Submitter : **Mr. Patrick Gardner** **Date: 10/12/2007**

Organization : **National Center for Youth Law**

Category : **Attorney/Law Firm**

Issue Areas/Comments

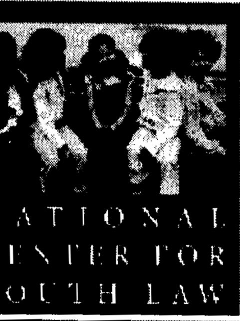
GENERAL

GENERAL

See Attachment

CMS-2261-P-1184-Attach-1.DOC

#1184



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F. O'Toole

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iam L. Grimm
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llee D. Stoll

October 11, 2007

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

To Whom it May Concern:

Reference: File Code CMS-2261-P

The National Center for Youth Law submits 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.

> The National Center for Youth Law (NCYL) is a non-profit organization that uses the law to improve the lives of poor children. NCYL works to ensure that low-income children have the resources, support, and opportunities they need for a healthy and productive future.

PROVISIONS OF THE PROPOSED REGULATIONS

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

440.130(d)(1)(v): Rehabilitation Plan

This subsection provides a definition of the rehabilitation plan and a general description of the planning process.

Requiring a rehabilitation plan is a good idea in that it may improve the fit between rehabilitative needs or goals and services. The requirement of "active participation by the individual" served is an essential component of an effective plan. The language of the regulation could be improved, however, because it appears to set two different standards of involvement: "input from the individual..." and "active participation of the individual..." We think the latter, more inclusive language, better achieves the purposes of the Act and the rehabilitation provisions.

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440.130(d)(1)(vi): Restorative services

This subsection defines restorative services as being conditioned on present and future functional goals. The proposed regulation emphasizes that the function need not have been performed in the past and also addresses requirements for restorative services that maintain current functioning.

The focus on an individual's ability to perform a function, and not conditioning services on whether the individual has been able to perform the function in the past is appropriate. That emphasis is especially important in the case of children as there will be many instances where certain functions could not have been performed previously given the child's developmental process.

The requirement that maintenance services must "help an individual achieve a rehabilitation goal defined in the rehabilitation plan" seems to single out this aspect of restorative services as requiring something more than is required of others. The impact may be that maintenance services are wrongly denied and states will require that individuals must experience a loss of function before they are provided appropriate care.

Recommendations:

1. 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.

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(d)(1)(vii) Definition of medical services

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person's functional capacity. 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.

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

Recommendation:

1. Add to section (vii) "assessment," before the word "diagnosis" and replace the word "care" with the word "rehabilitation."

440.130(d)(3): Written rehabilitation plan

This section sets forth the proposed requirements for a written plan that anchors the provision of rehabilitative services to eligible individuals. Some aspects of this subsection are unclear and a few issues are not addressed.

How does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Does there need to 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 is a major burden, especially when services are delivered to a group.) We recommend 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 principle should be that the record includes information necessary for clinical purposes and information is presented in a way that meaningfully demonstrates the nature and course of the child's rehabilitation.

Is it allowable for a service planning team to create a single service plan that includes both treatment 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 for CMS to state that this is allowable.

Why does the plan require information on alternate providers? It is not clear what purpose is served by including this information in the plan. A better approach would be to require providers to inform an individual of alternative resources where they are known and affirm in the plan that this has been done.

Recommendations:

Include the following written rehabilitation plan requirements:

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

2. Direct that the plan of services be based on a strengths-based assessment of needs.

3. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable.

4. Allow the plan to include provisions for unplanned crisis intervention.

5. Substitute for the requirement that providers identify 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).

6. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a default annual requirement.

440.130(d)(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, and mobile crisis vehicles.

Section 441.45: Rehabilitative Services

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).

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.

Recommendations:

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

2. 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 an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to eligible individuals if such services are furnished through a non-medical program and are considered intrinsic elements of that program. During the legislative debate over the Deficit Reduction Act, Congress considered and rejected the Administration's proposal to amend the definition of rehabilitative services to include the intrinsic element concept. Congress' rejection of this provision makes is unclear whether CMS has the authority to proceed with this proposed rule.

Assuming, for argument's sake, that the proposed regulation is within the agency's power to promulgate, the proposed rule is nevertheless fundamentally lacking in clarity. "Intrinsic elements" is undefined. References in the preamble to "services that are furnished," and services that are "the responsibility of other programs," are hardly illuminating, particularly when the preamble also assures that "enrollment in these non-medical programs does not affect eligibility for Title XIX services." All in all, deploying "intrinsic elements" as the conceptual means to determine FFP eligibility for rehabilitation services provided to Medicaid-eligible individuals involved with non-Medicaid programs is like replacing a traffic light at the intersection of two busy highways with a disco ball.

The proposed regulations assume, apparently, that Medicaid rehabilitation services could be provided with these other programs' resources. That may be true in cases where an individual has private insurance. Other programs such as foster care, juvenile justice, and

parole and probation simply do not have the resources or the legal duty to provide for the medically necessary rehabilitation services that are mandated under Medicaid.

In short, without revision, this proposed 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 under Medicaid's EPSDT provisions.

Recommendations:

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.

6. Similarly, a child with a mental health condition being reunified with his or her family may have specific issues related to the mental health condition that impact reunification. Mental health rehabilitation services to address these problems (as distinct from generic reunification services) should be covered.

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 regulation makes no acknowledgment that therapeutic foster care is 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, substantial administrative costs, and in most cases, poor outcomes for these Medicaid-eligible children.

Recommendations:

1. List therapeutic foster care as a covered rehabilitation service for children with serious mental disorders 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.

441.45(b)(3) Recreational or social activities

The Preamble includes examples of recreational or social activities that are covered services due to a focus on skill building or other rehabilitative needs. However, the rule does not include any examples or specific language explaining when these activities are covered services. This is a serious omission, as the rule alone may be interpreted as denying any

recreational or social activities no matter how therapeutic and how focused they are on restoring functioning.

Recommendation:

1. Preamble language that describes when a recreational or social activity is appropriately considered a rehabilitation services should be included in the rule at section 441.45(b)(3).

441.45 (b)(4) Individuals in secure custody and residing in public institutions

The addition of the phrase in secure custody is unnecessary as the proposed rule 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:

1. Delete the phrases "in secure custody" and "system."

OTHER ISSUES

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 also impede the provision of evidence-based mental health services that are more and more frequently designed as a package of interdependent 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.

Recommendations:

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.

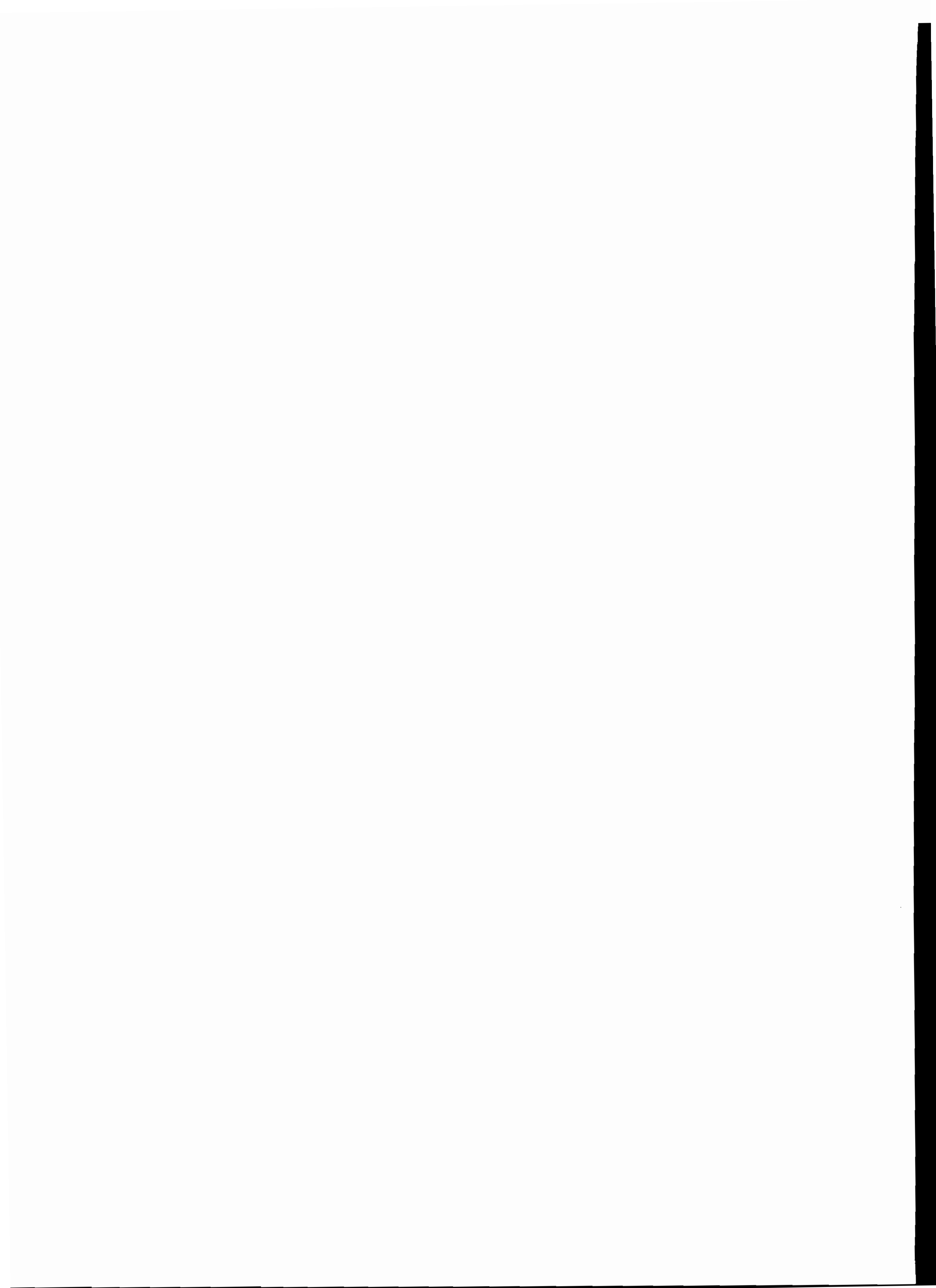
2. Clarify in section 441.45(b)(4) that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.

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.

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

Sincerely,

Patrick Gardner, JD
Deputy Director



CMS-2261-P-1185

Submitter : Ms. Candy Hill **Date:** 10/12/2007

Organization : Catholic Charities USA

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#1185

ARTMENT OF HEALTH AND HUMAN SERVICES
TERS FOR MEDICARE AND MEDICAID SERIVICES
ICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : **Mrs. Donna Boyce** **Date: 10/12/2007**

Organization : **Steuben Chapter, NYSARC -The Arc of Steuben**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

Attachment concerning proposed rehab regulations

CMS-2261-P-1186-Attach-1.TXT

#1186

One Arc Way, Bath, NY 14810-8315

October 11, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007. We are commenting on the impact of the proposed rule on people with intellectual and other developmental disabilities and access to habilitation services.

We strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. We urge you to withdraw this proposed rule.

Day habilitation (day hab) offers people with developmental disabilities services and supports to help them grow as people first, with interests, values and goals. The day hab provides the opportunity for someone to spend the day engaged in productive, meaningful activities that relate to the individual. Picture a young person with a developmental disability, 21 years old, newly graduated from high school, and seeking some help with the next steps along the path to adulthood. A day hab can provide some structure in terms of schedule and place, as a starting point; the person can choose from an assortment of planned activities to match her interests, like sorting clothes at the Salvation Army, or helping with lunch set-up at the homeless shelter, or volunteering at the museum store, or participating in a Circles group. There's no need for the person to do the same things every day; she can try something out and then, keep it in her schedule or not, depending on what she likes. It's flexible enough that it can be part of an overall plan with other services/supports, too, like supported employment.

COMMENTS ON THE PROVISIONS OF THE PROPOSED REGULATIONS:

1. We take great exception to the statement by CMS that it's "ultimate goal is to reduce the duration and intensity of medical care to least intrusive level possible which sustains health,"

which boils down to spending as little as possible to keep a person alive. It is our understanding that according to Section 1901 of the Social Security Act, the goal of these rehabilitative services should be to provide "rehabilitation and other services to help such families and individuals attain and retain capability for independence or self-care."

2. Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 (OBRA '89) clearly states that the HHS Secretary shall not promulgate or propose any rule that does not specify "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." This NPRM does not specify which day habilitation services a state may cover. Instead, the proposed regulation would prohibit provision 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.

3. We strongly oppose the proposed rule's exclusion of habilitation services, see Section 441.45(b) (2), including "services provided to individuals with mental retardation and related conditions," from covered rehabilitative services. 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, under Section 1902(a)(10(B) of the Social Security Act. This section further puts forth a false premise that people 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 rehabilitative 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.

4. Section (V) (Regulatory Impact Analysis) of the Proposed Regulation, beginning on page 45208 of the Federal Register, claims "this major rule would not have a direct impact on providers of rehabilitative services." Such a statement is a misrepresentation.

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. Clearly this impacts providers.

5. This section (V) also claims that "since this rule would not mandate spending in any 1 year of $120 million or more, the requirements of the UMRA (Unfunded Mandates Reform Act) are not applicable." For the same reasons stated above, this claim is false. States and local governmental units would most certainly be severely financially impacted by the implementation of this rule, and by CMS' own admission a few paragraphs below this claim, in the accompanying chart, it shows that the rule would impact $180 million in FY 2008 alone.

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

Sincerely,

Donna M. Boyce,
Community Supports Director
The Arc of Steuben Arc

CMS-2261-P-1187

Submitter : Ms. Karen Connor **Date:** 10/12/2007

Organization : City of Boston

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

1187

ARTMENT OF HEALTH AND HUMAN SERVICES
TERS FOR MEDICARE AND MEDICAID SERIVICES
ICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

CMS-2261-P-1188

Submitter : Ms. Sally Hart

Date: 10/12/2007

Organization : William E. Morris Institute for Justice

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1188-Attach-1.DOC

#1188

William E. Morris Institute for Justice

2033 East Speedway Boulevard, Suite 200, Tucson, Arizona 85719-4743

Phone 520-322-0126 **Fax 520-325-6025**

October 12, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

By Email to www.cms.hhs.gov/eRulemaking

RE: File Code CMS-2261-P
Notice of Proposed Rule
Medicaid Coverage: Coverage for Rehabilitative Services

Dear Sir or Madam:

The William E. Morris Institute For Justice is a non-profit advocacy program for low income people in Arizona. We submit these comments in response to the Notice of Proposed Rule entitled "Medicaid Program: Coverage for Rehabilitation Services," published in the Federal Register on August 13, 2007.

We do not believe that the proposed regulations comply with Executive Order 13132. And, contrary to CMS' assertion in the Preamble, this rule will have a significant impact on small business rehabilitation service providers. Thus, the regulations should not be finalized until the appropriate analyses of the impact of the rule on states and providers have been conducted.

We also think that these proposed regulations could result in the wrongful denial of coverage for medically necessary services. This is a particular problem with regard to coverage of services for beneficiaries under 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those services are covered for adults. 42 U.S.C. § 1396d(r)(5). The proposed definitions impermissibly narrow the scope of services that can be covered under the rehabilitation option. Moreover, the proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals *attain* or retain capability for independence or self-care . . ." 42 U.S.C. § 1396 (emphasis added). Specific illustrations and proposed revisions are provided below.

I. Regulatory Impact Analysis: Overall Impact

Executive Order 13132 imposes certain requirements when an agency promulgates a proposed rule that will impose "substantial direct compliance costs on States." Among other requirements, before an agency promulgates a rule that will impose such costs on states, it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the process of developing the rule prior to promulgation. Exec. Order No. 13,132, § 6(b). If exercising the consultation option, an agency must provide a federalism impact summary to OMB that describes the agency's consultation with the states, summarizes their concerns and explains how those concerns were addressed. *Id.* at (b)(2). CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states. 72 Fed. Reg. at 45209 (Preamble, V.A).

However, it is obvious that implementing these proposed regulations will result in significant costs to the state. Many states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them, they will be forced to pay for them with state only funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. No. 13,132 is to promote state autonomy and authority. This proposed rule runs counter to that notion because it will significantly limit state flexibility.

Accordingly, CMS should comply with the requirements of Executive Order 13132.

In addition, CMS asserts that this rule will not have a direct impact on providers of rehabilitation services. 72 Fed. Reg. at 45208 (Preamble, V.A.). This is also incorrect. These regulations narrow the scope of coverage of the rehabilitation service and, directly and indirectly, impose requirements that will have significant, direct impact on providers. The requirement of the detailed written rehabilitation plan, while commendable, will also require additional work by providers. The requirements governing therapeutic foster care would require providers to separate and bill for services that were previously "packaged." The discussion of how providers need to separate "incidental" personal care functions from rehabilitation services for billing, record keeping and administration shows how many additional duties will be necessary for providers. 72 Fed. Reg. at 45206 (Preamble, II.F.2). Clearly, the impact on providers will be significant.

II. Conflict with EPSDT

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a States' plan. 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5). There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements. These will be discussed in detail below. However, we suggest an overall restatement of the EPSDT requirement in the regulations.

Recommendation:

We agree with the recommendation in the comments of the Judge David L. Bazelon Center for Mental Health Law and the National Alliance on Mental Illness (NAMI), and recommend the following:

> Insert a new paragraph in § 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when necessary to correct or ameliorate a physical or mental illness or condition.
>
> Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct a physical or mental illness or condition.
>
> Amend § 441.45(b)(4), to specifically refer to the EPSDT statutory and regulatory requirements, 42 U.S.C. § 1396d(r)(5), 42 C.F.R. § 440.40(b), and instruct states to comply with them.

III. Conflict with the New Freedom Initiative

On February 1, 2001, President Bush announced the New Freedom Initiative as part of an effort to remove barriers to community living for people with disabilities. *See* Community Based Alternatives for People with Disabilities, Exec. Order No. 13,217. Coverage of rehabilitation services are crucial tools for individuals with mental or physical disabilities trying to live independently in the community. Numerous aspects of these proposed rules are at odds with this goal, as pointed out below. Generally speaking, any restriction on coverage of community-based rehabilitative services makes it more difficult for individuals to have meaningful lives and to live in the most integrated setting possible. CMS should be mindful of President's Bush's intention to "tear[ ] down the barriers to equality that face many of the individuals with disabilities . . ." and ensure that rehabilitation services are regulated and made available in a way that furthers this goal. New Freedom Initiative, Foreword (Feb. 1, 2001), http://www.whitehouse.gov/news/freedominitiative/freedominitiative.html (last visited Oct. 9, 2007).

