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

Organization : Chester County Intermediate Unit

Category : Academic

Issue Areas/Comments

Background

Background

The proposed regulations 'propose in section 441.45(b)(1) that coverage of rehabilitative services not include services furnished through a non-medical program as either a benefit or administrative activity, including programs other than medicaid, such as...education'.

The Individuals with Disabilities Act (IDEA) clearly indicates that in order to receive FAPE if a student requires a medicaid funded service then medicaid should pay for that service. I have grave concern that these proposed regulations seek to remove that obligation due to a service being provided in an 'Education' arena. This would be a disservice to families and children...as well as the educational community. Education will meet its obligation but seeks the same for medicaid services.

Has CMS done an analysis of the cost shifting implications of this proposal? ACCESS funding, for example, provides partial reimbursement in millions of dollars to school districts..and children with a wide variety of medically based needs are the beneficiaries of these reimbursements; to renege on this funding will affect the provision of services to students and have profound implications on school district budgets.

I support the emphasis on the need for detailed treatment plans delineating services provided by qualified professionals to MA eligible individuals.

Submitter : Dr. Mary Alice Brown-Johnston **Date:** 10/12/2007

Organization : Laurel Hill Center

Category : Other Health Care Provider

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

As a provider of outpatient mental health services, I wanted to make sure that therapy services 'under the direction of' refers to a Qualified Mental Health Professional (QMHP) rather than a MD or other LMP. The proposed rule notes that 'this definition applies specifically to providers of phsical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.' The QMHP should be equivalent to the 'therapist' in the proposed rule. It is the QMHP, not the MD/LMP who should be accountable in 'providing direction in supervising the individual's care, which at a minimum, includes seeing the individual initiallly, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuming professional responsibility for services provided, and ensuring that all services are medically necessary.' It is the QMHP who should be responsible for 'face-to-face contact...at the beginning of treatment and periodically thereafter.'

Thank you for including 'recovery goals' in the language of the rule and 'process to involve the beneficiary, and family or other responsible individuals.' The language regarding reevaluation of the plan will increase accountability (i.e,'whether the goals set forth in the plan are being met and whether each of services deseribed in the plan has contributed to meeting the stated goals.') The rule also stipulates 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.' This language supports person centered planning with 'recovery goals.'

The following language in the rule is also consistent with evidence-based practices. 'Since the rehabilitation plan identifies recovery-oriented goals, the individual must be at the center of the planning process.'

I have concern about the interpretation of the language concerning 'vocational services' and 'specific skills required by an individual to perform tasks associated with performing a job.' While specific skills required for a specific job would not be covered, I would hope that the rule would include skills training for the more general skills such as organization, dependability, interpersonal skills required for many recovery goals (including working).

Response to Comments

Response to Comments

States need to be required rather than encouraged to provide rehabilitative services for treatment of mental health and sustance-related disorders.

Submitter : Mr. Charles Duarte **Date:** 10/12/2007

Organization : Division of Health Care Financing and Policy

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1314-Attach-1.TXT

#1314

October 12, 2007

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

To Whom It May Concern:

The Division of Health Care Financing and Policy of the Department of Health and Human Services for the State of Nevada has the following comments on the:

PROPOSED CMS REGULATION REVISIONS PERTAINING TO THE MEDICIAID MENTAL HEALTH REBABILITATIVE OPTION: CMS-2261-P

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

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

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

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

Requirements for Rehabilitative Services

- **Requirement that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level: 441.45 (a) (2)**

  Recommendation: This language is in conflict with USC 42, Chapter 7, Subchapter XIX, Section 1396 (2): rehabilitation and other services to help such families and individuals attain *or retain capability for independence or self-care* (emphasis added) , there is hereby authorized to be appropriated for each fiscal years sum sufficient to carry out the purposes of this subchapter.

Limitations for Rehabilitative Services

Finally, CMS reliance on the 1991 Technical Assistance Guide for the "free care principle" is in conflict with the Department of Health and Human Services, Departmental Appeals Board, Appellate Division in the decision: Oklahoma Health Care Authority, dated June 14, 2004, which stated that "even if the free care principle were entitled to deference, however, CMS's refusal to waive it would under the circumstances of this case be arbitrary and capricious. Accordingly, we reverse the disallowance in full." This reference should be deleted in its entirety.

Thank you for the opportunity to responds to these proposed regulations on Coverage of Rehabilitative Services.

Sincerely,

Charles Duarte
Administrator

Submitter : Mr. Rusty Selix **Date:** 10/12/2007

Organization : California Council of Community Mental Health Agen

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1315-Attach-1.PDF

#1315

California Council of Community Mental Health Agencies

Leaders in the partnership that developed and promoted Proposition 63

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 California Council of Community Mental Health Agencies (CCCMHA) 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 mission of the Mental Health Association in California is to provide advocacy, education, information and other assistance necessary to ensure that all people who require mental health services are able to receive the mental health and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. As the so-called "glue" that holds the California Coalition for Mental Health together, the Mental Health Association in California must not only have a strong presence in Sacramento, but also must have a strong presence in every community in California.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We agree with the comments of other advocacy agencies in regards to the following four areas of the proposed rule:

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>

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:

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

B. 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.

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

D. that the plan include intermediate rehabilitation goals;

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

F. that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goal

G. 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.

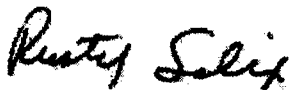
To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at both the state and provider agency 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,

Rusty Selix
Executive Director



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

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

Organization : Campaign for Mental Health Reform

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

This brief comment is submitted on behalf of 17 organizations comprising the Campaign for Mental Health Reform and representing the nation s mental health service administrators, providers, consumers, and their families. The Campaign appreciates the opportunity to offer comment, and many of our member organizations have also provided detailed comments on behalf of their individual memberships.

The Campaign was founded as the President s New Freedom Commission on Mental Health was completing its work. The Commission s findings and recommendations remain central to the Campaign s philosophy. We believe, as the Commission made clear, that mental health services must be delivered seamlessly and with maximum accessibility if clients and consumers are to achieve recovery. While we applaud the proposed rule s references to the goal of recovery expressed so emphatically by the President s Commission, we believe that in practice the regulation will impede, not promote, this desired outcome.

