

##### Recommendation:

Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

Insert additional language into this section (from the preamble) to state that it is helpful to scrutinize the purpose of the service as defined in the care plan in order to determine whether a specific service is a covered rehabilitative benefit.

#### 441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered “intrinsic elements” of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an “intrinsic element” of another program.

We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service – in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r). 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, in direct contradiction of the statute.

#### Recommendation:

We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.

Alternatively, the section should be clarified and narrowed so as to specifically focus on situations where an entity (e.g. an insurer) has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded from this provision.

Some subsections of Section 441.45(b) include language that ensures that children in the other settings that are cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all of the subsections (i) through (iv).

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

Similarly, a child with a serious mental disorder being reunified with its family may have specific issues directly stemming from the mental disorder. Mental health rehabilitation services to address these problems (as distinct from generic reunification services) should be covered.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at both the state and provider agency level. The development of new forms as well as staff training, administrative processes all pose significant challenges at the Agency level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of the State Plan Amendment by the Agency.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**John Buck**  
**Chief Executive Officer**

CC: Members of the CA State Congressional Caucus  
The Honorable Arnold Schwarzenegger, Governor of the state of CA



**Submitter :** Diana Eastwood

**Date:** 10/12/2007

**Organization :** Diana Eastwood

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1095-Attach-1.DOC

October 10, 2007

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention CMS-2261-P  
P.O. Box 8018  
Baltimore, MD 21244-8018

Re: File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services.

Dear Sir or Madam:

Thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am writing as a member of The National Alliance on Mental Illness (NAMI), the nation's largest grassroots organization representing individuals living with serious mental illnesses and their families. As members of NAMI, we have lived experience with mental illness and bring that unique perspective to our comments on these rules.

We know from personal experience that access to rehabilitative services can make all the difference in a person's life. We have seen people get services to help them recover from their illness. With services and support, individuals with serious mental illness can and do live very well in the community and have strong relationships with family and friends. We have also seen those who can't get help and have seen the pain and trauma from untreated mental illness for the individual and his or her family. Often the person will have multiple stays in hospitals and jails.

NAMI conducted a survey of the 50 state mental health agencies for our *Grading the States* report and found what individuals with mental illness and their family members already know – in all the states, there are gaps in services and many people with serious mental illnesses are not getting the help that they need. The average state grade was a D. So we know that there is much work to be done to ensure that people can get the treatment they need when they need it. NAMI members know that treatment works, if you can get it.

As a result, we are very troubled by the estimate in the proposed regulation that these rules would save the federal government 2.2 billion dollars. Our experiences tell us that creating barriers to vital services will not save money in the long run. Rather, it will increase the costs from hospitalization, incarceration and other bad outcomes that result from a failure to get needed treatment.

We appreciate the emphasis on recovery in the rules. All individuals with mental illness and their families want the system to make it easier to recover. We also like the provisions about the participation of the individual and their family in the rehabilitative

plan and receiving copies of the plan so we can hold the system accountable. We would like to see some flexibility to make sure that providers can still do outreach and provide crisis care, but we very much appreciate the agency's intent to encourage communication between providers, the individual and family members.

However, we have a few areas of deep concern where we hope the agency will reconsider its rules. We would like to see services provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

#### **Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan:**

The proposed regulations require that a written rehabilitation plan set out the services that will be provided. The plan is to be written with the involvement of the individual and the family. We very much applaud the agency for including the person and the family in the planning and for encouraging person centered planning.

We would like to see some flexibility in the rules to allow providers to conduct outreach to individuals who may not be ready to be part of a formal treatment planning process. Sometimes, it takes repeated visits before a person is ready and understands how treatment will be a benefit to him or her.

In addition, there are times when a person is in crisis and needs help. At that point, they might not be able to be part of a planning process. If they are new to a community or have recently been in the hospital or jail, they also may not have a treatment plan on record. The rules should allow treatment in these narrow circumstances.

#### **Recommendation:**

Clarify the provisions in the regulation to allow payment for outreach and emergency services.

#### **Section 440.130(d)(1) Rehabilitation and Restorative Services:**

Under the proposed regulations and the preamble, rehabilitative goals have to be targeted at progress. They can't be used to maintain stability unless that is linked to another goal where they are still working on improvement. But mental illness does not work in a straight line upward. For many of us and our loved ones, the path to recovery is not straight up or down. It is often a process with periods of progress and periods where symptoms may have to be closely managed to prevent deterioration. The changing course of serious mental illness must be factored into the proposed regulations governing rehabilitative services.

