CMS-2261-P-1109

Submitter : **Mr. John Turk** **Date: 10/12/2007**

Organization : **New Milford (CT) Board of Education**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

Implementation of the proposed rules will just add to the increasing burden imposed by Unfunded Mandates. Each and every one of these unfunded mandates is taking funds away from educating our students (see Regulatory Impact Analysis below). The case is compounded further when it affects our children with disabilities.

It appears to me that this change would run in conflict with Title 19 whose central purpose, if I read it correctly, is to provide rehabilitative services. Not only would it not further these services, it would hinder access to these services by interfering with states' ability to deliver preventive services.

The proposal does not seem to comply with Medicaid's Early Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. This 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. With nearly 13% of the district's student population classified as special needs, this is a significant factor.

IDEA entitles children with disabilities to a free, appropriate education and early intervention services in conformity with an individualized education program - IEP and an individualized family services plan - IFSP. For years, the Federal government has failed to supply anywhere near the level of funding promised in the IDEA statute. Connecticut's ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP/IFSP helps defray some, although not enough, of the state and local costs of implementing IDEA. A major concern here is that new requirements of this rule would be disruptive, especially to the degree that new provider qualification standards will restrict the ability of certain providers of services to children both in schools and in early childhood settings.

Response to Comments

Response to Comments

The New Milford (CT) school district has serviced the following special needs population over the past few years:

2004-5	683
2005-6	618
2006/7	635

During this period the district has received the following funds from the State of Connecticut:

2004/5	$32,522.86
2005/6	$24,150.00
2006/7	$52,881.25

It should be noted that the 2005/6 year was lower due to a staffing problem.

More significantly, this proposal would add to the time and cost of satisfying funded and unfunded mandates with which the district must comply. A quick analysis has indicated that over $2 million and an additional cost of over 20,000 hours was incurred by the district in satisfying such mandates. All of this time and cost further reduces the ability of educators to have the tools to service their client - the student, thus denigrating the educational process. It is no wonder that the US trails so many nations in the quality of our education.

CMS-2261-P-1110

Submitter : **David McGraw** **Date: 10/12/2007**

Organization : **Fred Finch Youth Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1110-Attach-1.DOC

#1110

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 : **Mr. Ron Benham** **Date: 10/12/2007**

Organization : **IDEA Infant and Toddler Coordinators Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1111-Attach-1.PDF

#11.

MEDICAID NPRM COMMENTS
OCTOBER 12, 2007

The IDEA Infant Toddler Coordinators Association (ITCA) thanks you for the opportunity to provide written comment on File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services. ITCA currently has 50 state and territory members and represents state lead agencies that are responsible for implementing Part C of the Individuals with Disabilities Education Act (IDEA) in all 50 states and other eligible jurisdictions. In 2006, the states and jurisdictions served 304,510 infants and toddlers birth through two years of age.

ITCA has significant concerns about the potential devastating impact that the proposed CMS regulations for the rehabilitation services option will have on the availability of services for children with disabilities. The elimination of these reimbursements would inevitably shift the financial responsibility for rehabilitation claims to states and individual early intervention 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) either in Part B or Part C that will enable states to make up for the reduction in Medicaid reimbursements for rehabilitation services option provided to children with disabilities.

Overall, ITCA requests that these proposed regulations not be promulgated and be withdrawn. We are very concerned that these proposed regulations seem to contradict clear statutory intent under IDEA and the Social Security Act itself. We will speak directly to the impact on Part C of IDEA although we note these regulations are extremely problematic for all services under IDEA.

IDEA statutory intent is clear that Medicaid is intended to be a significant payor of early intervention services provided under Part C of IDEA. According to the statute, funds under Part C "may not be used to satisfy a financial commitment for services that would have been paid for from another public or private source, ... but for the enactment of this part... " (20 U.S.C. 1440 (a)). Further, "Nothing in this part shall be construed to permit the State to reduce medical or other assistance available or to alter eligibility under title V of the Social Security Act (relating to maternal and child health) or title XIX of the Social Security Act (relating to medicaid for infants or toddlers with disabilities) within the State." (20 U.S.C 1440 (c)).

The ITCA is conducting a survey of its members to assess the impact of these proposed regulations on the ability of states to support appropriate, evidence–based, high quality services to its eligible population. With 54% of the members responding to the survey so far, the data are clear that Medicaid, as intended by Congress, is a significant payor of service to the Part C enrolled population. Preliminary results are also clear that for some states, Medicaid revenues under the rehabilitation option are a significant portion of those states' early intervention budgets.

ITCA notes the following specific concerns that the NPRM:

1. **Challenges efforts by states and early intervention providers to effectively deliver health care services to children with disabilities in early childhood settings.**

The Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to appropriately receive early intervention services in conformity with an individualized family service plan (IFSP). This is because at this time, all states are participating in this voluntary federal program. An IFSP is developed for eligible children with disabilities and their family and describes the range of services and supports needed to assist the child to maximize their development. The types of services provided under an IFSP include services such as service coordination, speech pathology and audiology services, and physical, and occupational therapies. For years, the Federal government has failed to provide anywhere near the level of funding necessary to fund Part C. States' ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IFSP helps defray some of the state and local costs of implementing Part C IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IFSPs have been a contentious issue in the past. Some time ago, HCFA attempted to limit the availability of Medicaid funding for services under IDEA. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP/IFSP. Under current law, the Social Security Act at section 1903 (c) reads,

"Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established

pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act."

Our concern here 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 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.

2. **The proposed rule would not further the purposes of Title XIX of the Social Security Act.**

CMS has full authority to allow rehabilitation services which will prevent regression or deterioration. 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).

CMS should be commended 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. This is particularly true for children, who 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.

3. The proposed rule does not fully comply with the EPSDT mandate for children.

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.

4. **The proposed rule would result in discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions.**

We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

5. The proposed rule would harm children receiving foster care

According to an Urban Institute analysis, 869,087 children were enrolled in Medicaid on the basis of receiving foster care in 2001, and 509,914 of these children were enrolled for Medicaid for the full year (Geen, Sommers, and Cohen, Urban Institute, August 2005). An analysis of Medicaid spending on these children found that 13.1% of Medicaid spending was for rehabilitative services. Prior research has shown that children receiving foster care have more health problems, especially mental health problems, than the general population or the population of poor children (Geen and others). As many as 80% of young people involved with child welfare have emotional or behavioral disorders, developmental delays, or other issues requiring mental health intervention (Farmer and others, *Social Service Review* 75(2):605-24).

State Part C systems have been struggling to meet new federal requirements under The **Child Abuse Prevention and Treatment Act** (**CAPTA**) that requires referral to Part C of any children birth to three involved in a case of substantiated abuse or neglect. There was no funding increase for this added responsibility but Medicaid can be a very important payor for this new requirement.

6. **Challenges efforts by states to effectively deliver health care services to infants and toddlers with disabilities in community settings.**

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles infants and toddlers with disabilities to supports and services in their communities, in conformity with an individualized family service plan (IFSP). In addition, 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. This is particularly true for children, who 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.

In summary, the Congress could not have been clearer in its intent that Medicaid should support the goals of Part C of IDEA. We believe that these proposed rules are inconsistent with that intent.

ITCA urges the Secretary to withdraw the proposed rule.

Thank you for allowing the public to provide comments on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid Program and for considering our recommendations.

For additional information or questions, please contact:

Ron Benham, President of ITCA ron.benham@state.ma.us
ITCA Office ideaitca@aol.com

CMS-2261-P-1112

Submitter : **Dr. Gay Searcy** **Date: 10/12/2007**

Organization : **Fred Finch Youth Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1112-Attach-1.DOC

#111

FRED FINCH YOUTH CENTER

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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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

<u>440.130(5) Settings</u>

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.

<u>Recommendation</u>:

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

<u>441.45(a)(2) Covered services requirements</u>

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).

<u>Recommendation</u>:

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

<u>441.45(b) Non-covered services</u>

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. Jonas Waizer** **Date: 10/12/2007**

Organization : **FEGS Health and Human Services System**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter from Dr. Jonas Waizer, Chief Operating Officer, FEGS Health and Human Services, to address the above comment fields (provisions to the proposed rule, background, etc)- a .pdf file is attached.

CMS-2261-P-1113-Attach-1.PDF

#1113

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October 11, 2007

Centers for Medicare & 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:

Reference: File code CMS-2261-P

FEGS, a large and diverse not for profit organization in New York City echoes the comments submitted by The Coalition of Behavioral Health Agencies, Inc. regarding the Proposed Rules for Coverage for Rehabilitative Services under the Medicaid program.

FEGS' Behavioral Health outpatient and residential divisions serve approximately 20,000 people annually, most with chronic mental illness. Through its network of services in the New York City metropolitan area FEGS provides services to people who are among New York's most vulnerable. Many have chronic mental illness, often with co-occurring substance abuse and medical problems; they have histories of hospitalization and incarceration as well as frequent involvement with the criminal justice system. Our Mental Health programs include clinics, residential programs, continuing day treatment and psychiatric rehabilitation programs, case management, club houses, PROS (Personalized Recovery Oriented Services) and an ACT team. We provide a wide range of interventions to help people with mental illness become more independent and be able to live successfully in the community.

We are deeply concerned that the proposed regulations will pose additional barriers and prove to be more burdensome for providers of rehabilitative

services, including non-profit community based organizations. We fear the new regulations will result in a decrease in both the quality and quantity of services individuals receive. With the implementation of the proposed regulations, consumers are at greater risk of depending on emergency services – including hospitalization – at a tremendous cost to individuals, communities and ultimately to federal and state governments. Below, please note the recommendations and comments as they pertain to the proposed rule.