A key component in a system built to encourage recovery is an individualized plan of care. For many, this means the integration of services that may wrap around or support an individual. For the individual, counseling, medication, health care, and rehabilitation services may be just part of an array that also includes housing, employment services, and other interventions that are most effective when delivered together in a coordinated way. The proposed rule specifically the section excluding payment for services that include an intrinsic element of other services could prevent coordinated delivery of these services. For this reason, we recommend that section 441.45(b) of the proposed regulations be deleted.

The President s Commission further recommended that federal programs be aligned to improve access and accountability for mental health services. This recommendation stems, in part, from a finding that many barriers prevent systems from providing services in a way that promotes and aids recovery. Chief among these barriers are reimbursement policies and practices that discourage collaboration among agencies and integration of services as part of an individualized treatment plan. We believe that section 441.45(b) on the exclusion of services including those that are an intrinsic element of other programs erects the very barriers the Commission recommended eliminating. For this reason, too, we recommend deletion of this section.

Along with mental health service administrators and providers, consumers and families have long worked to identify practices that increase accessibility for the system s clients and improve the outcomes they experience. Such practices ensure that a person in need of services receives them in a coordinated manner, reducing duplication and wasted resources. Frequently, rehabilitative services billed to Medicaid can be part of a complex array of services that together provide the support necessary to prevent exacerbation of symptoms and the need for higher-intensity, more costly services.

Much of the evidence that these programs are effective has been gathered in the field and then analyzed and disseminated by the Substance Abuse and Mental Health Services Administration, which is the sole agency of the federal government explicitly charged with oversight of mental health service delivery. We believe that in discouraging collaboration and coordination, the proposed regulation ignores the evidence base developed by SAMHSA and others. We urge you to invest time in a thorough examination, undertaken in coordination with SAMHSA, among others, of ways in which Medicaid billing practices for coordinated and integrated services can be developed.

Our greatest fear is that the proposed regulations will create unnecessary barriers to collaborative practices, leaving individuals without access to effective services.

Submitter : Ms. Annie Toro **Date:** 10/12/2007

Organization : American Psychological Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1317-Attach-1.DOC

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

October 12, 2007

Secretary Michael O. Leavitt
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

File Code: CMS-2261-P
Medicaid Program; Coverage for Rehabilitative Services

Dear Secretary Leavitt:

On behalf of the 148,000 members and affiliates of the American Psychological Association (APA), I would like to thank you for the opportunity to comment on the August 13 Proposed Rule regarding Medicaid coverage of rehabilitative services. We appreciate the time and consideration that the Centers for Medicare and Medicaid Services (CMS) dedicates towards drafting these proposed regulations to provide for much-needed beneficiary protections and to ensure fiscal integrity in the provision of Medicaid rehabilitative services.

APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and graduate students, APA works to advance psychology as a science, a profession, and a means of promoting health, education and human welfare. APA has a long-standing commitment to promoting the optimal development and care of all individuals with disabilities. Psychological research has played a pivotal role in our understanding of the social, emotional, and physiological aspects of human behavior.

The sections provided below highlight several important recommendations regarding the proposed regulations. We hope that you will consider these comments as you work to develop the final regulation.

Section by Section Analysis – Provisions of Proposed Regulations

SECTION 440.130(D)(1)(V) DEFINITIONS – REHABILITATION PLAN

Recommendation: APA supports the CMS requirement of a written rehabilitation plan.

Rationale: A written rehabilitation plan will ensure the input and participation of the individual, their family or authorized health care decision maker, and/or persons of the individual's choosing in the development, review and modification of the rehabilitation/recovery goals and services. For people with mental health and substance abuse problems, this person-centered approach is critical to an effective recovery. A secondary result of a written plan is that it increases state transparency and state accountability.

SECTION 440.130(D)(VI) DEFINITION OF RESTORATIVE SERVICES

Recommendation #1: APA supports the CMS language that clarifies that "the emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past" and urges CMS to further clarify the language within the regulation to 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.

Rationale #1: Clarification of eligibility for rehabilitation services to allow children to achieve age-appropriate skills is critical as they will not necessarily have had the ability to perform a function in the past due to their level of development and acquisition of age appropriate skills. In addition, the inclusion of the recommended language will mirror the language in the current CMS regulation of managed care plans at 42 CFR 438.210(a)(4)(ii)(B).

Recommendation #2: APA recommends that CMS revise 440.130(d)(1)(vi) to define, as an acceptable goal of a rehabilitation plan, the provision of rehabilitation services to assist individuals in retaining their current functional level or preventing a relapse.

APA also recommends the modification of the language in 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 . . ." to reflect the inclusion of prevention of relapse as an appropriate rehabilitation goal.

Rationale #2: The proposed regulation states that restorative services are those "provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function." This focus that rehabilitation services must reduce disability and restore function to be reimbursable under Medicaid is emphasized throughout the proposed rule.

However, the pervasive emphasis on restoring functioning and change in status rather than maintaining functioning could have the unintended effect of denying reimbursement for services that should be covered as rehabilitative for individuals with mental health and substance abuse problems. For these

individuals, the recovery process is varied and can be cyclical in nature with periods of stability, periods of regression or relapse and periods of restoration. The continuation of rehabilitative services is at times essential to retain these individuals' functional level and failure to provide a supportive level of rehabilitation could result in deterioration, necessitating a reinstatement of intensive services.

In addition, this section might be in direct conflict with section 1901 of the Social Security Act which specifically authorizes funds to furnish, "(2) rehabilitation and other services to help such families and individuals attain or retain [emphasis added] capability for independence or self-care..."

SECTION 440(D)(1)(VII) DEFINITION OF MEDICAL SERVICES

Recommendation: APA urges CMS to modify the language of 440(d)(1)(vii) to include: "services that are required for the "diagnosis, **assessment**, treatment or care of a physical or mental **condition**..."

