CMS-2261-P-1132

Submitter : Jon d'Alessio **Date:** 10/12/2007

Organization : Fred Finch Youth Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1132-Attach-1.DOC

#1132

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

Sincerely,

Submitter : Ms. Penny Wyman **Date:** 10/12/2007

Organization : Ohio Association of Child Caring Agencies

Category : Other Association

Issue Areas/Comments

Background

Background

See Attachment

Collections of Information Requirements

Collections of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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Provisions of the Proposed Rule

Provisions of the Proposed Rule

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Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Response to Comments

Response to Comments

See Attachment

CMS-2261-P-1133-Attach-1.DOC

1133

October 12, 2007

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

Re: CMS 2261-P; Comments on Proposed Rule *Medicaid Program; Coverage for Rehabilitative Services*

To Whom It May Concern:

The Ohio Association of Child Caring Agencies (OACCA), represents 70 public and private child- and family-serving member agencies across the state and, on their behalf, respectfully submits these comments on the Proposed Rule for the Medicaid Program's Coverage of Rehabilitative Services (CMS-2261-P) published in the Federal Register on August 13, 2007 (72 Fed. Reg. 45201).

OACCA appreciates that this proposed rule is intended to move the nation to a more accountable system that will promote administrative and managerial integrity and that will be more closely dependent on providers' ability to demonstrate on-going efficacy of treatment. In attempting to do so, however, significant ambiguity remains and OACCA and its member agencies are concerned that various provisions of the proposed regulation—albeit well-intentioned—will seriously impair our ability to provide effective community-based services for children involved with the child welfare, juvenile justice and behavioral health and foster care systems.

We are troubled by the Regulatory Impact Analysis's certification that CMS-2261-P "would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act." Since the proposed regulation significantly changes the scope of rehabilitative services that have been available to children and other individuals with mental and physical disabilities for quite some time and at the same time imposes a large number of new administrative requirements, it is certain that providers will be impacted, but more important will be the number of children who will suffer as a result.

Reducing federal Medicaid spending on rehabilitative services by $2.2 billion between FY 2008 and FY 2012, and not providing other means to serve this population calls into question the statement that "we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule." In fact, our state will not be able to continue to provide the services children in their care need in order to return home and rejoin their communities with current resources.. Meeting the requirements of the Child and Family Service Reviews will be impossible, as a result. We respectfully request CMS to continue to be Ohio's partner so that we can continue to provide health care, including behavioral health care, for eligible and therefore entitled, children and to meet our federal CFSR goals.

According to the Public Children Services Association of Ohio 2007-2008 Fact Book, there were 17,112 Ohio children in custody on January 1, 2006. Eighty-five percent (85%) or 14,545 of these children experienced some kind of mental health needs. Seventy percent (70%) of the children and youth in our juvenile justice have mental health diagnoses. Once they leave state detention, the need for services for these young people is both acute and chronic and prepares them for re-entry to school and community. Ohio depends on our federal partner, CMS/Medicaid, to meet these needs. These mental health services are not intrinsic to the child welfare system – their mission is child protection – nor to the juvenile justice system – their mission is public safety.

Regardless of the reason for removing children from their homes, breaking their familial ties and the instability (temporary, in most cases) that ensues, exacerbate any original mental health issues children may have. Numerous studies document that children in foster care have medical, developmental and mental health needs at a rate that far exceeds those of other children, even those living in extreme poverty.

When children are removed from their homes and placed in custody due to no fault of their own, Medicaid provides many of these children with health care that helps them get on the road to recovery. Medicaid Rehabilitative Services are especially vital, as they offer a realistic opportunity—in the least restrictive setting possible— to reduce the physical and/or mental disabilities that many children in foster care have, thereby restoring the child's functioning level, decreasing lingering and long-term negative impacts of trauma and exposure to violence, abuse or neglect, and ultimately reducing costs. Rehabilitative services are community-based and consumer- and family-driven services, in line with both the President's New Freedom Commission on Mental Health and the U.S. Surgeon

General's recommendations. In 2005, despite states' efforts to provide needed services, the U.S. Department of Health and Human Services Child and Family Services Reviews (CFSRs) found that only one state achieved substantial conformity by ensuring that children in their foster care system physical and mental health needs were met.

The staff and membership of OACCA appreciates this opportunity to comment on the proposed regulation. We look forward to working with you to ensure that federal enhances our ability to meet our children's needs.

PROVISIONS OF PROPOSED RULE:

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

440.130(d)(1)(iii), Qualified providers of rehabilitative services: We share CMS's desire for providers of rehabilitative services to be appropriately educated, certified and supervised. At the same time, we urge that States be allowed some latitude to ensure that service access is not further restricted as a result of standards set too high. Many areas of Ohio do have enough (or in some cases, any) licensed independent practitioners, but our citizens in these areas of the state remain in need of services.

440.130(d)(1)(v), Rehabilitation plan: The requirement for a written rehabilitation plan will help achieve accountability, but we suggest that children's developmental stages and the often difficult-to-predict phases of restoration, particularly after intense trauma, be taken into account. Children normally progress through developmental stages, to "restore them to functioning" may mean, for children, regression. Similarly, children—as all individuals suffering from physical or mental impairment—can quickly deteriorate, necessitating an adjustment to the rehabilitation plan's enumerated goals. Providers therefore should be granted ample flexibility to adjust children's rehabilitation plans in the form of crisis planning so that prior progress is not sacrificed.

As regards requiring that "the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing," must participate in treatment planning, we applaud the person- and family-centered approach taken. However, we respectfully remind CMS that children involved with the child welfare and foster care systems—though the beneficiary of services—are not always competent to be heavily involved in the process, and that their families may not be, either. Our preliminary research shows that it is the rare county case worker – otherwise known as 'the individual's authorized decision maker" – that is available or credentialed to make clinical decisions.

Similarly, much of this population has limited contact with certain members of their families, so we ask that CMS add language to ensure that "family" is defined broadly to include guardians and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, and group or residential care staff).

440.130(d)(1)(vi), Restorative services: Under the proposed definition, restorative services and covered rehabilitative services are contingent on the individual having a functional loss (i.e.: had the *ability* to perform the function in the past, even if not having actually performed it). This definition may work in the adult context, but does not appropriately incorporate children's developmental stages. A child may not have experienced a "functional loss" per se or have had the ability to perform the function in the past because they had not matured sufficiently to do so. For children, rehabilitative services should restore their ability to grow and develop to adulthood. This definition should be rewritten to include this concept.