For some of us and our family members who have been hospitalized or in jail, staying stable and in housing is not easy and is an achievement. It also requires services so we

do not deteriorate and get worse. We hope the agency will adjust its regulations to take into account the nature of our illnesses and those of our family members and allow services to prevent deterioration of the illnesses.

Recommendation:

Revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning.

**Section 441.45(b) Exclusion of services, including those that are an “intrinsic element” of other programs:**

Many adults and children with mental illness and their families are also part of other service systems— including criminal justice, juvenile justice, education, housing, and child welfare. In my community, people with mental illness are overrepresented in these systems and we face major challenges to make sure that people with mental illness do not fall through the cracks.

The proposed regulations could make that challenge much more difficult. We are just starting to see some of these other systems provide the help that people with mental illness need. If these regulations are a barrier to getting federal dollars for some of the costs, then other systems will either stop providing the care or they will stop serving people with mental illness. Either way, people with mental illness and their family members are the ones who will get hurt.

We have reviewed this proposed regulation and the preamble and we do not know how to determine whether something is “intrinsic” to another system. We urge the agency to use terms and factors that are easily understandable by those who use these services and their families as well as state policymakers.

Finally, Medicaid is a program that people rely upon to pay for their care. If Medicaid is required to pay for healthcare services, then it should not matter whether the service is “intrinsic” to another system. It is important that Medicaid remain a reliable source of payment for people.

Recommendation:

Delete all references to other systems and pay for rehabilitative services for individuals with serious mental illnesses when they need them and where they need them.

**Section 441.45(b) Exclusions for therapeutic foster care and classroom aides:**

Many children with mental illnesses rely upon therapeutic foster care. This is a service that works well and creates good outcomes such as going to school more, staying out of trouble with law enforcement, and living in a stable place. The proposed regulations

should give states the ability to get federal resources to support this effective service as long as the services are rehabilitative.

The proposed regulations say that the federal government will not provide resources for recess aides or classroom aides. We believe that the rule also needs to clearly inform schools that Medicaid will pay for behavior aides and other mental health providers who are giving services to a particular child. Children with mental illnesses and their families have been fighting a long battle to get mental health services provided to children in schools and this regulation should support that effort by clearly encouraging school based mental health services.

**Recommendation:**

Amend the proposed rule to allow therapeutic foster care and let states combine the services in one rate if that works best for them. The federal government can meet its goals by making sure that the rate only includes rehabilitative services.

Amend the regulation to say that the exclusion does not include behavior aides or other related service providers who are providing services to a particular child.

**Section 441.45(b)(2) Exclusion for Mental Retardation and other conditions and Habilitation Services:**

The proposed regulations appear to prohibit people with mental retardation or related conditions, like cerebral palsy, from receiving rehabilitation services. As advocates for one group – people with mental illness – we do not support the exclusion of any other group on the basis of their disability.

We also understand that Congress asked the federal agency to determine which habilitation services to cover. It did not give the agency the option to ban all habilitation services.

**Recommendation:**

The proposed rules should not exclude people with mental retardation and related conditions and habilitation services.

**Conclusion:**

Rehabilitation services can change the course of a person's life. Our experiences tell us what a difference they can make. The research data confirms what we already know – services are very effective at reducing symptoms, keeping people out of hospitals, and allowing people to live better lives in the community.

We know what works. But we also know that too many people can't access these treatments. And the terrible consequences are seen in every jail and prison in America.

The federal government should be doing everything possible to encourage states to provide better and more effective services for people living with mental illnesses. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

Since the federal government mandated the No Child Left Behind program to the states, resources need to be allocated for special needs children to receive the services they need and are not left behind. If adults suffering from mental illnesses do not receive the services they need, many will end up in hospitals and jails. One way or another, tax dollars will be used to pay the expenses. Wouldn't it be better to actually help people get back into the community so they can have a chance to contribute in a positive way? Jails are full of people suffering with mental illness. Understandably, justice must be served. But if they do not receive the services they need, once released, nothing will change and law enforcement and courts will be dealing with the same problem again, which does not benefit anyone.

We ask that you revise these regulations to make it clear that the federal government encourages any state system to do all they can to provide effective treatments to people with serious mental illnesses.