Rationale: The proposed regulations provide that medical services are those required for the diagnosis, treatment or care of a physical or mental disorder. It would be helpful to clarify that rehabilitation services include a functional assessment of the individual. It is critical for a provider to attain the correct diagnosis, but individuals with the same diagnosis may have very different rehabilitative goals and services based on their current functional level and stage of recovery.

This would provide consistency with later requirements in the proposed regulation for a rehabilitation plan which must be "based on a comprehensive assessment... including diagnosis and presence of a functional impairment in daily living."

SECTION 440.130(D)(4) IMPAIRMENTS TO BE ADDRESSED

Recommendation: APA urges CMS to modify the language of 440.130(d)(4) to include: "may address the individual's physical **or mental** impairments, mental health impairments, and/or substance-related disorder treatment needs."

Rationale: APA strongly supports the inclusion of individuals with "mental impairments" to this section. The proposed language may have the unintended consequence of individuals with cognitive impairments and developmental disabilities who meet the requirements for the provision of rehabilitation services being denied services.

SECTION 440.130(D)(5) SETTINGS

Recommendation #1: APA requests that CMS omit the language in the preamble granting states the authority to determine the setting.

Rationale #1: The preamble would seem to conflict with the statutory definition of 42 U.S.C. § 1396d(a)(13) which 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."

Recommendation #2: APA urges CMS to modify the language to include additional settings:
"...**school, workplace, foster home, group home, community mental health center, substance abuse treatment center, community settings**, and other locations."

Rationale #2: While the preamble includes some of the settings, a more inclusive statement in the proposed regulation of where rehabilitative services may be provided, reinforces the emphasis on the provision of services in a setting that is most appropriate and will yield the best results.

SECTION 440.140(D)(3) DEFINITION OF WRITTEN REHABILITATION PLAN

Recommendation #1: APA urges CMS to modify the language to include rehabilitation coverage for the prevention of relapse, and the retention of functional ability as appropriate goals within a written rehabilitation plan.

Rationale #1: The recovery process for individuals with mental health conditions and substance abuse problems is not always a linear process and unique to each individual. The inclusion of "prevention of relapse" for these populations recognizes this and allows states to continue to offer a supportive level of rehabilitation as a legitimate goal.

Recommendation #2: APA urges CMS to modify current language to include exigent circumstances by adding: "(xv) document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan **or document the exigent circumstances which prevented such participation in the development of the plan, signing of the plan and/or receipt of a copy of the plan."**

Rationale #2: There may be circumstances where an individual or their representative may not be able to be an active participant in the creation of a rehabilitation plan. The proposed regulations should have sufficient flexibility to allow for Medicaid financing in these cases. As an example, an individual

undergoing a psychological crisis may not be able to actively participate in a treatment plan at that time.

Recommendation #3: APA urges CMS to offer guidelines to clarify the requirements for participation in the development of a rehabilitation plan for children in foster care.

Rationale #3: For a child in foster care, and therefore under state custody, who is receiving rehabilitative services, it is unclear who has authority and who should be involved in the decision-making process. In addition, the provisions do not offer guidelines regarding what happens when a family is not accessible or chooses not to participate.

SECTION 441.45(A)(1)	ASSURANCE OF COMPLIANCE WITH OTHER FEDERAL REGULATIONS

Recommendation: APA strongly urges CMS to add the language: "Ensure that services are provided in accordance with Sec. 431.50, Sec. 431.51, Sec. 440.230, Sec. 440,240 ~~of this chapter~~ **and 440.40(b)** of this chapter and **42 U.S.C. Sections 1396(d)(r)(5) and 1396a(a)(43).**"

Rationale: With regard to the intersection of these provisions and other Federal regulations, it is crucial to also include the regulatory and statutory requirements of Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), which mandate that Medicaid beneficiaries under the age of 21 must receive all medically necessary services to ameliorate or correct a physical or mental condition regardless of whether the services are included in a state's Medicaid plan. 42 U.S.C. Section 1396d(r)(5) and 42 C.F.R. Section 440.40(b).

EPSDT is a critical requirement for children with mental health problems who require rehabilitative services to facilitate their recovery and full participation in their schools and communities. States should be required to ensure that nothing in the implementation of these regulations will compromise the mandate in the EPSDT provisions.

441.45(A)(2)	REHABILITATIVE SERVICES

Recommendation: APA urges CMS to include additional language to describe when services may be furnished with the goal of retaining or maintaining functioning.

Rationale: This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level, as defined in the law. However, it would be helpful to emphasize when services may be furnished to retain or maintain functioning.

SECTION 441.45(B)(1)	SERVICES THAT ARE EXCLUDED FROM REHABILITATION, INCLUDING THOSE THAT ARE INTRINSIC ELEMENTS OF OTHER PROGRAMS

Recommendation #1: APA strongly urges CMS to withdraw this section of the regulation.

Rationale #1: Requiring an intrinsic elements test without a definition creates an ambiguous standard that states and beneficiaries will be unable to apply.

In addition, with regard to children, this section directly conflicts with EPSDT. This is a clear mandate that applies regardless of whether the rehabilitative service is intrinsic to another program or is furnished as a benefit or administrative activity of another program. While the proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), without sufficient clarification eligible children may be denied appropriate services.

This requirement also appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.(A) of the preamble, it is noted that Medicaid has been used to fund services that are included under 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, third party liability rules under Medicaid have already recognized that states have an obligation to determine if another entity is legally liable for payment of services. 42 U.S.C. § 1396a(a)(25)(A) requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties..." 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).

Recommendation #2: Should CMS continue to require the limitation of rehabilitative services as outlined in this section, APA recommends the inclusion of guidelines and language to clarify that the exclusion will only apply if the non-medical programs that are providing them are legally obligated to provide the services to a specific Medicaid eligible individual. APA would also strongly recommend that discretionary appropriations and waiver-based programs do not constitute a legal obligation or liability to a specific individual.