OACCA hopes that CMS will continue to allow us to help vulnerable children and youth on the path towards *meaningful* recovery if at the moment s/he reaches the originally stated goal, services and accompanying funds are withdrawn. Were that to happen, the child's progress would be nullified, his/her health would likely rapidly deteriorate—only requiring more intensive and more costly intervention at a later date that could possibly force the child into a more institutional setting. Maintaining functioning should be a permissible goal under the rehabilitation plan if the child/youth's would otherwise deteriorate.

440.130(d)(2), Scope of services: This provision maintains the definition of rehabilitative services as "medical or remedial services," but to more accurately reflect the entire proposed regulation that encompasses certain "restorative services" as covered rehabilitative services (440.130(d)(1)(vi)), the phrase "restorative services" should be added.

440.130(d)(3), Written rehabilitation plan: OACCA supports the written rehabilitation plan's goals. We submit only the following clarification questions and recommendations:

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The written rehabilitation plan should incorporate any concurrent health or behavioral health plans that the child has, as well as with any child welfare service plan for the child and family. This will increase coordination of services and lessen administrative burden, resulting in better outcomes and lower costs.

OACCA recognizes the benefits of involving significant individuals to the child in developing, monitoring and modifying treatment plans and services, but asks that CMS add language that acknowledges the sometimes difficulties involved in this for many children involved with the foster care system. These children, especially those whose parents' rights have been terminated, may not have families to involve. We therefore recommend adding to 430.130(d)(3)(ii) and (iii) (or alternatively, to a new subsection) the following language: "For a recipient involved with the child welfare or foster care systems, input or guidance in the development, review, and modification of plan goals and services may be obtained from the child's parents when appropriate, guardians, and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, and group or residential care staff)."

We applaud CMS' desire to have the child involved in their treatment planning, but this should depend on the age and maturity of each child. Language or a new subsection should be inserted stating that "A child under 18 should be as involved in the development, review, and modification of the plan as is deemed appropriate."

If the child is found to be competent to participate in the process, any materials provided to the child to inform him/her should be developmentally and culturally appropriate.

In regards to 440.130(d)(3)(xi), a standardized list of alternate providers should be acceptable as it will provide the relevant information to all children and their families.

Section 440.130(d)(3)(xii) requires the written plan to include the individual's "relevant history, current medical findings, contraindications, and identify the individual's care coordination needs." This is not always available, particularly for children who are placed on an emergency basis. Many children in the foster care system do not have primary care doctors. This subsection should emphasis that the written plan should reference these documents *when available.*

441.45(b), Newly Deemed Non-Covered Services, Intrinsic Element Standard:

Rather than making sweeping changes through rulemaking, OACCA believes that these important decisions that impact vital community-based services should be debated thoroughly and done through the legislative process. It is our understanding that some of this debate already occurred when Congress deliberated over the Deficit Reduction Act of 2005 (DRA, P.L 109-171). During that process, Congress specifically rejected adopting the "intrinsic elements" test for Medicaid rehabilitative services that CMS-2261-P would put in place. This indicates that Congress foresaw the dangers of such language and instead, desires for Medicaid rehabilitative services to remain a strong and viable source of services. The language proposed in 440.145(b) will ultimately burden already struggling programs and further restrict access to services for children in foster care who are eligible for Medicaid.

Denying services to children who come to us because they are victims of abuse, neglect and dependency compounds their injury. It is especially egregious considering their extreme health needs and that the Department of Health and Human Services, in analyzing the Federal Child and Family Services Reviews (CFSRs), found that only one state achieved substantial conformity in ensuring that children involved with the child welfare system's physical and mental health needs were met. In other words, the situation for these children—many of whom have experienced life-altering trauma and have little or no familial support—is already dire and should Medicaid step out of the picture, will only worsen.

We are further concerned that 440.45(b) provides no guidance on how to determine whether a service is an "intrinsic element" of a program other than Medicaid. The specific mention of child welfare and foster care, we assume in contrast to mental health, makes this population appear likely targets of this language. Please keep in mind that the child welfare system's role is to respond to reports of abuse and neglect, help at risk families, and help secure permanent, safe, and secure homes for children. **Behavioral health care is not intrinsic to that system.** In fact, it is exempt from the requirement for licensed mental health providers because they do not provide mental health services. Child welfare workers may provide social services, but these are not Medicaid billable.

Similarly, Medicaid rehabilitative services are not "intrinsic to" foster care. Title IV-E, Section 475(4) of the Social Security Act and the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20 state that foster care maintenance payments are "to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel for a child's visitation with family, or other caretakers." Clarifying further that rehabilitative services are not intrinsic to foster care, the Code of Federal Regulations prohibits States from claiming Title IV-E federal financial participation

(FFP) for "costs of social services provided to the child, the child's family or foster family *which provide counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions*" (45 CFR, Chapter XIII, Part 1356.60(c)(3)) (emphasis added) States have more discretion under Title IV-B, but because its primary purpose is not to provide medical assistance, rehabilitative services are not "intrinsic to" it, either. Moreover, IV-B is a capped program that does not envision providing and is not able to provide all necessary services.

OACCA urges the Department to allow the child welfare system and Medicaid to complement each other to support the wellbeing and healthy development of each child in care. It is essential that the systems be able to, even encouraged to, work together rather than shifting the full burden onto an already stressed child protection system, as 441.45 permits Medicaid to do. The section also completely defeats the Substance Abuse and Mental Health Services Administration's (SAMHSA) diligent work to promote a system of care that provides a coordinated network of community-based services and supports to meet the challenges of children and youth with serious mental health needs and their families. As such, OACCA strongly urges 441.45(b) to be deleted.

441.45(b)(1)(i) and (ii), Therapeutic Foster Care and Packaged Services Furnished by Foster Care and Child Care Institutions: OACCA urges the exclusion of therapeutic foster care services except for "medically necessary rehabilitative services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers" (441.45(b)(1)(i)) and similar packaged services furnished by foster care or child care institutions (445.45(b)(1)(ii)) from the definition of Medicaid rehabilitative services. As the Surgeon General indicated in his 1999 report on mental health, with care provided in private homes with specially trained foster parents, therapeutic foster care is considered "the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders." It provides evidence-based care for children who otherwise would be placed in more institutional and costly settings—settings which can also reap emotional tolls on children and their families. The Surgeon General recommended therapeutic foster care as a community-based alternative for children's health. This is consistent with the President's New Freedom Commission on Mental Health report.