Thank you,

Diana Eastwood

**Submitter :** Elizabeth Woodyatt

**Date:** 10/12/2007

**Organization :** Elizabeth Woodyatt

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

As the mother of a developmentally disabled adult I urge you to withdraw proposed regulations that will severely curtail services to DD people who urgently need them. We simply cannot afford to ignore the needs of those who are not able to fully help themselves.

**Submitter :** Douglass Fitch  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1097-Attach-1.DOC





3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
 Department of Health and Human Services  
 Attention: CMS-2261-P  
 P.O. Box 8018  
 Baltimore, MH 21244-8018

To Whom It May Concern:

I am a board member of Fred Finch Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of mental health and social services to California's most vulnerable and troubled youth and families.

Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

#### GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

#### PROVISIONS OF THE PROPOSED RULE

##### 440.130(d)(1)(vi) Definition of Restorative Services

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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be

custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

#### 440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

#### Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

#### 441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.
5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**Submitter :** Dr. Luis Cotto-Ibarra

**Date:** 10/12/2007

**Organization :** PM&R Chapter Colegio de Medicos Cirujanos

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1098-Attach-1.DOC

October 12, 2007

**Leslie V. Norwalk,**  
Acting Administrator,  
Centers for Medicare &  
Medicaid Services

Dear Ms. Norwalk

We are respectfully requesting the following important amendments of the proposed rule CMS-2261-P.

(**Bold** entries are additions of the proposed text and ~~Strikethrough~~ are deletions of the proposed text)

Amendments:

Under the section  
§440.130 Diagnostic, screening, preventative, and rehabilitative services.

(i) "Recommended by a physician or other licensed practitioner of the healing arts" means that a physician or other licensed practitioner of the healing arts, **authorized to diagnose medical diseases or conditions and prescribe medical treatment**, on a comprehensive assessment of the individual, has—.....

(ii) "*Other licensed practitioner of the healing arts*" means any health practitioner or practitioner of the healing arts, **with similar educational and clinical training as physicians, i.e. osteopaths and others**, who is licensed in the State to diagnose **medical diseases or medical conditions** and ~~treat~~ **prescribe medical treatment** to individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.

(iv) "*Under the direction of*" means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see §440.110, "Inpatient hospital services, other than services in an institution for mental diseases") the Medicaid qualified therapist providing direction is a licensed practitioner ~~of the healing arts~~ qualified under State law to ~~diagnose~~ **evaluate, make assessments** and ~~treat~~ **make professional recommendations** to individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, ~~prescribing~~ **make professional recommendations** of the services to be provided, and reviewing the need for continued services throughout the course of treatment. **The Medicaid qualified**



**therapist must get pre-authorization from the physician or other licensed practitioner of the healing arts –before applying the treatment- if the professional recommendations include application of physical medicine therapeutic devices and/or physical medicine prosthetic devices as defined in (ix). .....**

We suggest to add a 9<sup>th</sup> definition:

**(ix) Physical medicine therapeutic devices and/or physical medicine prosthetic devices:**

**Are medical treatment devices described in the Food and Drug Act, Title 21 Chapter I, Subchapter H, Part 890, Subpart D and F usually used in the treatment of patients with functional limitations or disabilities.**

Justification for the amendments:

The terms diagnosis and prescription are recognized in the scope of practice of the medical professionals that have the formal education and clinical experiences in accredited institutions, and have a State Board approval to have that right. To be prepared adequately to diagnose and prescribe takes physicians at least more than twice the period of education that receive therapists.

Physical and occupational therapists are trained in the application of physical medicine therapeutic devices and/or physical medicine prosthetic devices under a medical prescription. The treatments are given in within a medical context.

In order to prescribe a physical medicine device or prosthetic device the authorized professional should have knowledge of the the pathologic and pathophysiologic process to be treated, from the microscopic to the macroscopic to the clinical features. Therapists are not trained in this basic knowledge. Physical medicine devices (like prescription drugs) have effects on human tissues that may improve the function but may cause transient non harmful side effects and permanent harmful side effects that may worsen the original impairment or disability.

We urge you to include our recommendations in the CMS-2261-P proposal for the benefit and protection of our patients and people with disabilities.