Rationale #2: Medicaid rehabilitation services must be available for all eligible individuals based on an identified medical need to address a functional

impairment regardless of any involvement in another program. The preamble specifically states that "enrollment in these non-Medicaid programs does not affect eligibility for Title XIX services." Without additional guidelines and protections, there is no assurance that eligible individuals will have access to equivalent necessary rehabilitative services as compared to the services provided under Medicaid.

Recommendation #3: Should CMS continue to require the limitation of rehabilitative services as outlined in this section, APA also recommends the inclusion of specific language within the regulation to reflect that children are covered under EPSDT and will receive all necessary services to correct or ameliorate a physical or mental condition, regardless of whether the rehabilitative service is intrinsic to another program or is furnished as a benefit or administrative activity of another program.

Rationale #3: Without sufficient clarification in the regulation regarding the provision of rehabilitative services to children, eligible children may be denied appropriate services.

SECTIONS 445(B)(1)(I-IV) EXCLUSION OF THERAPEUTIC FOSTER CARE SERVICES

Recommendation: APA urges CMS to include therapeutic foster care as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. APA supports the inclusion of 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.

Rationale: Therapeutic foster care is one of the least restrictive out-of-home placements for a child with a serious mental disorder. These services have been effectively used to avoid out of home placement and more trauma to the child and family.

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)).

PROPOSED § 441.45(B)(2) HABILITATION SERVICES

Recommendation: APA urges CMS to withdraw the language that seems to indicate a categorical exclusion for habilitation services and add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from eligibility for rehabilitation services.

Rationale: The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services because they are designed to help individuals acquire new functional abilities rather than to restore function. 42 C.F.R. § 441.45(b)(2), *see also* 72 Fed. Reg. at 45205 (Section II.F.2). Such a provision may lead to automatic exclusion of services for individuals with cognitive impairments and developmental disabilities, when those services may be appropriate.

In addition, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental health conditions, and may lead to a denial of medically necessary covered services for this population.

SECTION 445(B)(3):	EXCLUSION FOR RECREATION OR SOCIAL ACTIVITIES THAT ARE NOT FOCUSED ON REHABILITATION.

Recommendation: APA urges CMS to include language stating that "**Recreational or social activities that are addressing a particular impairment or functional need, such as social activities addressing the goal of social skills development, are reimbursable as rehabilitation services.**"

Rationale: CMS states in the preamble 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." APA urges CMS to utilize this clarifying language in the regulation itself.

SECTION 441.45(B)(4):	EXCLUSION OF SERVICES PROVIDED BY PUBLIC INSTITUTIONS.

Recommendation: APA urges CMS to modify the language: "... that are not part of the public institution ~~system~~, when the services are identified due to a medical condition targeted under the State's Plan."

Rationale: APA requests CMS to remove the word "system" to be clear that community services which are rehabilitative are reimbursable regardless of whether a child or adult remains part of the juvenile justice or correctional system. This is particularly important for rehabilitation services that are provided in the community while the adolescent or adult with mental health problems is still under the auspices of the correctional system. This may include mental health services in a group home for youth who are under juvenile court jurisdiction or community treatment for adults who are still in the corrections system. This clarification is very important given the large numbers of juveniles and adults with mental health problems who come under the jurisdiction of these systems. This is consistent with other sections of the preamble and regulation which recognize

that involvement in other programs does not affect Medicaid eligibility for services.

SECTION 441.45(B)(8):	EXCLUSION OF SERVICES THAT ARE NOT PROVIDED TO A SPECIFIC INDIVIDUAL.

Recommendation: APA urges CMS to modify the language to include: **"Contacts with and services to family members and other non-eligible individuals for the purpose of treating the Medicaid eligible individual may be covered as a rehabilitative service."**

Rationale: APA applauds the inclusive language in the preamble recognizing that "effective rehabilitation of eligible individuals may require some contact with non-eligible individuals," specifically "contacts with family members for the purpose of treating the Medicaid eligible individual may be covered under Medicaid." APA urges CMS to include specific language into the regulations.

Thank you for your consideration of these comments concerning the proposed regulations on the Medicaid program and coverage for rehabilitative services (CMS-2261-P). We welcome the opportunity to work with CMS in helping to provide for beneficiary protections and to ensure fiscal integrity in the provision of Medicaid rehabilitative services. For additional information, please contact Day Al-Mohamed, J.D., in APA's Public Interest Government Relations Office at (202) 336-6061.

Sincerely,

Annie Toro, J.D., M.P.H.
Associate Executive Director
Public Interest Directorate

Submitter : Ms. Esphur E. Foster **Date:** 10/12/2007

Organization : Club Nova Community, Inc. Board of Directors

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1318-Attach-1.RTF

CMS-2261-P-1318-Attach-2.TXT

CMS-2261-P-1318-Attach-3.DOC

#1318

Club Nova

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Carrboro, North Carolina 27510
919-968-NOVA (6682)
Fax 919-968-1764

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

Submitted By:
Esphur E. Foster, President
Club Nova Community, Inc. Board of Directors
103 D West Main Street
Carrboro, North Carolina 27510

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
Post Office Box 8018
Baltimore, Maryland 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 President of Club Nova Community, Inc. Board of Directors for 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.

★ Club Nova promotes and provides opportunities for individuals with mental illness to lead meaningful and productive lives of their choice, in the community. ★

Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better out comes, 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 I call it panic control). Most importantly, we consider such rules inhumane.

Even with federal, state, and local government funding, the mental health system remains under funded. 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. A reduction in funding will certainly ensure that the recent tragedies will continue to occur with even more frequencies.

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,

Esphur E. Foster
President
Club Nova Community, Inc. Board of Directors

Submitter : Mrs. Elizabeth Seipel **Date:** 10/12/2007

Organization : Child & Family Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1319-Attach-1.PDF

#1319

Child & Family Center

"Strengthening Families Through Counseling, Education and Support"

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 Child & Family Center 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.

Our private, non-profit center has served the Santa Clarita Valley community for over 30 years. It provides mental health, case management, and supportive services for over 2,000 children, adults, and their families annually. We provide Crisis Intervention, Outpatient Mental Health, School Based Services, Substance Abuse Treatment, and a several other programs for some of the most severe and needy residents of our community by utilizing County, State, and Federal funding, as well as community fund raising support.