IV. Specific Issues

Proposed § 440.130(d)(1)(v)-(vii), (2) - Maintenance v. Restorative services

The discussion of services that maintain, rather than restore, function can be expected to lead to inappropriate denials of services that should be covered as rehabilitative. Throughout the preamble and proposed regulations, CMS emphasizes that rehabilitation services must reduce disability and restore function in order to be reimbursable under Medicaid. *See, e.g.,* 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A)). The discussion of a written rehabilitation plan in the preamble emphasizes the "ultimate goal" of reduction of medical care. *Id.* at 45203 (Preamble, II.C). Moreover, the preamble states that "[i]t is important to note that this benefit is not a custodial care benefit but should result in a change in status." *Id.* At the

same time, the proposed regulations acknowledge that maintaining a functional level may be necessary to achieve a rehabilitation goal. *Id.* at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi)). But, the discussion of the written plan in the preamble states that "[i]f 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 . . ." *Id.* at 45204 (Preamble, II.C).

This discussion creates confusion. This emphasis on change in status and on achievement of specific goals may lead states to deny coverage for medically necessary rehabilitation services merely because such services may not lead to immediate results or may only prevent a condition from worsening. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse problems. Rehabilitation services for degenerative conditions such as Multiple Sclerosis may have as a goal slowing the deterioration of the condition; it is important that the rules do not imply these services are excluded from coverage Again, the Medicaid statute emphasizes the importance of rehabilitation services to *attain* independence and health. 42 U.S.C. § 1396. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations.

This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is an even greater likelihood that the actual service needed will be coverable under the federal Medicaid statute. Moreover, this agency has a long-standing policy of recognizing that maintenance therapy may be covered. *See, e.g.,* Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, *Medicaid State Bulletin,* 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991). Thus, the overly restrictive definition and interpretation in this area may conflict with longstanding agency policy.

Recommendation:

Add the following language to proposed regulation § 440.130(d)(1)(vi): "Failure to make measurable progress toward a particular goal within a certain time period does not necessarily indicate that a service is not necessary to help achieve a rehabilitation goal."

Add the following language to, and withdraw from, proposed regulation § 440.130(d)(1)(vi): "In these instances services that provide assistance in maintaining functioning may be considered rehabilitative ~~only~~ when necessary *to prevent regression*

based on a documented history and severity of illness or to help an individual achieve a rehabilitation goal . . ."

Add a new subsection (c) to § 441.45, with the following language: "If a service cannot be covered as a rehabilitative service, states shall determine whether the service can be covered under another category of Medicaid services." Also, add discussion to Section II.C. of the preamble to the effect that that maintenance services could qualify for coverage under another category of services and give examples of other categories.

Delete the language at 72 Fed. Reg. at 45204, Section II.C of the preamble stating that "[i]f 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 . . ."

Proposed § 440.130(d)(5): Settings for Service Provision

Proposed § 440.130(d)(5) reiterates the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be provided." 72 Fed. Reg. at 45205 (Preamble, II.E). This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the functional definition, regardless of the setting in which they are provided. Moreover, this definition is directly at odds with the New Freedom Initiative's central goal of community integration of people with disabilities.

Recommendations

Clarify that rehabilitation services should be covered in any setting permitted by state law.

We concur with the Bazelon Center for Mental Health Law and recommend that the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) be added to § 440.130(d).

Proposed § 440.130(d)(1)(vi) – Restorative Services

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option. *Dear State Medicaid Director,* Peer Support Services - SMDL #07-011 (August 15, 2007). As CMS acknowledges in the letter, this is an important service for individuals with mental illness and

substance abuse services. Given its obvious importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in these proposed rules.

Recommendation: Section 440.130(d)(1)(vi), which describes "restorative services" should be amended and language added stating that peer guidance is a covered rehabilitation service.

Proposed § 441.45(b)(1) – Non-covered Services

The proposed rule states that services will not be provided if they are an "intrinsic element" of a program other than Medicaid. 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1)). The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services. Moreover, it is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. Thus, these children will all be eligible for EPSDT, under which a service should be covered if it is necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity.

For example, the regulation states that therapeutic foster care services cannot be covered, but makes an exception for medically necessary rehabilitation services "that are clearly distinct" from packaged therapeutic foster care services. Since packaged therapeutic foster care services are not defined, it will be difficult to identify services that are not included in that package. Moreover, in describing adoption services (at (iii)) and routine supervision in schools (at (iv)), the regulation does not include the same exception for medically necessary rehabilitation services. 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1)(iii) - (iv)). In addition, the term "packaged" is problematic. Many services that are covered under Medicaid, such as physicians' services, are packaged. The use of this term will be confusing to states and create serious administrative issues. There should be an explanation of what this term means and how it would be applicable to other services.

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding third party payment and Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA). The Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . ." 42 U.S.C. § 1396a(a)(25)(A). Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party. 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007). Thus, when a service is the responsibility of a third party, the other program is still a third party payer. Also, in Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included under the IDEA. 72 Fed. Reg. at 45202. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply

because the services are included in an individualized education plan for IDEA services. 42 U.S.C. § 1396b(c).

Finally, it is important to note that during consideration of the Deficit Reduction Act of 2005 (Pub. L. 109-171), Congress considered *but rejected* an "intrinsic element" test for rehabilitation services. *See* Jeff Crowley, Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues*, 1 (August 2007). This is indicative that the "intrinsic element" test does not reflect Congress' intent with regard to coverage of rehabilitation services.

Recommendation:

We concur with the recommendation of the Bazelon Center for Mental Health Law that § 441.45(b) should be withdrawn, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Omit the intrinsic element test. Define and explain in § 441.45(b)(1)(ii) and (iii) what constitutes a "packaged" therapeutic foster care or child care service. Add the phrase "except for medically necessary rehabilitation services" to subsections (iii) and (iv).

Section 441.45(b)(1)(iv) should be amended to clarify that Medicaid coverage should not be denied merely because a service is provided in an individual education plan.

The responsibilities for states regarding third party payers, and the third party payers' own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

Proposed § 441.45(b)(2) - Habilitation Services

The proposed regulations exclude coverage of habilitation services for persons with mental retardations and related conditions under the rehabilitation option. 72 Fed. Reg. at 45212 (proposed § 441.45(b)(2)). *The Secretary claims that the authority to do so comes from section 6411(g) of OBRA 89. 72 Fed. Reg. at 45206 (Preamble, I.F.2); see also Id. at 45203 (Preamble, I.B). To the contrary, however, this exclusion is not authorized by the language of the statute. Therefore, it exceeds CMS authority and is invalid.*

When a court reviews an agency's construction of a statute that it administers, it must determine whether Congress has directly spoken to the precise question at issue. Chevron U.S.A. v. Nat'l Resources Defense Council, 467 U.S. 837, 842 (1984). If the intent of Congress is clear, that is the end of the matter; for the court as well as the agency must give effect to the unambiguously expressed intent of Congress. Id. at 842-843. Moreover, the rules of statutory construction provide that "a statute should be 'interpreted so that no words shall be discarded as meaningless, redundant, or mere surplusage.'" United States v. DBB, Inc., 180 F.3d 1277,

1285 (11th Cir. 1999) (citation omitted).

The statute prohibits the Secretary from taking any adverse action against a state that is offering day habilitation and related services under the rehabilitation or clinic service options until a "final regulation" that "specifies the types of day habilitation and related services that a state may cover [under the rehabilitation or clinic service option] on behalf of persons with mental retardation or with related conditions, and . . . any requirements respecting such coverage" is enacted. OBRA 89, § 6411(g)(1)(A). The Secretary has not authorized coverage of day habilitation or related services but instead, in contravention of the plain language of the statute, has excluded coverage of any habilitation services under 1905(a)(9) or (13). Such an interpretation reads out the reference to "the types of. . .services . . . a state may cover" in contravention of the rules of statutory construction. The only logical reading of this statutory provision is that Congress intended that some types of day habilitation services be covered pursuant to the rehabilitation or clinic option. If Congress intended to allow the Secretary to exclude the coverage of all habilitation services, it would have said so, for example, by including the phrase "if any" when referencing the services that may be covered.

The legislative history supports this reading. "HCFA should be encouraging states to offer community based services to this vulnerable population (i.e., individuals with mental retardation or related conditions), not restricting their efforts to do so." Omnibus Budget Reconciliation Act of 1989 (H.R. 3299): Report of the House Budget Committee (Explanation of the Commerce and Ways and Means Committees Affecting Medicare-Medicaid Programs) (Sept. 20, 1989), as reprinted by Medicare & Medicaid Guide (CCH), Extra Edition No. 596, p. 494 (Oct. 5, 1989).

The proposed regulatory provision is problematic for several additional reasons. It will result in erroneous deprivation of coverage and conflicts with the goals of the President's New Freedom Initiative.

First, the treatment of habilitation services seems to be based on the premise that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate.

Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy. 42 C.F.R. § 435.1010 (2007). These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services.

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental health and/or substance related disorders can be appropriately treated with rehabilitation services. *See* 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2)). However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is

likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

We commend CMS for suggesting other Medicaid options states may use to cover habilitation services under other service authorities. *Id.* at 45106 (Preamble, II.F.2). It is not correct, however, that the alternative coverage authorities suggested will offer coverage equal to coverage under the rehab or clinic services option. In order to qualify for services under a 1915(c) waiver, because individuals must meet an institutional level of care, which is not required under the rehabilitation or clinic service option. Moreover, states are permitted to limit eligibility for 1915(c) waiver services, as well as for home and community-based services under 1915(i). Across the country, more than 206 thousand people are on waiting lists for 1915(c) waiver services. (Kaiser Commission on Medicaid and the Uninsured). It is not realistic to suggest that these options will meet the need for services.

CMS states that habilitation services could be covered under other service options such as physician services, therapy services or "medical or remedial care provided by licensed practitioners." 72 Fed. Reg. at 45206 (citing 42 C.F.R. §§ 440.50, 440.60, and 440.110. Coverage under the physician services or therapy option, however, would be narrower because, unlike coverage of these services under the rehabilitation option, such services need to be provided by physicians or licensed therapists. Moreover, some habilitation services would not fall under either category. If the option of coverage under medical or remedial care would indeed encompass many of the services covered under rehabilitation, CMS should provide further explanation and examples of coverage.

Recommendation:

Withdraw § 441.45(b)(2) excluding coverage of habilitation services.

In the alternative:

Add language to § 441.45(b)(2) providing that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health services.

Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.

Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to physician services, defined at 42 C.F.R. § 440.50; therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy); and medical or other remedial care provided by licensed practitioners, defined at 42 C.F.R. § 440.60."

Elaborate on the statement in the preamble that habilitation services can be covered under 42 C.F.R. § 440.60 ("medical, remedial, or other care provided by a licensed practitioner").

Amend Proposed § 440.130(d)(4), listing the impairments to be addressed, by adding language to provide that services "may address the individual's physical **or mental** impairments, mental health impairments, and/or substance related services" to include individuals with developmental disabilities.

Proposed § 441.45(b)(4)

Among the excluded services listed are "services . . . provided to inmates living *in the secure custody* of law enforcement and residing in a public institution.". It is not clear whether this is intended to be a narrower category of individuals than those individuals living in a public institution, as defined by 42 C.F.R. § 435.1010 (2007). If so, this would be undesirable. If not, it would be unnecessary and confusing.

Recommendation: omit the phrase "in the secure custody of law enforcement."

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

Although we are concerned about some aspects of the written rehabilitation plan, we commend CMS for this requirement and believe that it will ultimately improve care for Medicaid beneficiaries. We do, however, agree with the concern expressed by NAMI in their comments that other service plans required under other programs, such as IEPs, should be able to qualify as rehabilitation plans if they meet the regulatory requirements.

Recommendation: Add the following language to this provision: "The requirement for a rehabilitation plan may be met by a treatment plan, individualized education program plan, or other plan if the written document meets the requirements in Section 440.130(d)(3).

Thank you for your consideration of these comments.

Yours truly,

Sally Hart

Staff Attorney,
William E. Morris Institute for Justice

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

Organization : **ACCSES**

Category : **Other**

Issue Areas/Comments

GENERAL

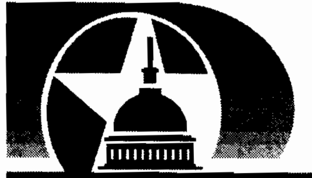
GENERAL

See Attachment

CMS-2261-P-1189-Attach-1.DOC

#1189

ACCSES



The Voice of Disability Service Providers

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 CMS-2261-P from ACCSES

Dear Acting Administrator Weems:

These comments are submitted on behalf of ACCSES, the voice of the disability service provider. The mission of ACCSES is "to promote and enhance community-based solutions that maximize employment and independent living opportunities for people with disabilities." As a result of our mission, ACCSES members provide services under the Medicaid rehabilitative services options in nearly every state we represent.

The Centers for Medicare and Medicaid (CMS) issued a Notice of Proposed Rule Making (NPRM) on August 13, 2007. The rule would save the Federal government $2.2 billion over five years by restricting services provided under the Medicaid rehabilitative services option. Despite the NPRM's intent as stated 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 and ultimately result in decreased access to home- and community-based living. This harmful proposal stands in stark contrast to goals associated with President Bush's New Freedom Initiative, the Americans with Disabilities Act, the Olmstead Supreme Court decision, Medicaid's Money Follows the Person grants, and other government initiatives aimed at improving access to independent, community living.

We note that a similar proposal was first seen in 2005 as a legislative proposal sent from the Secretary of the Department of Health and Human Services (HHS) to Congress. HHS offered this legislative proposal as a potential means of achieving savings in the Deficit Reduction Act of 2006 (DRA); however, the proposal was

ultimately rejected 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. ACCSES remains unclear as to why HHS once believed these highly controversial changes had to be accomplished legislatively, but now is attempting to implement them via the regulatory process. ACCSES encourages CMS to withdraw this NPRM and, to the extent that any policy changes are needed with regard to this benefit, work with Congress to make such changes through the legislative process.

The following are ACCSES' comments pertaining to the section (I) titled "Provisions of the Proposed Regulations."

I. Written Rehabilitation Plan (C)((§440.130 (d)(3))

The proposed rule would create a new requirement that a written rehabilitation plan 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 yearly and if no progress is determined upon evaluation, it appears that a new plan would have to be drafted.

ACCSES does not oppose the implementation of a written rehabilitation plan requirement if it will improve accountability and quality of services. Additionally, we support the NPRM's requirement that virtually all stakeholders be involved in the process of establishing the written rehab plan including the individual receiving services and their family/guardians.

However, we fear that the written plan could be used as a basis for termination of services when "progress" is not achieved according to the plan. Given the variability of developmental disabilities and mental illness, 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. We encourage CMS to allow a significant level of flexibility when it comes to evaluating individuals' progress based on their rehabilitation plans. Determination of appropriate rehabilitative "progress," and any termination of services, should be made on a case-by-case basis by clinicians and other rehabilitation experts.

Additionally, ACCSES has concerns with this section's use of the term "recovery goals," in the written rehabilitation plan. While it may be reasonable for federal Medicaid to look for documented progress in rehabilitative services provided to some individuals, in terms of psychosocial rehabilitation, the concept of "recovery" generally does not apply as few individuals with mental illness or developmental

disabilities will ever "recover" from their disabilities. We urge CMS to recognize that, in this context, recovery should imply attainment of functionality, independent living and/or participation in the community.

Finally, we encourage CMS to closely monitor the administrative burden of compiling such plans on rehabilitation providers and agencies.

II. Requirements and Limitations for Rehabilitative Services (F) (Limitations for Rehabilitation Services (2))

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

This subsection proposes that federal Medicaid cease from covering services that are "intrinsic elements" of other programs. ACCSES believes this to be the most damaging provision of this NPRM in terms of access to services. While at face value this may seem a reasonable provision, its implementation would be a significant and dangerous departure from the current standard, restricting the ability of disability services providers to provide necessary rehabilitation services.

This provision essentially removes the Medicaid safety net, a defining characteristic of this entitlement program. Medicaid coverage is always subject to third party liability and considered the "payor of last resort;" however, this new policy appears to exempt federal Medicaid from covering its share of the cost of rehabilitative services that are allowed under - but may not be provided or are denied by - vocational, prevocational, educational, substance-abuse, mental health, and assisted living programs. More clarity is needed regarding implementation of this new standard; however, it appears to establish a very alarming precedent.

In *Section V "Regulatory Impact Analysis," Subsection A "Overall Impact,"* the NPRM states that the rule would not impose any costs on State or local governments. Then, in *Subsection C "Alternatives Considered,"* CMS 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 continues, 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." ACCSES strongly disagrees with these assumptions.

Denial of FFP does not render important Medicaid rehabilitative services unnecessary. Some state and local governments will likely 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, and as these governments' abilities to shoulder this cost-shifting is challenged, 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.

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Put simply, ACCSES members and other clinicians and providers will not have the necessary funding to provide vital rehabilitation services to individuals currently in need and will have to cease such care if this "intrinsic element standard" is implemented. Removing the Medicaid safety net which ensures continued access to these services will lead to greater long-term costs as individuals are forced into institutions. This policy change clearly contradicts the intent of the Olmstead Supreme Court Decision, the New Freedom Initiative, and Americans with Disabilities Act (ADA), all aimed at increasing access to community living for individuals with disabilities.

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

This subsection 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.

ACCSES is aware that several states currently provide important day habilitation services to Medicaid recipients with disabilities. Section 6411(g) of the Omnibus Budget and Reconciliation Act of 1989 (OBRA 89) put a moratorium on elimination of coverage of day habilitation services for people with mental retardation for states who included such services in their state Medicaid plan prior to enactment. The statute states that CMS may issue an NPRM outlining the specific types of day habilitation and related services that a state may cover under the rehabilitative services option. CMS contends that the NPRM issued on August 13, 2007 serves as the NPRM referenced by OBRA 89. However, ACCSES argues that the terms put forth in the August 13th NPRM 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 permit CMS to specify the *types* of day habilitation and related services covered under this option.