Thank you,

Luis Cotto-Ibarra, MD  
President  
Physical Medicine and Rehabilitation Chapter  
Colegio de Médicos Cirujanos de Puerto Rico



Submitter : Kathy Tenney

Date: 10/12/2007

Organization : NAMI

Category : Academic

#### Issue Areas/Comments

##### Background

##### Background

File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services  
Specific comments on sections of the preamble and regulations follow:

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

Section 440.130(d)(1)(iii) Definition of qualified providers of rehabilitative services

Section 440.130(d)(1)(v) Definition of Rehabilitation Plan

Our members report great barriers to coordinating their services and supports so we would like to ensure that the burden is not shifted to consumers and their families to find service providers who will accept Medicaid because other systems such as education are no longer providing someone to give the service. Nothing in the current regulations prohibits schools and other systems from using their own employees, but CMS should clarify in the preamble that such practices are permissible as long as individuals are informed of their choice to seek another Medicaid provider if they wish to do so.

Section 440.130(d)(vi) Definition of Restorative Services:

Section 440(d)(1)(vii) Definition of Medical Services

Section 440.140(d)(3) Definition of Written Rehabilitation Plan

##### Collections of Information Requirements

##### Collections of Information Requirements

WE members of NAMI are grateful for the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program. With 1100 affiliates, Many of our members have personally experienced the effectiveness of rehabilitation services and have been able to live, work and participate in their communities as a direct result of these services.

Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better outcomes, such as stable housing and employment. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses and their families.

NAMI conducted a survey of the 50 state mental health agencies and found that evidence-based practices funded by Medicaid under the rehabilitation services option were woefully inadequate in the states. In our 2006 Grading the States report, the average state grade was a D. For every poor grade NAMI gave, we know that there are hundreds of thousands of individuals who are being jailed, living on the streets or dropping out of school because they were unable to access the services that we know work. For this reason, we are particularly concerned that any new regulations governing rehabilitation services facilitate the provision of these services and in no way discourage systems and providers from increasing the availability of these critical services. Many of our members are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars from an already under-resourced service system.

NAMI is very appreciative of the effort in the proposed rules to encourage states to use rehabilitative services to meet the goals of the New Freedom Commission. We particularly agree with the quote from the Commission referenced in the preamble to the rules, [m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs.

We believe that the emphasis on recovery and person-centered planning and the inclusion of the individual, their families and other individuals in treatment planning is a very positive development that will further improve access to treatment. However, other sections of the proposed regulations have the potential to frustrate the ability to engage individuals in the process of recovery and provide evidence based and tailored services. We are particularly concerned about the prohibition on billing for services that may maintain a person s functioning and the broad exclusion of services that are intrinsic to other programs. We will describe these concerns in greater detail below.

Overall, NAMI believes that a system of rehabilitative services must follow these principles:

Services should attain a high degree of accessibility and effectiveness in engaging and retaining persons in care.

The effects of these services shall be sustained rather than solely crisis-oriented or short-lived.

Services must be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one s recovery.

Whenever possible, services should be provided within the person s home and/or community, using the person s natural supports.

## Provisions of the Proposed Rule

### Provisions of the Proposed Rule

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

Section 440.130(d)(1)(iii) Definition of qualified providers of rehabilitative services

WE face enormous barriers coordinating our services and supports so we would like to ensure that the burden is not shifted to consumers and their families to find service providers who will accept Medicaid because other systems such as education are no longer providing someone to give the service. Nothing in the current regulations prohibits schools and other systems from using their own employees, but CMS should clarify in the preamble that such practices are permissible as long as individuals are informed of their choice to seek another Medicaid provider if they wish to do so.

Section 440.130(d)(1)(v) Definition of Rehabilitation Plan

We have concerns about the relationship between a rehabilitation plan and other service plans. CMS should clarify that plans produced by other entities, such as an individualized education plan or provider treatment plan, can be the rehabilitation plan as long as they meet the requirements of Section 440.130(d)(3).

Section 440.130(d)(vi) Definition of Restorative Services:

The proposed regulation and the preamble indicate that services that provide assistance in maintaining functioning may only be reimbursed as a rehabilitative service when necessary to help an individual achieve a rehabilitative goal. Further clarify that rehabilitative goals must be designed to assist with the regaining or restoration of functional loss. We have an overwhelming concern with the exclusive emphasis on restoring functioning rather than maintaining functioning. The personal recovery process for many is varied, with periods of maintenance as well as periods of restoration. As one NAMI member stated, recovery is not a linear process trending upward. Instead, consumers and family members describe their illnesses as up, down and stable depending on the period of time. In addition, many times these fluctuations did not depend on the rehabilitation services, but rather on outside events, changes in the course of the illness, or changes in medication effectiveness.