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

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>

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, continuation of rehabilitative services are at times essential for people with serious mental

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or emotional disorders in order 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 may be 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 and more costly services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

Section 1901 of the statute specifically authorizes funds for rehabilitation and other services to help individuals retain the 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 as 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:

1) Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it 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.

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

440.130(viii)(3) Written Rehabilitation Plan

There are some issues where the regulation is unclear and issues are unaddressed. Without attention to the suggestions below, 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 unrealistic 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. Second, 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 as to 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 includes 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 as to 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 includes intermediate rehabilitation goals.
- That, as indicated, the plan includes provisions for crisis intervention.
- That the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals.
- That the requirement that the plan list the potential alternate providers of the same service is substituted by a requirement that the plan include an assurance that the individual has received information regarding all known existing providers.

It is also crucial that CMS also clarifies that a single treatment and rehabilitation plan is acceptable and encourage a single planning team and service planning meetings.

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

federal financial participation for the Medicaid-covered individual?

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

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 received medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase needs to 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 regulations 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 his/her 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 instates 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 and administrative processes all pose significant challenges at the agency level. At a minimum, State 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,

Liz Seipel

Liz Seipel
CEO

C: Members of the California State Congressional Caucus
The Honorable Arnold Schwartzenegger, Governor of the State of California

Submitter : Ms. Susan Stephens **Date:** 10/12/2007

Organization : Lutheran Child and Family Services of Illinois

Category : Religious Nonmedical Health Care Institution

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1320-Attach-1.DOC

#1320

Lutheran Child and Family Services of Illinois

October 12, 2007

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

To Whom It May Concern:

Reference : File code CMS-2261-P

Lutheran Child & Family Services of Illinois 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.

I. BACKGROUND - GENERAL COMMENTS

Impact on Poor Children

The proposed amendments by CMS to protect Medicaid beneficiaries would in effect limit access to Medicaid for currently eligible poor children and we see it as an effort to cut vital federal funds to states by reducing funding for children. We ask that states not be penalized for stepping up to meet the needs of the nation's poor children and families. According to the Medicaid regulations which identifies **mandatory eligibility groups**, "states have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, states are required to provide Medicaid coverage for most people who get Federally assisted income maintenance payments, as well as for related groups not getting cash payments. Some examples of the mandatory Medicaid eligibility groups include the following:

- Limited income families with children, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the state's Aid to Families with Dependent Children (AFDC) in effect on July 16, 1996;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act."

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While we welcome rule clarifications and your commitment to protect the fiscal integrity of the Medicaid program, many of these rule changes could be used to narrow or potentially eliminate the very children it was written to help rehabilitate as identified in the mandatory eligibility groups. We strongly recommend that CMS work with child welfare providers, the states, and other federal agencies to create a system of fiscal accountability, which supports best practice for children with mental health needs and allows for the provision the most appropriate Medicaid rehabilitative services in the least restrictive setting.

To protect the nation's poor children Lutheran Child & Family Services of Illinois asks for the following considerations.

Importance of Rehabilitative Services for Children in Foster Care and Child Care Institutions

Children that enter the foster care system or are placed in child care institutions under the federal requirements applicable to Title IV-E are at an extremely high risk for both physical and mental health issues as a result of biological factors and the maltreatment they were exposed to at home. 80% of children in out of home care meet the clinical criteria for behavioral problems or psychiatric diagnosis.

When children are removed from their home base and placed in state custody, child welfare agencies funded through Title IV-E are responsible for meeting their health and mental health needs, and virtually all children in foster care and child care institutions are eligible for and obtain health care services through Medicaid.

Funding for those most applicable Rehabilitative services have increasingly been accessed by states – especially for children with mental illness – for two reasons. The increase was promoted in part by the recommendations from the President's New Freedom Commission on Mental Health, issued in 2003, to improve the nation's mental health system. Secondly, the Children's Federal Services Review (CFSR) has identified mental health services as the major area of deficiency that is not being met within the child welfare system funded with Title IV-E.

II. PROVISIONS OF THE PROPOSED RULE

C. Written Rehabilitation Plan

In Section 440.130(d)(3), it adds a requirement that covered rehabilitative services for each individual must be identified in a written rehabilitation plan.

Concerns:
We are concerned about the extent of the requirements that must be included in the written rehabilitation plan. This would place an administrative burden on Medicaid providers in order to address the overall extent of all requirements.

The plan requirement to indicate the anticipated providers of the services and the extent to which the services may be available from alternate providers of the same service would be administratively burdensome.

Recommendation: Substitute for the requirement that the plan list the potential providers of the same service requirement that the plan include an assurance that the individual received this information to the extent the service planning team is aware of all existing providers.

F. Requirements and Limitations for Rehabilitative Services

2. Limitations for Rehabilitative Services – Intrinsic Elements

Under this section it explicitly states that rehabilitation does not include services "furnished through a non medical program as either a benefit or administrative activity including services that are intrinsic to elements of programs other than Medicaid, such as foster care, child welfare, education, child care ..... juvenile justice. (Proposed Section 441.45 (b) (1) through (b) (8). The proposed rule seems grounded in the assumption that rehabilitation services serve as "intrinsic elements" within a series of other federally funded programs, and that states are duplicating their funding streams in seeking support from Medicaid for these services. This leaves the questions of what is considered to be "intrinsic to" a program. How would that be defined?

Concern: Congress explicitly rejected adopting an "intrinsic to" test in regards to Medicaid rehabilitative services when debating and finalizing the Deficit Reduction Act, so the authority to make this application to Medicaid Rehabilitation Services would need to be done through change in the law and not through regulation.

Concern: While it is helpful to clarify what is covered by Medicaid and what is covered by other federal programs, the proposed regulation and its "intrinsic to" test does not properly consider the child welfare system funded under Title IV-E

and the application of Medicaid programs to children's services. The child welfare system is required to ensure that the children in their care get the services they need, including medical and mental health. The results of the CFSR's of the 50 states indicate that state child welfare agencies are already struggling to meet these needs largely because the mental health system as reported by the President's New Freedom Commission is "fragmented and in disarray".