ACCSES is also concerned that in this provision, CMS is trying to force a medical model onto a benefit clearly designed to provide psychosocial rehabilitation services to individuals with extremely complex disabilities and chronic conditions. Medical rehabilitation, which one might complete following an injury or accident, is not a concept often applicable to individuals with cognitive disabilities, mental illness, and substance abuse issues. For such individuals, maintenance of function is as important as attainment and/or regaining of function and must be achieved through continuous 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. In a medical context, would it be reasonable to provide hip replacement surgery to someone

who fell and shattered their hip, but deny the same surgery to someone born without functional hip sockets? No, it would not be reasonable at all. ACCSES finds denial of services based on whether an individual is 'attaining' versus 'regaining' a skill wholly unjust and contrary to statutory Medicaid requirements (e.g. comparability).

The regulation states that Medicaid currently covers habilitation services in two ways - in an ICF/MR or under the HCBS waiver/HCBS option – and seems to imply that this provision would not deny access but result simply in transitioning services from one benefit to another. However, we do not believe that solely providing habilitation services under these alternatives will reach all of the individuals in need of such care. Clearly, if this were the case, there would be no 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 help them from reaching the institutional level of care required by the ICF/MR benefit. Additionally, the HCBS waiver has much stricter eligibility requirements, as does the new HCBS option, although regulations implementing this option have yet to be published. We urge CMS to refrain from pushing states to use 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 population.

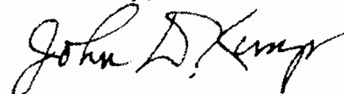
IV. Conclusion

ACCSES believes that growth in the Medicaid Rehabilitative Services benefit is clearly a result of increased access to community living for individuals with disabilities who might otherwise be institutionalized. We think 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, and we strongly oppose any action by CMS to restrict the ability of states and providers to provide the services that essentially allow this shift to take place.

It is for these reasons that ACCSES strongly urges CMS to withdraw this proposed rule.

Thank you for this opportunity to comment.

Sincerely,



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CEO
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CMS-2261-P-1190

Submitter : Ms. Jennifer Ondrejka **Date:** 10/12/2007

Organization : Wisconsin Council on Developmental Disabilities

Category : Other Government

Issue Areas/Comments

Background

Background

The Wisconsin Council on Developmental Disabilities has heard conflicting assessments of the impact of the proposed rules on legitimate services for people with developmental disabilities. The Council is particularly concerned about habilitative services provided to people so they can work, such as assistance from job coaches. Those services are inherently habilitative and necessary to the well-being of the individual. It would be a serious mistake by CMS to disallow such services. Though the description of the proposed rule states that habilitative day services will be allowed under the appropriate waiver, the Council has also heard many concerns about CMS s intent. The Council urges CMS to provide clarification on this matter.

Thank you for your consideration. If you have any questions, please contact Jennifer Ondrejka, Executive Director, at (608)266-1166 or ondrejm@dhfs.state.wi.us.

CMS-2261-P-1191

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

Organization : **DCBHA**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

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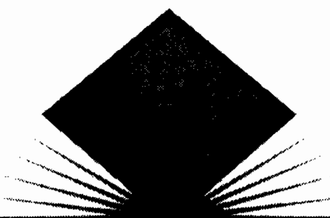

DISTRICT OF COLUMBIA
BEHAVIORAL HEALTH ASSOCIATION

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

The District of Columbia Behavioral Health Association 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.

The District of Columbia Behavioral Health Association (DCBHA) is an organization made up of 25 mental healthcare providers that provide community based mental health and ancillary services to support the independence of low income consumers. Our members serve a wide spectrum of consumers with varying degrees of mental illness. Our members' consumer population includes very young children to the elderly with all suffering from mild cases of mental illness to those that have schizophrenia and are institutionalized from time to time.

For thirty years, DCBHA's mission has been to expand and improve community based mental healthcare services. Each month, our members assist an average of 5000 consumers with housing, employment, case management, counseling and crisis management. These services are paid with a combination of Medicaid dollars as well as locate funding from the District Government.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our member agency serves. We would like to

comment on the following four areas of the proposed rule:

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

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

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

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

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

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

patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."

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

Additionally, The preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss has a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR 438.210(a)(4)(ii)(B)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

Secondly, revise the definition of when services may be furnished to maintain functioning to include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

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

440.130(viii)(3) Written Rehabilitation Plan

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

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for

every encounter will become a major burden, especially when services are delivered to a group.) We would recommend that progress notes be required at least monthly, leaving it to states to require, or providers to make, more frequent notes in cases where that may be appropriate. The guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

Is it allowable for a service planning team to create a single plan of services that address both treatment issues and rehabilitation issues? Frequently in mental health service delivery clinical issues (such as medication and therapy) are planned in conjunction with rehabilitation needs (skill building, etc.). Requiring two separate planning processes and two separate planning documents is burdensome not only on providers but also on the individual consumer. Clearly, multiple service plans do not facilitate coordination or accountability. The regulation does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

We are puzzled by the requirement that the plan include information on alternate providers of the same service. In almost all communities, the number of providers willing to accept Medicaid reimbursement is small. This reality is even more problematic in rural and frontier areas of the country. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation.

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative in some rare cases may be problematic. There are two factors to consider.

First, severe mental illness is episodic, and it is not always possible to determine when an exacerbation of the illness may occur. There may be instances in which a person, because of the symptoms of their illness, may not believe they are sick or comply with the signing the treatment plan, and it is also true, that at this point in the individual's life, retention of services are critical to prevent hospitalization, incarceration, or other public or personal safety consequences. There is also no guarantee that the individual has appointed a representative, or that the consumer in crisis could identify this person. Therefore, CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.

Recommendations:

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

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

- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.

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

- that the plan include intermediate rehabilitation goals;

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

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

- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers.

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

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

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

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

appropriations from states or localities should be specifically excluded from this provision.

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

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

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

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

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

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

Sincerely,

Daryll Griffin
Executive Director
District of Columbia Behavioral Health Association

CMS-2261-P-1192

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

Organization : Seven Counties, INC.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

My name is Stephanie Gerber, and I serve as a case manager for Seven Counties. I want to apologize for this being an informal comment up front. Seven Counties is a mental health agency that serves a great population of people. It is my opinion that this will do more harm than good for the clients we serve. Already several of our clients suffer with lack of medical insurance, housing, poverty, debt, transportation, and anything else that affects their lives. Our clients experience these problems of life every day, and many of them can not deal with them on their own, which is why there is case management and rehabilitative services. Case management gives support to adults with a severe mental illness that covers everything that affects a person's life. Some need more help than others, but the fact remains that the service is there. There are so many clients who have no family or friends to rely on. I cannot even begin to explain how many clients I have worked with who have said that I was their only support in the community. With the services they receive from our agency, there have been many clients who have recovered. Therefore that being said, there are just as many clients who are on the road to recovery, and need our services to function in the community. Our agency is about quality care for our clients. When things like this comes up, it affects everyone. We all work very hard to give the very best care to our clients. To us, working for Seven Counties isn't about working just to be working. We work for the good of our clients because we believe they can grow and recover from their mental illness. Recovery isn't a quick process, and it takes not only all of us at our outpatient services, but it encompasses ALL the services outside of it as well. When I think about rehabilitation services, they are an integral part of what we do. Our centers can only do so much, and through rehabilitation services, clients are able to obtain the self confidence it takes to get a job, to reach out and show other clients that they can recover, and to overall instill them with the skills and the means necessary to empower them to self support. It is my sincerest hope that things will work out for the best because everyone should have the opportunity to live life to its fullest.

CMS-2261-P-1193

Submitter : Ms. Candy Hill **Date:** 10/12/2007

Organization : Catholic Charities USA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1193-Attach-1.DOC

#1193

Providing Help. Creating Hope.

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Alexandria, VA 22314
Phone 703.549.1390
Fax 703.549.1656
www.catholiccharitiesinfo.org

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SCN
Treasurer
John L. Young
President
Rev. Larry J. Snyder

October 11, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore MD, 21224

Attention: File code CMS-2261-P

Catholic Charities USA appreciates the opportunity to submit the following comments on the proposed rule governing the Coverage of Rehabilitative Services under the Medicaid Program (file code CMS-2261-P). Catholic Charities USA is one of the nation's largest private networks of social service agencies serving nearly 8 million poor and vulnerable children, youth, adults and elderly across the country. Many of these individuals participate and contribute to their own and their community's well-being because of the life-saving health and mental health services and supports that Medicaid covers.

The proposal has raised a number of questions and concerns for Catholic Charities USA, its member agencies and the vulnerable individuals and families who receive service that address multiple, complex needs. We submit that the proposed changes would jeopardize important health and mental health rehabilitative services along with opportunities to secure safe and permanent families for many children who have been abused, neglected or abandoned. These children require an array of mental health and other medically necessary services to address immediate and long-term effects, to heal and restore healthy functioning, and to achieve safe and healthy permanency. These important national objectives are closely linked but not consistently pursued in the various programs that touch those in great need.

We agree with the importance of setting goals, measuring progress toward goal attainment, and developing individualized planning, treatment and reviews. Indeed, an emphasis on individualized services is a foundational principle in evidence-based practices that yield good results. However, a number of the proposed new requirements, we believe, operationally stand in conflict with that principle and could severely undermine opportunities that have been shown to ensure successful and cost-effective outcomes.

Research and practice have extensively documented the serious health and mental health needs that vulnerable children and families face and that demand well connected and multifaceted service options. The proposed requirement functionally segregates planning for rehabilitative services and fails to address how it must connect with other necessary interventions. It limits the potential effectiveness of the individualized services planning and delivery not merely for rehabilitative purposes, but overall.

In addition, while the importance of good record keeping cannot be overstated, the proposed new requirements fail to take account the special factors that affect particular populations, such as children in foster care who have high mobility and many of the poor with serious mental health or addiction problems. For many in these populations, the current lack of capacity to provide and track services within systems, much less across systems, will likely be exacerbated by the proposed changes and result in even further limiting access and denying services for those in legitimate need rather than clarifying and improving appropriate service provision.

It also remains unclear what and when services to children in foster care would be covered under the proposed rule. For example, the proposed regulations specify that Medicaid reimbursement would not be available 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." Nearly all service categories, including those that would be legitimate rehabilitative services could be attached to one or more areas cited in this list and could be inappropriately excluded. Additional clarification is needed in this area. Furthermore, this provision also appears in contradiction to Congressional intent and action during deliberations on the recently enacted Deficit Reduction Act. The proposed changes related to therapeutic foster care are troubling, as well. In this instance, reimbursement for therapeutic foster care would be excluded "except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers." While understanding the unit service costs is important to tracking and monitoring expenditures, the resulting actions will not only impact accounting practices.

The required administrative tasks will no doubt be highly complicated and differ widely by program and service arrangements. The accounting activities actually might become the most influential driver in decision to provide or to deny them. Also, the initially anticipated savings from implementing the proposed changes likely do not take into account the actual cost benefit of packaged and coordinated services that produce positive outcomes. Moreover, the critical and appropriate rehabilitative services that were made possible because of the packaging links might have much reduced availability, if accounting resulted in service disaggregation as well.

We appreciate this opportunity to record our concerns and opposition to the proposed rule changes because of serious adverse implications for poor and vulnerable children and families across the country, particularly those involved in child welfare and mental health care. We urge CMS to withdraw the proposal.

Sincerely,

Candy Hill
Senior Vice President for Social Policy and Government Affairs

CMS-2261-P-1194

Submitter :

Date: 10/12/2007

Organization : Michigan Assoc. of CMH Boards

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1194-Attach-1.PDF

#1194

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

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

The Michigan Association of Community Mental Health Boards 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. MACMHB represents all 46 community mental health services programs in the state of Michigan through which public mental health and developmental disability services are coordinated.

Members of MACMHB have raised serious issues and questions about the proposed regulations, and the impact they may have on the vulnerable children and adults that our system serves everyday. Specifically, we have concerns with the following:

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

We are concerned that this definition needs further clarification. Language about restorative services not needing to be limited to those functions which were performed in the past is critical, particularly for children who may never have experienced the function prior to service delivery.

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. 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. For people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. In fact, failure to provide a supportive level of rehabilitation would

426 S. Walnut • Lansing, MI 48933 • 517-374-6848

result in deterioration necessitating a reinstatement of intensive services. We are concerned that if the individuals we serve are not eligible for services necessary for retention of improved functioning as well as maintaining the highest possible functional level, they may 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 and specifically this cycle of deterioration.

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

Another concern is the preamble and section 441.45(b) of the proposed rules exclude prevocational services. Rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss has a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

Clarify that a child need not demonstrate that he or she was once capable of performing a task in the past if it were not possible or age-appropriate for the child to have done so. Restorative services should be used to assist children in reaching their age-appropriate goals -- an example of this would be helpful.

Additionally, revise the criteria of when services may be delivered to maintain functioning to include a rehabilitation plan that retains the functional level for individuals who can be expected to otherwise deteriorate as an acceptable goal. Clarify that pre-vocational services are still allowable services when appropriately tied to a rehabilitation goal.

440.130(viii)(3) Written Rehabilitation Plan

We are extremely concerned that this new requirement will add significantly to the administrative time and expense of agencies delivering rehabilitative services.

Requiring progress notes for every encounter is overly aggressive particularly given CMS is currently requiring providers to account for and bill services in 15-minute increments. We would support the recommendation that progress notes be required at least monthly, and allow 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.

Possible requirement of two separate plans for treatment issues and rehabilitation issues is not good coordination of care for the individuals our members serve. Clarification that one service plan for an individual is acceptable or even preferred would be an improvement. A process should also be created for the rare circumstances when the signature of the consumer of their representative is not possible, obviously recognizing that all person-centered planning processes must be followed and advance directives respected if known.

Recommendations:

We believe the following items would improve upon the written rehabilitation plan:

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan recognizing that there may be rare cases where a signature is not possible;
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received information about the choices of providers in their area.

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

We are most troubled by this new language about "intrinsic elements" that we believe conflicts with federal statutory requirements. To deny Medicaid coverage for covered services to covered individuals if such services are possibly furnished through another program creates a dangerous scenario. Our members use a variety of funding mechanisms to deliver mental health services for persons who are uninsured or underinsured. They also deal with individuals who have other insurance (where the insurer has a contracted legal liability to pay) or they receive federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services). There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

The implication is either that there is Medicaid fraud for which case there are federal statutes to address or that our members have other means (state funds, grants, local funds, etc.) available to them to provide Medicaid services. Our members could quickly exhaust their other sources of funding while creating huge unmet need for the non-insured, non-Medicaid population. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), (1396d(r)). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

We strongly recommend that this entire section be dropped, because it conflicts with the Medicaid statute and will create huge unintended consequences.

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. Our community mental health

services programs that operate on defined state appropriations and local county match funds should be exempt from this provision.

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

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

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service. Similarly, a child with a serious mental disorder being reunified with its family may have specific issues directly stemming from the mental disorder. 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, we encourage CMS to work with the state of Michigan to develop an implementation timeline that will include time for a federal waiver amendment, as well as adequate time for administrative and programmatic changes at the state, community mental health services program and provider level. The development of new forms as well as staff training and administrative processes all pose significant challenges at the provider level. At a minimum, we would encourage a one-year planning and implementation period from the time of approval of any waiver amendment and State Plan Amendment.

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

Sincerely,

Douglas Ward
President

David LaLumia
Executive Director

CC: All Michigan U.S. Senators and Representatives
Governor Jennifer M. Granholm, Washington, DC office

CMS-2261-P-1195

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

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

please do not cut any funding.

CMS-2261-P-1196

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

Organization : Utah Behavioral Healthcare Network

Category : Health Care Professional or 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..

CMS-2261-P-1197

Submitter : **Ms. Ann Hardiman** **Date: 10/12/2007**

Organization : **NYSACRA**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007. These comments are submitted on behalf of the New York State Association of Community and Residential Agencies (NYSACRA). NYSACRA is a catalyst and leading advocate for people who have developmental disabilities and organizations that support them. NYSACRA represents the collective voice of its almost 200 provider members in promoting the full participation of persons with developmental disabilities in the communities of New York State. We are commenting on the impact of the proposed rule on people with intellectual and other developmental disabilities and access to habilitation services.

We strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. We urge you to withdraw this proposed rule.

We worry that the impact of these proposed regulatory changes going forward will further erode essential services provided to individuals with developmental disabilities, such as day habilitation.

Day habilitation (day hab) offers people with developmental disabilities services and supports to help them grow as people first, with interests, values and goals. The day hab provides the opportunity for someone to spend the day engaged in productive, meaningful activities that relate to the individual. Picture a young person with a developmental disability, 21 years old, newly graduated from high school, and seeking some help with the next steps along the path to adulthood. A day hab can provide some structure in terms of schedule and place, as a starting point; the person can choose from an assortment of planned activities to match her interests, like sorting clothes at the Salvation Army, or helping with lunch set-up at the homeless shelter, or volunteering at the museum store, or participating in a Circles group. There s no need for the person to do the same things every day; she can try something out and then, keep it in her schedule or not, depending on what she likes. It's flexible enough that it can be part of an overall plan with other services/supports, too, like supported employment.

GENERAL

GENERAL

SEE ATTACHMENT IN MS WORD FORMAT

Provisions of the Proposed Rule

Provisions of the Proposed Rule

COMMENTS ON THE PROVISIONS OF THE PROPOSED REGULATIONS:

1. NYSACRA takes great exception to the statement by CMS that it's "ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health," which boils down to spending as little as possible to keep a person alive. It is our understanding that according to Section 1901 of the Social Security Act, the goal of these rehabilitative services should be to provide rehabilitation and other services to help such families and individuals attain and retain capability for independence or self-care.

2. Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 (OBRA '89) clearly states that the HHS Secretary shall not promulgate or propose any rule that does not specify "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." This NPRM does not specify which day habilitation services a state may cover. Instead, the proposed regulation would prohibit provision 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.