Comments re: PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130: Diagnostic, screening, preventive and rehabilitative services

440.130(d)(1)(i)
The final rule should clarify the requirements of an acceptable "individualized recovery goal."

The proposed regulations do not include the criteria for a Medicaid reimbursable "individualized recovery goal". A client's goal may be to: (1) reduce frequency of hospitalization, (2) prevent hospitalization, and/or (3) remain in the community. Often times, once an individual stabilizes he or she may wish to maintain contact with the behavioral health care system because it is a resource and a support for them. It is unclear if these are acceptable recovery goals.

Recommendation:
We urge CMS to clarify the requirements of a Medicaid reimbursable "individualized recovery goal".

440.130(d)(1)(v) Definition of Rehabilitation Plan
The final rule should clarify the definition of an individual providing "input" and "active participation".

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. We applaud CMS for including requirements that are designed to ensure the individual's participation in this process, but believe the wording could be improved. There is a significant difference between an individual providing "input" and an individual having "active participation." By including both terms in different places, the regulation confuses this issue.

Recommendation:
We urge CMS to clarify the role of the individual and the definition of "input" and "active participation". We also urge CMS to ensure that the active participation of "collaterals" meets all of the necessary HIPAA requirements for the privacy rule.

440.130(d)(1)(vi) Definition of Restorative Services
The final rule should clarify the meaning of restorative services.

The proposed 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.

The proposed regulations state that "services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan." 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. We are concerned that states and providers will interpret the current proposed regulations as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services.

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.

The preamble and section 441.45(b) of the proposed regulations exclude prevocational services as covered rehabilitation services. However, rehabilitative services should include prevocational services when they are provided to individuals who have experienced a functional loss and have a specific rehabilitation goal of regaining that functioning. Examples include communication and social skills building and cognitive interventions such as taking instructions and/or guidance, asking for help, working at an appropriate pace, staying on task, increased attention span, and increasing memory.

Recommendation:
We urge CMS to indicate in the final rule that a child does not have to 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 have 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 the above point may be a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate.

Secondly, we strongly urge CMS to allow the "retaining of functional level" to be an acceptable individualized recovery goal and to reimburse services that enable an individual to maintain their functional level.

Lastly, we urge CMS to cover pre-vocational services that are tied to an individual's recovery goal.

440.130(d)(1)(vii) Definition of medical services
The final rule should include diagnosis as a covered rehabilitation service.

The proposed regulations state" medical services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care..." However, it is extremely difficult to create an effective and meaningful plan of services without an assessment of the person's functional capacity. Typically, clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

The proposed definition also includes the word "care" after treatment, but that term is nowhere else defined. Does it mean clinical care? The word rehabilitation should be inserted here to make clear the term "medical services" includes rehabilitation. This is important because the term "medically necessary" is used in this regulation to indicate necessary rehabilitation services.

Recommendation:
We urge CMS to revise the final rule to cover functional assessments as a rehabilitation service. Specifically, we ask CMS to add to section (vii) the word "assessment" before the word "diagnosis" and replace the word "care" with the word "rehabilitation."

440.130(d)(1)(viii)(2)Scope of Services
The final rule should clarify the definition of scope of services.

The proposed definition of scope of services is limited to medical or remedial services. However, the term restorative services are also used in this regulation to describe covered rehabilitation services.

Recommendation:
We urge CMS to insert the word "restorative" after "medical" in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

The preamble phrase "services are to be provided at the least intrusive level to sustain health and ensure the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level" should be added to the definition of the scope of services. We also urge CMS to indicate in the final rule that services be required to be provided in a coordinated manner and in the most integrated, appropriate setting.

440.130(viii)(3) Written Rehabilitation Plan
The final rule should clarify the requirements of the written rehabilitation plan.

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, some of the language in this provision is unclear and needs clarification. The proposed requirements will be burdensome, both administratively and financially, for agencies serving individuals in need of rehabilitative services. They will also create another level of complexity for documentation compliance and audits.

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 include 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 requirement to "indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternative provider(s) of the same service" is very problematic. First, it is unlikely and time-consuming for a practitioner to list all potential providers of a service. This can also become a conflict of interest because it is typically the clinician who is providing the service who will develop the rehabilitation plan. Lastly, if an individual chooses to go to another provider, that provider typically does not want to be handed a rehabilitation plan developed by someone else.

The proposed regulations recommend the use of "person-centered planning", which requires the active participation of the individual, involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative can be problematic. 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 treatment plan. There is also no guarantee that the individual will appoint a representative, or that the consumer when in crisis could identify this person.

Recommendation:
We urge CMS to include the following requirements regarding the written rehabilitation plan:

- that the plan be written plainly in multiple languages so that it is understandable to all individuals;
- that the plan indicate the individual's level of participation, as well as his or her concurrence with the plan;
- that the plan allow for a qualified provider to sign the treatment plan when the client or their representative is unable to do so or has no family or designated representative;
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that the plan include, if necessary, provisions for crisis intervention;
- that the plan include individualized anticipated review dates that correspond with the anticipated achievement of long-range and intermediate rehabilitation goals;
- provide certification that the individual has been informed about their rights regarding advance directives;
- that the plan allow providers to provide information on potential alternate providers of the same service instead of listing all of the alternative providers in the treatment plan.

We also urge CMS to indicate in the final rule the use of a single treatment and rehabilitation plan and a single planning team and service planning meetings. The content of the plan needs to be flexible in order for providers to feel comfortable providing flexible level of services without risking disallowances.

We urge CMS to revise the language under paragraph (v) to require that the plan be developed by a team, led by "a qualified provider working within the State scope of practice act". The plan should require the active participation of the individual (unless it is documented that he/she is unable to actively participate due to his or her medical condition), the individual's family (if a minor or if the adult's individual desires), individual's authorized decision maker (of the individual's choosing) in the development, review and modification of the goals and services provided. We also urge CMS to ensure that the active participation of "collaterals" meet all of the necessary HIPAA requirements for the privacy rule.

440.130(4) Impairments to be addressed

The final rule should state that all individuals are eligible for coverage of rehabilitation services.

The proposed regulations state that "services may address an individual's physical impairments, mental health impairments and/or substance-related disorder treatment needs." The preamble states that "because rehabilitative services are an optional service for adults, states have the flexibility to determine whether they will be limited to certain services for specific populations."

Limiting services to only one group, based on diagnosis or disability violates Medicaid's requirement that services be furnished in sufficient amount, duration and scope to reasonably achieve their purpose. Not providing coverage of rehabilitative services to individuals with a mental illness would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:
We urge CMS to delete the word "or" after the word "and" in Section 440.130(4).

440.130(5) Settings

The final rule should include a more extensive list of settings where rehabilitative services can be provided.

Recommendation:
We urge CMS to add to the list of appropriate settings for rehabilitation services described in the preamble and to include the list in all sections of the proposed regulations. Specifically, we urge CMS to include schools, therapeutic foster care homes, and mobile crisis vehicles to the list of appropriate settings where rehabilitation services can be provided.

Section 441.45: Rehabilitative Services

441.45(a)(2)

The final rule should clarify the definition of a rehabilitative service.

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.

Recommendation:
We urge CMS to insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning (see previous comments). We also urge CMS 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.

441.45(b) Non-covered services

The final rule should not deny Medicaid coverage for services provided to Medicaid-covered individuals if such services are furnished through another program.

This section introduces a whole new concept into Medicaid, one that conflicts with current federal statutory requirements. It denies Medicaid coverage for services provided to Medicaid-covered individuals if such services are furnished through another program, including when they are "intrinsic elements" of that program. There is little clarity on how to determine whether a service is an "intrinsic element" of another program or how it would be applied.

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 result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other programs due to lack of resources (i.e. therapeutic foster care, foster care or child care institutions for a foster child). What is the legal basis for denying federal financial participation (FFP) for the Medicaid-covered individual? Thus, the rule effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

Recommendation:

We strongly urge CMS to remove this entire section, because it conflicts with 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.

We strongly urge CMS to include a list of settings (therapeutic foster care, foster care or child care institutions for a foster child) where children can receive medically-necessary rehabilitation services as long as they are provided by qualified Medicaid providers. Specifically, this language should be included in Section 441.45(b)(1).

We also urge CMS to include language in Section 441.45(b) that will indicate Medicaid rehabilitative services must be coordinated with services furnished by other programs (similar to language in the preamble)

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

The final rule should list therapeutic foster care as a covered rehabilitation service for children with serious mental disorders.

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. 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). 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. The alternative for most children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, a significantly more costly setting.

The proposed regulations deny payment for therapeutic foster care as a single program, requiring instead that each component be billed separately. If states are not able to provide and bill for services as a package, the effectiveness of treatment will decrease while administrative costs rise.

Recommendation:
We strongly urge CMS to list therapeutic foster care as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

In discussing therapeutic foster care, the preamble states that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, states should be given the discretion to define therapeutic foster care as a single service and pay through a case rate, daily rate or other appropriate mechanism.

We also urge CMS to include language in Section 441.45(b)(1)(i) to clarify that mental health rehabilitation providers are eligible to provide and bill for rehabilitation services for children in therapeutic foster care.

441.45(b)(2)

The final rule should clarify the difference between "exclusion for habilitation services as opposed to the exclusion from Federal Financial Participation (FFP) for rehabilitative services."

The Omnibus Reconciliation Act of 1989 (OBRA 89) prohibited CMS (the HCFA) from disallowing claims for day habilitation services until CMS issued a new regulation that specified the types of habilitation services that would only be covered. Therefore, the provision in the proposed regulations that would exclude coverage for habilitation services for persons with mental retardation and related conditions is unprecedented, inconsistent with Congressional intent, and not justified.