We noted that a person's history and severity of illness could be such that a period where the person is not regressing is meeting a rehabilitative goal. For example, an individual with schizophrenia who has experienced multiple hospitalizations and contacts with law enforcement and who has gained sufficient living skills to maintain stable housing may need services to continue those skills. Withdrawing services as soon as the person's living skills were sufficiently restored to allow him or her to live in home for a brief period is inadvisable because the person's history and severity of illness indicate that he or she is likely to regress without further support.

Section 1901 of the Medicaid Act clearly authorizes expenditures for rehabilitation and other services to help families and individuals attain and retain capability for independence and self-care. (emphasis added).

WE commend CMS for specifying that rehabilitative services enable an individual to perform a function, but the individual is not required to demonstrate that they actually performed the function in the past. Many children will not necessarily have had the ability to perform a function in the past due to their level of development and acquisition of age appropriate skills. It would be helpful for CMS to further clarify that rehabilitation services may be provided to children to achieve age appropriate skills and development.

Medicaid is a critical funding source for evidence based practices for children with serious mental illnesses. The proposed regulations should encourage the further dissemination of evidence based services for children by clarifying that rehabilitative services are available to allow children to gain age appropriate skills and development.

**Submitter :**

**Date: 10/12/2007**

**Organization :**

**Category : Individual**

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

As an advocate of and a professional who serves individuals with developmental disabilities, I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential services.

**Submitter :** Kweli Gibson  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1101-Attach-1.DOC



3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

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A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
P.O. Box 8018  
Baltimore, MH 21244-8018

To Whom It May Concern:

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Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
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Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention



4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

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#### Recommendation:

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#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.
5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**Submitter :** Mr. John Allen  
**Organization :** Nat. Assoc. Consumer/Survivor Mental Health Admin.  
**Category :** Consumer Group

**Date:** 10/12/2007

**Issue Areas/Comments**

**Background**

Background  
Please see attached.

**GENERAL**

GENERAL  
Please see attachment.

CMS-2261-P-1102-Attach-1.DOC

**National Association of Consumer / Survivor Mental Health Administrators Inc.  
% New York State Office of Mental Health  
44 Holland Avenue, 8<sup>th</sup> Floor – Consumer Affairs  
Albany, New York 12229**

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Post Office Box 8018  
Baltimore, Maryland 21244-8018  
Re: CMS-2261-P

October 7, 2007

To Whom It May Concern:

The National Association of Consumer / Survivor Mental Health Administrators (NACSMHA) is pleased to comment on behalf of its members who are the point of contact (typically Office of Consumer Affairs) in state offices of mental health for the 6.1 million individuals served annually by state public mental health systems. These offices are tasked by their states in to facilitate or be the representative voice of users of mental health services in policy making discussions. It is based on the collective experiences of the people who actually utilize mental health services affected, that we offer the following comments on the proposed regulations related to Medicaid’s Rehabilitation Services Option.

NAC/SMHA supports the goal [§440.130(d)(3)] that “covered rehabilitation services for each individual must be identified under a written rehabilitation plan”. We are concerned that the “best possible functional level” is not clearly defined to promote individual recovery and could lead to providers setting artificial maintenance of effort ceilings. We would propose a change to the following text which would help address our concerns “In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health” then add the following “and promoted recovery”.

In the same section further clarity would be achieved in the section “It is our expectation that, for persons with mental illnesses and substance-related disorders, the rehabilitation plan would include recovery goals” by adding at the end “identified by the recipient of services”.

Many individuals who utilized mental health services have expressed major concerns to us about confidentiality. Those concerns could be addressed in the section “It would provide for a process to involve the beneficiary, and family or other responsible individuals, in the overall management of rehabilitative care” by adding “as authorized by the individual”.

Many individuals who utilized mental health services have taken the time to create advanced directives, wellness recovery action plans and or living wills to express their preferences in regards to treatment. These issues could be addressed in the language “The proposed requirements state that the written rehabilitation plan must:” by adding a new bullet which would state:

“be developed in accordance with the individual’s preferences as identified in advanced directives, individual recovery action plans and living wills.”