3. We strongly oppose the proposed rule's exclusion of habilitation services, see Section 441.45(b) (2), including "services provided to individuals with mental retardation and related conditions," from covered rehabilitative services. 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, under Section 1902(a)(10(B) of the Social Security Act. This section further puts forth a false premise that people 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 rehabilitative 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.

Response to Comments

Response to Comments

4. Section (V) (Regulatory Impact Analysis) of the Proposed Regulation, beginning on page 45208 of the Federal Register, claims "this major rule would not have a direct impact on providers of rehabilitative services." Such a statement is a misrepresentation.

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. Clearly this impacts providers.

5. This section (V) also claims that "since this rule would not mandate spending in any 1 year of $120 million or more, the requirements of the UMRA (Unfunded Mandates Reform Act) are not applicable." For the same reasons stated above, this claim is false. States and local governmental units would most certainly be severely financially impacted by the implementation of this rule, and by CMS' own admission a few paragraphs below this claim in the accompanying chart, it shows that the rule would impact $180 million in FY 2008 alone.

CMS-2261-P-1197-Attach-1.DOC

#1197

NYSACRA

NEW YORK STATE ASSOCIATION OF COMMUNITY & RESIDENTIAL AGENCIES

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Lifespire

Ann M. Hardiman
Executive Director

First Vice President
Steve Klein
Schenectady ARC

Secretary
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Aspire of Western New York

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Evelyn Alvarez
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Small Business
Development Center

Maxine George
Alternative Living Group

Lee Rambeau
FEGS

Matthew Sturiale
YAI/NIPD

Jim Wilson
ARC of Schuyler County

IMMEDIATE
PAST PRESIDENT

October 11, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007. These comments are submitted on behalf of the New York State Association of Community and Residential Agencies (NYSACRA). NYSACRA is a catalyst and leading advocate for people who have developmental disabilities and organizations that support them. NYSACRA represents the collective voice of its almost 200 provider members in promoting the full participation of persons with developmental disabilities in the communities of New York State. We are commenting on the impact of the proposed rule on people with intellectual and other developmental disabilities and access to habilitation services.

We strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. We urge you to withdraw this proposed rule.

We worry that the impact of these proposed regulatory changes going forward will further erode essential services provided to individuals with developmental disabilities, such as day habilitation.

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her interests, like sorting clothes at the Salvation Army, or helping with lunch set-up at the homeless shelter, or volunteering at the museum store, or participating in a Circles group. There's no need for the person to do the same things every day; she can try something out and then, keep it in her schedule or not, depending on what she likes. It's flexible enough that it can be part of an overall plan with other services/supports, too, like supported employment.

COMMENTS ON THE PROVISIONS OF THE PROPOSED REGULATIONS:

1. NYSACRA takes great exception to the statement by CMS that it's "ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health," which boils down to spending as little as possible to keep a person alive. It is our understanding that according to Section 1901 of the Social Security Act, the goal of these rehabilitative services should be to provide "rehabilitation and other services to help such families and individuals attain and retain capability for independence or self-care."

2. Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 (OBRA '89) clearly states that the HHS Secretary shall not promulgate or propose any rule that does not specify "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." This NPRM does not specify which day habilitation services a state may cover. Instead, the proposed regulation would prohibit provision 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.

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following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

4. Section (V) (Regulatory Impact Analysis) of the Proposed Regulation, beginning on page 45208 of the Federal Register, claims "this major rule would not have a direct impact on providers of rehabilitative services." Such a statement is a misrepresentation.

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

Sincerely,

Ann M. Hardiman

Ann M. Hardiman
Executive Director
NYSACRA

CMS-2261-P-1198

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

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-1198-Attach-1.DOC

#1198

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: 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:

We appreciate the opportunity of offer comment on the proposed CMS-2261-P-Rehabilitation Services: State Plan Option Rule. As a not-for-profit, multi-service treatment agency providing a wide array of behavioral health services to children and families in crisis in our community for 120 years, we are well aware of the need for fiscal integrity and the value of coordinating the delivery of services and treatment through a variety of local, state and national funding resources.

We also recognize the need for a reduction in Medicaid costs and an increase in accountability. However, we strongly believe this proposed ruling will have detrimental, long-term and unintended negative consequences on children and ultimately result in increasing costs for Medicaid.

441.45(b) Non-Covered Service and Intrinsic Element
Evidence shows that children entering the foster care system experience many more and more complex physical and mental health conditions than other children. Evidence also indicates that therapeutic foster care improves the lives of children served and that improvement results in reducing the use of Medicaid permanently. We strongly recommend that Therapeutic Foster Care not be eliminated as a covered Rehabilitative Service.

Additionally, we are 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. Despite this lack of clarity, foster care is listed as a non-covered service. Congress explicitly rejected adopting an "intrinsic to" test in regard to Medicaid rehabilitative services when debating and finalizing the Deficit Reduction Action. We believe Medicaid rehabilitative services are not "intrinsic to" foster care and would request the language about foster care and other child welfare programs be removed.

441.45(b)(1)(i) and (ii) Therapeutic Foster Care and Packaged Services Furnished by Foster Care and Child Care Institutions
States are utilizing Medicaid Rehabilitation services as encouraged by the President's 2003 New Freedom Commission on Mental Health to provide services within the community. This proposed rule then appears in direct conflict to this goal by eliminating Medicaid funds for therapeutic foster care services. Therapeutic foster care services are designed to be comprehensive, person-centered services delivered in a least restrictive setting where a child is

treated holistically. This attains the goal of reducing cost, reducing the use of Medicaid and reducing the use of significantly higher cost institutional settings over the long-term. We request that States maintain the flexibility to define therapeutic foster care services as a single service and pay through a case or daily rate.

441.45(b)(5) Institution of Mental Disease
The Home of the Innocents is a unique, state-of-the-art designed and cost-effective facility providing, among a broad range of services, several "community residential treatment" homes. The innovative, award-winning design offers significant savings in overhead costs with several homes located contiguously thus enabling more treatment provision.

Excluding services provided to residents of an "institution for mental disease," including residents of community residential treatment facilities more than 16 beds, would once again increase costs and force children into more restrictive higher cost settings. This goes against the New Freedom Commission and the best interests of the child and family. We strongly recommend this language be deleted.

440.130(d)(1)(vi) – Definition of Restorative Services
This definition defines restorative services as 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. We recommend the language should state that restorative services include services that 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. We also request that the definition be revised to clarify that services may be furnished to maintain functioning as an acceptable goal of the rehabilitation plan when the retaining of functional level for those individuals is necessary to avoid deterioration that would be expected without consistent and persistent treatment. For these children, not maintaining that functional level will ultimately mean more and higher cost Medicaid treatment services as deterioration in their condition continues.

According to the EPSDT mandate, all children under age 21, appropriately screened, are eligible for all federal Medicaid-covered services, regardless of the State plan. We support this mandate. We agree that children, especially those who have been abused and neglected, must obtain vital Medicaid services. However, with this ruling CMS 2261-P, we believe treatment services will no longer be available to these vulnerable children who are eligible under federal statutes.

We respectfully submit our comments for consideration.

Sincerely,

Gordon Brown, CEO & President
Home of the Innocents
1100 E. Market Street
Louisville, KY 40206
gbrown@homeoftheinnocents.org

Judith Bloor, Senior VP-Childkind Center
Home of the Innocents
1100 E. Market Street
Louisville, KY 40206
jbloor@homeoftheinnocents.org

CMS-2261-P-1199

Submitter : **Ms. Kim Wooden** **Date:** **10/12/2007**

Organization : **Clark County School District**

Category : **Other Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1199-Attach-1.DOC

#1199

STUDENT SUPPORT SERVICES DIVISION

5100 WEST SAHARA AVENUE • LAS VEGAS, NV 89146 • (702) 799-5471 • FAX (702) 799-5043

CLARK COUNTY SCHOOL DISTRICT

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Dr. Walt Rulffes, Superintendent

October 12, 2007

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

To Whom It May Concern:

The Clark County School District (CCSD) expresses concern with proposed Rule 2261-P which outlines the intention of CMS to redefine rehabilitative services for students receiving Medicaid. The potential impact to school-based Medicaid billing is significant. The proposed rule may require that CCSD staff develop and implement "individualized rehabilitation plans" which may be duplicative of the individualized education programs already developed for each child under Individuals with Disabilities Education Act (IDEA). CCSD is already facing a critical shortage of service providers and adding burdensome paperwork will only deter qualified staff from accepting positions.

Fundamentally, the schools are the best providers of services to students especially to low income families who may not readily access health care. In some cases, the medical services provided to some students in the school setting may be the only services for that student. The proposed rule may be interpreted to preclude reimbursement for rehabilitative services because they are provided as required by IDEA.

The proposed rule is contrary to the Medicare Catastrophic Coverage Act of 1988 which authorized Medicaid to reimburse for IDEA medically necessary services. The passage of this act clearly showed Congress' intentions to ensure payment for services provided by IDEA.

We respectfully request that CMS withdraw the rule and continue to reimburse at the current levels.

Sincerely,

Kim Wooden
Director of Quality Assurance
Student Support Services Division

CMS-2261-P-1200

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

Organization : **RI Dept. of MH, Retardation, and Hospitals**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1200-Attach-1.DOC

#1200

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Mental Health, Retardation, and Hospitals
Office of the Director
14 Harrington Road
Barry Hall
Cranston, Rhode Island 02920-0380
(401) 462-3201; Fax (401) 462-3204

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

Reference: File Code CMS-2261-P

To Whom It May Concern:

The Rhode Island Department of Mental Health, Retardation, and Hospitals submits the following comments on the Proposed Rule: *Medicaid Program; Coverage for Rehabilitative Services.*

COMMENTS ON SPECIFIC ITEMS IN PROPOSED RULE

§440.130(d)(1)(v) *Rehabilitation Plan*
This section requires that the Rehabilitation Plan is "developed by a qualified provider(s)...with input from the individual, the individual's family, the individual's authorized decision maker and/or of the individual's choosing in the development, review and modification of the goals and services."

Comments:
We agree that active participation in the development of the plan as well as in all required reviews and modifications is important. However, along the lines of client-centered planning and the client's right to determine their own goals, we suggest that the term "family" be preceded by the phrase "..., if clinically appropriate," to allow for situations in which family participation is not in the client's best interests. This change should carry throughout the entire document.

Also, the word "persons" was inadvertently left out of the rule although it immediately follows the term "and/or" in the preamble. Taking these two items into account, the section should read as follows:

> "...developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family (if clinically appropriate), the individual's authorized decision maker and/or persons of the individual's choosing and also ensures the active participation of the individual, individual's family (if clinically appropriate), individual's authorized decision maker and/or persons of the individual's choosing in the development, review, and modification of the goals and services."

This section requires that the plan have a timeline that includes reevaluation at a period of no longer than one year.

Comment:
We believe that a timeline of "one year" is excessive and recommend review at least every 6-months.

§440.130(d)(1)(vi) *Restorative Services*
Comment:
This definition contains wording stating that "restorative services" are those that enable an individual to perform a function but also state that the individual does not have to have actually performed the function in the past. This section should be modified to reference the needs of children with serious emotional disturbances and provide a specific exemption in their case rather than leaving the issue up to reviewer discretion.

Of even more concern is the thought that services designed to help a client maintain their current level of functioning are only allowable when they are necessary to help an individual achieve a rehabilitation goal. Given the cyclical nature of mental illness, we recommend this section be modified to allow services that are required to preserve a client's level of functioning and prevent them from deteriorating to the point that more intensive, and often more costly, services are required.

We recommend inclusion of language that reflects the concept that some recreational activities or vocational services can be regarded as rehabilitative if the primary purpose is to reduce disability and restore a person to a previous functioning level.

§440.130(d)(3) *Written Rehabilitation Plan*
Comments:
We are concerned that this requirement has the potential to add to the administrative time and expense of providers, thereby further stressing a system that is already stretched thin.

For example, this section at least implies that the rehabilitation plan is to live as a separate document. In the behavioral health field, it is more common for individuals to have an overall treatment plan addressing all aspects of their care. While this does not appear to be specifically prohibited, we suggest that this section allow for a consolidated plan.

With regard to client participation, the requirement that the individual must participate in planning and sign the final document needs to be modified to allow for situations in which the individual cannot, or will not, actually participate/sign. In this case, agency clinical records documenting their attempts to engage the client, even if they are unsuccessful, should be considered adequate.

In cases in which the provider does participate/sign, it is also important that the plan contain evidence of the extent of their participation, preferably in the form of case notes documenting ongoing involvement as opposed to a simple signature.

§441.45(a)(2) *Rehabilitative Services*
Comment:
This section should be modified to state that rehabilitative services can be provided with the intent to maintain a client at their highest functional level under certain circumstances.

§441.45(b)(2) *Rehabilitative Services*
Comment:
This section refers to "habilitation services." We recommend that a clearer definition of "Habilitation services" be included. Also, the parenthetical statement should be deleted and a revised statement should be included that states that persons with developmental disabilities who need rehabilitative services as described in §441.45(a) should be able to access them.

PAYMENT FOR SERVICES

While it does not appear to be a specific requirement of this regulation, CMS recently began requiring States to implement approaches that move away from daily or case rates towards a system of paying for 15-minute increments of service. This approach is detrimental to the provision of the some of the primary, evidence-based mental health services that are increasingly being offered as a unified set of interventions. The primary example of this is Assertive Community Treatment (ACT) which was recognized as an EBP in the Surgeon General's Report.

What is especially concerning is that while one Federal agency under the HHS umbrella, SAMHSA-Center for Mental Health Services, is moving at top speed to promote the ACT model which is most effectively funded as a single, integrated service, a sister agency (CMS) is showing all signs of pulling the model apart through unrealistic payment requirements.

We urge CMS to work with other federal agencies and states to devise and implement payment methodologies that best support evidence based practice.
Thank you for the opportunity to comment,

Ellen R. Nelson, Ph.D.
Director

Submitter : **Mr. Ken Brynien** **Date: 10/12/2007**

Organization : **Public Employees Federation**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-1201-Attach-1.PDF

CMS-2261-P-1201-Attach-2.PDF

1201

New York State
PUBLIC EMPLOYEES FEDERATION AFL-CIO
1168-70 Troy-Schenectady Road
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Albany, NY 12212-2414

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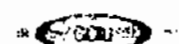


October 11, 2007

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

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

Dear Sir or Madam:

As President of the New York State Public Employees Federation (PEF), representing 58,000 Professional employees in New York State Government, I am writing to express strong opposition to the proposed rules on coverage for rehabilitative services.

I am very troubled by the estimate in the proposed regulation that these rules would save the federal government 2.2 billion dollars. Our experience tells us that creating barriers to vital services usually does not save money in the long run. Rather, it usually increases the costs.

The proposed rules add new requirements and restrictions proposed by the Centers for Medicare and Medicaid (CMS) to govern Medicaid's rehabilitation service category. These restrictions could restrict access to intensive community mental health services needed by children and adults with disabilities who rely on Medicaid for their healthcare. As the single most significant source of financing for the public mental health system, Medicaid provides needed access to community-based care through the rehabilitative services option to help children and adults. The new rules could also have a profound effect on Medicaid services and the New York State workers who provide these services.

Section 441.45(b) Exclusion of services, including those that are an "intrinsic element" of other programs

This section introduces a whole new concept into Medicaid. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There is little clarity in the regulation on how this provision would be applied, as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

The result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program.

Therapeutic Foster Care: 441.45(b)(1)(i)

The regulation denies payment for therapeutic foster care as a single program, requiring instead that each component part be separately billed.

Therapeutic foster care is a widely covered evidence-based practice. The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

If states are not able to create a package of covered services such as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs.

Rehabilitative Services: 441.45(a)(2)

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level. Language should be inserted to describe when services may be furnished with the goal of retaining or maintaining functioning.

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

This 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 further clarify that a child need not demonstrate that he or she was once capable of performing a specific task that was not possible or age appropriate.

EPSDT Mandate

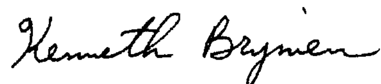
The regulation appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults.

The New York State Public Employees Federation opposes these regulations because they will jeopardize our members, their jobs and the services our members provide to New York State residents.

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

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

Sincerely,



Kenneth Brynien
President

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

Organization : Georgia Parent Support Network

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachments.

CMS-2261-P-1202-Attach-1.DOC

CMS-2261-P-1202-Attach-2.DOC

#1202-

GEORGIA PARENT SUPPORT NETWORK

1381 Metropolitan Parkway • Atlanta, Georgia 30310 • Atlanta: 404-758-4500 • Fax: 404-758-6833
Outside Atlanta Area: 1-800-832-8645 • www.gpsn.org • E-mail: gpsn@mindspring.com

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

Reference: File Code CMS-2261-P

Georgia Parent Support Network is submitting the following comments on the Proposed Rule for Rehabilitative Services under the Medicaid program published in the Federal Register, August 13, 2007.

In addition to lending our full support to the comments made above by Mental Health America, we wish to call special attention to how the Proposed Rule would affect children with mental illness or substance abuse needs. The Rule's language continually separates activities and programs focused on social or educational development goals from those that reduce disability and restore a person to his or her best possible functional level, but then acknowledges how integral such activities are in achieving many rehabilitative goals, especially those associated with mental illness. We fear that, though harm to all consumers of such services may result from any confusion in interpreting such conflicting messages, children stand to lose the most, as their recovery/resilience can not be severed from such factors as social and educational activities, and a trusting and therapeutic environment. The responsibility of discriminating between which factors in a child's treatment plan are therapeutic or not should lie with a clinical treatment team, not be dictated by blanket policy.

Further, the assumption that another funding stream COULD provide necessary services without ensuring that is indeed the case flies in the face of the collaborative community-based programs that are elsewhere being endorsed and encouraged by our administration. Such a "not my job" attitude creates gaps in care and dire consequences for our country's most vulnerable children, instead of working toward an integrated system of care. Particularly for children in state custody, the proposed restrictions for providing the very community-based services they need to reduce the effects of their mental disability put these children at great risk of being ineligible due to their current placement.

In short, we urge the revision of the Proposed Rule in light of the effect it will have on our children, and we thank you for your consideration of our comments.

Sincerely,

Sue Smith and Anna McLaughlin
Co-CEOs

#1202-

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

Reference: File Code CMS-2261-P

Mental Health America is submitting the following comments on the Proposed Rule for Rehabilitative Services under the Medicaid program published in the Federal Register, August 13, 2007.