Unfortunately, the proposed language, while not explicitly prohibiting therapeutic foster care, whittles away at its core so much that access will surely be restricted, if not completely shut off. As a result, because there is a continuum of care in foster care, children who cannot be maintained be in family foster care due to serious emotional or other health issues will be forced into residential or hospital settings..

Only therapeutic foster care services that are "clearly distinct from packaged therapeutic foster care services" could be billed as rehabilitative services, but it is unclear what is meant by "clearly distinct." OACCA strongly advocates that states be afforded the discretion to define therapeutic foster care as a single service and pay through a case, daily, or appropriate mechanism. Packaged services allow the necessary amount of time and attention to be spent on children suffering from intense mental health issues. The alternative imposes significant administrative burden, which ultimately takes time away from the child and reduces services' effectiveness and the child's progress.

441.45(b)(5), Institution of Mental Disease: Summarily excluding services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of community residential treatment facilities with more than 16 beds will send costs soaring. This goes against the best interests of children and again, conflicts with the President's New Freedom Commission on Mental Health's reports urging more community-based care. This subsection must be stricken, at least as it applies to residents under **21**. Alternatively, before changes go into effect, an appropriate and reasonable transition period must be provided for impacted parties to try to find alternative care.

CONCLUSION

On behalf of OACCA, its members, and the children and families we serve, we thank you for the opportunity to comment on this proposed rule. We hope that you will consider our input in the spirit it was given, keeping children and families' needs paramount.

Sincerely,

Penny M. Wyman, MA, MSW, LSW
Executive Director

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

Organization : **Family Service Council of Ohio**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment regarding CMS-2261-P - Section 441.45(b)(1)

CMS-2261-P-1134-Attach-1.DOC

#1134

October 12, 2007

TO: Centers for Medicare and Medicaid Services *(CMS)*

FR: Margaret F. Burns, Executive Director
Family Service Council of Ohio *(FSCO)*

RE: **CMS-2261-P - Section 441.45(b)(1)**

On behalf of the Family Service Council of Ohio *(FSCO)*, I am requesting additional clarification relative to the **definition of the term "intrinsic elements"** and **intent of the phrase "services that are intrinsic elements of programs other than Medicaid"** as used in **Section 441.45 "Rehabilitative Services" under (b)(1)** of the proposed rules entitled "Medicaid Program: Coverage for Rehabilitative Services" as published in Volume 72, Number 155 of the Federal Register on Monday, August 13, 2007.

The Family Service Council understands that the proposed rules apply to medically necessary rehabilitative services provided through the Medicaid Program and that they are not intended to address the comprehensive needs of needs of children, adults or families. The Council, however, is concerned that the proposed rules may be interpreted to minimize the importance of the provision of medically necessary outpatient rehabilitation services to Medicaid eligible children/adults who may also be receiving services through non-medical programs.

The Council respectfully is requesting additional clarification as to the definition of "intrinsic elements" and the intent of Section 441.45(b)(1) and would particularly appreciate it if CMS could provide examples of "intrinsic elements" that relate specifically to behavioral health services.

Thank you for the opportunity to comment and for your consideration.

STRONG FAMILIES MEAN STRONG COMMUNITIES

Family Service Council of Ohio
Margaret F. Burns, Executive Director
50 West Broad Street - #1906 * Columbus, Ohio 43215
Phone: 614-461-1476 * Fax: 614-461-0204 * E-Mail: FSCO@fsco.org

Submitter : **Ms. Kathy Wilhoit** **Date: 10/12/2007**

Organization : **Special Education District of McHenry County**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

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.

Submitter : **Mr. Dean Crocker** **Date: 10/12/2007**

Organization : **Maine Children's Alliance**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1136-Attach-1.DOC

CMS-2261-P-1136-Attach-2.DOC

#1136

October 11, 2007

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

Re: CMS 2261-P

To Whom It May Concern:

The Maine Children's Alliance is gravely concerned by the CMS proposed rules for Medicaid's coverage of rehabilitative services. We ask that CMS reconsider and withdraw these regulations for the following reasons:

Child Welfare – The Child Welfare League of America has done a wonderful analysis of the impact of these regulations on one of this Country's most important programs. We support their analysis. State level reform efforts aimed at better family support and reduced use of expensive out of home options will be crippled.

Education and Corrections – New language denying participation for what are viewed to be "intrinsic elements" of other programs will have a devastating impact on children in those programs. It is also contrary to federal law and intent. Congress amended Medicaid to require cooperation with state educational programs.

Cost of administration – While stating an objective of more efficient and effective administration, these requirements actually increase documentation and service plan requirements contrary to the intent.

Increased hospitalization and residential care – By limiting Medicaid's coverage of preventive or habilitative services, children now supported in their home and community will need to rely on more restrictive, less normalizing and less effective residential and hospital based services.

Fiscal impact – CMS's analysis of fiscal impact is grossly understated. For Maine alone, loss of federal revenue is projected at more than $148,000,000 for both children and adults (Source – Maine Department of Health and Human Services).

We ask that CMS withdraw these regulations and work with Congress and the States to find truly efficient and effective ways to improve the administration of this most critical program.

W can be more specific about our concerns and would welcome the opportunity to discuss them with you. We can suggest better ways to control Medicaid growth.

Yours truly,

Elinor Goldberg
President and CEO

CMS-2261-P-1137

Submitter : **Ms. Mary Ann Bergeron** **Date: 10/12/2007**

Organization : **VA Assn of Community Services Boards**

Category : **Other Association**

Issue Areas/Comments

GENERAL

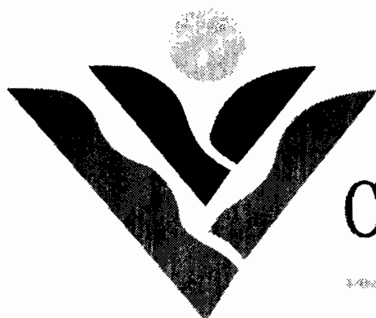
GENERAL

See attachment

CMS-2261-P-1137-Attach-1.DOC

CMS-2261-P-1137-Attach-2.DOC

#1137



Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

TO: Kelly Weems, Acting Administrator, CMS

FROM: Mary Ann Bergeron, Executive Director

DATE: October 12, 2007

SUBJECT: Comments of the VACSB Regarding CMS-2261-P

Thank you for the opportunity to comment upon the recently-published draft regulations for State Rehabilitation Option Services. The Virginia Association of Community Services Boards (VACSB) speaks for the forty (40) Community Services Boards (CSBs) in Virginia, charged by the Code of Virginia to assure community-based services, in all localities of Virginia, for children and adults with mental illness, mental retardation, and substance use disorders. As partners with state agencies and local governments, the CSBs work with those individuals with the most severely disabling conditions, assisting these individuals to remain in the community and avoid the most expensive care, institutionalization.