If the proposed "intrinsic to" test is applied to child welfare and Medicaid resulting in the requirement that the services needed by the child in care would come only from the child welfare system, this would eliminate critical mental health services that the CFSR's have even identified. If Medicaid is not there to assist, what will be done to infuse greater dollars into the Mental Health system so that the services that are needed are being provided and available?

Recommendation: We would propose the removal of the reference "intrinsic to" in the rule and use the basic definitions from the other federal programs as the guideline for determining the coverage of services. In the definition for Title IV-E it specifically provides for payment for a child placed in a foster family home or child care institution and that these children are Medicaid eligible and therefore eligible for Medicaid defined services. As stated by the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20, Title IV-E covers the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child and reasonable travel for a child's visitation with family or other caretakers. For child care institutions it must also "include the reasonable costs of administration and operation of such institutions as are necessarily required to provide the items described in the preceding sentence".

The Code of Federal Regulations at 1356.60 Fiscal Requirements (Title IV-E) specifically prohibit States from claiming Title IV-E federal financial participation (FFP) for medical or rehabilitative services as "Allowable administrative costs do not include the costs of social services provided to the child, the child's family or foster family which provide counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions."

Mental health services are a critical portion of the services that need to be made available to children in foster care and child care institutions but are not covered under Title IV-E and should be covered by Medicaid if they meet the Medicaid regulations.

2. Limitations of Rehabilitative Services – Provider Choice

Section 441.45 (b) (1) emphasizes language that requires that "the individual must have free choice of providers".

Concern: The clients in the child welfare system are children and adolescents who are wards of the state and do not choose these services amongst a list of available providers. For those children, the choice should include birth parent, the child who is old enough, and legal guardian.

Definitions for Rehabilitation Services versus Habilitation Services

Section 441.45(b)(2) speaks to a distinction between the terms "habilitation" and "rehabilitation". Rehabilitation refers to measures used to restore individuals to their best functional levels. It states that individuals receiving rehabilitation services must have had the capability to perform an activity in the past rather than to actually have performed the activity.

Section 441.45(a)(2) states that rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.

Concern: These sections of the proposed rule as with numerous other sections of the proposed rules have language that is geared more for adults than for children. In children's services, we have to be sensitive to the developmental levels of children. In such cases rehabilitative services are geared to move children to expected levels they have not reached. Rehabilitative services should be used to achieve these type of functional goals for children. Such rehabilitative steps are not geared to restoring a child to a previous level of functioning as with an adult.

Recommendation: Language should be included that references rehabilitative services are also used to achieve an "expected level" of development for children.

Exclusion of Services Provided to Residents of an Institution for Mental Disease

In section 441.45 (b) (4) it is proposed to exclude payment for services that are provided to residents of an institution for mental disease (IMD) including residents of a community residential treatment facility of over 16 beds, that is

primarily engaged in providing diagnosis, treatment or care to person with mental illness, that does not meet the requirements at Section 440.160.

Concern: It appears that language here is more readily applicable to the adult population in determining what is an IMD. In the child welfare system, funding is provided through Title IV-E to child care institutions as referenced in 45 CFR Chapter 13 Part 1355 and 1356 and, although the interchange of wording used when speaking about them may at times include residential treatment facility, they are not licensed as a residential treatment facility within the child welfare system. Child welfare programs are licensed as child care institutions per the language of the IV-E federally funded program and not as psychiatric under 21 residential treatment facilities. Title IV-E pays for room and board costs for the placement of children in foster family homes or child care institutions.

Recommendation: According to the definitions for Title IV-E under the Social Security Act (45 CFR Chapter 13 Part 1356) for foster care and child care institutions, these settings would be allowable for Medicaid services if the state licensing provisions (Title 89: Social Services, Chapter III, Dept. of Children and Family Services, Subchapter e: Requirements for Licensure, Part 404) are so established within a state and the services provided meet the definitions for Medicaid rehabilitative services. The inherent intent of the child care institution is to improve the level of functioning of the child so that they would be moved to a less restrictive setting so this would meet the definitions for rehabilitative services.

Any child welfare program licensed as a child care institution should not be included in the language of a community residential treatment facility referenced in section 441.45 (b) (4). The reference to an IMD should not apply to child care institutions as defined by state licensing rule.

E. Settings

Also under section 440.130(d)(5), it is proposed that rehabilitative services may be provided in a facility, home or other setting.

Recommendation: Child care institutions should be included as an example of one of these settings. Inpatient is associated with a psychiatric facility and child care institutions do not meet that definition according to licensing regulations of the state (Title 89: Social Services, Chapter III, Dept. of Children and Family Services, Subchapter e: Requirements for Licensure, Part 404) and should not meet that definition in order to provide a level of care needed in a community

based setting, but not within the inpatient setting of a hospital. It is agreed that rehabilitative services do not include room and board in an institutional setting as that is paid through other federal funding in the child welfare system such as Title IV-E. Rehabilitative services provided within the child care institution setting should be eligible for Medicaid if they meet the definitions.

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

Sincerely,

Susan Stephens, LCSW
Vice President and Senior Consultant for Organizational Development
Lutheran Child & Family Services of Illinois

Submitter : Mr. Ted Williams **Date:** 10/12/2007

Organization : Maricopa Consumers, Advocates & Providers

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

#1321

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE AND MEDICAID SERIVICES
FICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : Mr. Ted Williams **Date:** 10/12/2007

Organization : MCAP

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1322-Attach-1.PDF

#1322

MCAP

Maricopa Consumers Advocates and Providers

1406 N. 2nd Street
Phoenix, AZ 85004
(602) 330-3700

October 12, 2007

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

Dear Acting Director Weems:

The Maricopa Consumers Advocates and Providers (MCAP) members provide services in the largest public behavioral health system in the country. This group, based in Maricopa County, AZ, submits the following comments on the proposed regulations regarding Medicaid Coverage for Rehabilitative Services, published at 72 Fed. Reg. 45201 (August 13, 2007). As you know, the Arizona Health Care Cost Containment System (AHCCCS) is the state's Medicaid agency. Arizona has chosen to "carve out" behavioral health services to the Arizona Department of Health Services (ADHS) through contract with AHCCCS that remains responsible for the administration of behavioral health services for AHCCCS members. ADHS then subcontracts service delivery with Regional Behavioral Health Authorities (RBHAs) around the state.