It should be noted that the exclusion of habilitation services does and should not equal exclusion from FFP for any rehabilitative services provided to persons with mental retardation or related conditions (i.e. cerebral palsy and epilepsy) that would gain functionality from rehabilitative services. Individuals with serious mental illness may experience periods of cognitive impairment as a result of their illness. If they do experience cognitive impairment, will the rehabilitation services they receive be covered?

If CMS approves this change, it is going to require a considerable amount of time and planning to transfer coverage of habilitation services from the rehabilitation option into another appropriate Medicaid authority. The proposed rule does not specify how CMS will provide technical assistance during the transition period.

Recommendation:
We urge CMS to provide clarification as to the difference between exclusion for habilitation services as opposed to the exclusion from FFP for rehabilitative services provided to persons with mental retardation and related conditions.

441.45(b)(3)
The final rule should clarify when recreational and/or social activities are a covered rehabilitation service.

The preamble includes examples of when recreational or social activities may be covered rehabilitation services due to a focus on skill building or other rehabilitative needs. However, the proposed regulations do not include any examples or any specific language explaining when these activities are covered services. This is a serious omission, as the regulation alone may be interpreted in the field as denying any recreational or social activities no matter how therapeutic or focused they are on restoring functioning.

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are a covered rehabilitative service. The proposed regulations are unclear regarding when personal care services are covered rehabilitation services.

Recommendations:
We urge CMS to include language in section 441.45(b)(3) that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation service. The final rule should also clarify how personal care furnished as an integral part of personal care skills training is covered and how it is to be documented.

Individuals in Secure Custody and Residing in Public Institutions
The final rule should not include the phrase "in secure custody" and "system".

The addition of the phrase "in secure custody of" law enforcement is unnecessary as the regulation also requires that the individual be residing in a public institution. The law only stipulates that FFP not be available for individuals in a public institution and does not reference secure custody. Similarly, the addition of the word "system" to public institution is confusing and unnecessary.

Recommendation:
We urge CMS to delete the phrase "in secure custody" and "system".

441.45(b)(7) Services for individuals who are not Medicaid eligible
The final rule should clarify when services for individuals who are not Medicaid eligible are a covered rehabilitation service.

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered rehabilitation services. In the preamble (page 45207) there is an

explanation of when services may be provided to non-Medicaid eligible individuals if it is directed exclusively toward the treatment of the Medicaid-eligible child or adult. No such explanation, however, is included in this section of the proposed regulations.

Recommendation
We urge CMS to include language in Section 441.45(b)(7), similar to that in the preamble, explaining when services may be provided to non-Medicaid eligible individuals if it is directed exclusively toward the treatment of the Medicaid-eligible child or adult.

OTHER ISSUES

Payment and Accounting for Services
Although not specifically described in this regulation, the language used supports recent efforts by CMS to require providers to account and bill for services through 15-minute increments and the denial of payment through daily rates, case rates and similar arrangements.

This new shift in rate setting methodology is inconsistent with evidence-based mental health practices that are based on delivering services together in a flexible and coordinated way. The shift in documentation and billing procedures significantly increases the amount of time that clinicians must spend completing paperwork, thus reducing the amount of time available to spend with clients. Furthermore, if providers are asked to bill services individually, they will be moving away from the evidence-based model (i.e. therapeutic foster care). Current evidence-based practices include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

There are alternative ways to hold states accountable for ensuring that non-covered activities are not reimbursed. For example, it is possible to devise rate structures that do not pay providers for time spent on non-covered activities.

Recommendation:
We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support best practices and the most successful outcomes for children and adults with mental disorders. We strongly urge CMS NOT to require providers to bill for services separately that are part of a "package of services".

EPSDT Mandate
The proposed regulations 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.

Recommendation:
We strongly urge CMS to do the following:

- Insert a new paragraph to Section 441.45(a) that will make clear 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.

- Clarify Section 441.45(a)(5) to state that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically-necessary.

- To reference the federal EPSDT mandate in Section 441.45(b)(4), which refers to services having to be targeted under the State's plan.

CONCLUSION

We would like to thank CMS for the opportunity to submit comments on the provisions of the proposed rule for the Coverage for Rehabilitative Services.

A reduction in federal support for rehabilitation services would force States to make a choice between continuing service provision at the same level at a greater cost in state/local dollars; decreasing the amount and quality of essential services individuals receive; reducing eligibility, benefits, or payments to providers; cutting back on other state programs and using those funds to replace federal Medicaid dollars lost; or a combination of all of the above.

If funding for rehabilitation services is eliminated, overall expenditures for both the Federal Government, States and localities may actually increase because consumers will be re-directed into more costly Medicaid-funded settings, including in-patient psychiatric beds. Other individuals may end up in homeless shelters or in jail, settings which are exorbitantly expensive for taxpayers and personally debilitating for consumers. We are deeply concerned that the proposed rule will harm vulnerable beneficiaries with severe mental illnesses.

To the extent that any of these provisions become final, CMS must work with States to develop implementation timelines that allow for adequate time for administrative and programmatic changes to be made at both the state and provider level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of their State Plan Amendment. **We strongly urge CMS to postpone the implementation of the proposed rule until there has been a full analysis of the financial and regulatory impact of the proposed regulations.**

If you have any questions, please do not hesitate to contact me at (212) 366-8024.

Sincerely,

Jonas Waizer, Ph.D.
Chief Operating Officer

cc: Phillip A. Saperia, Executive Director
Coalition of Behavioral Health Agencies

CMS-2261-P-1114

Submitter :

Date: 10/12/2007

Organization :

Category : State Government

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2261-P-1114-Attach-1.PDF

#1117

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO Box 712
TRENTON NJ 08625-0712
TELEPHONE 1-800-356-1561

JON S. CORZINE
Governor

JENNIFER VE
Commission

JOHN R. GU
Director

October 11, 2007

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-801

Re: In the Matter of Proposed Medicaid Program Rules on Rehabilitative Services - CMS 2261-P

Dear CMS Staff:

These comments are submitted on behalf of the New Jersey Department of Human Services--the single state agency responsible for administering the Medicaid program in New Jersey--to the proposed rule "Medicaid Program: Coverage for Rehabilitation Services" published August 13, 2007, at 72 Fed. Reg. 45201.

Comment: 42 C.F.R. 440.130 and 42 C.F.R. 441.45 go beyond statutory authority

Among other things, the proposed rules dramatically narrow the scope of services which States can provide under the rehabilitation provision (rehab option) thus limiting the number of children and adults who will be able to receive much needed rehabilitative services. In effect, these proposed rules are in direct contravention of the intent of Congress and the provisions of Title XIX of the Social Security Act.

Specifically Section 1901 (42 U.S.C. 1396) authorizes federal appropriations for the Medicaid Program and provides in pertinent part: "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals... and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care...." Clearly the Act treats "rehabilitation and other services" as on an equal footing with "medical assistance". In contravention of Congressional intent, these proposed regulations

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dramatically reduce the status of the rehab option and seriously curtail the scope of services available under that option.

In the past when CMS (then HCFA) attempted to restrict the use of the rehab option (in particular, habilitation services), Congress responded by enacting Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) which prohibited CMS from taking adverse action against States with approved habilitation provisions pending the issuance of a regulation that "specifies types of day habilitation services that a State may cover under paragraphs (9) (clinic services) or (13) (rehabilitative services) of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions."

Now, after 17 years of inaction, CMS suddenly and without the benefit of any discussion with, or input from, beneficiaries, providers, advocates or the States, springs into action by proposing regulations directly conflicting with federal law and Congressional mandate. Rather than issuing a regulation that "specifies types of habilitation services that a State may cover", CMS ignores Congress and instead prohibits FFP for habilitation services. Moreover, proposed 42 C.F.R. 441.45(b)(2), not only provides that "habilitation services, including services for which FFP was formerly permitted under OBRA 89" are not available for FFP, but also makes clear that that prohibition also includes services provided to individuals with "mental retardation and related conditions." (It bears emphasizing that this provision has the potential to frustrate States' efforts to comply with Olmstead v. L.C., 527 U.S. 581 (1999) if individuals with mental retardation have to be institutionalized to receive comparable services rather than being able to receive them as they can now in the most appropriate integrated setting.) Moreover, in proposed 42 C.F.R. 441.45(b), CMS takes the position that services furnished through a program other than Medicaid, are excluded from the definition of "rehabilitation". CMS cites no statutory authority for that exclusion, nor can it.

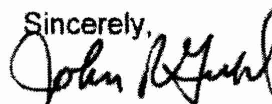
The proposed regulations not only restrict the breadth of services but also fail to give the requisite deference to the States. This is in direct contrast to the Act which recognizes the right of each State to determine its needs and what is best for its residents. For example, 42 U.S.C. 1901 authorizes appropriations for the Medicaid Program "...for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance ... and (2) rehabilitation and other services...." In addition, 42 U.S.C. Section 1905 (a) 13 speaks in terms of rehabilitative services being recommended by a physician or other licensed practitioner of the healing arts "within the scope of their practice under State law." In contrast, proposed 42 C.F.R 440.130(d)(1)ii and iii does not defer to the States. In the case of provider qualifications, CMS adds a federal overlay on top of State licensing requirements for being a qualified provider in certain scenarios. That is, under the proposed rule, in addition to meeting State requirements, the provider must meet provider qualifications under federal law that would be applicable to the

same service when it is furnished under Medicaid benefit categories. This proposed requirement is unduly burdensome and will significantly reduce the number of available providers which will interrupt the provision of services.