While the stated goals of the draft regulations seem to be in line with good administrative practices, these regulations, because of the nature of the unique approach each state has taken in this Option, would provide CMS the opportunity to mandate changes to states' plans and, before approval of the changes, insist that states make additional adjustments that may or may not be in keeping with the spirit or intention of Rehabilitation Option Services in a particular state. Since savings is one of the goals, there will be only so many strategies for CMS to utilize to drive the savings. Within a program as lean as Virginia's with its 80% FPL eligibility for its Aged, Blind, and Disabled group and already at a 50% match for FFP, this can mean only restricting services in some way and/or driving fee for service rates lower than current rates.

Neither strategy is acceptable for consumers to be served appropriately. While the President's Freedom Commission emphasized the need for a recovery focus on services for individuals with mental illness, these draft regulations and other dictates accomplished through letter directives to state Medicaid agencies seem to undermine the very tools for consumers to use in their paths to recovery. Taking away or restricting tools that are not expensive in the long term can result in only one thing, the high price of an institutional setting, which may be in Medicaid-reimbursed facilities, defeating the purposes of savings, stabilization and normalcy in communities, and of recovery.

In CMS efforts to use a more medical approach for rehabilitation services, equating the services to more of a joint replacement approach for example, there is a lack of recognition of the nature of mental illness and that each person progresses toward recovery at a different rate, on a

different path, and may have setbacks along the way because of the complexity of the illness and any corresponding medical conditions.

From a state and provider perspective, these regulations could doom the innovative services and service modalities that have been developed and demonstrate effectiveness for consumers, who may, in Virginia, be service recipients and service providers through peer support vehicles. Additionally, administrative changes that may be forced by the draft regulations can result in more severe administrative burdens for providers.

Virginia DMAS is already developing a system for additional management of the Rehabilitation Option Services with prior authorization and utilization review. No state and no Virginia agency, state or local, is in the business of providing more services than consumers need. In Virginia, these draft regulations are not needed as it is a well-managed and lean program, evidenced by the relatively few providers of Rehabilitation Option Services.

It is the recommendation of the VACSB that CMS note the stringent eligibility for Rehab Option Medicaid services in Virginia, the work in assisting consumers in the development of and adherence to Wellness, Action, and Recovery Plans (WRAP), and consumer employment in the field of mental health. That done, CMS should recognize that there is no need for further change in Virginia's State Plan.

Thank you again for this opportunity. For additional information or questions, please contact me at 804.330.3141 or via email at mabergeron@vacsb.org.

CMS-2261-P-1138

Submitter : **Ms. Deborah Becker** **Date: 10/12/2007**

Organization : **Dartmouth Psychiatric Research Center**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am responding to your invitation to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am a former rehabiltation counselor and director of a community support program serving people with severe mental illness in a community mental health center. Currently I am an assistant professor at Dartmouh Medical School. I am part of the Dartmouth Psychiatric Research Center. My comments are based upon my experience in each of these positions. Evidence-based supported employment is the best mental health treatment for people with severe mental illness. Employment is the only service that decreases medicaid and SSA costs. Any decrease in employment supports would be tragic.

1. I do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

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

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

4. Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

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

Sincerely,

Deborah R. Becker
Dartmouth Psychiatric research Center

Submitter : **Ms. Debra Deater** **Date: 10/12/2007**

Organization : **Ottawa County Mental Health**

Category : **Local Government**

Issue Areas/Comments

Background

Background

I would just like to say that by allowing these cuts to go through you would be hurting so many lives. Thousands of michigan residents would be effected by these appalling changes. Persons with Developmental disabilities need these services to maintain a healthy fulfilled quality of life. In passing these cuts the last 40 years in gains for people with disabilities would be completely erased. My hope is that you will please hear our comments and question your actions before making such drastic cuts. Not only would people with Developmental Disabilities be effected, but the thousands of people that work with them daily would no longer have full-time jobs. If you think Michigan has a high unemployment rate now, just think about what it would be after such cuts. Please consider the consquences of your actions before passing such cuts. Thank You

Submitter : **Mr. Neill Horton** **Date: 10/12/2007**

Organization : **Mr. Neill Horton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1145-Attach-1.TXT

#1145

October 12, 2007

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

To Whom It May Concern:

Reference: File Code CMS-2261-P
Comments on 42 CFR Parts 440 and 441: Medicaid Program: Coverage for Rehabilitative Services

I am writing as an interested community member of Montgomery County, Maryland. I concur with the comments submitted by St. Luke's House, Inc.

St. Luke's House, Inc. is a private, non-profit, non-sectarian organization that helps people live, learn and work successfully in their communities by offering integrated mental health services and resources. St. Luke's House serves adults who have serious and persistent mental illness and youth who have been identified as seriously emotionally disturbed through a wide array of community based services, such as psychiatric and residential rehabilitation, supported employment, supported living, case management, outpatient mental health clinics and crisis residential services. St. Luke's House is certified to provide two of the SAMHSA Evidence Based Practice models, Supported Employment and Family Psychoeducation, as well as integrates other evidence based models, like DBT into its programs. St. Luke's House has provided services for 36 years and serves more than 1,000 individuals each year. Our primary focus is on individuals needing services through the public mental health system, and as such, most of our funding comes from Medicaid, Medicare and state and local government.

It is critical that the proposed regulations support the people we serve in maximizing their functioning in the community. We are seriously concerned that the proposed regulations, as written, may create significant obstacles to the recovery process for adults and children. Therefore, we respectfully submit these comments in hopes of eliminating these potential barriers and promoting the well being of these individuals. We ask that you consider changing the following specific areas:

440.130(d)(1)(vi) Definition of Restorative Services and 3(xiv) Measurable Reduction of Disability

It is critical that these regulations fully recognize the nature of mental illnesses and the recovery process. The regulatory language must reflect the flexibility needed to help children grow and develop and to support adults in dealing with relapse and the challenges in sustaining levels of functioning. Therefore the following changes to language are recommended:

Section 440.130 (d)(1)(vi) Definition of "restorative services"

Recommendations:

- Include language that states 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.