Background: Overarching Concerns

As one considers the significance and implications of the proposed rule, it is critical to understand the importance of the Medicaid program, and in turn, the Rehabilitative Services option to low-income individuals with mental health needs, especially those with significant disability related to mental illness. In short, adoption of the proposed rule would have a sweeping and profoundly detrimental impact on millions of very vulnerable Americans, particularly children. Additionally, the proposed rule would likely result in overall increased cost to Medicaid since its constraints on community-based services would place many beneficiaries at risk of functional deterioration, with resultant greater use of Medicaid-reimbursed hospital and nursing home care. Overall, the proposed changes would be regressive. They make no sense in terms of the science of community-based care, the desires of Medicaid enrollees or their families, or the experience of thousands of individuals whose rehabilitation and recovery has been greatly assisted through the rehab option.

It is fair to say that the Medicaid program provides a lifeline of support for millions of Americans who need mental health care. Medicaid enables them to access critical mental health services ranging from inpatient hospital care to psychologist and psychiatrist services, rehabilitation, and prescription drug coverage. Importantly, many of these Medicaid-covered services and benefits enable individuals to remain in their homes and communities instead of costly institutions. Without Medicaid, most of these individuals would have no other treatment options, given the very limited support available through other programs.

The rehabilitation services option (rehab option) in the Medicaid program is a primary source of funding for community-based mental health services, and nearly every state uses it to provide services and supports for individuals with mental illness. This option enables states to offer a wide range of services in community-based settings that foster an individual's rehabilitation and recovery far more effectively than services offered in traditional clinical facility settings. The rehab option was intended to be flexible, in contrast to a funding category like the **clinic option** where services must be provided in a medical setting to receive Medicaid reimbursement.

The rehab option currently authorizes Medicaid reimbursement for "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." Examples of community-based services funded through the rehab option include supported employment services, case-management services, consumer-run services, and day treatment –which enable individuals with mental illnesses to remediate functional disabilities that are directly associated with their illness and reach desirable levels of community participation in terms of employment and residential status.

In short, this important option has provided the kind of flexibility so vital to realizing the widely supported goals and recommendations of the President's New Freedom Commission on Mental Health, fostering the recovery of people with mental illness. Although the preamble to the proposed rule cites the Commission approvingly, adoption of major changes in the proposed rule would almost assuredly thwart realization of the Commission's recommendations and realization of its vision. There is inherent tension in the Notice of Proposed Rulemaking (NPRM): first, conflict in the Preamble between passages that reflect understanding of the rehabilitative needs of individuals with chronic mental illnesses and other text that almost invites the imposition of arbitrary barriers to continued rehab coverage, and second, conflict between supportive passages in the preamble, and new limitations (or ambiguities that invite the imposition of new limitations) in the body of the proposed rule.

<u>Catch- 22: The Intrinsic Element Test. Section 441.45(b)(1)</u>

The NPRM proposes to eliminate Medicaid payment for services through the rehab option "when the services are 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."

With this language, the NPRM would create an irrebuttable presumption, namely that if rehab services <u>could</u> be funded through another mechanism those services <u>are</u> otherwise available and, accordingly, that Medicaid shall not be a payer for them. The proposed rule would deny enrollees the provision of medically necessary services by eliminating the entitlement to those services and subjecting enrollees to state and local capacity constraints and idiosyncratic eligibility requirements. This sweeping regulatory step is at odds with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan and for children those covered by 42 USC section 1396d(a). Indeed Congress' rejection (in developing the Deficit Reduction Act of 2006) of the Administration's recommendation that it enact a provision reflecting this policy underscores the tenuous nature of this exercise in rulemaking authority.

Were one to assume that some frail basis in law could be established to permit CMS on a purely technical level to consider adoption of this provision, its substantive implications dictate that it be withdrawn. Federal law already protects Medicaid's financial integrity in providing that Medicaid does not cover rehab or other services for which another party (or program) is legally liable. The "intrinsic element" rule would establish a wholly different "principle," and constitute a dramatic shift in policy. Its adoption would greatly reduce access to community-based mental health services because of what the NPRM deems alternative sources of support that are widely recognized as totally inadequate. This new policy would also undermine one of the most helpful features of the rehab option with regard to mental health treatment – the capacity it offers states to cover a range of comprehensive community-based services that are fully coordinated with clinical services. This coordination would be lost if states are required to piece together what little alternative funding might be available for needed services from different programs, with resultant fragmentation of services. The President's New Freedom Commission on Mental Health singled out fragmentation of mental health services as one of the principal barriers to effective mental health service delivery and as a primary cause of so many people with mental illness "falling through the cracks." To adopt this proposed change would be to ignore the findings of this important Commission, whose views CMS cites approvingly in the Preamble to the NPRM, and to impose a devastating new barrier to recovery for low-income individuals with mental illness and persons with psychiatric disabilities. We strongly urge removal of this section or least clarification explaining that reimbursement will be denied only when another entity has legal liability for the service at issue and specifically excluding programs operated under capped or discretionary appropriations from being considered to have legal liability for providing services.

Maintaining Functioning as a Goal of Rehabilitation. Section 440.130(d)(1)(vi)

The Preamble states that the rehabilitation benefit "is not a custodial care benefit" and "should result in a change of status (emphasis added)." More specifically, it states that there must be "measurable reduction of disability and restoration of functional level." CMS does acknowledge that "rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning," but the proposed rule states 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." Sec. 440.130(d)(1)(vi). These expressions of policy, read in light of the Preamble and its "should-result-in-a-change-of-status" posture, could be interpreted as barring use of this benefit to provide services to prevent deterioration. That would represent a fundamental and cruel change in policy wholly at odds with the rehabilitative goal of enabling an individual to function at the highest possible level and to slow or eliminate the functional decline that would occur without the provision of rehab services. We urge that the rule be clarified to state that services to maintain functioning may be reimbursed through Medicaid as rehabilitative services and that retaining the functional level for individuals whose functional level can otherwise be expected to deteriorate IS an acceptable goal of a rehabilitation plan.

Written Rehabilitation Plan: Benefit or Barrier? Section 440.130(d)

The NPRM introduces a potentially valuable new requirement in requiring a written rehabilitation plan that identifies the rehabilitative services each individual requires to achieve recovery goals. But without changes to the provision, its adoption could thwart rather than achieve the important policy objectives of fostering recovery and engaging the individual in the planning process.

Proposed section 440.130(d)(v) calls, on the one hand, for specifying individualized rehabilitation goals and services to achieve them, while, on the other hand, stating that **"[t]he plan must have a timeline...not longer than one year**," (emphasis added) a directive that could be read or misread to set arbitrary limits on the duration of covered services. Were the rule to have the effect of limiting to an arbitrary time period services that people need on a long-term basis, the establishment of a rehabilitation plan would be transformed from a recovery tool to a crude cost-containment mechanism. While rehab services associated with an injury or other "physical" condition may only be needed for a relatively brief time, rehab services for people with chronic mental illnesses may be needed for very extended periods. Given that a large majority of the services provided through the rehab option are for mental health conditions, we urge that the rule be clarified to take account of the range of circumstances in which rehabilitation occurs and specify that rehabilitation plan timelines must be flexible and may not be used to set strict time limits on coverage of needed services.

As acknowledged with sensitivity in the Preamble, it is critical that a rehabilitation plan be person-centered. (The Preamble itself reflects inconsistency on the point, however, stating at once that "the individual **must** be at the center of the planning process," while immediately reverting to "**recommend** the use of a person-centered planning process. Emphasis added.) The rule itself at section 440.130(d)(v) falls short of articulating the point with meaningful clarity and specificity. It employs vague language in stating that "the plan is developed by a qualified provider(s)...with **input** from the individual...." (emphasis added). The meaning and extent of so-called "input" appears limited given that the provision goes on to call for "active participation of the individual...in the development, review, and modification of the goals and services." We urge that the rule be clarified to ensure that input from the individual receiving services is central to the development of the rehabilitation plan.

Therapeutic Foster Care. Section 441.45(b)(1)(i)

The proposed rule at section 441.45(b)(1)(i) would prohibit Medicaid reimbursement for "therapeutic foster care services by foster care providers to children, except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers." Therapeutic foster care is recognized as an effective alternative to institutional care for children and adolescents with severe mental disorders. It is a widely covered evidence-based mental health service provided to children who need to be removed from their home environment for a period and furnished intensive mental health services. It is not a service solely for children in the foster care system. The final rule should list this important service as a covered rehabilitation service for children with

serious mental disorders who are at imminent risk of placement in a residential treatment facility.

Coverage of Community-based Services Provided as Alternative to Incarceration. Section 441.45(b)(4)

The proposed rule at section 441.45(b)(4) would specify that reimbursement for rehabilitative services provided to inmates of a public institution is prohibited. In an attempt, however, to clarify circumstances under which rehab services could be reimbursed notwithstanding that general rule, the provision states that such reimbursement would be available "on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system...." (emphasis added). We are concerned that inclusion of the underscored phrase could result in this provision being read to bar reimbursement where, for example, an adolescent with a mental health disorder receives services in a community-based facility instead of being incarcerated in a juvenile justice facility. We recommend that the phrase "that are not part of the public institution system" be deleted from this section of the proposed rule.

We urge careful attention to these comments, and thank you for the opportunity to comment on the proposed rule.

Sincerely,

CMS-2261-P-1203

Submitter : Mrs. Clara Berg **Date:** 10/12/2007

Organization : NYSTAP

Category : Individual

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

My son is 27 yrs. old and needs to have a companion/job coach/assistant during work hours

GENERAL

GENERAL

As a family member of a person with developmental disabilities, I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential services. We need your help!

CMS-2261-P-1204

Submitter : Patricia Melaragno

Date: 10/12/2007

Organization : Butler Hospital

Category : Hospital

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 beel 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-1205

Submitter : **Mrs. Kathryn Cromwell** **Date: 10/12/2007**

Organization : **Center for Independent Living**

Category : **Individual**

Issue Areas/Comments

Background

Background

October 12, 2007

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

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

Dear Sir or Madam:

As a disability advocate with the Ann Arbor Center for Independent Living and the National Alliance for the Mentally Ill (NAMI) whose mission is to help improve the quality of life for persons with disabilities. I am writing today regarding the proposed rules on the Medicaid Rehabilitation Services option. The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services.

The importance of the multi-systemic therapy for children and adolescents (MST) is well documented as being very effective. At an educational seminar sponsored by the NAMI they had a doctor explaining the brain and mental illness. He stated that the earlier the intervention via medications and counseling the less damage to the brain the mentally ill person incurs. So the healing process is much quicker. So, if children are diagnosed sooner their recovery rate would excel. Children would be much less likely to become drug users and alcoholics.

Assertive Community Treatment just makes good sense. One of the most prevalent symptoms of those with mental illness is the thought process where one thinks, Well I don t need medications I m much better now. That specific thought process is only found among those with mental illness. People with other diseases such as arthritis or diabetes never stop taking their medications because they know better.

Please reauthorize this vital funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. If you would like to contact me, I can be reached at (734) 971-0277 (ext. 31). Thank you for your time and consideration.

Respectfully Submitted,

Kathryn Cromwell
Disability Advocate

CMS-2261-P-1206

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

Organization : **AIM Center**

Category : **Individual**

Issue Areas/Comments

Background

Background

Psychosocial rehabilitation programs are the most effective way to provide recovery services to adults with mental illness. Any funding cuts to these programs will directly effect consumers leading to increased hospitalizations, incarcerations, isolation, and other anti-social behaviors.

CMS-2261-P-1207

Submitter : Mrs. Karen Dunn

Date: 10/12/2007

Organization : Club Nova

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1207-Attach-1.RTF

CMS-2261-P-1207-Attach-2.RTF

#1207

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program

Submitted By:

Karen Kincaid Dunn, Executive Director
Club Nova
103 D West Main Street
Carrboro, NC 27510

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

Dear Sir or Madam:

We appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am the Executive Director of Club Nova, a certified clubhouse model program. The clubhouse model is one of the most comprehensive, cost effective, successful programs in the nation working with individuals living with severe and persistent mental illness. Our members have personally experienced the effectiveness of rehabilitation services offered through the clubhouse and have been able to participate in their communities as a direct result of these services.

The changes in the rules proposed by the Centers for Medicare and Medicaid (CMS) to govern Medicaid's rehabilitation service category set forth exclusion after exclusion after exclusion. Individuals living with mental illness already experience enough exclusion without having their most basic mental health care coverage "excluded". The proposed rules will restrict access to necessary intensive community mental health services needed by children and adults with disabilities who rely on Medicaid for their health care. We need changes for individuals living with mental illness that are inclusive, not exclusive.

As the single most significant source of financing for the public mental health system, Medicaid provides needed access to community-based care through the rehabilitative services option to help children and adults living with mental illness

avoid more costly institutionalization. The new rules could also have a profound effect on Medicaid services needed by other vulnerable populations, including people with physical and developmental disabilities.

Access to rehabilitative services can make all the difference in a person's life. We have seen people utilize services to help them recover from their illness. With services and support, individuals with serious mental illness can and do live meaningful lives in the community. We have also seen those who can not get help and the pain and trauma that results from untreated mental illness for the individual, his or her family, and the community.

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

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

For every poor grade NAMI gave, we know that there are hundreds of thousands of individuals who are being jailed, living on the streets, dropping out of school, and dying because they were unable to access the necessary services that we know work. These services not only work, these services save lives.

For this reason, we are particularly adamant that any new regulations governing rehabilitation services ***include and facilitate*** the provision of these services ***and in no way discourage and exclude*** systems and providers from increasing the availability of these critical services.

We are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars by the year 2012 from an already under-resourced service system.

Our experiences tell us that creating barriers and excluding vital services will not save money in the long run. Rather, it will increase the costs for hospitalization, incarceration and other negative outcomes that result from a failure to obtain

needed treatment. We disagree with rules that lead to a solely crisis-oriented system which is not cost effective. Most importantly, we consider such rules inhumane.

Even with federal, state, and local government funding, the mental health system remains underfunded. Individuals living with mental illness have already carried more than their fair share of burdens and many lives will be jeopardized by any one of these government sources of funding deciding to reduce dollars spent. While this may be an effort to transfer the costs of services from the federal to the state level, in reality, most states will not be able to afford the additional cost, which will mean a reduction in services that are already scarce. This will have a devastating effect on the lives of our citizens who live with mental illness. We must provide the necessary support networks that have allowed Americans with serious mental illness to begin and continue the long and difficult process of rebuilding their lives.

Thank you for your consideration and attention to this letter. Please read the comments that follow this letter regarding proposed rules changes that effect the lives of our valuable and most vulnerable citizens who live with mental illness.

I encourage you to consider true reform of the mental health system in the United States. True reform would guarantee individuals living with mental illness the basic human rights to the rehabilitation necessary to begin and remain on the path to recovery.

Sincerely,

Karen Kincaid Dunn

Karen Kincaid Dunn
Executive Director
Club Nova Community, Inc.

#1207-2

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

Please read the following concerns and recommendations. I am commenting from the perspective of the someone who has worked for 18 ½ years in the successful clubhouse model of rehabilitation. I have seen recovery in action. I could cite a multitude of individual success stories from our vibrant community. I invite everyone from CMS to visit a clubhouse model program nearest you.

While many concerns are addressed in this document, not all have been addressed. What follows represents a sample of some of the issues that must be considered prior to implementing new rules.

Summary of Proposed Rule - Objection

First and foremost, there is nothing in the summary that mentions the rights of individuals living with mental illness to receive necessary supports and rehabilitation services in order to live meaningful lives in the community. Furthermore, we strongly object to the initial focus in the summary referring to "important beneficiary protections" as being a person centered written rehabilitation plan and maintenance of case records." We recognize the importance of the plan and record. However, it is contradictory to refer to the plan and record as the "important beneficiary protections" while in the same paragraph excluding individuals from social, educational, housing, prevocational, and vocational services. These important aspects of life should be included as the **most** important beneficiary protections.

It is as though the case record transcends the importance of the individual's recovery. Rehabilitation services make the difference in an individual's life in the community, and sometimes these services make the difference between life and death. With all of these exclusions, there will be very little left beyond the plan and the case record. And soon there will be no need for the case record because there will be no services to document because they have been excluded.

If I am diagnosed with cancer today, if my insurer, Blue Cross Blue Shield, listed my "important beneficiary protections" as being a written plan and case record and then in the same paragraph excluded all of the treatment I might need to address the cancer, it would hardly matter to me that BCBS considered maintenance of my case record a beneficiary protection. The fact that my insurer focuses on "important beneficiary protections" as being a plan and a case record provides little assurance or protection when facing such serious illness.

It may seem a stretch to use cancer as an example. Yet in many respects, it is not a stretch. There are similarities. Both cancer and mental illness require treatment. Both illnesses are devastating. Untreated, these illnesses can get out of control. Both illnesses can be fatal.

than maintaining functioning. Under the proposed regulations and the preamble, rehabilitative goals have to be targeted at progress. The goals can't be used to maintain stability unless that is linked to another goal where a person is still working on improvement. The following is another example of the contradictions in the rules where the rules state:

> *"in all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which* ***sustains*** *health."*

Please note the important word "***sustain***." For many individuals who have been hospitalized, maintaining stability is not easy and is quite an achievement. It requires hard work. It also requires services so a person does not deteriorate and get worse. Requiring that a person deteriorate before services can be provided is not cost effective. For individuals with serious mental illnesses, a break in services and support can lead to a downward spiral and long period of acute illness. We have also seen individuals who never recovered from this downward spiral. We hope the agency will adjust its regulations to take into account the nature of mental illnesses and allow services to prevent deterioration of the illnesses.

Mental illness does not manifest in a linear fashion; nor does recovery progress in a linear fashion. Many of our members describe their personal recovery process as varied, with periods of maintenance, periods of restoration, and periods of fragility and instability.

Many times these fluctuations are related to outside events, changes in the course of the illness, or changes in medication effectiveness. The changing course of serious mental illness must be factored into the proposed regulations governing rehabilitative services.

Recommendation:
Delete all language that conflicts with "SUSTAINING HEALTH."