The existing rule 42 C.F.R. 440.130(d), which implements Section 1905(a)(13) of the Social Security Act and which CMS has applied over the last 17 years, provides a comprehensive definition of rehabilitative services which enables the States flexibility to meet the needs of children with developmental delays and emotional and behavioral disorders, at risk children and individuals with developmental disabilities and mental illness in a variety of settings and programs. This breadth of services allows seamless transfer between settings, enabling providers to adjust an individual's services as the individual's needs change without navigating burdensome system requirements. This fluidity promotes an individual's stability by reducing breaks in service, in turn reinforcing continuity of care and providing the best opportunity for successful, cost-effective service delivery.

Because the proposed rules will effectively diminish the availability of much needed rehabilitation services thereby putting Medicaid beneficiaries at risk, these proposed rules should be withdrawn or, after receiving input from all interested parties, be modified extensively to address the issues stated above.

Sincerely,



John R. Guhl
Director

JRG:bpw

c. Ann Clemency Kohler
Valerie Harr
David Lowenthal
Barbara Waugh
Sue Kelly, CMS

CMS-2261-P-1115

Submitter : Beverly Shamana **Date:** 10/12/2007

Organization : Fred Finch Youth Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1115-Attach-1.DOC

#11.

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 : **Mariana Torres** **Date: 10/12/2007**

Organization : **Fred Finch Youth Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1116-Attach-1.DOC

#1116

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,

CMS-2261-P-1117

Submitter : **Date: 10/12/2007**

Organization : **PORTALS-A Division of Pacific Clinics**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachmcnt"

CMS-2261-P-1117-Attach-1.PDF

#1117

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

CMS-2261-P-1118

Submitter : Dr. Juve Vela **Date:** 10/12/2007

Organization : Fred Finch Youth Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1118

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

CMS-2261-P-1119

Submitter : Mr. Stephen Langley Langley **Date:** 10/12/2007

Organization : Steppiung Stones of Rockford, IL

Category : Social Worker

Issue Areas/Comments

Background

Background

The document states that Medicaid payment is excluded for individuals who live in "a community residential treatment facility of over 16 beds". There are likely several hundred thousands of individual with chronic mental illnesses who live in apartments in buildings that may contain any where from two to hundreds of units. This is based upon their choice and ability to pay. Often these units are section 8 subsidize by HUD. Safe, secure and affordable housing is the cornerstone to survival and success in the rehabilitation plan in the community for people who suffer from mental illness, substance abuse and other co-occurring problems. Some of these buildings, a very small percentage, are owned and/or managed by providers of service. Almost always they are not. If a person lives in a provider owned/managed building of 17 people, is that considered an IMD, especially if the units are part of a HUD selection process and the individual has a HUD lease on a complete and self contained apartment unit to live in. If an individual is one of say 100 individuals with illnesses that live in a 250 unit complex in a large city, would that complex be considered an IMD and all 100 of the tennants would be ineligible for Medicaid and Medicaid services? It would appear that the number of 16 chosen in the document is arbitrary and does not stand in the face of reality. The large cities are full of such apartment buildings and complexes and there seems to be a conflict with the Fair Housing Act, and the freedom from discrimination, and the arbitrary number of 16 chosen by this document. As with the current immigration problem, there is no way to simply move that many people out of these buidlings/complexes nation wide so that they may receiv Medicaid services. That kind of housing stock and selection simply does not exist in the urban areas of this country. It could be understood if the individuals did not have a complete self contained unit, and lease, and had to share facilities with others, but to deny independent living opportunities to people who have few choices would seem to be diametrical to rehabilitation and to deny services on the same basis to be discrimination and a violation of the Fair Housing Act. It would seem to me that the 16 number would be an appropriate cut off for people living in the same building and sharing common living needs such as a sleeping place, cooking, eating, bathing, hygiene, with the concurrent loss of privacy would fit the idea of an "institution", and I did work in one for years, but not independent, self contained living units, especially those that conform to HUD guidelines, leases, section 8 support, and regular inspections.

I would request that my concern is misplaced the intention of the rule, unstated, were not as it seems, but if my concern is correct, CMS should consider my suggestion, which I imagine many people have shared with you,to define institution carefully to include 16 people only with shared facilities within a defined building.

I have been in the field for 40 years now. The housing stock open to people with rehabilitative needs is not usually very good and often crowded. There is no viable option to move these people and no viable reason to deny them serives. The rule of 16 must be defined properly or a disaster that include hundreds of thousands of people will follow. I know this can not be the intention of the administration of Medicaid. Thank you for your attention to my comments.

Collections of Information Requirements

Collections of Information Requirements

In the Overview, the document specifically states the "rehabilitation benefit has expanded from physical rehabilitation to also include mental health and substance abuse treatment rehabilitative services". It also states that "services currently provided by States under the rehabilitative benefit include services aimed at physical disabilities". This would seem to indicate that both physical and mental impairments are included in Medicaid rehabilitative benefits as is stated elsewhere in the document. If this is correct, then how does CMS view the inclusion of the supervision of properly ordered physical treatments for mental illness, or, associated physical treatments if they are part of the necessary intervention to reach the assessed and rehabilitative planned goals. For instance, if the assessment and plan set a goal of psychiatric stability and the need for psychotropic medication, and, this is substantiated in the plan by a State certified psychiatrist, then as an essential adjunct to achieve this goal, medication must be prescribed, monitored to ensure compliance and, education, to ensure proper use of the drugs (need,use,purpose,side effects,storage,ect) to achieve the goal of psychiatric stability, then is this activity not an acceptable part of the rehabilitation definition and a Medicaid billable activity if provided by individuals who are considered 'qualified' by the State plan ?

In addition, if an individual contracts medical problems as a result of their illnes, poor judgment, poor health care, and the rehabilitative process is linked to this medical problem, then is the medical problem not part of the process as it is essential to treat it in order to achieve the rehabilitative goals. For example, if an individual has contracted diabetes as a result of poor nutrition, or even as a result of the side effects of a psychotropic medication, is the education to the individual of that condition, the close monitoring to ensure accuracy and safety in the taking of blood sugar levels for treatment and the individual's use of insulin, not an integral part of supporting movement toward the rehabilitation goals which can not be achieved if the individual is not healthy. If provided by a person who meets the State plan requirements of that kind of activity is it not billable to Medicaid.

The 'best pracices' guidelines set forth by SAMSA for co-occurring illesses (mental health and substance abuse)are clear that managing and treating both illnesses under one structure is required, then wouldn't the same 'practice' be considered best for people who have physical problems and mental illnesses that must be treated together.

The document does not seem to clearly divide those physical problems as to what is associated with illnesses and what activities would qualify as acceptable and billable treatment in co-occurring (mental-physical)situations. The prescribing of medication is the most common somatic (medical)treatment provided to people with mental illnesses and not using it properly is the most common reason people deteriorate, lose gains they have made in rehabilitation, or sometimes are hospitlized for some time, and must 'start over' in the process. The two problems, physical and mental, are often one and need to be treated as such and should be part of the rehabilitative process (benefit) and should be billable to Medicaid.

I believe the above should be clarified and included in this document. Thank you for your attention to my comments.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

In the Overview, the document specifically states the "rehabilitation benefit has expanded from physical rehabilitation to also include mental health and substance abuse treatment rehabilitative services". It also states that "services currently provided by States under the rehabilitative benefit include services aimed at physical disabilities". This would seem to indicate that both physical and mental impairments are included in Medicaid rehabilitative benefits as is stated elsewhere in the document. If this is correct, then how does CMS view the inclusion of the supervision of properly ordered physical treatments for mental illness, or, associated physical treatments if they are part of the necessary intervention to reach the assessed and rehabilitative planned goals. For instance, if the assessment and plan set a goal of psychiatric stability and the need for psychotropic medication, and, this is substantiated in the plan by a State certified psychiatrist, then as an essential adjunct to achieve this goal, medication must be prescribed, monitored to ensure compliance and, education, to ensure proper use of the drugs (need,use,purpose,side effects,storage,ect) to achieve the goal of psychiatric stability, then is this activity not an acceptable part of the rehabilitation definition and a Medicaid billable activity if provided by individuals who are considered 'qualified' by the State plan ?

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I believe the above should be clarified and included in this document. Thank you for your attention to my comments.

CMS-2261-P-1120

Submitter : **Date: 10/12/2007**

Organization :

Category : **Private Industry**

Issue Areas/Comments

GENERAL

GENERAL

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.

CMS-2261-P-1121

Submitter : **Richard Walter** **Date: 10/12/2007**

Organization : **Fred Finch Youth Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1121-Attach-1.DOC

#1121

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 : **Dawn Ryan** **Date: 10/12/2007**

Organization : **Dawn Ryan**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

My son currently receives wraparound services and due to this intervention, he is making excellent progress. Without the support of his TSS, he would be unable to attend his current school. Wraparound services have been incredibly important in his therapy and continued development.

I know there are other children who are unable to attain wraparound services due to personnel and fund limitations. This area needs increased funds rather than any cuts. There are many children who could benefit from wraparound services the way my son has - please do not deny them that chance!

Thank you,

Dawn Ryan

CMS-2261-P-1123

Submitter : **Date: 10/12/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

CMS-2261-P-1124

Submitter : Michael Ward **Date:** 10/12/2007

Organization : Fred Finch Youth Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1124-Attach-1.DOC

#112

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.

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Recommendations:

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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.

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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,

CMS-2261-P-1125

Submitter : Rodney Wray **Date:** 10/12/2007

Organization : Fred Finch Youth Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1125-Attach-1.DOC

#112

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:

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

Sincerely,

Submitter : **Kathie Jacobson** **Date: 10/12/2007**

Organization : **Fred Finch Youth Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1126-Attach-1.DOC

#1126

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:

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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. Please contact me at 510-482-2244 if you have any further questions.