- Add the following language to the end of section:

  "Examples of acceptable rehabilitation goals in this context would include: living in the community without long-term or intermittent hospitalization; reduction or control of symptoms to avoid further deterioration or hospitalization."

440.130 (d)(3) (xiv) Requirement of "Measurable Reduction of Disability"

Recommendation: Add the following language to the end of the section:

"For some individuals, particularly those with serious mental illness, 'reduction of disability' and 'restoration of functional level' may be measured by comparing the effect of continuing rehabilitation versus discontinuing it. Where there is reasonable expectation that if rehabilitation services had been withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion is met."

440.130 (3) preamble, (3)(xi), (xv), (xvi) Written Rehabilitation Plan

There are four specific areas we would like this section to address. First, the preamble of this section refers to a written rehabilitation plan. While it does not prohibit an integrated treatment and rehabilitation plan, it also does not specifically allow for one. Since integrated planning and service delivery is in the consumer's best interest, we feel that the regulations should support an integrated plan. Second, (re: 3xi) while there is great value in consumers knowing their options for alternate providers, we think that information should be shared earlier in the process than during rehabilitation planning, at any time the consumer expresses a desire to consider other options or at specific progress review periods. The rehabilitation planning process is an important time of partnership. The routine inclusion of information about alternate providers during this process may disrupt the therapeutic bond, may cause confusion and anxiety for the consumer and also places an unnecessary burden on the provider. Third, (re: 3 xv) due to the episodic nature of serious mental illness and sometimes due to specific symptoms, some consumers may not be able or willing to sign the treatment/rehabilitation plan at a given time.

The need for the services is still likely to be critical. The individual may not have appointed a representative who could sign on behalf of him/her. Therefore, CMS should allow for documentation of efforts of the provider to secure the signature and the reasons that the consumer or his/her representative is not able to sign the plan. Finally, (re: 3xvi) since the provider is already bound by Medicaid requirements, the inclusion of the statement in the last bullet below seems unnecessary and inappropriate for inclusion in the service plan and seems to add no real value. In the interest of time and clarity, we recommend it be deleted from this section.

Recommendations:

- Specifically clarify that a single integrated treatment and rehabilitation plan is acceptable (3 preamble)
- Delete the section that reads "Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." (3xi)
- Allow providers to document attempts to involve consumers in the development of their treatment/rehabilitation plans and to secure their signatures. (3xv)
- Delete the section that reads "Document that the services have been determined to be rehabilitative services consistent with the regulatory definition." (3xvi)

441.45 (a) (2) : Rehabilitative Services

This recommendation serves to reinforce what has been said regarding restorative services and "measurable reduction of disability."

Recommendation: Reiterate here when services may be provided to retain or maintain functioning.

441.45 (b) (1) Non-Covered Services

In order to strongly support the concept of integrated and coordinated services and to ensure that consumers have access to covered rehabilitation services, the following clarifications are recommended.

Recommendations:

- Add the following to the end of the first paragraph in Section 441.45(b) (1):

  "...except for medically necessary rehabilitation services for an eligible individual that are clearly distinct from these non-covered program services and are provided by qualified Medicaid providers. One way to demonstrate this distinction is by clearly and reasonably distinguishing the funding stream for the rehabilitation services as being distinct from that of non-covered services.'

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

Thank you for this opportunity for commenting and for your consideration of these recommendations.

Sincerely.

Neill Horton
Bethesda, MD
hortonn7@yahoo.com

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

Organization : **Arizona Health Care Cost Containment System AHCCCS**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

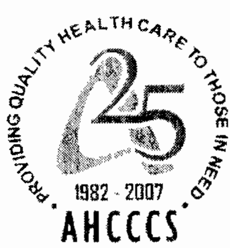
See Attachment.

CMS-2261-P-1146-Attach-1.DOC

CMS-2261-P-1146-Attach-2.DOC

#1146

Janet Napolitano, Governor
Anthony D. Rodgers, Director



801 E. Jefferson, Phoenix, AZ 85034
P.O. Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

October 12, 2007

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

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS) I am pleased to submit comments on the proposed regulations regarding Medicaid Coverage for Rehabilitative Services, published at 72 Fed. Reg. 45201 (August 13, 2007). AHCCCS is the state agency that administers Arizona's Medicaid program, which covers over one million members.

The rehabilitative services option is the primary basis of Arizona's outpatient behavioral health services program. Some of the behavioral health services AHCCCS provides under the rehabilitation services option include screening, assessment, and evaluation; counseling, including individual, group, and family therapy; behavior management services, including peer support; psychosocial rehabilitation, including living skills training; and medication management. AHCCCS has elected to provide most physical, occupational, and speech and hearing services under the separate state plan option related to those services; therefore, these comments relate specifically to the coverage of behavioral health services.

Rehabilitative services are essential to help people with mental illness improve or maintain their functioning, allowing people with mental illness to reduce their dependence on inpatient services.

42 C.F.R. § 440.130(d)(1)(iii)
The proposed rule defines the term "qualified providers of rehabilitative services." It is unclear if this definition includes peer support services, which, as provided in State Medicaid Director Letter #07-011 "are an evidence-based mental health model of care" that "can be an important component in a State's delivery of effective treatment." AHCCCS recommends clarifying in the preamble to the final rule that peer support specialists can be qualified providers of behavioral health rehabilitative services.

42 C.F.R. § 440.130(d)(1)(iv)
The definition of "under the direction of" in the proposed rule requires that a licensed practitioner supervise the provision of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. While the proposed rule states that this definition applies specifically to providers of those services, the last sentence of the definition states that the "language is not meant to exclude appropriate supervision arrangements for other rehabilitative services." AHCCCS is concerned that this language will be construed as requiring comparable levels of supervision for behavioral health services. Arizona is experiencing a shortage of licensed behavioral health providers, and requiring a comparable level of supervision for behavioral health services would severely jeopardize the availability of behavioral health services; therefore, AHCCCS recommends that the last sentence of the definition be removed.