Revise and clearly state in the proposed rule language to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning. Amend the rule to allow provision of rehabilitative services based on the individual's history and severity of illness. Such an amendment is truly "person centered."

Clearly stipulate in the definition that services may be furnished to maintain functioning and stability for individuals who can be expected to otherwise deteriorate as an acceptable goal of a rehabilitation plan.

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

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).This provides authority for CMS to allow states to furnish service that will maintain an individual's functional level.

Non-covered services: 441.45(b)
This section introduces a whole new concept into Medicaid. The concept conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

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

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

The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other non cited program (due to lack of resources in the other program). Thus, the rule effectively denies individuals medically necessary Medicaid services, in direct contradiction of the statute.

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

Recommendation:
It is strongly recommended that this entire section be dropped, because it conflicts with the Medicaid statute.

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

If there is an agency that is legally obligated to provide particular services, clearly delineate the agency and their legal obligations in the rules.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. Whether in a classroom or a clubhouse setting, mental health rehabilitation services to address these problems should be covered.

Develop consistent rules that pay for rehabilitative services for individuals with serious mental illnesses when they need them and where they need them.

Section 440.130(d)(1)(v) and 440.130(d)(3) Written Rehabilitation Plan:
The proposed regulations require that a written rehabilitation plan set out the services that will be provided and guide treatment. We fully agree with and already utilize the person centered planning process. The member is at the center of the planning process setting recovery oriented goals.

We strongly urge additional language to provide needed flexibility to address some of the unique aspects of mental illness. We would like to see some flexibility in the rules to allow providers to conduct outreach and offer other necessary supports to engage individuals in services. Sometimes, it takes time with repeated contacts before a person establishes a trusting enough relationship to participate in the treatment planning process. Additionally, sometimes services need to be provided for a period of time before an individual is ready to sign a rehabilitation plan. In some circumstances, for example, an individual experiencing paranoid symptoms may not be comfortable signing anything. Providers and other support persons need the flexibility to develop the plan and provide services with the goal of developing rapport and establishing enough trust such that the individual is able to more actively participate in treatment planning.

The proposed regulations should have sufficient flexibility to allow Medicaid financing for crisis stabilization services. There are times when a person is in crisis and needs help. At that point, the person may not be able to be part of a planning process. If the person is new to a community or has recently been in the hospital or jail, they also may not have a treatment plan on record. Of course, it is preferable to have a planning process and a crisis plan included in the rehabilitation plan. However, the regulations should have sufficient flexibility to recognize that this will not always be possible. The rules should allow flexibility for treatment in these circumstances.

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

Recommendation:
Clarify the provisions in the regulation to allow payment for outreach, other necessary supports, and emergency services that may not be in a written plan due to the unique circumstances and nature of mental illness. Emphasize in the rules that critical situations can often arise with individuals living with mental illness and include coverage for crisis and other necessary life saving care.

Section 445(b)(3): Exclusion for recreation or social activities that are not focused on rehabilitation.
We agree with CMS's statements in the preamble that specifically note that "for an individual with a mental illness, what may appear to be a social activity may in fact be addressing the rehabilitative goal of social skills development as identified in the rehabilitation plan." We also appreciate earlier clarification that an activity that may appear to be recreational may be rehabilitative if it is addressing a particular impairment and functional loss. We urge CMS to include this clarifying language in the regulation itself in addition to the discussion in the preamble.

We also urge CMS to clarify that personal care services that are performed to teach the individual some independent living skills are coverable services. For individuals with mental illness, modeling and cuing are often used to teach these skills and personal care services may be provided as part of the process in furtherance of the rehabilitation goal. The purpose of the service is to achieve a rehabilitative goal, rather than to provide personal care to the individual. The preamble recognizes this distinction by specifying that teaching an individual to cook a meal to restore living skills may be a coverable rehabilitation service. It would be helpful to provide that clarification in the regulation as well.

Recommendation:
Include and cover in the rules the supports and rehabilitation work necessary for an individual to return to and sustain educational or vocational pursuits.

Add: Recreational and social activities that are addressing a particular impairment or functional need, such as social activities addressing a goal of social skills development, are reimbursable as rehabilitation services.

Add: Include personal care services which are furnished to teach a skill in furtherance of a rehabilitative goal.

Related Medicaid Rehabilitation Issues:
Payment and Accounting for Services

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services through 15-minute increments, requiring daily notes, is supported by language in the regulation, at least by inference.

These methodologies are not efficient and, moreover, are extremely detrimental to the provision of best practice mental health services that are increasingly being offered as a package of intertwined interventions delivered flexibly. These services include assertive community treatment, community support, day rehabilitation services, and other services.

There are alternative ways to hold states accountable for ensuring that non-covered activities are not reimbursed, yet remove the currently imposed extreme administrative burden on services that are covered.

The requirements in this regulation regarding service planning and documentation are relevant here. The new rules should negate the need for overly prescriptive micro-management of Medicaid providers.

Recommendation:
It is strongly urged that CMS work with other federal agencies, states and the field to devise payment methodologies that support the best practice and the most successful outcomes for children and adults with mental disorders.

Eliminate the daily note requirement for psychosocial rehabilitation.

Section 441.45(b)(8): Exclusion of services that are not provided to a specific individual.

We concur with the preamble recognizing that "effective rehabilitation of eligible individuals may require some contact with non-eligible individuals."
We urge CMS to amend the rule to add language from the preamble to be clear on this point and include contact with other support persons involved with the individual.

Recommendation:
Add: Contacts with family members and other non-eligible individuals, agencies, and organizations for the purpose of treating the Medicaid eligible individual may be covered as a rehabilitative service.

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

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

The proposed regulations prohibit people with mental retardation or related conditions, such as cerebral palsy, from receiving rehabilitation services. Although our work focuses on people with mental illness, we do not support the exclusion of any other group on the basis of their disability.

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

Recommendation:
The proposed rules should not exclude people with development disabilities and related conditions and habilitation services.

Paperwork Reduction Act of 1995, Regulatory Flexibility Act, Unfunded Mandates Reform Act of 1996, and Executive Order 12866
The Regulatory Impact Analysis appears to be inaccurate and does not meet the requirements which directs agencies to "assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits including potential economic, environmental, public health and safety effects, distribute impacts, and equity."

Our paperwork has increased dramatically. With no input from providers or consumers, daily notes were suddenly required and enforced by CMS. A daily note in a rehabilitation setting such as a clubhouse is first and foremost not informative, meaningful, or effective, especially for small non profit businesses, and secondly these notes place a tremendous undue burden on programs. For years a monthly progress note was the standard. We wrote approximately 100 notes per month. With the change to daily case notes, currently we write approximately 1128 notes per month. The cost to our program annually for this one change is approximately $30,000 plus. Multiply $30,000 by the number of psychosocial rehabilitation programs in the United States and the cost becomes staggering, not to mention that there is no gain or benefit in a daily note in this type of setting. We believe that this change from a monthly progress note to daily case notes is in violation of the Paper Reduction Act of 1995, the Regulatory Flexibility Act, and the Unfunded Mandates Reform Act of 1995. Psychosocial Rehabilitation Programs need relief from the daily case notes now! Regarding the written rehabilitation plan, the principles set forth represent excellent practice with the individual included, as well as other significant support persons of the person's choosing. As noted, there is a significant cost associated with burden of time and effort required by the provider to coordinate various individuals, gather the information, and develop a specific written rehabilitation plan. While it may be best

practice, we request that this not become another unfunded mandate. The cost of this excellent, yet costly, practice for rehabilitation plans must be covered.

Regulatory Impact Analysis

The following contains inaccuracies, unacceptable abdication of responsibility, and outright violation of the New Freedom Initiative.

> *"The Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1505(a)(13) of the Act."* This statement is inaccurate. The impact on providers will be huge.
>
> *"CMS is unable to determine the percentage of providers of rehabilitative services that are considered small business."* There are many small businesses currently inundated by requirements that place undue administrative burdens on them. The proposed rules appear to offer no relief from the administrative burdens.
>
> *"The rule would directly affect states and we do not know nor can we predict the manner in which sates would adjust or respond to the provisions of this rule."* This seems to be an unacceptable abdication of the responsibilities of the United States Government. The impact of the proposed rules will be that our citizens living with mental illness will be left without necessary services and the cost in the long run will be extraordinarily more expensive.

Conclusion

The President's New Freedom Commission report decried a fragmented service system that denied hope and opportunity to adults and children with serious mental illnesses. They wrote:

> ***"The promise of the New Freedom Initiative-a life in the community for everyone - can be realized."***
>
> *"Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic-the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities."*

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program

Now is the time to develop policies and rules that facilitate and keep the promise of the New Freedom Initiative - "a life in the community for everyone." The proposed rules, as well as some of the current rules, are barriers to a life in the community.

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

We know what works. But we also know that too many people can't access these treatments. And the terrible consequences are seen in every jail and prison in the United States of America. The federal government should be doing everything possible to facilitate better and more effective services for people living with mental illnesses. This includes supporting rehabilitation services at the federal, state, and local levels.

We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind with very little or no hope.

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

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

Karen Kincaid Dunn
Club Nova Community, Inc.

CMS-2261-P-1208

Submitter : Dr. Laura Tyler **Date:** 10/12/2007

Organization : Dr. Laura Tyler

Category : Other Practitioner

Issue Areas/Comments

Background

Background

See Attachment

CMS-2261-P-1208-Attach-1.PDF

#1208

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PSYCHIATRIC RESEARCH INSTITUTE

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

October 12, 2007

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

Via e-mail

To Whom It May Concern:

Reference: File code CMS-2261-P

I appreciate the opportunity to provide comments in response to the notice of proposed rule making on the Coverage for Rehabilitative Services published in the August 13, 2007 Federal Register (72 FR 45201).

Let me begin with two general comments related to procedures and then address some specific concerns. First, it seems that the proposed rule-making process is a departure from the long-standing precedent of requiring legislative endorsement prior to making changes to CMS' state optional program. Second, as you have noted in section V. Regulatory Impact Analysis, B. Anticipated Effect a comprehensive review of possible impact has not been conducted. Thus, changes are proposed without adequate understanding of their impact. These two procedural concerns would indicate that proposed changes are premature. It seems that a delay is warranted until such time as the full impact on services can be more specifically understood.

What follows are comments related to the ***Provisions of the Proposed Rule***.

440.130(d)(1)(vi) Definition of Restorative Services
The assertion that services are only appropriate for the achievement of rehabilitation is inconsistent with the clinical needs of a subset of individuals diagnosed with serious mental illness. At times, rehabilitation services are necessary to prevent deterioration and are appropriately provided to ensure that functioning is retained. One might surmise from the proposed rule that this is no

longer a legitimate rehabilitative service. The result of such a summation would be the withdrawal of services that are preventing more restrictive and costly care. This would be tragic for individuals, families and communities. It is generally accepted that chronic conditions require stabilization, symptom management and maintenance of functions. These medically necessary services should be clearly included.

It is generally accepted that the recovery process is one that is multi-dimensional and nonlinear. As such, the recovery process encompasses components that are uniquely linked to functional role performance. Although CMS has recognized aspects of this, there are some proposed rules that appear to be inconsistent with recovery. The common rehabilitation goal of attaining or regaining functions that are prerequisite for employment is one aspect that has been compromised in the proposed rules. The common recovery goal of gaining or regaining employment generally requires services to address relevant functional skill deficits. Services to address functional skill deficits should be included when tied to a recovery or rehabilitation goal of employment. .

440.130(d)(1)(vii) Definition of Medical Services
The current gap between the definition of medical services and recovery could be substantially closed if the definition of medical services would clearly delineate that rehabilitation is included in medical services. It is recommended that this change be made to clearly affirm the recovery model as a necessary component of proper medical care for the treatment of mental illness.

440.130(vii)(3) Written Rehabilitation Plan
It seems as if the proposed rules are suggesting segmented planning with separate plan documents rather than a single process that integrates treatment and rehabilitation issues into one plan. Clarity on this issue would be helpful. A single process with one plan has distinct advantages for all parties. The emphasis on person-centered planning is applauded. It is suggested that there be some provision for recommending the client's signature rather than requiring it as this will be problematic for some individuals especially at the initiation of treatment when symptoms such as paranoia might be a barrier to signature. A provision to document such instances in lieu of a client's signature seems warranted. It is also recommended that the plan be in the language of the person served.

440.130(4) Impairments to be Addressed
In this section, states are provided an option with regard to serving adults. Services could be limited by service or population. As written, this provision would potentially severely limit access to care and could result in unintended discrimination because of age for individuals with mental illness. Language that clarifies this is not an option and is clearly inclusive to adults is needed.

440.130(5) Settings
The regulations would provide enhanced guidance if they were to acknowledge acceptable settings for services such as schools, homes, etc.

441.45(b)Non-covered Services
This section appears to create conflict in the implementation of services that are consistent with promising or best practices. In particular, the provision of services in school settings by qualified providers would seem to be problematic should the proposed regulations be adopted as published.

The need for specialized, medically necessary services often occurs in school settings. Teachers and aides are not positioned to provide these services.

441.45(b)(2)
The proposed exclusion of rehabilitative services for persons with mental retardation are indeed problematic. It is well established that functionality for such persons can change. Functionality can be improved as well as temporarily lost functionality and then restored. This proposed regulation would clearly be regressive unless clarity is added to distinguish between exclusion for habilitation services.

441.45(b)(4) Service Exclusions related to Inmates and Inpatients
The proposed payment exclusions for rehabilitative services clearly apply to individuals who are inmates or inpatients of specified facilities or institutions. It would be helpful if language were included that clearly establishes that such prohibitions are about the inpatient or incarcerated status of the recipient of care. It would be helpful to explicitly state that the exclusion does not prohibit the provision of rehabilitation services in physical space of such facilities to individuals who are not in custody or residence at such a facility when services are provided.

Finally, I would offer that changes of the magnitude proposed will require ample time for implementation. Changes to systems as well as training of direct care staff and education to clients and families will be needed. Thus, it would seem reasonable to offer an adequate implementation phase following final adoptions and prior to implementation.

In closing, I thank you for the opportunity to make comments.

Sincerely,

Laura H. Tyler, Ph.D., LPC
Psychiatric Research Institute Administrator

CMS-2261-P-1209

Submitter : **Ms. Ann Herrick** **Date: 10/12/2007**

Organization : **Board of Education of City of Chicago**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment of letter from Mr. Arne Duncan, Chief Executive Officer, in behalf of the Board of Education for the City of Chicago. It failed to attach to previous submission under his name.

CMS-2261-P-1209-Attach-1.DOC

1209

CHICAGO PUBLIC SCHOOLS ▪ 125 S. CLARK STREET, 5TH FLOOR ▪ CHICAGO, ILLINOIS 60603

Arne Duncan
Chief Executive Officer

October 10, 2007

COMMENTS ON PROPOSED REHAB RULE 2261

From: Arne Duncan, Chicago Public Schools

On behalf of the Board of Education for the City of Chicago I would like to present to the Centers for Medicare and Medicaid Services (CMS) our comments on CMS's proposed rule 2261 regarding rehabilitative services.

We believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: *"Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." [Social Security Act, Section 1905(a)(13)]* As the Bazelon Center for Mental Health Law points out, the fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources "has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service." [http://www.bazelon.org/issues/medicaid/9-05TalkingPoints.htm] Like Bazelon, we believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Therefore, we respectfully request that CMS retract this proposed rule to the extent that it applies to school-based rehabilitative services and/or Medicaid administrative activities provided to or on behalf of children with disabilities.

Our strong objections to rule 2261 are described in more detail, below.

Proposed Elimination of School-Based Rehabilitative Services

Proposed rule 2261 redefines Medicaid reimbursable rehabilitative services and, among other things, excludes from Medicaid reimbursement the rehabilitative services that are "intrinsic elements of programs other than Medicaid, such as... education... ." We cannot believe that CMS intends to find that Medicaid services delivered in an educational setting are not reimbursable; the rule should be revised to avoid this conclusion.

CMS failed to define the term "intrinsic elements", as used in the proposed rule, leading to an easy conclusion that CMS intends to use this proposed rule to eliminate all Medicaid reimbursement for rehabilitative services and administrative activities provided in a school setting. However, the proposed regulation states, *"In §440.130(d)(5), consistent with the provisions of section 1905(a)(13) of the Act, we propose that rehabilitative services may be provided in a facility, home, or other setting. For example, rehabilitative services may be furnished in freestanding outpatient clinics and to supplement services otherwise available as an integral part of the services of facilities such as schools, community mental health centers, or substance abuse treatment centers."* Research shows that healthy students have better attendance and perform better in school, academically. In full support of this research, Chicago now has nineteen school-based health clinics

sponsored jointly with hospitals and clinics. We are committed to expanding our linkages to social service agencies through a network of community schools. The attempt by CMS to reduce specific federal costs in fact creates reimbursement disincentives for schools' to provide wrap-around services where they are "intrinsic elements of programs other than Medicaid, such as ... education".

Overall, Chicago Public Schools (CPS) currently serves 52,000 students with disabilities and health related needs by providing 1,000 case managers and counselors as well as 1,600 clinical professionals including social workers, psychologists, nurses, speech pathologists, physical and occupational therapists and hearing/vision technicians to these students at over 600 school sites. We provide these services not only to comply with federal Individuals with Disabilities Education Act (IDEA) requirements, but because we know that health is a prerequisite to success in school as measured in No Child Left Behind goals. Furthermore, the policy of Early Prevention Screening Diagnosis and Treatment (EPSDT) will contribute to the life-long goal of reducing future health needs and costs for our communities. Reports have shown that states are not fully complying with EPSDT requirements and need more, not less, collaborative assistance from their local partners in schools and health clinics.

CPS also currently provides and receives Medicaid reimbursement for the health screening, evaluation and therapeutic services we directly provide each year to approximately 25,000 Medicaid-eligible children with chronic disabilities that impede them from participation in normal activities of daily living, including education. Rule 2261 states, *"This proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers."* CPS related service providers (i.e. occupational and physical therapists, psychologists, social workers, etc.) are qualified and hold appropriate state licensure to provide rehabilitative services which is in the best interest of the students receiving a service.