Sincerely,

#1127

Building 3, Suite 200 ▸ 2101 North Front Street ▸ Harrisburg, PA 17110-1063
Tel: 717-364-3280 ▸ Fax: 717-364-3287 ▸ mail@paproviders.org ▸ www.paproviders.org

October 12, 2007

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

To Whom it May Concern:

The Pennsylvania Community Providers Association (PCPA) submits the attached comments on proposed rulemaking *Medicaid Program; Coverage for Rehabilitative Services* (CMS-2261-P) that was published in the August 13 *Federal Register*. PCPA is a statewide trade association whose mission is to promote a community-based, responsive and viable system of agencies providing quality services for individuals receiving mental health, mental retardation, addictive disease and other related human services. PCPA represents almost 225 community–based providers that offer and support mental health, mental retardation, and substance abuse services. Member agencies cover all 67 counties in the Commonwealth and serve an estimated one million Pennsylvanians each year. As such, PCPA is in a uniquely qualified position to discuss the availability and accessibility of community-based services to persons with mental illness, mental retardation, and addictive disease.

Pennsylvania Community Providers Association comments on Centers for Medicare and Medicaid Services proposed rulemaking on Medicaid rehabilitation services (CMS-2261-P)

Provisions of the Proposed Regulations

§ 440.130(d) (1) (v) Definitions, Rehabilitation plan

Pennsylvania behavioral health services providers appreciate that requirements for a rehabilitative plan reinforce recovery principles of inclusion, choice, and responsibility. Individuals must be afforded opportunities to participate in and guide the needed services that they choose.

§ 440.130(d) (1) (VI) Definitions, Restorative services

The distinction between restorative services and rehabilitative services is not clear in this definition. The statement that "services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan" is not in keeping with the federal administration's recognition of the non-linear progression of mental health recovery. If supports are not provided, individuals' functional abilities often decline, necessitating more intensive and costly services and supports that could have been avoided had lesser intensity services been provided. Continuous improvement is not the norm for many individuals in recovery for behavioral health issues and maintenance and supportive services are often needed.

§ 440.130(d) (1) (vii) Medical services

It must be clear that both clinical and functional assessment is included. Functional assessment is essential for completion of a meaningful plan of services. Assessments must be strength-based.

§ 440.130(d) (3) Written Rehabilitation Plan

The use of a single plan that addresses treatment and rehabilitation needs is preferable for clearer understanding of recovery goals and the services and supports needed to reach those goals. Integration of treatment and rehabilitative services is more comprehensive and effective than the disjointed, traditional services of the past. Although in some circumstances, separate plans may be useful, it should be clear that a single plan is preferred. Development of a recovery plan should be phased in for existing consumers of behavioral health services as existing plans are renewed and revised. Also, although it is reasonable to assume that a rehabilitation plan addresses multiple services and supports for one individual, it is possible to interpret the rehabilitation plan as one that addresses what an individual provider of services does for an individual, for example in a team approach to services each team member develops a separate plan. CMS should clarify what is expected.

§ 440.130(d) (3) (xv) Documentation that the services have been determined to be rehabilitative services consistent with the regulatory definition.

Documentation will, in many cases, be problematic. For example, many behavioral health rehabilitative services integrate teaching and reinforcement of skills that are pre-vocational in nature, but are not focused on finding employment immediately. These may address deficits in listening, following directions, focusing on tasks, communicating and many other skills. Teaching these skills is a legitimate rehabilitative service, but it takes some writing skill and time to clearly distinguish the rehabilitative purpose and methods from a vocational program that would be covered by a different funding stream. In some cases, staff competencies and the availability of time for documentation will make defensible documentation very difficult, with potential for improper disallowances and penalties. At the least, more resources will be needed for documentation and risk management purposes that should be available for care and services and needed, legitimate services will not be provided because of varying interpretations of requirements.

§ 440.130(d) (5) Settings.

Other settings should include schools, therapeutic foster care, mobile crisis intervention services in various community settings, and other "normalizing" settings. It should be reinforced that rehabilitative services can be provided in a variety of settings, including those that are primarily paid through other funding sources. The provision of rehabilitative services in the home and community contexts in which the resulting outcomes will be used is essential for assessment of progress and to develop individuals' confidence in using the skills in applicable venues.

§ 441.45 Rehabilitative services

§ 441.45(a) (2) Requirements. Services limited to those that maximize function

Language should be included to clarify that services to attain or maintain function are covered.

§ 441.45(a) (3) Require that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

See comment on documentation above. Is this a separate plan for the individual for all rehabilitation services or an integrated plan addressing both treatment and rehabilitation needs and services?

§ 441.45(a) (4) (iv) The nature, content, and units of the rehabilitation services.

For some rehabilitative services, units of service are difficult to quantify in standard (time-based) service descriptions. Services do not always fit neatly into 15-minute increments and are more effectively provided as integral parts of an array of services, rather than discrete services.

§ 441.45(a) (4) (v) The progress made toward functional improvement and attainment of the individual's goals as identified in the rehabilitation plan and case record.

Does CMS expect a certain frequency for progress notes and recording of outcomes?

§ 441.45(b) (1) Rehabilitation does not include...services furnished through a non-medical program as either a benefit or an administrative activity, including services that are intrinsic elements of programs other than Medicaid...

Individuals have better outcomes when treated as whole persons. Providers are able to provide services when and where needed. This exclusion would fracture a system that has struggled to mold itself to focus on the individual, rather than separate systems issues. It will be extremely difficult and costly to separately identify specific services that are rehabilitative as opposed to "intrinsic elements" of programs other than Medicaid. This difficulty is apparent in many programs, but particularly for children's services. For example, through requirements for Early Periodic Screening, Diagnosis and Treatment (EPSDT) licensed practitioners can prescribe rehabilitative services that are not medical in nature (e.g., a pediatrician may prescribe swimming at a local

community pool for rehabilitation of a physical injury. Similarly, a psychologist may prescribe swimming at a local community pool for rehabilitation for an anxiety disorder.) Clear guidance is needed to identify whether and how specific services should be isolated, documented, and claimed. Determinations whether a service is rehabilitative or an intrinsic element of another program will be highly subjective and open to many interpretations. Further EPSDT requires that medically necessary services be provided. Services that are intrinsic to another program may be necessary, but capacity is often limited and the individual cannot access the program. Therefore the service must be provided, but may not be covered under these requirements.

§ 441.45(b) (2) Habilitation services

Providers have serious concerns that individuals will be adversely affected by the prohibition on Medicaid coverage of habilitation services. Individuals with mental retardation and mental health disorders will not receive needed services under this rule. It is likely that persons with mental health disorders related to autism spectrum disorders, fetal alcohol spectrum disorders, traumatic brain injury, and other developmental disorders will also be excluded from needed services because of this prohibition. For example, behavioral health rehabilitation services are integral components of service plans for children with mental retardation and serious emotional disturbances, autism, or fetal alcohol spectrum disorder. This requirement would eliminate, or severely restrict coverage of behavioral health rehabilitative services for these individuals.

§ 441.45(b)(3) Recreational or social activities that are not focused on rehabilitation and not provided by a Medicaid qualified provider; personal care services; transportation; vocational and prevocational services; or patient education not related to reduction of physical or mental disability and the restoration of an individual to his or her best possible functional level.

Documentation that distinguishes rehabilitative purpose from others will be very difficult to maintain. These activities and services are essential to recovery, yet will become unavailable due to overly restrictive interpretations and potential for recoupment and penalties. Some examples of social and recreational activities that may not be provided by a "qualified Medicaid provider," yet clearly serve a rehabilitative purpose, were provided above in comments to § 441.45(b) (1). Many older persons with behavioral health issues in particular, rely on social and recreational activities that reinforce social connectedness that is essential for overall health and wellbeing of older adults. These should be covered services.

Personal care services are sometimes needed in the course of treatment. Personal care needs should be addressed and treatment resume without having to complete excessive documentation and with minimal disruption to service. Also, skills training in personal care, which may include provision of personal care services, is a rehabilitation service. It should be clear that these services are covered.

Prevocational services related to recovery and rehabilitation for a behavioral health condition should be covered when they are provided in the context of a rehabilitative

goal. Examples of these skills include increasing attention span, staying on task, and communication and social skills that are necessary for daily living, among other skills.

V. Regulatory Impact Analysis
B. Anticipated Effects

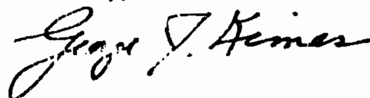
Estimates of cost savings to Medicaid are based on estimates of funds that would no longer be paid to "inappropriate other third parties or other Federal, State, or local programs." The Centers for Medicare and Medicaid Services acknowledge that they are unable to determine the fiscal impact of the rule. PCPA suggests that there will be little real savings, as providers will be forced to increase staff time and training for documentation, risk management processes to check documentation and service provision, and increased utilization of higher intensity services if many rehabilitative services are disallowed.

A payment mechanism is needed that allows services to be provided as flexible packages of services, such as assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care, and other services.

Should these regulations be finalized, implementation must be delayed to incorporate sufficient time for states to prepare, to redefine services where necessary and request waivers as appropriate, to train staff, providers, and other stakeholders, and to establish the state guidance needed to enable implementation.

Thank you for the opportunity to comment on the proposed regulations. Please contact me if there are any questions about these comments.

Sincerely,



George J. Kimes
Executive Director

cc: Joan L. Erney, Deputy Secretary, Office of Mental Health and Substance Abuse Services
Sabrina Tillman-Boyd, Director, Bureau of Policy and Program Development
Kevin Casey, Deputy Secretary, Office of Developmental Programs
Jeffrey Petraco, Director, Bureau of Program Operations

CMS-2261-P-1128

Submitter : **Emily Niederman** **Date: 10/12/2007**

Organization : **Coalition to Preserve Rehabilitation**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment.