As an advocacy group that serves as a spokesperson on behavioral health issues, MCAP is quite concerned about the impact these proposed regulations will have on provision of services in our state. As the AHCCCS director, Tony Rodgers, has indicated in his letter rehabilitative services option is the primary basis by which Arizona delivers outpatient behavioral health services. Our view is that rehabilitative services are essential to help people with a mental illness improve or maintain their functioning and promoting independent living rather than placement in an inpatient setting or other institutional setting.

Listed below are concerns that we wish to point out.

440.130(d)(1)(iii)

MCAP is in total agreement with the AHCCCS Director in seeking clarification about the definition of "qualified providers of rehabilitative services" under the proposed regulations. Peer support services are an evidence-based mental health model of care that is an important component in the effective treatment of mentally ill individuals in Arizona. We highly recommend inclusion of these groups as a qualified provider under the regulations.

440.130(d)(1)(iv)

We concur with AHCCCS issue on the need to clarify the "under the direction of" language. With our shortage of licensed behavioral health providers and the apparent need for supervision, if there were a strict interpretation of the regulation we might be unable to comply and deliver services.

440.130(d)(1)(v)

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. It is a positive step to assure that the individual is involved in planning his/her care. We understand that some of the national advocacy groups have suggested improvements in the wording to assure that the intent as outlined in the preamble will be actualized even when the individual has a mental illness that may cyclical with a changing need for service provision.

440.130(d)(1)(vi)

We would like to associate with the comments provided by the Judge David L. Bazelon Center for Mental Health Law on this particular issue. Our concerns are with the definition that stipulates 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. The regulation needs modification to make the meaning of this section clearer. Additionally, the regulation appears too restrictive and may negatively affect a plan that would, especially for individuals with a mental illness, to continue to receive rehabilitation services that would retain and maintain functioning.

440.130(d)(1)(viii)(2)

The definition of scope of services appears to be limited to medical or remedial services. This appears to be limited and further clarifying language may be necessary to assure that services should be in the least restrictive setting.

440.130(4)

We would like to agree with the concerns that the Bazelon Center has made about this regulation and call upon CMS' to assure that rehabilitative services needed by individuals with a mental illness be provided in sufficient amount, duration and scope to reasonably achieve the purpose of such services.

441.45(b)

Because of the concerns identified with the coordination of services between Medicaid and other services especially for those needing mental health services, we believe extensive clarification would be necessary to add sufficient guidance to both the state and service providers.

441.45(b)(1)(i)

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice with clinical trials that demonstrate positive outcomes for the children. Because of the value of these settings and need for clarity, therapeutic foster care should be listed as a covered rehabilitative service for children with a mental disorder at risk of placement in a residential treatment facility. We do recognize that room and board for therapeutic foster care would not be a covered service.

EPSDT Mandate

The proposed regulations appear to ignore the Title XIX mandates of the EPSDT program that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is in the state plan or covered for adults. The regulation need to be consistent with the mandates of the EPSDT provision.

We do recognize the work necessary to prepare and circulate these proposed regulations. We do hope that the comments provide will help in refining and improving the regulations in order to assure that individuals with mental illness have full access to the array of essential services to improve and preserve their well-being.

Sincerely,

Ted Williams

Ted Williams
Chairman

CMS-2261-P-1323

Submitter : Ms. Barbara Siegel **Date:** 10/12/2007

Organization : Ms. Barbara Siegel

Category : Individual

Issue Areas/Comments

Background

Background

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.

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.

Submitter : **Dr. Edwardo Ramos** **Date: 10/12/2007**

Organization : **Puertorrican Asociation of Physical Medicine & Reh**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

October 12, 2007

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

Dear Ms. Norwalk

We the Puerto Rican Society of Physical Medicine and Rehabilitation are respectfully requesting the following important amendments of the proposed rule CMS-2261-P.

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

Amendments:

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

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

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

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

We suggest to add a 9th definition:

(ix) Physical medicine therapeutic devices and/or physical medicine prosthetic devices:
Are medical treatment devices described in the Food and Drug Act, Title 21 Chapter I, Subchapter H, Part 890, Subpart D and F usually used in the treatment of patients with functional limitations or disabilities.

Subpart D--Physical Medicine Prosthetic Devices
? 890.3025 - Prosthetic and orthotic accessory.
? 890.3075 - Cane.
? 890.3100 - Mechanical chair.
? 890.3110 - Electric positioning chair.
? 890.3150 - Crutch.
? 890.3175 - Flotation cushion.
? 890.3410 - External limb orthotic component.
? 890.3420 - External limb prosthetic component.
? 890.3475 - Limb orthosis.
? 890.3490 - Truncal orthosis.
? 890.3500 - External assembled lower limb prosthesis.
? 890.3520 - Plinth.
? 890.3610 - Rigid pneumatic structure orthosis.
? 890.3640 - Arm sling.
? 890.3665 - Congenital hip dislocation abduction splint.

? 890.3675 - Denis Brown splint.
? 890.3690 - Powered wheeled stretcher.
? 890.3700 - Nonpowered communication system.
? 890.3710 - Powered communication system.
? 890.3725 - Powered environmental control system.
? 890.3750 - Mechanical table.
? 890.3760 - Powered table.
? 890.3790 - Cane, crutch, and walker tips and pads.
? 890.3800 - Motorized three-wheeled vehicle.
? 890.3825 - Mechanical walker.
? 890.3850 - Mechanical

CMS-2261-P-1324-Attach-1.DOC

#1324

October 12, 2007

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

Dear Ms. Norwalk

We the Puerto Rican Society of Physical Medicine and Rehabilitation are respectfully requesting the following important amendments of the proposed rule CMS-2261-P.