42 C.F.R. § 440.130(d)(1)(v)
The proposed rules define "rehabilitation plan" and introduce requirements for the written rehabilitation plan. The regulation is silent on the relationship between the rehabilitation plan and the treatment plan, and AHCCCS is

concerned that the proposed rules will require two plans and two planning processes for the written rehabilitation plan and a separate treatment plan. AHCCCS recommends that the rules clarify that the treatment plan can be the written rehabilitation plan (as long as the treatment plan includes all requirements for the rehabilitation plan) rather than require two separate planning processes and plans.

42 C.F.R. § 440.130(d)(1)(vi)
The proposed regulation defines "restorative services"; however, it is unclear how the term will be used in the final rule because the term is not used in the proposed rule or the statute. The definition states that the "emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past." AHCCCS is concerned that this definition may be used to exclude services for young children because the child's capacity to perform the function may not be known. AHCCCS is recommending that the proposed rules or the preamble clarify the application of this rule to young children who had not yet reached developmental milestones.

The proposed definition also states that "services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services." It is unclear if this sentence allows the rehabilitation goal to be maintenance of function; however, maintenance of function is often an appropriate goal for individuals with behavioral health conditions. AHCCCS recommends that the regulations are written or applied in a manner consistent with the Medicare Hospital Manual § 230.5(B)(3) which provides: "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."

42 C.F.R. § 440.130(d)(3)(xi)
The proposed rule requires that the written rehabilitation plan "indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." This is apparently included to ensure patients have a choice of providers; yet there are already several processes in place to ensure patient choice, including informed consent and the grievance and appeal process. Further, in the managed care setting, individuals are provided a comprehensive directory of network providers. Listing all providers in the rehabilitation plan is onerous and makes the rehabilitation plan unwieldy and can lead to a delay in accessing services.

42 C.F.R. § 440.130(d)(3)(xiv)
The proposed rule provides, "If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods." Consistent with the above comment regarding the definition of "restorative services," AHCCCS recommends that the regulation be written or applied in a manner consistent with Medicare.
The Medicare Hospital Manual § 230.5(B)(3) provides:

> "The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.
>
> "It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. 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."
>
> "Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the

evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment."

42 C.F.R. § 440.130(d)(3)(xv)

The proposed rules require the rehabilitation plan to "document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan." This requirement can become a barrier to services for individuals who refuse to sign the form for reasons related to their disease or disability. For example, individuals who have been court-ordered to receive treatment may refuse to sign the form. Individuals with paranoid disorders or cognitive disabilities such as dementia, may refuse to sign because they do not understand. AHCCCS recommends that there be a means of opting out, if the reason for failing to obtain the individual's signature is included in the rehabilitation plan.

42 C.F.R. § 440.130(d)(3)(xvi)

The proposed regulation requires that the rehabilitation plan "document that the services have been determined to be rehabilitative services consistent with the regulatory definition." It seems unreasonable to require a clinician to document compliance with the proposed regulation, and including this makes the document more complex for both clinicians and individuals and their families. As required by 42 C.F.R. § 440.130(d)(3)(x), the document has already been signed by the individual responsible for developing the plan. Individuals may be even more uncomfortable signing the document. AHCCCS recommends deleting this provision.

42 C.F.R. § 440.130(d)(3)(xvii)

Under 42 C.F.R. § 440.130(d)(3)(i), the rehabilitation plan must "be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living." The requirement that the rehabilitation plan must "include the individual's relevant history, current medical findings, contraindications" essentially forces the rehabilitation plan to rewrite or duplicate the comprehensive assessment required by 42 C.F.R. § 440.130(d)(3)(i). This requirement contains unnecessary work and makes the document even larger and more confusing for the individual or their family. AHCCCS recommends deleting this provision.

42 C.F.R. § 441.45(a)(5)

The proposed rule requires the state to "ensure the State plan rehabilitative services . . . specifies the methodology under which rehabilitation providers are paid." In the past year, several states have been forced by CMS to abandon case rate or the bundled approach which is paying for services and pay for billing of services in 15 minute increments. This approach significantly increases the amount of time that clinicians must spend completing paperwork and thus reduces the amount of time available to spend with clients. AHCCCS recommends that CMS provide states with necessary flexibility in reimbursement.

42 C.F.R. § 441.45(b)(1)

This section prohibits federal financial participation (FFP) for services that are "intrinsic elements of programs other than Medicaid." While the rule provides a few examples of services that are believed to be intrinsic elements of other non-Medicaid programs, it fails to identify the criteria used to determine whether a service is an intrinsic element of another program. This vague standard provides no guidance to states trying to implement the proposed regulations. At the same time, it appears to provide great latitude to CMS and the Office of Inspector General in interpreting this standard. Further, this appears to run counter to the goals developed by the President's New Freedom Commission on Mental Health. The report establishes goal 2.3, "align relevant Federal programs to improve access and accountability for mental health services" and states that "States will have the flexibility to combine Federal, State, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between health care, employment supports, housing, and the criminal justice systems." The "intrinsic element" standard establishes a new bureaucratic boundary that will have a chilling effect on state's efforts. AHCCCS recommends deleting this entire portion of the proposed rule.

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

Sincerely,

Anthony D. Rodgers,
Director

Submitter : **Dr. Simcha Goldman** **Date: 10/12/2007**

Organization : **Pacific Clinics**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

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.

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

Organization : **New York State Department of Health**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attached letter re proposed CMS regulation No. 2261-P

CMS-2261-P-1148-Attach-1.PDF

STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

October 11, 2007

Ms. Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8018
Baltimore, MD 21244-8018

Dear Ms. Norwalk:

We have reviewed the proposed CMS regulations regarding Coverage for Rehabilitative Services. It is our belief that these regulations are both complex and far-reaching, and may drastically reduce the availability of important medically necessary services currently provided under this option. New York State cannot support these regulations as written. These comments reflect the concerns of not only the New York State Medicaid Program, but those of our Offices of Mental Health and Mental Retardation & Developmental Disabilities, as well. We further believe that there are a number of issues which need to be addressed and modified. It is important to remember that rehabilitative services are provided to the most vulnerable populations, and as such, an adequate level of service must be maintained. In order to do so, we recommend changes to the proposed regulation in the following areas.