CMS-2261-P-1128-Attach-1.DOC

#112

October 12, 2007

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

Re: Comments on the Medicaid Rehabilitative Services Option (CMS-2261-P) from the Coalition to Preserve Rehabilitation

Dear Acting Administrator Weems:

These comments are submitted on behalf of the Coalition to Preserve Rehabilitation ("CPR"). CPR is a coalition of national consumer, clinician and membership organizations with the goal of preserving access to rehabilitation services. CPR members strongly support policies that ensure access to rehabilitative care so that individuals with disabilities, injuries or chronic conditions may regain and/or maintain their maximum level of independent function.

On August 13, 2007, the Centers for Medicare and Medicaid (CMS) issued a Notice of Proposed Rule Making (NPRM) that would save the federal government $2.2 billion over five years by restricting access to services provided under the Medicaid Rehabilitative Services Option. Despite the NPRM's stated intent in the preamble – to ensure provision of services in the "best interests" of the recipients – these proposed changes will dramatically decrease access to community-based rehabilitation services for individuals with mental illness, developmental disabilities, and substance abuse, as well as children in our nation's child welfare and foster care systems experiencing physical and mental disabilities. This harmful proposal stands in stark contrast to goals associated with President Bush's New Freedom Initiative, the Americans with Disabilities Act and its Olmstead Supreme Court decision, Medicaid's Money Follows the Person grants, and other government initiatives aimed at improving independent, community living outcomes.

Many CPR members opposed a similar proposal in 2005 as legislative language sent from the Secretary of the Department of Health and Human Services (HHS) to Congress. HHS offered this legislative proposal as a potential means of achieving savings in the Deficit

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Reduction Act of 2005 (DRA). However, the proposal was ultimately rejected by Congress due to serious concerns regarding its impact on access to community living for individuals with disabilities and the financial strains it would place on state and local governments. CPR members remain unclear as to why CMS continues to push these harmful changes when there is such widespread concern regarding their impact from Members of Congress, states, providers, clinicians, and advocates. If changes to this benefit are needed, we believe that the legislative process is the appropriate process and therefore request that CMS withdraw this proposed rule to make substantial changes to the Medicaid Rehabilitative Services Option without Congressional directive.

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

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

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

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

Given the variability of mental illness and developmental disabilities, it would be difficult for many providers, clinicians, consumers and other stakeholders to develop written rehabilitation plans that accurately predict the functional progress to be made by most individuals with these disabilities. In addition, some of these conditions are episodic in nature and change dramatically over time. We encourage CMS to ensure that determinations of appropriate rehabilitative "progress" (and any termination of services based on these determinations) are made on a case-by-case basis by qualified experts.

Requirements and Limitations for Rehabilitative Services – Limitations for Rehabilitation Services

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

The NPRM would disallow Federal Financial Participation (FFP) for services under the rehabilitative services option that are considered an "intrinsic element" of another federal, state

or local program. *Section V "Regulatory Impact Analysis," Subsection C "Alternatives Considered,"* of the NPRM states that, in drafting this regulation, the agency considered "not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs." However, the rule also states that the absence of this provision would result in a "less efficient use of Medicaid funding because.... increased Medicaid funding would have simply replaced other sources of funding." CPR strongly disagrees with these assumptions.

Implementation of the intrinsic element standard would essentially remove the Medicaid safety net, a defining characteristic of this entitlement program. Medicaid coverage is already subject to third party liability – a standard which establishes Medicaid as the "payor of last resort" without harming the beneficiary. CPR members feel that this proposed "intrinsic element" standard is not only unnecessary in light of third-party liability standards already in place, but will have the unfortunate impact of reducing access to vital rehabilitative services for many individuals currently receiving them under this option.

As written, the new policy appears to exempt federal Medicaid from covering its share of the cost of Medicaid-covered rehabilitative services that may be *allowable* under vocational, prevocational, educational, substance-abuse, mental health, foster care, and assisted living programs. However, the rule does not indicate that the services have to be provided by these other programs or received by the beneficiary in order for Medicaid to withhold FFP. As a result, the onus is taken off Medicaid to ensure access to these services and placed instead on the Medicaid recipient who is likely an individual with mental illness, development disability and/or substance abuse issues and often have difficulty navigating the bureaucracy that limits access to rehabilitation.

Denial of FFP does not simply render important Medicaid rehabilitative services unnecessary. State and local governments may attempt to help ensure that individuals maintain access to these services at substantial costs to their governments. However, state and local governments have budgetary constrains and are often financial strained. The ability of these governments to absorb this cost-shift will vary widely and significant access problems will result. While there indeed may be discretionary federal, state, and local programs that allow similar rehabilitative services to those currently being provided under Medicaid, there is no indication that these other programs will be able to provide such services to a large influx of Medicaid recipients. This disruption in the continuum of care for some of that nation's most vulnerable individuals will ultimately lead to greater institutionalization and less independent living, likely costing Medicaid more in the long-term.

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

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

CPR members are very concerned that CMS is trying to force a medical model onto a benefit clearly designed to provide psychosocial rehabilitation services to individuals with complex disabilities and chronic conditions. Medical rehabilitation, which one might complete following an injury or accident and likely involves time-limited services, is not a concept often applicable to individuals with cognitive disabilities, mental illness, and substance abuse issues. For such individuals, maintenance and attainment of function is as important as regaining of function and will only achieved through ongoing access to rehabilitative/habilitative care.

Additionally, we believe it is discriminatory for CMS to provide services under this option to those who have once had skills associated with independent living, but deny similar services to those who have never attained such skills. It would be wholly unreasonable to cover hip replacement surgery to someone who fell and shattered their hip, but deny the same surgery to someone born without functional hip sockets. In the same manner, denial of services based on whether an individual is 'attaining' versus 'regaining' a skill is inequitable and contrary to statutory Medicaid requirements regarding comparability of benefits.

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

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

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

Additionally, CPR members recognize that there are several states currently providing important habilitation services to Medicaid recipients with disabilities through adult day habilitation programs. Section 6411(g) of the Omnibus Budget and Reconciliation Act of 1989 (OBRA 89) placed a moratorium on elimination of coverage of day habilitation services for people with mental retardation in states that included such services in their state Medicaid plan prior to enactment. The statute states that CMS may issue a proposed rule outlining the specific types of day habilitation and related services that a state may cover under the rehabilitative services option and CMS contends that the NPRM issued on August 13, 2007 serves as the NPRM referenced by OBRA 89. However, CPR argues that the terms set forth in this proposed rule would completely *eliminate* day habilitation services from coverage under the Medicaid

rehabilitative services option and, thus, are inconsistent with the terms set out in OBRA 89 which explicitly permit CMS to specify the *types* of day habilitation and related services covered under this option.

Conclusion

In conclusion, CPR believes any increased utilization of community rehabilitative services represents a much delayed shift in the Medicaid program away from outdated, institutional living to independent, community living for people with disabilities. For this reason, CPR strongly opposes this NRPM because it will restrict the ability of state Medicaid programs to provide the services that essentially allow this broadly supported shift to take place. **We strongly urge CMS to withdraw the proposed rule.**

We thank you for this opportunity to comment.

Sincerely,

American Association of People with Disabilities

American Association of Physical Medicine and Rehabilitation

American Occupational Therapy Association

American Therapeutic Recreation Association

Association of Academic Physiatrists

ACCSES

Brain Injury Association of America

Center for Medicare Advocacy, Inc.

Child Welfare League of America

Christopher and Dana Reeve Foundation

Goodwill Industries International, Inc.

National Association for the Advancement of Orthotics and Prosthetics

National Association of Social Workers

National Council on Independent Living

National Multiple Sclerosis Society

National Spinal Cord Injury Association

Paralyzed Veterans of America

United Spinal Association

CMS-2261-P-1129

Submitter : **Date: 10/12/2007**

Organization : **Nat'l Assn for Children's Behavioral Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1129-Attach-1.DOC

#112

1025 Connecticut Avenue, NW, Suite 1012, Washington, DC 20036
(202) 857-9735 phone (202) 362-5145 fax nacbh@verizon.net

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-2261-P

Dear Gentlepersons:

The National Association for Children's Behavioral Health (NACBH) appreciates the opportunity to comment on the proposed rule pertaining to the Medicaid Program: Coverage for Rehabilitative Services, published in the Federal Register on August 13, 2007.

As an association representing providers treating and attending to the needs of children and youth with serious emotional disturbances and their families, we are acutely aware of the benefits of rehabilitative services under Medicaid, the value of coordinating these services with other treatment and service plans, and their vital importance to this population's health, resilience and recovery.

NACBH represents multi-service treatment agencies providing a wide array of behavioral health and related services. Services provided by NACBH members include assessment, crisis intervention, residential treatment, therapeutic group homes, in-home treatment, therapeutic foster care, independent living, alternative educational services, respite, day treatment, outpatient counseling and myriad community outreach programs. Providers serve clients from the mental health, social service, juvenile justice and educational systems. Nearly one hundred percent of the clients served are publicly funded children and youth, and as such, Medicaid provides the critical safety net for their health care needs. We have closely monitored changes to the Medicaid program over the past three decades.

The evolution of the Medicaid program has been coupled with the devolution of the traditional health care service delivery system. Beginning in 1981 with the passage of the Medicaid Home and Community Based Services Program, continuing with the Supreme Court Olmstead decision in 1999, informed by that year's Surgeon General's report on mental health, and pursuant to the recommendations of the President's New Freedom Commission in 2003, federal emphasis has been to move away from institutional services to develop a broad array of intensive community-based services and supports to maintain individuals in their homes and communities when appropriate. States participated in the evolution, in part, by adopting the rehabilitation option to cover far more therapies and treatments, using the Congressionally-approved definition of rehabilitation services as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for

maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." As a result, and due in large part to the varying and multiple ways in which states have developed their federally-approved plans, rehabilitation services have been offered in a variety of settings, by a range of providers, and through diverse and creative treatment models.