Children with disabilities served by CPS are entitled access to a free and appropriate public education under IDEA. CPS makes every effort, in accordance to IDEA, to ensure that these children have access to an education with their peers in the least restrictive environment, as determined by each student's specific health care and special education needs. No one can reasonably dispute that providing these services in schools is a significant financial benefit to the Medicaid program and an important enhancement to the health and well-being of our nation.

According to Dr. Vernon K. Smith of Health Management Associates based on CBO Medicaid Baseline, March 2007, the elderly and disabled account for 26% of enrollees but 68% of Medicaid spending, while children account for 48% of enrollees but only 19% of spending. A goal to slow the growth in costs in the long run would be to slow the demand for treatment in such areas as chronic disease including diabetes and obesity, asthma and depression. Proactive cost containment involves assuring that reimbursement systems reward higher performance in areas like disease management and other care management approaches, not sending patients to higher cost treatment alternatives in emergency rooms, hospitals and doctor's offices.

CMS has historically taken the position that services provided pursuant to IDEA are education services and, therefore, not subject to Medicaid reimbursement. However, in 1988 the United States Supreme Court made it perfectly clear, in **Bowen v. Massachusetts** (47 U.S. 879), that Medicaid is responsible for paying for medically necessary services provided by education programs to Medicaid-eligible children with disabilities.

In **Bowen**, the Supreme Court upheld a determination by the United States Court of Appeals, First Circuit, that ***it is the nature of the services, not what the services are called or who provides them*** that determines whether the services qualify for Medicaid reimbursement. Based on this decision, CMS cannot determine that a service is not eligible for Medicaid reimbursement by calling a medical service "education" or by pointing out that the services are provided by education personnel. Likewise, if the nature of a school-based service is medical or therapeutic, CMS cannot determine that the service is not eligible for Medicaid reimbursement by labeling it as an "intrinsic element" of an education program.

Subsequent to the **Bowen** decision, the United States Congress amended federal Medicaid law, at Section 1903(c) of the Social Security Act, to further clarify Medicaid's responsibility to pay for school-based health services provided in accordance with IDEA. Proposed rule 2261 that would exclude Medicaid reimbursement for school-based health services because they are identified as intrinsic elements of an education program appears to be an effort by CMS to blatantly defy current Medicaid law as established by the United States Congress and United States Supreme Court.

CMS's proposed rule 2261 may also have the impact of circumventing the federal Medicaid laws and rules requiring EPSDT services for children. EPSDT requires state Medicaid agencies to provide health services to children when the services are determined medically necessary through EPSDT screenings. Medicaid must pay for the health services even if the services are not included in the State's plan for Medicaid. This would include rehabilitative services; however, proposed Rule 2261 may be interpreted by CMS to preclude reimbursement for rehabilitative service when provided through an education program, such as IDEA. This is clearly not the intent of Congress.

Proposed Elimination of Transportation Services

Proposed rule 2261 would eliminate Medicaid reimbursement for transportation services that are provided for under the rehabilitative services option (rehab option) under a state's plan for Medicaid.

The Illinois School-Based Health Services program, including school-based transportation services, is included under the rehab option in the State plan for Medicaid. The Illinois State plan was approved by CMS and allows Medicaid payments for school-based transportation services provided for a child with a disability using a specially adapted bus and only on days that the child receives a medical service identified in the IEP and the child's specialized transportation needs are specifically identified in the IEP.

Under proposed rule 2261, CMS seems to imply that transportation services are not appropriate "rehabilitative" services under the rehab option and that elimination of reimbursement for the services is the appropriate remedy to correct the state plan amendments that CMS previously approved. This approach is extreme, unreasonable and fundamentally unfair to school districts unless CMS is only requiring that the State Medicaid agency to amend the State plan to provide for school-based transportation services under an alternative section. This can be done without any disruption in current school-based transportation services or Medicaid revenue.

Imposition of Proposed Requirements for Rehabilitation Plans

If proposed rule 2261 is interpreted by CMS to allow continued Medicaid reimbursement for school-based rehabilitative services, CPS staff would be required by the proposed rule to develop and implement individualized rehabilitation plans which may be duplicative of the individualized education programs (IEP) required under IDEA.

CPS believes that the IEP developed in accordance with IDEA should satisfy CMS's stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student's physical or mental disability and restoration of the student to the best functional level. The IEP process includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore, CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Unless these requirements above are clarified, the rule could result in the elimination of all of the Medicaid reimbursements to the Chicago Public Schools for a loss of $38 million annually. In that case, CPS cannot support proposed rule 2261 and we, hereby, request that CMS retract the proposed rule in its entirety.

CMS-2261-P-1210

Submitter : Mr. Steve Shroyer **Date:** 10/12/2007

Organization : Mr. Steve Shroyer

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-1210-Attach-1.RTF

#1210

October 12, 2007

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

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

Dear Sir or Madam:

Thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am writing as a father of a child that receives services and as a member of the community that receives services.

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

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

I appreciate the emphasis on recovery in the rules. All individuals with mental illness and their families want the system to make it easier to recover. I also like the provisions about the participation of the individual and their family in the rehabilitative plan and receiving copies of the plan so we can hold the system accountable. I would like to see some flexibility to make sure that providers can still do outreach and provide crisis care, but I very much appreciate the agency's intent to encourage communication between providers, the individual and family members.

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

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

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

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

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

Recommendation:

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

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

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

For myself who has been hospitalized, staying stable and in housing is not easy and is an achievement. It also requires services so we do not deteriorate and get worse. I hope the agency will adjust its regulations to take into account the nature of my illnesses and those of my family members and allow services to prevent deterioration of the illnesses.

Recommendation:

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

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

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

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

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

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

Recommendation:

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

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

Many children with mental illnesses rely upon therapeutic foster care. This is a service that works well and creates good outcomes such as going to school more, staying out of trouble with law enforcement, and living in a stable place. The proposed regulations should give states the ability to get federal resources to support this effective service as long as the services are rehabilitative.

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

Recommendation:

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

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

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

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

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

Recommendation:

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

Conclusion:

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

I know what works. But I also know that too many people can't access these treatments. And the terrible consequences are seen in every jail and prison in America.
The federal government should be doing everything possible to encourage states to provide better and more effective services for people living with mental illnesses.
I do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. I do not want to see adults and children ignored and left behind in school, work, and life.

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

Thank you,

Steve Shroyer

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

Organization : **Minnesota Council of Child Caring Agencies**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Thank you for the opportunity to comment on the proposed rules for Medicaid coverage of rehabilitative services.

The Minnesota Council of Child Caring Agencies is a statewide association of providers of treatment services for children, adolescents and their families. Our members operate over 100 community-based and residential programs which serve youth and families who need assessment, intervention and follow-up care for a range of emotional and behavioral disorders.

The proposed rules and clarification around the necessity for person-centered care, based on a comprehensive assessment, delivered by qualified staff and involving the family and client with a focus on outcomes and the requirements for a comprehensive rehabilitation plan are welcomed as appropriate and essential for quality care. However, there are other regulations in the proposed rules that appear not to be consistent with this clear intent to improve the services and outcomes for clients and their families. We will comment on two areas in particular below.

Section 440.130(d)(1)(vi) The definition of rehabilitative services, in the context of working with children, needs to be broad enough to recognize that rather than the loss of functioning seen in adults, children suffering from mental illness are diverted from the opportunity to learn functional skills and therefore may, in fact, need to be taught these skills uniquely and for the first time. To define rehabilitation as restoring someone to a prior level of functioning would be too limiting and would inappropriately prohibit coverage for many of the truly effective skill building services these children need. The developmental trajectory for a child can be interfered with by emotional problems in a way that can prevent them from moving ahead with normal functioning in a myriad of settings. Their treatment needs may include learning to relate appropriately with peers, for example, if their illness has prevented them from developing healthy responses to normal interactions with others. They may well have never had these skills so wouldn t be restored to a prior level of higher functioning.

441.45(b) Intrinsic Element Standard
This language rather than clarifying the importance of distinguishing between eligible and ineligible services appears to broadly exempt children who are concurrently involved in multiple systems child welfare and education, for example. Certainly, it is important to have service eligibility standards and documentation requirements that ensure that the Rehab option under Medicaid is used only to fund eligible services. However, this language is confusing and could be interpreted to be strictly an effort to reduce costs by restricting access.
Children, especially, are frequently best served within the context of the environment in which they live and function. This is often either their home, an educational setting or, for youth placed out of the home, in foster care settings. It is both more effective and cost efficient to provide cohesive, coordinated services within these contexts. In Minnesota, we have established clear distinctions between which services are rehabilitative, medically necessary and eligible for Medicaid and those that are not. Eliminating the option of packaging these services and providing them within these settings would unnecessarily increase costs and reduce the opportunity for coordinated care. There are methods for verifying service eligibility and tracking/monitoring payments that preserve the fiscal integrity of the claimed Medicaid expenditures .

Thank you for the opportunity to comment on these proposed rules. We support many of the components of the rules as improvements that will increase the quality and effectiveness of services under this option. We hope you will consider our concerns in your revisions.

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

Organization : USPRA

Category : Health Care Provider/Association

Issue Areas/Comments

Background

Background

To Whom It May Concern:

The United States Psychiatric Rehabilitation Association (USPRA) requests the opportunity to follow up on two of the comments submitted in its September 11th letter regarding the provisions of the proposed regulations to Medicaid s Rehabilitative Services Option. Specifically, we believe examples may be needed to demonstrate the use of engagement services and how services by another agency, such as housing or employment, could mirror services provided under the Rehab Option.

As noted in its earlier comments, USPRA believes some individuals will need to become engaged in the rehabilitation process and, therefore, the Rehab Option should be expanded to recognize engagement services under ?440.130(d)(3). In the absence of a signed rehabilitation plan, USPRA recommends that early engagement services should be utilized and that the service provider should be responsible for documenting efforts to revise approaches and engage the person to build a mutually satisfying course of action, including documentation of engagement goals and related services. Based upon the collective experience of our members, USPRA believes this process could realistically be accomplished within six months. If the individual has not engaged within this six-month period, he or she may not be ready for rehabilitation services or should seek another service provider better suited to supporting the individual s recovery.

Also noted in its earlier comments, USPRA recommended that the term intrinsic be further clarified within ?441.45(b)(1) as services that are the major focus of another agency based on statutory requirements, and is not meant to preclude funding of services which may mirror service provided by another agency. Examples of services that mirror services provided by another agency include the following:

Supported employment is an intrinsic element of Assertive Community Treatment (ACT). Vocational Rehab services within a state may also fund supported employment services; however, these services are typically time limited and based on eligibility for vocational rehabilitation services, not mental health services. Support through Medicaid funding should be based on an identified medical need, and would involve symptom management and skills building in areas such as dealing with stress on the job, interacting with coworkers, and dealing with discrimination and stigma rather than job skills training.

Supported housing services may appear similar to traditional housing services at first glance. However, services funded through the Medicaid Rehab Option would not involve housekeeping or chore services, but rather skills in handling independent finances away from payeeship, interacting with neighbors appropriately, problem solving and managing stress as recommended by a practitioner of the healing arts for the purpose of reducing the psychiatric disability and restoring functional level.

The proposed regulations state that patient education provided in an academie setting is not covered under the Medicaid Rehab Option. However, supported education does not deal with academic prep but rather symptom management and skills in areas such as interacting appropriately with other students and faculty, stress management and advocating for oneself when illness interferes with academic progression. Medicaid funding would be appropriate based on an identified medical need and as outlined in the rehabilitation plan.

Thank you for considering these additional comments and for allowing USPRA to provide further clarity on these important issues.

Sincerely,

Marcie Granahan
CEO
US Psychiatric Rehabilitation Association
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Linthicum, MD 21090
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www.uspra.org
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GENERAL

GENERAL

See Attachment

CMS-2261-P-1212-Attach-1.TXT

#1212

USPRA US Psychiatric Rehabilitation Association

October 11, 2007

Deleted: September

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

Re: CMS-2261-P

To Whom It May Concern:

The United States Psychiatric Rehabilitation Association (USPRA) requests the opportunity to follow up on two of the comments submitted in its September 11th letter regarding the provisions of the proposed regulations to Medicaid's Rehabilitative Services Option. Specifically, we believe examples may be needed to demonstrate the use of engagement services and how services by another agency, such as housing or employment, could mirror services provided under the Rehab Option.

Formatted: Superscript

Deleted: is pleased to comment on behalf of its 1,400 psychiatric rehabilitation agencies, practitioners, and interested organizations and individuals who are dedicated to promoting and strengthening community-oriented rehabilitation services that support recovery from the disabling effects of serious mental illness. Based upon the collective experience of our members over the past 30 years, we offer the following comments on the provisions of the proposed regulations related to Medicaid's Rehabilitative Services Option.¶

As noted in its earlier comments, USPRA believes some individuals will need to become engaged in the rehabilitation process and, therefore, the Rehab Option should be expanded to recognize engagement services under §440.130(d)(3). In the absence of a signed rehabilitation plan, USPRA recommends that early engagement services should be utilized and that the service provider should be responsible for documenting efforts to revise approaches and engage the person to build a mutually satisfying course of action, including documentation of engagement goals and related services. Based upon the collective experience of our members, USPRA believes this process could realistically be accomplished within six months. If the individual has not engaged within this six-month period, he or she may not be ready for rehabilitation services or should seek another service provider better suited to supporting the individual's recovery.

Also noted in its earlier comments, USPRA recommended that the term "intrinsic" be further clarified within §441.45(b)(1) as services that are the major focus of another agency based on statutory requirements, and is not meant to preclude funding of services which may mirror service provided by another agency. Examples of services that mirror services provided by another agency include the following:

Supported employment is an intrinsic element of Assertive Community Treatment (ACT). Vocational Rehab services within a state may also fund supported employment services; however, these services are typically time limited and based on eligibility for vocational rehabilitation services, not mental health services. Support through Medicaid

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Page 2: [1] Deleted Marcie Granahan 10/11/2007 5:55:00 PM

USPRA enthusiastically supports the inclusion of a required rehabilitation plan and recovery-oriented goals that is developed with the individual and requires a signature to demonstrate involvement, approval and receipt of the plan [§440.130(d)(3)]. The creation of a rehabilitation plan is good practice and is necessary for shared decision making and accountability. It is our belief that quality rehabilitation services are strength-based and person-centered, and are built upon the values of choice and self-determination within the cultural context of the individual receiving services. We are pleased that these values have been applied in the proposed regulations, and hope CMS will consider making person-centered planning a formal requirement of the written rehabilitation plan [§440.130(d)(3)(iii)] beyond the proposed recommendation. In fact, we believe these values should apply to all Medicaid funded services, not just rehabilitation.

We also appreciate the recognition of psychosocial rehabilitation services as an integral component of mental health services and its role in an individual's recovery. The presence (or absence) of psychosocial rehabilitation services directly impacts the achievement of recovery-oriented outcomes. In this context, recovery refers to the process the individual goes through as they rebuild their lives, not just the treatment of symptoms. Certainly, treatment or medical activities should be incorporated within the rehabilitation plan, but are not necessarily the primary driver under the rehab option.

Unfortunately, because of prior negative experiences or stigma, some individuals may not be initially ready or willing to become engaged in an intensive and formally documented rehabilitation plan. Therefore, USPRA recommends that CMS consider including the following language to §440.130(d)(3) to recognize the need for and use of early engagement services: *In the event that an individual is initially unwilling or refuses to participate in the development of a rehabilitation plan, early engagement services may be used as a short-term reimbursable expense that encourages a sense of trust, hope and empowerment to improve an individual's participation in rehabilitation goal setting, assessment, planning and/or development activities. In the absence of a signed rehabilitation plan, early engagement services must document efforts to revise approaches and engage the person to build a mutually satisfying course of action, including documentation of engagement goals and related services.* Examples of early engagement services include opportunities to sit in on group activities and meet other people in recovery using the program; educating the individual about the recovery process, recovery outcomes, and the individual's rights and responsibilities; and motivational interviewing techniques or other explorations of personal interests and values.

USPRA is pleased that the proposed regulations allow for flexibility in how rehabilitation services are paid. Allowing States to specify the methodology under which rehabilitation providers are paid [§441.45(a)(5)] will ensure the continuation of many highly effective programs, such as Assertive Community Treatment, Clubhouses, and Crisis and Transitional Residential Treatment Programs, that tend to bill through a single daily rate or case rate. If executed correctly, these services would focus on the improvement of the disability and achievement of specific rehabilitative goals, as specified in the

rehabilitation plan, and not duplicate services that are intrinsic to programs outside of Medicaid.

Because of this, USPRA recommends that the term "intrinsic" be further clarified within §441.45(b)(1) of the regulations, and suggests that CMS consider defining it in the following way: *Intrinsic services are those that are the major focus of another agency based on their statutory requirements. This definition is NOT meant to preclude funding of services under the rehabilitation option which may mirror those by another agency (e.g., housing, employment) but which are provided pursuant to an approved rehabilitation plan as defined in these regulations [§440.130(d)(1)] and are consistent with medical necessity.*

USPRA supports allowing States the flexibility to set forth the qualifications for providers of rehabilitation services [§440.130(d)(1)(iii)]. However, while the proposed regulations imply a set of core competencies are required, USPRA recommends that CMS emphasize within the regulations the need to employ professionals who are competent in mental health rehabilitation practice (e.g., those with national certification as psychiatric rehabilitation practitioners), as well as persons in recovery trained as peer providers as indicated in the CMS guidance letter valuing Medicaid Peer Support services.

CMS-2261-P-1213

Submitter : **Mr. Jeffrey Simering** **Date: 10/12/2007**

Organization : **Council of the Great City Schools**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment for comments on CMS 2261-P

CMS-2261-P-1213-Attach-1.DOC

#1213

Council of the Great City Schools
1301 Pennsylvania Avenue, N.W. ♦ Suite 702 ♦ Washington, D.C. ♦ 20004
(202) 393-2427 ♦ (202) 393-2400 (fax)
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Council of the Great City Schools

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD. 21244-1850

ATTENTION: **CMS – 2261 – P**

COMMENTS ON PROVISIONS OF THE PROPOSED REGULATIONS BY THE COUNCIL OF THE GREAT CITY SCHOOLS

The Council of the Great City Schools, the coalition of the nation's largest central city school districts, submits the following comments to the August 13, 2007 proposed rule [CMS 2261-P] regarding Medicaid rehabilitative services.