Nexus of rehabilitation services and EPSDT:

Because of the complexity of these regulations, and the fact that their interactions with EPSDT rules are not addressed, we are concerned that they may interact with the EPSDT program in a way that unintentionally reduces services. They may adversely affect access to needed services for children with disabilities. We are specifically concerned that these regulations may reduce access to services under programs such as those authorized under the Individuals with Disabilities with Education Act (IDEA) to provide early intervention services to infants and toddlers with disabilities. These services authorized under Part C of IDEA are provided to address developmental needs of children rather than educational needs. IDEA specifically provides that [20 U.S.C.A. § 1440(c)] States maintain medical assistance for children as a supplemental source of funding to be combined with IDEA funds. Further, we believe that CMS needs to positively state that these rules do not interfere with the Federal requirement that all Medicaid eligible services are available to children under the EPSDT program, whether or not they are currently covered in the New York's State Plan.

Exclusion of habilitation services:

As the State reads the proposed regulation, it would not prohibit habilitation services from being provided under the clinic option. Existing regulations define "clinic services" at 42 C.F.R. §440.90, and "rehabilitation services" at §440.130(d). The State requests clarification that CMS also reads the proposed regulation to allow habilitation services to be claimed under the clinic option. If CMS reads the proposed regulation as prohibiting states from providing habilitation services under the clinic option, the State takes the position that the regulation is clearly not what Congress intended and would not lift the moratorium in OBRA '89.

The State also objects to any restriction on habilitation services being provided as clinic or rehabilitation services. Any such restriction will be impossible for healthcare practitioners to follow, will have the effect of discriminating against persons with developmental disabilities, and will reduce cost-effective preventive services to children.

The distinction CMS makes between "rehabilitation" and "habilitation" is simplistic and unworkable. Clinicians are not trained to distinguish between habilitation and rehabilitation services provided to children and persons with developmental disabilities. It is not realistic to expect that they could be trained to make such a distinction. It is difficult if not impossible for clinicians to always know enough about the etiology of a particular sign or symptom to discern if it is based on the loss of a skill or relates to a skill that was never acquired, or in the case of children, have not yet had the opportunity to acquire.

By reducing services needed by children with disabilities, including those with developmental disabilities, the proposed rule will create the need for more expensive and less desirable services later in life. If a child's needs in areas of occupational therapy, physical therapy, speech and language, behavioral, and socialization are not comprehensively addressed, he or she is at risk for a lifelong disability and the need for more intensive and costly services later in life. These more intensive and costly services may well include institutionalization. This is especially true for children with Autism Spectrum Disorders (ASD), for whom it has been demonstrated that early diagnosis followed by appropriate, intensive interventions as early as possible prior to age eight can significantly ameliorate symptoms and reduce the functional deficits common to ASD.

Limiting habilitation services to ICFs/MR, the 1915(c) HCBS waiver or the 1915(i) HCBS state plan option is bad fiscally and programmatically. Many individuals with developmental disabilities do not now meet ICF/MR level of care, but need habilitation services to maintain function and prevent loss of function. Under the proposed regulation, these individuals would have to be placed in more costly residential care. Other individuals would be eligible for 1915 (c) HCBS waiver services if they applied, but can successfully remain in the community with a limited amount of habilitation services. If these people enrolled in a waiver, they would be eligible for the full array of waiver services at a much higher cost to the state and federal governments.

Provider Qualification:

The proposed regulations require that rehabilitation services are provided by a "qualified provider". Qualified providers are defined as individuals rather than agencies. This is a departure from the State's current approach, which views a "qualified provider" from the perspective of the licensed agency, rather than the perspective of individual staff members.

The requirement that qualified providers be specified for each service could result in limitations on the scope and amount of reimbursable services that could be delivered by non-professionals, necessitating increased levels of professional staffing in programs that currently rely heavily on paraprofessionals and peer staff. This in turn would increase program costs, exacerbate professional staff and recruitment problems, and decrease provider agencies' willingness to employ peers.

Eligible Services:

In order to be eligible for Medicaid reimbursement, rehabilitation services must be specifically related to an identified rehabilitative goal, of time-limited duration, and designed to result in the maximum reduction of mental disability and restoration to the best functional level. Services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a specific rehabilitation goal.

While most individuals served in rehabilitation programs are actively engaged in pursuit of recovery goals, there are also numerous individuals who rely on long-term services to retain current levels of functioning and to avoid hospitalization. Individuals who continue to need critical support services from their rehabilitation programs beyond the point where continuous progress toward specific recovery goals can be demonstrated will require non-Medicaid financial support from the State.

The need to show measurable reduction of disability and restoration of functional level will be particularly difficult for the most vulnerable recipients, particularly long-term residents of community residence programs.

Coverage Restrictions for "Intrinsic Elements"

The State is concerned about the provision that Medicaid coverage for rehabilitation services is prohibited for services that are furnished through a non-medical program as either a benefit or administrative activity. The actual impact on various State programs and recipients will depend on how broadly this provision is interpreted by CMS. Specifically, would this type of restriction include situations where there is theoretical coverage by another program, but where funding is unavailable?

Recommendations for Specific Regulatory Revisions:

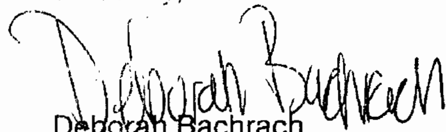
- Rehabilitation services by a licensed program should be treated in the same manner as services provided under the clinic option of the State Plan, where the "qualified provider" is the program and not the practitioner.
- Existing programs operating pursuant to approved State Plan Amendments should be "grandfathered" and further Plan amendments should not be necessary as long as changes are made in State regulations to conform to the new federal requirements.
- While Medicaid is the payer of last resort, payment will not be denied for otherwise reimbursable services unless it can be demonstrated that another program was mandated to pay for them.

Requests for Additional Clarification:

- Can employment be the recovery goal, itself, as long as Medicaid only reimburses for medically necessary services to improve functional impairments that are a barrier to achievement of the goal?
- In an integrated program, can treatment and rehabilitation goals and services be addressed within the same plan, or are separate plans required?
- Will CMS provide more substantive guidance on such issues as:
    - Timeframes for determining that progress is insufficient and that rehabilitation goals/plans need to be revised?
    - Criteria for determining whether a service is an "intrinsic element" of another program?
    - The kinds of documentation that would satisfy the new standards?

We thank you for the opportunity to comment on these proposed regulations, and look forward to working with CMS to ensure that recipients continue to receive the necessary medical services in a timely manner.