We understand that the increased reliance of states on the rehabilitation option, and Medicaid in general, has raised policy concerns about the costs and proper utilization of the program, but question whether the appropriate manner in which to answer or investigate those concerns is with a broad and sweeping administrative change to overall practice and the entire rehabilitation option.

CMS' Authority to Proceed with Rulemaking

We also question CMS' authority to propose this rule. The Deficit Reduction Act of 2005 proved to be the penultimate in Congressional approval in now allowing states broad flexibilities in benefit design, cost-sharing and eligibility requirements for Medicaid. It was, however, during these same discussions that Congress rejected efforts to restrict the definition and application of the rehabilitation option, while specifically addressing similar concerns with the optional targeted case management benefit. For CMS to now attempt changes that Congress expressly rejected is against statutory intent.

Proposed Rule: Background: Missing Element: EPSDT

Both the Background and proposed rule are silent on the specific and complex needs of children and youth. Medicaid mandates that all beneficiaries under the age of 21 receive all federal Medicaid covered services, whether or not the service is defined in the state plan or covered for adults. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are required to "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan." Perhaps the rule was silent on EPSDT because of the inherent mandate and understanding that children will continue to receive all services necessary to correct and/or ameliorate their condition. To assure clarity and intent, language should be added acknowledging the role of EPSDT in assuring that all eligible children receive all necessary and appropriate services as part of comprehensive, individualized treatment plans.

Background: Ensuring Fiscal Integrity

In proposing this rule, CMS has stated its intent to ensure the fiscal integrity of claimed Medicaid expenditures. We support CMS in its desire to assure program integrity and fiscal accountability. CMS currently has the authority and responsibility to identify and act upon fraud and abuse within the system. Furthermore, CMS has the authority and opportunity to provide clear guidance and adequate technical support to states as they develop their Medicaid plans prior to approval. CMS is then responsible for compliance oversight. In lieu of sweeping regulatory changes, we recommend that CMS first properly exercise these existing authorities.

Regulatory Impact Analysis: Federal Requirements Not Met

CMS correctly enumerates its responsibilities to analyze the proposed rule's costs and benefits, then acknowledges that no analysis has been done. CMS states that it does not collect data on spending for rehabilitative services, did not conduct a comprehensive review of the services, and developed its estimate of the proposed rule's federal savings "after consulting with several experts." Since all states and the District of Columbia are delivering some form of rehabilitative services under Medicaid, we believe that more than several experts were available for consultation. The disclaimer that "there is a significantly wide range of possible impacts" does not absolve CMS of its responsibility to produce an informed analysis, including consideration of regulatory alternatives. CMS' statement that it has not determined

"what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, state or local government agencies or geographic regions" directly calls into question the Secretary's certification that this major rule would not have a direct impact on small businesses, nonprofit organizations, governmental jurisdictions or rural hospitals that currently provide rehabilitative services. We also question CMS' assertion that the rule would not mandate spending in any one year of $120 million or more. Without knowledge of the consequences of state plan amendments, how can CMS make this assertion? Before CMS chooses or is allowed to proceed with regulatory changes, consultation with all affected parties should take place, including states, counties, managed care contractors, providers and consumers. We recommend that the proposed rule be withdrawn until CMS conducts the required regulatory impact analysis.

Provisions of the Regulations: Rehabilitation Plan

We strongly support the description and proposed elements of written rehabilitation plans, but would add that they should be coordinated with other treatment or service plans. This is particularly critical for children, since they are often served by multiple systems and programs.

Provisions of the Regulations: Intrinsic Elements of Programs Other Than Medicaid

Concerned that the "broad language of the current statutory and regulatory definition" has had the unintended consequence of allowing states inappropriate flexibility in covering rehabilitation services, CMS is proposing to deny coverage for services that may be "intrinsic to" other public programs, i.e., that Medicaid not cover services "furnished through a non-medical program either as a benefit or administrative activity, including 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." The introduction of this new "intrinsic element" language directly conflicts with Medicaid's obligation to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services identified under EPSDT. The proposed rule provides no clarity on what is meant by "intrinsic element," how determinations would be made to assess whether a service was intrinsic to another program, or any acknowledgment that while other federal, state or local programs may sometimes provide or identify the need for services like Medicaid's, they may not be obligated nor adequately funded to assure provision of such services.

In the case of public education programs, we would remind CMS that as a result of the Medicare Catastrophic Coverage Act of 1998, the Secretary is prohibited from denying or restricting federal Medicaid payment to states for covered services provided as part of an Individualized Educational Program or an Individualized Family Services Plan under the Individuals with Disabilities Education Act.

In the case of foster care and other child welfare programs, we note that children receiving Title IV-E foster care or adoption assistance are automatically entitled to Medicaid, confirming Congressional intent that Medicaid provide all necessary health care services to these children.

In the case of parole, probation and juvenile justice programs, we believe current regulations are sufficiently clear on when federal Medicaid funds are not available. In the case of the other programs referenced, it also seems sufficiently clear that their purposes and responsibilities are not primarily related to health care.

Provisions of the Regulations: Therapeutic Foster Care

The rule proposes to limit payments for therapeutic foster care "except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services." CMS seems to have identified therapeutic foster care as a particularly high risk for fraudulent

or abusive federal claiming by states. As in other areas of the proposed rule, we believe CMS already has the authority to require states to define services, qualified providers and payment methodology in their state plans, within federal Medicaid law, while recognizing that states have the authority to license and qualify providers in their programs. If CMS has approved inadequate or improper state plans or has identified fraudulent or abusive federal claiming, those are issues to be addressed outside of new regulation.

If CMS' objection to "packaged therapeutic foster care services" is the bundling of services and payment, CMS should consult with states and other experts to determine whether there is a more appropriate manner of administering this effective benefit. "Packaging" is not unprecedented in Medicaid. For example, capitation exists in managed care, all-inclusive rates are accepted for inpatient psychiatric hospitals and nursing homes, and daily or case rates are used for rehabilitation services such as Assertive Community Treatment.

We would hope that CMS is not questioning the validity or value of therapeutic foster care itself. According to the 1999 Mental Health: A Report of the Surgeon General, therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders, and the evidence base indicates that it is more effective for children who can be safely served in the community than are more intensive treatment settings. States have defined licenses and standards for therapeutic foster care, and three national accrediting bodies recognized by CMS (the Joint Commission, the Council on Accreditation and the Commission on Accreditation of Rehabilitation Facilities) accredit therapeutic foster care providers.

Finally, if there is a need for states to entirely redefine therapeutic foster care in their state plans, sufficient time and technical assistance should be available to do so without broadly and abruptly disrupting services to children, similar to the delayed compliance period planned for states to transition habilitation services to a more appropriate Medicaid authority.

Provisions of the Regulations: IMD Exclusion

The proposed rule reiterates current law which excludes payment for services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of a "community residential treatment facility of over 16 beds." The rule, however, written in the future tense, conflicts with long-standing practice where states have been paying certain child care facilities for rehabilitation services as part of federally-approved state Medicaid plans. Practice has evolved concurrent with the development of community-based services and the plethora of settings in which services are now provided. The vagaries and varieties of state licensure have contributed to the current confusion of what is or is not an IMD. To summarily prohibit payment for services which have long been part of the fabric of the states' delivery systems would create an inordinate disruption in service. Congress has made it clear over the years, specifically in repeated affirmation for retaining the EPSDT mandate, that it is necessary to provide a comprehensive array of services to children and youth. Before this rule is implemented, a thorough assessment of all levels of 24-hour care should be undertaken to assure that children and youth have access to and are receiving the most appropriate and effective services.

Proposed Regulatory Language

§ 440.130(d)(1)(v): Include coordination with other treatment and service plans in the definition of rehabilitation plan.

§ 441.45(b): Delete this entire section. This partial list of exclusions is not necessary as most of the services listed clearly do not meet the requirements of § 441.45(a) or other relevant sections of Medicaid regulations, and the remainder are too broadly referenced to be identified as excluded.

We appreciate the opportunity to comment and offer the resources of this Association as you assess the implications of this rule on the unique needs of children and youth.

Sincerely,

Joy Midman
Executive Director

CMS-2261-P-1130

Submitter :

Organization :

Category : **Individual**

Date: **10/12/2007**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1130-Attach-1.TXT

#112

October 10, 2007

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

Dear Sir(s) or Madam(s):

The Council for Exceptional Children (CEC) is the largest professional organization of teachers, administrators, parents, and others concerned with the education of children with disabilities, gifted and talents, or both. As a member of CEC, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

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.

Major Issues and Concerns

CEC has major issues with the proposed rule. We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures 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. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

1) **Unjustified and unnecessary, the proposed rule would not further the purposes of Title XIX of the Social Security Act.**

A central purpose of the Medicaid law is to provide rehabilitative services. Section 1901 of the Social Security Act reads,

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish...(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

Not only does the proposed rule not further this core goal of Medicaid, it 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. The Regulatory Impact Analysis makes numerous assertions that are contradictory and appear intended to mask the impact of the proposed rule. For example, it states that, "the Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act." In reality, the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on providers. The proposed rule also states that, "...because FFP [Federal financial participation] will be excluded for rehabilitative services that are included in other Federal, State, and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This would impose substantial increased costs on states that must change many of their administrative practices and that must either limit access to medically necessary services or increase state spending to provide services that were previously eligible for Medicaid FFP.

2) **Contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.**

In several instances, we believe that the proposed rule exceeds the Executive's regulatory authority and is inconsistent with Medicaid law.

a. **The proposed rule would hinder access to prevention services.**

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).

b. **The proposed rule illegally imposes an intrinsic element test.**

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." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

c. The proposed rule does not fully comply with the EPSDT mandate for children.