A shared decision approach to services that are built upon choice through individualization, cultural appropriateness, strength-based and person-centered will not only promote accountability but actually produce true rehabilitation and recovery. We hope that CMS will consider making person-centered planning a formal requirement of the written rehabilitation plan [§440.130(d)(3)(iii)] beyond the proposed recommendation by making these values apply to all Medicaid funded services, not just rehabilitation.

The proposed regulations state: “Under existing provisions at [§440.230(a)]. States are required to provide in the State plan a detailed description of the services to be provided. In reviewing a State plan amendment that proposes rehabilitative services, we would consider whether the proposed services are consistent with the requirements in [§440.130(d) and sections 1905(a)(13) of the Act.” Although you point out that “States are not required to provide rehabilitative services for treatment of mental health and substance-related disorders, they are encouraged to do so”, we would suggest adding language in the review process that would consider whether States have provided rehabilitative services appropriately for mental health and substance-abuse disorders in other parts of the state plan.

In [§440.130(d)(5)] you describe the locations that rehabilitative services may be provided. We would ask that “peer-run and family-run support centers” be added to the list. This would make the proposed changes consistent with guidance you have provided states on the value of “peer specialists” and peer-run services.

In [§441.45(b)(3)] we would ask that you provide clarification to “patient education not related to the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal” so that education on self-care is specifically included as a covered service.

Section [§440.170] states that “patient education in an academic setting is not covered under the Medicaid rehabilitation option.” We would ask that to be stricken so that self-management, diabetes care, weight reduction, and training that supports independence could be included if provided in an academic setting.

In [§441.45(b)(4)], you list “local jails” as a place excluded for payment of services. Since not all individuals served in local jails have been adjudicated of an offense, we would ask that you clarify to make it possible for individuals who are awaiting trial to continue to receive services for which they would otherwise be eligible.

In Section V. Regulatory Impact Analysis, Part C. Alternatives Considered, we would ask that the definition include Certified Rehabilitation Counselors (CRC's) and Certified Psychiatric Rehabilitation Practitioners (CPRP's).

We thank you for considering these comments and believe they will add value to the draft regulations that you have promulgated. We would welcome the opportunity to further share our experience and expertise should you desire.

Sincerely,

John B. Allen Jr., President



**Submitter :** Renae Extrum-Fernandez  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1103-Attach-1.DOC



3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

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A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
P.O. Box 8018  
Baltimore, MH 21244-8018

To Whom It May Concern:

I am a board member of Fred Finch Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of mental health and social services to California's most vulnerable and troubled youth and families.

Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

#### GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

#### PROVISIONS OF THE PROPOSED RULE

##### 440.130(d)(1)(vi) Definition of Restorative Services

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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be

custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

#### 440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

#### Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

#### 441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
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The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

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Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

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Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**Submitter :** Renae Extrum-Fernandez  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1104-Attach-1.DOC





3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
 Department of Health and Human Services  
 Attention: CMS-2261-P  
 P.O. Box 8018  
 Baltimore, MH 21244-8018

To Whom It May Concern:

I am a board member of Fred Finch Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of mental health and social services to California's most vulnerable and troubled youth and families.

Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

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#### PROVISIONS OF THE PROPOSED RULE

##### 440.130(d)(1)(vi) Definition of Restorative Services

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custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
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441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**Submitter :** Mr. William A.B. Ditto  
**Organization :** National Association of State Head Injury Adminis  
**Category :** Other Association

**Date:** 10/12/2007

**Issue Areas/Comments**

**Background**

**Background**

The National Association of State Head Injury Administrators is gravely concerned about your proposed rulemaking (NPRM) pertaining to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007. We urge you to withdraw this proposed rule as we believe it will be very harmful to individuals with traumatic brain injury who rely on rehabilitative services to restore physical, cognitive, sensory and behavioral functioning after injury. We are concerned that rehabilitation is viewed as only necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with traumatic brain injury, continuation of or intermittent rehabilitative services is critical to retain their functional level. Failure to provide a supportive level of rehabilitation results in deterioration, necessitating hospital or emergency department treatment. Secondly, by eliminating day habilitation services to people with developmental disabilities and related conditions, it also eliminates opportunities for those with traumatic brain injury who may be eligible as the result of the age at the time of their injury from receiving many rehabilitative services through these programs in many of our states. Without these day services, many of these individuals would be relegated to more restrictive and costly nursing home placements. (The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function.) 42 C.F.R. ? 441.45(b)(2), see also 72 Fed. Reg. at 45205 ( Preamble,II.F.2).