Sincerely,



Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Submitter : Mr. Fernando Serrano **Date:** 10/12/2007

Organization : State of NV Division of Child and Family Services

Category : Individual

Issue Areas/Comments

Background

Background

See Attachment

Collections of Information Requirements

Collections of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Response to Comments

Response to Comments

See Attachment

CMS-2261-P-1149-Attach-1.DOC

#1149

JIM GIBBONS
Governor

STATE OF NEVADA

MICHAEL J. WILLDEN
Director

FERNANDO SERRANO
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD AND FAMILY SERVICES
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Carson City, Nevada 89706
(775) 684-4400

MEMORANDUM

DATE: October 12, 2007

TO: Centers for Medicaid & Medicaid Services
Department of Health and Human Services

FROM: Fernando Serrano, Administrator
Nevada Division of Child and Family Services

RE: CMS – 2261 - P

Comments Regarding the Proposed Rule for Coverage for Rehabilitative Services
Written Rehabilitative Plan: 440.130 (d) (3)

- The requirement for a Written Rehabilitative Plan adds another plan required for recipients of mental health services. Potentially a single recipient could have a treatment plan, a targeted case management plan and a rehabilitative plan.

  Recommendation: Allow for a rehabilitative plan as either a stand-alone plan or as part of a treatment or targeted case management plan to support single coordinated behavioral health plans for a recipient. This would support stronger care coordination and integration of behavioral health services for the recipient.

- The expectation for the involvement of the beneficiary child's family in the re-evaluation of the rehabilitative plan is a positive addition to the regulations.

  Recommendation: Strengthen the family involvement further by requiring the involvement of the beneficiary, family or other responsible individuals in the development and re-evaluations of plans.

Requirements for Rehabilitative Services

- **Requirement that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for maximum reduction of physical or mental**

disability and restoration of the individual to the best possible functional level: 441.45 (a) (2)

Recommendation: Add language describing when rehabilitative services may be used to retain or maintain functioning.

Limitations for Rehabilitative Services

- **Exclusion of coverage of rehabilitative services that are furnished through a non-medical program...such as foster care, child welfare, education, child care, vocational and pre-vocational training, parole and probation, juvenile justice, or public guardianship...intrinsic elements: 441.45 (b) (1)**
  There is no clear definition of "intrinsic elements." This section would deny covered Medicaid services for a covered Medicaid recipient if that recipient is involved in other public programs. This proposed rule would deny medically necessary services to a Medicaid recipient, in direct contradiction of federal statute 42 U.S.C. 1396.
  The provision of services to non-Medicaid eligible recipients through other federal and/or state funding sources should not deny Medicaid participation by a Medicaid recipient. Per the proposed language in this section, "enrollment in these non-medical programs does not affect eligibility for Title XIX services."

  In addition, Rehabilitative Services are community-based and in a facility, home, or other setting per 440.130 (d) (5). They need to be provided in the community-settings that best meet the rehabilitative needs of the recipient. For children with serious emotional disturbances, they may need rehabilitative services in their family home or their foster home; in their child care center or school classroom, etc. Rehabilitative services address the child's functional impairment rehabilitative needs, not their caretaking or education, and therefore are not duplicative of other services.

  Recommendation: Delete this entire section

- **Therapeutic Foster Care is denied reimbursement as a single service type: 441.45 (b) (1)**
  Therapeutic foster care is the least restrictive level of residential treatment care for a child with a serious emotional disturbance. It has been established as an evidence-based practice over multiple research studies. Therapeutic foster care is not and should not be a treatment service type that is limited to children in the child welfare system. In Nevada, children in parent/family custody and children in public custody are eligible for therapeutic foster care if they meet medical necessity criteria. Many of these children meet medical necessity criteria for residential treatment center care and are treated in therapeutic foster care as the least restrictive level of care that can meet their needs. This regulation would require that each component of therapeutic foster care be billed separately. This will greatly increase administrative work – from direct treatment providers through support functions such as billing and a resultant increase in costs for this service.

Recommendation: Therapeutic foster care/treatment homes should be listed as a Rehabilitative Option service type and paid through a single rate. It should be listed as a covered service for children with serious emotional disturbances whose least restrictive level of treatment is residential treatment.

Regulatory Impact Analysis

Only the impact to Federal Medicaid spending on Rehabilitative Services was analyzed. It appears that because Fee for Service will be excluded from rehabilitative services that are included in other federal, state and local programs these costs are being shifted to other federal streams as well as state and local funding streams.

Recommendation: CMS in collaboration with other federal agencies such as the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, Department of Education, Office of Juvenile Justice and Delinquency Prevention should analyze the impact of the proposed regulation changes on other federal programs as well as the impact on state and local funding streams.

Concerns regarding Medicaid coverage of services that are intrinsic elements of other programs are raised in CMS 2261-P and are disallowed in 441.45 (b) (1) while it is affirmed that enrollment in these non-medical programs does not affect eligibility for Title XIX services:

Recommendation: CMS in collaboration with other federal agencies that fund or oversee the program cited under intrinsic elements map out how services can be coordinated and how funding streams can be utilized to develop rate methodologies.

Restorative Services Definition: 440.130 (d) (1) (vi)

The inclusion in this definition on covering rehabilitative services for an individual who may not have had the ability in the past is important for children and adolescents who may never have achieved a functional ability that is an age-appropriate functional ability. This definition also recognizes that services which provide assistance in maintaining functioning may be considered rehabilitative when necessary to help attain a rehabilitative goal. This language is not included in the Requirements and Limitations for Rehabilitative Services, section 441.45.

Recommendation:

- Include the above cited language in section 441.45.
- Clarify the language further that a child does not have to have achieved a functional ability in the past, as may not have been age or developmentally appropriate
- Clarify when services which provide assistance in maintaining functioning may be considered rehabilitative and add an example for both children and adults

Other Issues Related to CMS – 2261 – P

Covered Services

Services that have been established and recognized nationally as evidence-based practices are not covered.

Recommendation: Add evidence-based practices with the most appropriate rate methodology to the particular practice (e.g. daily) such as therapeutic foster care, multi-dimensional treatment foster care, multi-system therapy, day treatment, etc.

Rate Methodology

The proposed regulation does not specifically address rate methodology. It does however, support rates in 15 minute increments as CMS has begun to require. A change to 15 minute increment billing for many of these services will increase administrative functions and costs which will increase rates and/or decrease direct services to recipients.

Recommendation: CMS work with other federal agencies, states and providers to develop efficient and appropriate rate methodologies for Rehabilitative Services types.