In General

It is a central purpose of the statutory authorization of the Medicaid program in section 1901 of the Act to furnish "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care." All of the rehabilitation provisions of the Act should be read within the context of this central purpose. In addition, any administrative rules and policy should similarly be crafted within the context of section 1901.

The Council, therefore, objects to the new definitions and limitations in the proposed "rehabilitative services" rule that undermine this central rehabilitative purpose of the Act, and strongly recommends withdrawal of the entire proposed rule until Congress acts on these issues.

Medical services and therapies considered rehabilitative in nature have long been eligible and reimbursable to Medicaid providers in medical facilities, clinics, schools, and other community settings. Many such services could become ineligible and non-reimbursable immediately following CMS administrative action on this proposed rule. This CMS discretionary action appears harsh and unwarranted. Additionally, justifying any component of these administratively-created limitations based on an 18-year-old delegation of regulatory authority from the Omnibus Budget Reconciliation Act of 1989 is highly questionable (72 Fed. Reg. at 45203).

The Council finds the proposed rule to be arbitrary and ill-considered. CMS admits that "a comprehensive review of these rehabilitative services had not been conducted" and that "there is a significantly wide range of possible impacts." Moreover, CMS is "unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government agencies or geographic regions." (72 Fed. Reg. at 45209).

The proposed rule at minimum is inconsistent with the statute by limiting eligible services and FFP for services furnished as a benefit or administrative activity that are "intrinsic element[s]" of other programs. Section 1903(c) of Title XIX explicitly states that the Secretary has no authority to "prohibit or restrict payment ... for medical assistance ... furnished to a child with a disability because such services are included in the child's individual education plan establish under Part B of the Individuals With Disabilities Education Act." This proposed regulation clearly exceeds the Secretary's authority with respect to services interpreted to be "intrinsic" to an IEP and Individuals with Disabilities Education Act (IDEA).

Prohibition of FFP for "Intrinsic Elements" of Other Programs, specifically IDEA

There is no statutory basis for prohibiting federal Medicaid payments (FFP) on behalf of Medicaid-eligible individuals for rehabilitative services or other eligible medical assistance merely because such services are allowable costs under another program or funding source. This is particularly true with regard to services provided under the Individuals with Disabilities Education Act and its predecessor statutes.

In previous comments submitted to CMS/HCFA in 2000, 2002, and 2003, the Council underscored that the Secretary has no authority to prohibit or restrict payments for medical assistance for services included in a child's IEP under the Part B or Part C program of IDEA. Section 1903(c) of Title XIX, added in 1988 by the Comprehensive Omnibus Budget Reconciliation Act, constrains the Secretary's authority with regard to IDEA. Even preceding this statutory constraint, a lower court held and the Supreme Court later upheld that medically necessary services for Medicaid eligible children were reimbursable (FFP) despite such services also being included in the provisions of IDEA (Bowen v. Massachusetts 487 U.S. 879). Contrary to both case law and statutory law, CMS expressly targets services to students with disabilities under IDEA for exclusion under this proposed rule (72 Fed. Reg. at 45202).

Recommendation: Strike section 441.45(b)(1) in its entirety. In the alternative, add a new subsection 441.45(c) as follows: "(c) Subsection (b) shall not be applicable to services that are included in a child's individualized education plan established pursuant to Part B of the

Individuals with Disabilities Education Act or an individual family service plan adopted pursuant to Part C of such Act."

Harmful Effects of the Proposed Rule on Individuals with Currently Covered Conditions, Including Students with Disabilities

The ongoing CMS effort to characterize virtually every medical, therapeutic or health service provided by schools as an educational function continues in this proposed regulation. Section 441.45(b)(1) effectively prohibits rehabilitative services that would be otherwise eligible and reimbursable merely because they are an allowable cost item and are deemed an "intrinsic element" of an "education" or other program – specifically IDEA as stated in the regulatory overview.

For preschool and school-aged children, the impact of these proposed regulations may be particularly harsh. Individuals begin life with minimal skills, and often it is not until children fail to appropriately develop that specific service needs can be identified. A child often does not suffer from a functional loss as referenced in section 440.130(d)(1)(vi), therefore in the strictest reading the child would not be regaining a function. Nonetheless, the reduction of physical or mental disabilities in children through the provision of rehabilitative services occurs on a daily basis in schools, and other community and clinical settings.

The Council cannot imagine that CMS intends to preclude a sizable segment of children from the benefit of rehabilitative services for the reduction of their physical or mental disabilities. Similarly, the need for rehabilitative services to maintain a current or adequate level of functioning is often essential for the development of other skills that will contribute to a productive and self-sufficient life. Rehabilitative services are both proper and necessary in the case of either a physical, mental, or mental health function that would degenerate without such services. This is particularly true for children with developmental disabilities. The Council finds it unimaginable that CMS would require the deterioration of a particular function before a child would be provided Medicaid support for the restoration of the function. Assuming this is the result of this proposed rule, then the entire regulation should be stricken.

By example, Jamie has cerebral palsy. At an early age, it was difficult to determine to what extent this disability would affect his development. As he started to develop, it was noticed that he had weakness on one side of the body, affecting both his arm and leg. His speech skills were also not advancing at a developmentally appropriate rate. At age three he was assessed and then provided OT and PT services to improve the functional use of his affected arm and leg, as well as provided with appropriate adaptive equipment which would allow him to use these limbs to his best advantage. Assessment by the speech pathologist identified the need to develop some form of communication for this student, whose cognitive abilities were noted to be normal, although he had no expressive

communication. Through the use of argumentative communication systems, the speech pathologist and other school staff were able to provide a mechanism by which the student could communicate. The OT, PT, and speech therapy are rehabilitative services which have reduced the child's physiological disabilities. These disabilities, which were present at birth, are not the result of a functional loss, and therefore, Jamie's rehabilitative services may not be eligible or reimbursable under the proposed rules.

Due to ambiguities in the two-page regulatory definition of rehabilitative services, as well as the variety of possible interpretations of the component parts of the definition, some of the largest school districts among the Great City Schools estimate a loss of Medicaid financial support ranging from $1.5 million to over $20 million per district. This major budgetary reduction will unavoidably impact the availability of services for children.

Recommendation: Strike the entire proposed rule and return to current law. In the alternative, insert a new paragraph in section 440.130(d) to read as follows: "(_) Rehabilitative services for preschool and school-aged children. For the purposes of this subsection and section 441.45, rehabilitative services for preschool and school-age children shall not require a functional loss or regaining a previous function."

Ambiguities in the Proposed Definitions and Interpretations

Even with five pages of explanatory material and two pages of regulatory language, the scope and limits of a rehabilitative service is difficult to discern. Experienced practitioners will have difficulty delineating the fuzzy distinctions between terms like rehabilitative, restorative, maintenance, custodial, remedial, and habilitative. At worse, these ambiguities will be used to justify arbitrary denials of services and FFP. The regulations are even more difficult to interpret when applied to children, as stated above. The one provision of the regulations with the most clarity is the prohibition of payment for analogous services authorized "intrinsically" under another non-medical program – and that provision suffers from the lack of a statutory foundation.

Services that are considered rehabilitative services in some states are considered EPSDT services in other states. It is particularly important to clarify that the definitions and restrictions in this rule may not be construed to limit the state service responsibilities for children under EPSDT (section 1905(r) of the Title XIX). Moreover, this rule must also not be construed to override the express statutory protection of services included in a child's IEP or IFSP of IDEA under section 1903(c) of the Title IX as stated above.

Recommendation: Insert another new paragraph in section 440.130(d) to read as follows: "(__) Applicability. Nothing in this subsection or section 442.45 shall affect the State requirements to provide services specified in section 1905(r) of the Act."

Federal Cost Shifting and Reduction in Levels of Service
Despite the acknowledged imprecision of the CMS financial impact assessment, the estimated $2.2 billion in FFP cost savings represents a major withdrawal of federal funding from government and community agencies, schools and other Medicaid providers. Individuals currently receiving these Medicaid services may be either deprived of those services, or the costs of those services will be shifted to other governmental units, like school districts. Consumers who were eligible for Medicaid assistance on the day preceding the effective date of these regulations will be scrambling to seek financial support for these services from other state or local agencies once CMS abdicates its responsibilities and shifts those costs to others. In the school setting, the impact will most often be a shifting of cost from the federal government to the state and local taxpayers, rather than service elimination. School-aged children require these rehabilitative services not only to improve or maintain their functional abilities, but also in order to derive the benefits of the educational services provided by the school. But, million of dollars in lost federal financial reimbursements cannot be readily absorbed in tight local budgets. School will be forced to choose between cutting services to this former Medicaid-served clientele or cutting services to other subsets of students. The proposed rule regarding "intrinsic elements" of other programs appears to assume that these other programs will shoulder the financial burden – a classic case of federal cost shifting.

Additional Burdens and Costs
The proposed rule excessively micromanages the details of a services plan. The current definition of rehabilitative services is one sentence in its entirety. Yet, just the rehabilitation plan provisions of the proposed rule [section 440.130(d)(1)(v) and (3)] consume some two-thirds of page 45211 of the Federal Register. CMS proposes to federally mandate at least 17 distinct requirements for a written rehabilitation plan [section 440(d)(3)] with the case records provision adding 5 more requirements [section 441.45(a)(4)].

Even the federally mandated Individualized Education Plan under IDEA, well known for its detailed and costly procedures and requirements, may not cover all the components of the CMS written rehabilitation plan. Ironically, while CMS is mandating excessive administrative activities to plan and develop a written rehabilitation plan, CMS is refusing to provide FFP for the development of a medical plan of care in its proposed school-based administrative reimbursement prohibition [CMS 2287-P].

Requiring a rehabilitation plan is not unreasonable. However, such plans often become more of a procedural and compliance mechanism than a blueprint for services. The cost of this massive proliferation of planning and documentation requirements and the associated paperwork and administrative burdens on providers is a major concern and sufficient reason to roll back many of these overreaching new federal requirements. In addition, the 17 requirements of the written rehabilitation plan in section

440.130(d)(3) appear to duplicate much of the definition of a rehabilitation plan in section 440.130(d)(1)(v).

Recommendation: strike paragraph (3) of section 440.130(d), while retaining the definition in section 440.130(d)(1)(v).

Changes in Provider Qualifications

Section 440.130(d)(1)(iii) is confusing and potentially inconsistent with the unnecessarily elaborate set of qualifications elsewhere in Part 440. Moreover, the proposed rules seeks to federally micromanage the supervision of therapeutic services in section 440.130(d)(1)(iv), which should be left to state and local regulation or policy.

Recommendation:
1) in section 440.130(d)(1)(iii) after "federal law" strike "that would be applicable to the same service when it is furnished under other Medicaid benefit categories" and after "applicable State" strike "scope of practice"; and
2) strike subparagraph (iv) in section 440.130(d)(1) and redesignate the following subparagraphs accordingly.

CMS should recognize the clear congressional skepticism over this proposed rule, both in the rejection of similar proposed language in 2005 and in the recently passed Children's Health Insurance Program reauthorization. CMS should withdraw this proposed rule and beginning working with Congress and representatives of the thousands of governmental agencies, Medicaid providers, and consumers of Medicaid services who oppose this rule, in order to develop a lawful and workable policy on Medicaid assistance for rehabilitative services.

Sincerely,

Jeffrey A. Simering
Director of Legislative Services
(202)-393-2427

CMS-2261-P-1214

Submitter : Mr. Mark Trail **Date:** 10/12/2007

Organization : Georgia Department of Community Health

Category : State Government

Issue Areas/Comments

Background

Background

attached

GENERAL

GENERAL

general comments in attached word document

Provisions of the Proposed Rule

Provisions of the Proposed Rule

attached

Regulatory Impact Analysis

Regulatory Impact Analysis

responses in attached word document

CMS-2261-P-1214-Attach-1.WPD

#1214

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, Comments on Proposed Rule *Medicaid Program: Coverage for Rehabilitative Services, 72 FR 45201*

The Georgia Department of Community Health and the Department of Human Resources' Division of Mental Health, Developmental Disabilities, and Addictive Diseases have reviewed the Centers for Medicare and Medicaid Services (CMS) notice of proposed rule making (NPRM) on the coverage for Rehabilitative Services in the Federal Register (72 FR 45201). We appreciate the opportunity to make the following comments on the proposed rule.

1) Section 440.130: Diagnostic, screening, preventative and rehabilitative services; 440.130(d)(1)(ii) "Other licensed practitioner of the healing arts":

   The proposed definition of this term specifies that a licensed practitioner of the healing arts is an individual "who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue". In Georgia, Medicaid rehabilitative services are only provided to those individuals who have verified diagnoses from those who are licensed in the state to diagnose mental illnesses and addictive diseases and services are required to be provided by qualified providers in accordance with the state's practice acts.

   In Georgia, there are three types of licensed practitioners (Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists) who provide treatment for mental illnesses and addictive diseases and who are authorized in the State's practice acts to assess and evaluate, recommend a course of treatment and provide such treatment in independent practice. However, these clinicians are not granted the authority to assign formal diagnoses. Under the proposed definition, they would be unable to perform the statutorily defined function of recommending a course of rehabilitative treatment.

Centers for Medicare and Medicaid Services
October 12, 2007
Page 2

This definition would be extremely detrimental to the public behavioral healthcare system by limiting the pool of available licensed practitioners able to evaluate and recommend medically necessary services for Medicaid recipients to only physicians and psychologists. This would be particularly problematic for Georgia where 72% of counties are designated in whole or in part as mental health professional shortage areas and where it is already difficult for provider agencies to recruit and retain these licensed practitioners. Adoption of this restrictive definition will exacerbate the situation, limit access to medically necessary services, and would challenge the state's ability to comply with the Medicaid "state wideness" tenet.

2) Section 440.130: Diagnostic, screening, preventative and rehabilitative services; 440.130(d)(1)(iv) Definition of "under the direction of":

We have the same concerns as expressed above regarding the definition of "under the direction of". This section describes the direction and supervision of therapies such as physical therapy, occupational therapy and language services, but specifies that this is "not meant to exclude appropriate supervision arrangements for other rehabilitative services." We wholeheartedly agree that services should be provided by or under the direction of qualified providers. In the provision of behavioral healthcare services such as, but not limited to, individual, family, and group therapy, addictions counseling, and community support services, the independently licensed practitioners listed above may, according to state law, perform the direction and supervisory functions for other mental health professionals who operate under their professional responsibility.

The new definition would restrict this function to only those who can diagnose mental illnesses and addictive diseases and there are simply not enough of these professionals (doctoral-level psychologists and physicians) in Georgia to provide appropriate supervision. In addition, although physicians are qualified to diagnose mental illnesses and addictive diseases and prescribe medications to treat these conditions, they are not appropriate clinical supervisors for the provision of services such as psychotherapy, which they themselves are not trained to provide. In Georgia, this would leave only doctoral-level psychologists and psychiatrists to provide supervision for all of the counseling and psychotherapy services provided under the Medicaid program. This is neither practically possible nor economically efficient. Where services could be provided, the costs would be higher and access to medically necessary rehabilitative services would be severely limited.

It appears from the language in this section that CMS meant to include supervision provided by qualified "therapists" and not just physicians,

psychiatrists and psychologists. Again, we recommend removing the requirement that a licensed practitioner of the healing arts must be authorized by the state to diagnose in order to avoid severe restriction of the state's ability to provide needed rehabilitative services. We recommend that CMS continue to permit states to determine their own definition of allowable practitioners within state law.

3) 440.130(d) (1) (vi), Restorative services.
Covered rehabilitative services under the proposed definition are dependent upon the individual having experienced a functional loss and having had the capability to perform the function in the past. The application of this definition has the potential to be quite subjective. It will be extremely difficult for providers to comply with this requirement when delivering services to individuals whose complete histories and past functioning levels are not known as well as in the provision of services to children or those whose disabilities were manifested prior to reaching developmental maturity. These individuals may not have had the capability to perform the function in the past simply because of their age or the developmental stage at which their disability began to impair their functioning. We recommend that CMS make specific allowances for these circumstances in the definition.

4) Section 440.130(d)(3)(v) – (vii) Written rehabilitation plan:
There are certain services that need to be provided prior to the development of the written rehabilitation plan or are an essential part of developing the written rehabilitation plan. Diagnostic and behavioral health assessments must be delivered prior to and as part of the development of the rehabilitation plan. Emergency crisis intervention services may be the first behavioral healthcare services provided to a Medicaid beneficiary and must be provided where the individual needs them and without delay. When it is not clinically indicated or reasonably possible to develop a written rehabilitation plan prior to the delivery of a service, providers should continue to be able to deliver and be reimbursed for these essential assessments and interventions.

5) Section 440.130(d)(3)(xv) Written rehabilitation plan:
The requirement that the individual must sign the rehabilitation plan will pose a barrier in some circumstances in providing needed services to individuals who verbally indicate their agreement with the written plan but refuse to sign. This is a situation which frequently arises with mentally ill individuals who have paranoid symptoms that lead them to be suspicious and refuse to sign any documentation. This occurs even when the individual is willing to participate in the development of rehabilitative goals and are receptive to treatment. CMS should provide a remedy which specifically permits providers to document this circumstance while they continue with attempts at each subsequent treatment plan review to acquire the signature on the rehabilitation plan.

6) Section 441.45(b)(1) Rehabilitative Services: We would like to express our concerns regarding the inclusion of the term "intrinsic element" without adequate

definition of the term or a description of how determinations would be made to assess whether a service was intrinsic to another program. Additionally, there appears to not be consideration of the fact that even though other federal, state or local programs may sometimes provide or identify the need for services, these other programs may not be obligated to provide such services and there may not be adequate funding to assure provision of such services. We believe that this conflicts with Medicaid's obligation to provide funding for all medically necessary services covered by the state Medicaid plan.

DCH appreciates the opportunity to comment on this important NPRM. We look forward to hearing the final decision for the NPRM.

Sincerely,

Mark Trail, Chief
Division of Medical Assistance Plans

Cc: Judy Hagebak
Chris Gault
Maya Carter
APHSA

CMS-2261-P-1216

Submitter : Ms. Joy Johnson Wilson **Date:** 10/12/2007

Organization : National Conference of State Legislatures

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-1216-Attach-1.PDF