**GENERAL**

**GENERAL**

See Attachment

CMS-2261-P-1105-Attach-1.DOC

CMS-2261-P-1105-Attach-2.DOC



## National Association of State Head Injury Administrators

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October 10, 2007

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Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-2261-P**  
P.O. Box 8018  
Baltimore, MD 21244-8018

To Whom It May Concern:

The National Association of State Head Injury Administrators is gravely concerned about your proposed rulemaking (NPRM) pertaining to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. We urge you to withdraw this proposed rule as we believe it will be very harmful to individuals with traumatic brain injury who rely on rehabilitative services to restore physical, cognitive, sensory and behavioral functioning after injury. We are concerned that rehabilitation is viewed as only necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with traumatic brain injury, continuation of or intermittent rehabilitative services is critical to retain their functional level. Failure to provide a supportive level of rehabilitation results in deterioration, necessitating hospital or emergency department treatment.

Secondly, by eliminating day habilitation services to people with developmental disabilities and related conditions, it also eliminates opportunities for those with traumatic brain injury who may be eligible as the result of the age at the time of their injury from receiving many rehabilitative services through these programs in many of our states. Without these day services, many of these individuals would be relegated to more restrictive and costly nursing home placements. (The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function.) 42 C.F.R. § 441.45(b)(2), *see also* 72 Fed. Reg. at 45205 (Preamble, II.F.2).



Our specific concerns are as follows:

**Non-covered services: 441.45(b)** -- This section denies Medicaid coverage if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There is little clarity in the regulation on how this provision would be applied, as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program. Very few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. This new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r). As a result, Medicaid-eligible individuals with traumatic brain injury 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, in direct contradiction of the statute.

The proposed rule would deny FFP for services furnished, through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship." We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress and we believe it is vague and could be applied to restrict services that are appropriately covered.

**Rehabilitative Services: 441.45(a)(2)** -- This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level, as defined in the law. However, it would be helpful to reiterate in this section when services may be furnished to retain or maintain functioning.

**Definition of Restorative Services: 440.130(d)(1)(vi)** -- 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.

However, this definition also includes as appropriate rehabilitation services designed to maintain current level of functioning, but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with traumatic brain injury, continuation of or intermittent rehabilitative services is critical to retain their functional level. Failure to provide a supportive level of rehabilitation results in deterioration, necessitating hospital or emergency department treatment.

**EPSDT Mandate.** -- The regulation appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. In several places, the regulation needs to be amended to reflect the EPSDT provision

In closing to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner, NASHIA recommends the following:

October 20, 2007

- (1) That the entire Section 441.45(b) relating to non-covered services be eliminated, because it conflicts with the Medicaid statute.
- (2) Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning. Additional language would be helpful to scrutinize the purpose of the service as defined in the care plan in order to determine whether a specific service is a covered rehabilitative benefit.
- (3) Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not possible or age-appropriate for the child to have done so. Specifically, the language 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)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult. Second, 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.
- (4) That CMS work with other federal agencies, states and the field to devise payment methodologies that support the best practice and the most successful outcomes for children and adults with brain injuries. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.
- (5) Section 441.45(a), insert a new paragraph clearly stating that states must ensure that children receive all federally covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition. Section 441.45(b)(4), which refers to services having to be targeted under the state's plan should be amended to reference EPSDT for children. Section 441.45(a)(5) should clarify that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically necessary.

For these and other reasons, we urge the Secretary to withdraw the proposed rule. Thank you for the opportunity to comment on the proposed rule.

Sincerely,



William A.B. Ditto, M.S.W.  
President  
National Association of State Head Injury Administrators

cc: Kenneth H. Currier  
Executive Director

**Submitter :** Renae Extrum-Fernandez  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1106-Attach-1.DOC



3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

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A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
P.O. Box 8018  
Baltimore, MH 21244-8018

To Whom It May Concern:

I am a board member of Fred Finch Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of mental health and social services to California's most vulnerable and troubled youth and families.

Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

#### GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

#### PROVISIONS OF THE PROPOSED RULE

##### 440.130(d)(1)(vi) Definition of Restorative Services

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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be

custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

#### 440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

#### Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

#### 441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.
5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.



Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

**Submitter :** Mr. Thomas Miller  
**Organization :** Muskegon Area Intermediate School District  
**Category :** Other Government

**Date:** 10/12/2007

**Issue Areas/Comments**

**Background**

**Background**

I am deeply concerned about the devastating impact that the proposed CMS regulations for the rehabilitation services option will have on the welfare of children with disabilities. The elimination of these reimbursements would inevitably shift the financial responsibility for rehabilitation claims to individual school districts and early childhood providers across the nation. The Administration estimates that the elimination of the reimbursement for the Medicaid rehabilitation services option will provide a savings of \$2.29 billion over the next five years. However, there is no corresponding increase in funding for the federal special education law, the Individuals with Disabilities Education Act (IDEA), that will enable schools and early childhood providers to make up for the reduction in Medicaid reimbursements for rehabilitation services option provided to children with disabilities.

**Collections of Information Requirements**

**Collections of Information Requirements**

The proposed rule does not further the core goal of Medicaid, that being to provide services to help families and individuals attain or retain capability for independence or self-care. The proposed rule erects new obstacles for Medicaid beneficiaries to receive medically necessary rehabilitative services. It does not justify the need for new rules and it does not provide a reasonable description of the impact of the proposed rule on Medicaid beneficiaries or rehabilitative services providers

**GENERAL**

**GENERAL**

Based on the reasons stated and other reasons, we urge the Secretary to withdraw the proposed rule.

**Provisions of the Proposed Rule**

**Provisions of the Proposed Rule**

We are troubled that the proposed rule could interfere with states' ability to deliver preventive services, authorized by section 1905(a)(13) of the Social Security Act, as defined by 42 C.F.R. ? 440.130(c). Although the proposed rule ostensibly amends only 42 C.F.R. ? 440.130(d), it creates the clear impression that numerous preventive services would be prohibited under section 1905(a)(13), even if they could be covered as preventive services.

Any revised rule should make clear that states can continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. ? 440.130(c).

**Provisions of the Proposed Rule**

**Provisions of the Proposed Rule**

We are very troubled by the potential impact of the proposed rule on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that the proposed rule complies with Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a state's Medicaid plan. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement.

**Response to Comments**

**Response to Comments**

Our concern is that while the proposed rule does not explicitly restrict access to rehabilitative services in school and early childhood settings, new requirements of this rule could be disruptive and could make it more difficult to use the school and early childhood environments to assure that children with disabilities receive the rehabilitative services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools and early childhood settings. While we share the goal of ensuring that all rehabilitative services are of the highest quality and are only provided by providers who meet state credentialing standards, we are concerned that this rule would limit state flexibility to establish provider qualification requirements in school and early childhood settings. Further, we are concerned that the any willing provider requirement could be disruptive to efforts to serve children. We believe that the existing free choice of provider which guarantees parents the right to access medically necessary therapy and other services by other providers outside of the school/early childhood environment is an appropriate way to protect parents' right to access the Medicaid qualified provider of their choice. Again, the Secretary has not provided a policy justification for this new requirement, and we believe the net impact will be to make it less desirable for Medicaid programs to use school/early childhood settings to provide essential rehabilitative services to children. The Congress could not have been clearer in its intent that it wants Medicaid to support the goals of IDEA; we believe that these narrow interpretations of the law are inconsistent with that intent.

**Submitter :** James Harris  
**Organization :** Fred Finch Youth Center  
**Category :** Comprehensive Outpatient Rehabilitation Facility

**Date:** 10/12/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-1108-Attach-1.DOC



3800 Coolidge Avenue ♦ Oakland, California 94602-3399 ♦ 510-482-2244 ♦ FAX: 510-530-2047

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A century of serving children

October 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2261-P  
P.O. Box 8018  
Baltimore, MH 21244-8018

To Whom It May Concern:

I am a board member of Fred Finch Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of mental health and social services to California's most vulnerable and troubled youth and families.

Fred Finch Youth Center is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

#### GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

#### PROVISIONS OF THE PROPOSED RULE

##### 440.130(d)(1)(vi) Definition of Restorative Services

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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be

custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language 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.
2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable
2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful
3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist
5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

#### 440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

#### Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

#### 441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

#### Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

#### 441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

1. We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute.
2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.
3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).
4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.
5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

441.45(b)(1)(i) Therapeutic foster care

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.
2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.
3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.



Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.
3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,