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.

3) Implementation of the proposed rule would severely harm several Medicaid populations.

We believe that the proposed rule could severely restrict access to services and cause significant harm to several Medicaid populations:

a. The proposed rule would harm people with mental illness.

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would place Medicaid beneficiaries with mental illness at risk for poorer health outcomes and this could lead to relapse or new episodes of illness. Such incidents typically result in increased utilization of high cost services such as emergency room care and inpatient care. The proposed rule does not alter Medicaid eligibility, it would simply restrict access to certain services—often those that are most effective and the least costly.

Therefore, we also worry that this proposal could lead to increased Medicaid spending if individuals are forced to get more costly, but less effective or appropriate services. In particular, we are concerned that the proposed rule could lead to increased hospitalizations that would be otherwise preventable, through the provisioning of community-based rehabilitative services.

It should be noted that given the high proportion of Medicaid beneficiaries receiving rehab option services that have mental illness, all of the harms and concerns and raised in these comments should be considered to apply to people with mental illness.

b. The proposed rule would harm people with intellectual and other developmental disabilities

The proposed rule would severely harm people with intellectual disabilities (formerly called mental retardation) and other developmental disabilities in two major ways: it eliminates longstanding programs for providing day habilitation services to people with developmental disabilities, and it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions (a statutory term for people with intellectual and other developmental disabilities).

Elimination of FFP for habilitation services provided under the rehab and clinic options: In 2006, roughly $808 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities. In the same year, it has been estimated that approximately 52,000 people with intellectual and other developmental disabilities received day habilitation services through the clinic and rehab options (Unpublished estimates, David Braddock, Coleman Institute for Cognitive Disabilities, University of Colorado). We believe that this proposed restriction contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239). This section reads:

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

In contradiction to the plain language of Section 6411(g) of OBRA '89, the proposed rule **does not** specify which day habilitation services that a state may cover. Instead, the proposed regulation would prohibit the provisioning of *any* habilitation services under paragraphs (9) and (13) of section 1905(a) of the Social Security Act. We believe that this NPRM exceeds the regulatory authority granted by the Congress and must be withdrawn. At a minimum, since the regulation does not comply with the OBRA '89 language, the Secretary would not have authority to deny FFP for habilitation services provided in those states with approved state plan coverage prior to June 30, 1989.

We also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that individuals receive the highest quality habilitative and rehabilitative services according to current standards of treatment. The preamble of the proposed rule states that the rehab option is not a "custodial" benefit. We agree with the Secretary that state programs operated under the rehab and clinic options should set high standards for delivering active treatment and for innovating to develop programs for people with intellectual and other developmental disabilities that maximizes their ability to attain, maintain, and retain their maximum ability to function, consistent with the original conception of rehabilitation, as found in section 1901 of the Social Security Act.

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under their state plans to transition to appropriate Medicaid coverage authorities, such as section 1915(c) waivers or the Home and Community-Based Services State plan option under section 1915(i)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

Further, section 1915(c) waivers and the section 1915(i) option are not equivalent to the rehab or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something that is not required for rehab or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the

option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists, something that is not permitted for clinic or rehab option services. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006). Shifting habilitation services to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable.

We strongly recommend that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions : We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehab option services for people with mental retardation and related conditions. CMS policy appears to be that these individuals should receive services only through waiver programs (or the related 1915(i) option), and this is nonsensical in circumstances such as where a person with an intellectual disability has a knee replacement and needs services to regain physical functioning of the knee or where a person with epilepsy develops a substance abuse disorder. Further, this policy is likely to increase federal and state costs, as benefits for home- and community-based services (HCBS) waiver programs tend to be far more extensive than is generally provider under the rehab option.

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" -- people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. This policy was not the result of Congressional action and preceded a period of significant progress in advancing the civil rights of people with disabilities.

While the Americans with Disabilities Act (ADA) does not apply to federal administration of Medicaid, we believe that this policy violates, at a minimum, the spirit of the ADA, wherein the Congress was intending to impose a comprehensive national prohibition against discrimination on the basis of disability.

We urge the Secretary to rescind this constraint on rehab option services that is so blatantly stigmatizing and discriminatory to people with intellectual and other developmental disabilities.

4) **Challenges efforts by states, school districts, and early intervention providers to effectively deliver health care services to children with disabilities in school/early childhood settings.**

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to a free, appropriate public education and early intervention services in conformity with an individualized education program (IEP) and an individualized family service plan (IFSP). An IEP/IFSP is developed for eligible individuals with disabilities and describes the range of services and supports needed to assist individuals in benefiting from and maximizing their educational/developmental opportunities. The types of services provided under an IEP/IFSP include services such as speech pathology and audiology services, and physical, psychological and occupational therapies. While IDEA confers rights to individuals and obligations on the part of school systems/early intervention providers, it is not directly tied to a specific program or an automatic funding source. For years, the Federal government has failed to provide anywhere near the level of funding promised in the IDEA statute. States' ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP/IFSP helps defray some of the state and local costs of implementing IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IEPs/IFSPs have been a contentious issue in the past. Some time ago, HCFA attempted to limit the availability of Medicaid funding for services under IDEA. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP/IFSP. Under current law, the Social Security Act at section 1903 (c) reads,

> "Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act."

Our concern here 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.

For these and other reasons, we urge the Secretary to withdraw the proposed rule.

Thank you for allowing the public to provide comments on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid Program and for considering CEC's recommendations.

Sincerely,

Denise D. Woods

Submitter : **Date: 10/12/2007**

Organization : **NHS Human Services**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1131-Attach-1.DOC

#1131

October 12, 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

NHS Human Services, Inc. (NHS) 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.

NHS is a non-profit corporation which, along with its subsidiary corporations, provides behavioral health, addictive disease, intellectual and developmental disability, autism, juvenile justice, therapeutic foster care and eldercare services. NHS began operations in 1981 and has become one of the largest non-profit providers of community-based services to the public sector. NHS and its directly and indirectly wholly owned subsidiaries provide nearly $300 million of services annually. NHS employs over 6,500 individuals in Pennsylvania, New Jersey, Virginia and Ohio and provides support to over 45,000 adults and children each year. Ninety-eight percent of the funding NHS receives comes from public sources including Medicaid, Medicaid MCO, child welfare and county funding. NHS supports some of the most vulnerable individuals in the human service system through outpatient, residential, education, and foster care programs.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our organization 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 a disability 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).

Failure to provide a supportive level of rehabilitation would result in an individual's deterioration necessitating a reinstatement of more intensive services. We are concerned that the current proposed regulation could be interpreted as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services.

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 and have 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. This should 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(viii)(3) Written Rehabilitation Plan

Our recommendations for amendments are identified below. In addition, there are some issues where the regulation is unclear and issues are unaddressed. Without attention to the suggestions and recommendations from providers, this new requirement will add significantly to the administrative time and expense of organizations serving individuals in need of rehabilitative services.

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Is a progress note needed 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. Each individual who does qualify for services will have to have an additional new 'rehab' plan completed which delineates all services. For any bundled treatment service, such as Community Treatment Team/Assertive Community Treatment, each service would need to be unbundled and each service would need to meet the new definition. Any service that is maintenance or habilitation would not be funded. The regulation does not prohibit a single plan of service, but it would be extremely helpful if CMS would clarify what is preferable.

The proposed regulation does discuss recommending alternate providers; however, it is unclear as to whether all providers or an alternate provider needs to be identified. So as it stands, the language is unclear in terms of the requirement. This requirement could be place an undue burden on providers.

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.

<u>Recommendations</u>:

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

X that the plan be written in plain English so that it is understandable to the individual.

X 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.

X that the plan of services be based on a strengths-based assessment of needs;

X that the plan include intermediate rehabilitation goals;

X that, as indicated, the plan include provisions for crisis intervention;

X that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

X 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. NHS Human Services has programs that are treatment-focused for children and adults that should be considered treatment. We believe that Therapeutic Foster Care is treatment and that it should be considered a residential treatment program that includes components that make it clinically effective and therefore should be covered by Medicaid – behavioral interventions and a therapeutic milieu that are part of the comprehensive treatment program. These components should be Medicaid reimbursable. These treatment interventions

are developed and overseen by Mental Health professionals through a formal treatment planning process – all things that conform to Medicaid requirements. The room and board component would be covered through Children &Youth funding.

In addition, it is not clear whether family based mental health services would be impacted as the proposed bill makes reference to services being provided only to the identified client thus eliminating treatment to family members.

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). We certainly concur with Medicaid's concern in terms of delivered services not being reimbursable under the rehabilitative rule – in such instances as non-medical services and potential fraud. However, we think that the proposed rule goes too far in including services which, at least we consider, are bona fide treatment services which should not be excluded from being Medicaid reimbursable where they deliver treatment services regardless of the setting in which they are delivered - such as Therapeutic Foster Care or treatment services in Juvenile Justice Programs or in educational settings.

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), 1396 (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:

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.

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.

The preamble states that Medicaid-eligible individuals in non-medical programs are entitled to

all Medicaid rehabilitative services that would have been provided to individuals outside of those non-medical 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.

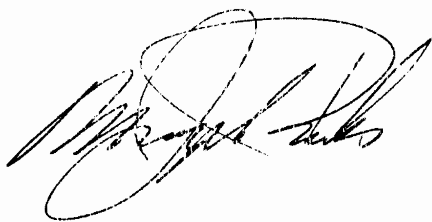
It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence 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 organization level. The re-design of programs, development of new forms as well as staff training, and administrative processes all pose significant challenges at the provider level.

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

Sincerely,



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