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

Amendments:

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

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

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

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

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

We suggest to add a 9th definition:

(ix) Physical medicine therapeutic devices and/or physical medicine prosthetic devices:
Are medical treatment devices described in the Food and Drug Act, Title 21 Chapter I, Subchapter H, Part 890, Subpart D and F usually used in the treatment of patients with functional limitations or disabilities.

Subpart D--Physical Medicine Prosthetic Devices
§ 890.3025 - Prosthetic and orthotic accessory.
§ 890.3075 - Cane.
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§ 890.3110 - Electric positioning chair.
§ 890.3150 - Crutch.
§ 890.3175 - Flotation cushion.
§ 890.3410 - External limb orthotic component.
§ 890.3420 - External limb prosthetic component.
§ 890.3475 - Limb orthosis.
§ 890.3490 - Truncal orthosis.
§ 890.3500 - External assembled lower limb prosthesis.
§ 890.3520 - Plinth.
§ 890.3610 - Rigid pneumatic structure orthosis.
§ 890.3640 - Arm sling.
§ 890.3665 - Congenital hip dislocation abduction splint.
§ 890.3675 - Denis Brown splint.
§ 890.3690 - Powered wheeled stretcher.
§ 890.3700 - Nonpowered communication system.
§ 890.3710 - Powered communication system.
§ 890.3725 - Powered environmental control system.
§ 890.3750 - Mechanical table.
§ 890.3760 - Powered table.
§ 890.3790 - Cane, crutch, and walker tips and pads.
§ 890.3800 - Motorized three-wheeled vehicle.
§ 890.3825 - Mechanical walker.
§ 890.3850 - Mechanical wheelchair.
§ 890.3860 - Powered wheelchair.
§ 890.3880 - Special grade wheelchair.
§ 890.3890 - Stair-climbing wheelchair.
§ 890.3900 - Standup wheelchair.

§ 890.3910 - Wheelchair accessory.
§ 890.3920 - Wheelchair component.
§ 890.3930 - Wheelchair elevator.
§ 890.3940 - Wheelchair platform scale.

Subpart F--Physical Medicine Therapeutic Devices
§ 890.5050 - Daily activity assist device.
§ 890.5100 - Immersion hydrobath.
§ 890.5110 - Paraffin bath.
§ 890.5125 - Nonpowered sitz bath.
§ 890.5150 - Powered patient transport.
§ 890.5160 - Air-fluidized bed.
§ 890.5170 - Powered flotation therapy bed.
§ 890.5180 - Manual patient rotation bed.
§ 890.5225 - Powered patient rotation bed.
§ 890.5250 - Moist steam cabinet.
§ 890.5275 - Microwave diathermy.
§ 890.5290 - Shortwave diathermy.
§ 890.5300 - Ultrasonic diathermy.
§ 890.5350 - Exercise component.
§ 890.5360 - Measuring exercise equipment.
§ 890.5370 - Nonmeasuring exercise equipment.
§ 890.5380 - Powered exercise equipment.
§ 890.5410 - Powered finger exerciser.
§ 890.5500 - Infrared lamp.
§ 890.5525 - Iontophoresis device.
§ 890.5575 - Powered external limb overload warning device.
§ 890.5650 - Powered inflatable tube massager.
§ 890.5660 - Therapeutic massager.
§ 890.5700 - Cold pack.
§ 890.5710 - Hot or cold disposable pack.
§ 890.5720 - Water circulating hot or cold pack.
§ 890.5730 - Moist heat pack.
§ 890.5740 - Powered heating pad.
§ 890.5765 - Presssure-applying device.
§ 890.5850 - Powered muscle stimulator.
§ 890.5860 - Ultrasound and muscle stimulator.
§ 890.5880 - Multi-function physical therapy table.
§ 890.5900 - Power traction equipment.
§ 890.5925 - Traction accessory.
§ 890.5940 - Chilling unit.
§ 890.5950 - Powered heating unit.
§ 890.5975 - Therapeutic vibrator.

Justification for the amendments:

The terms diagnosis and prescription are recognized in the scope of practice of the medical professionals that have the formal education and clinical experiences in accredited institutions, and have a State Board approval to have that right. To be prepared adequately to diagnose and prescribe takes physicians at least more than twice the period of education that receive therapists.
Physical and occupational therapists are trained in the application of physical medicine therapeutic devices and/or physical medicine prosthetic devices under a medical prescription. The treatments are given in within a medical context.
In order to prescribe a physical medicine device or prosthetic device the authorized professional should have knowledge of the pathologic and pathophysiologic process to be treated, from the microscopic to the macroscopic to the clinical features. Therapists are not trained in this basic knowledge. Physical medicine devices (like prescription drugs) have effects on human tissues that may improve the function but may cause transient non harmful side effects and permanent harmful side effects that may worsen the original impairment or disability.

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

Thank you,

Edwardo Ramos-Cortes, MD
President
Puertorrican Association of Physical Medicine and Rehabilitation

Submitter : Dr. Roderick Calkins **Date:** 10/12/2007

Organization : Marion County Health Department

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1325-Attach-1.DOC

#1325

Marion County
OREGON

HEALTH DEPARTMENT

12 October 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

Marion County Health Department 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.

Marion County Health Department provides Public Health and Behavioral Health services to Oregon's 5th largest county. Last year services were provided to over 87,000 community members. Over 12,000 individuals were served with mental health services. As a county which also contracts many services through a panel of providers, we have a number of concerns about the proposed regulations.

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

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>

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) - (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,

Roderick P. Calkins, PhD
Administrator

CC: Members of the Oregon State Congressional Caucus
The Honorable Ted Kulongoski, Governor of the state of Oregon

Submitter : Ms. Jean Kedl **Date:** 10/12/2007

Organization : Ms. Jean Kedl

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a parent of a child on the autism spectrum. We have struggled to get our son the help he needs to try to lead a normal life. We have exhausted our own funds. With the help from state funding we were able to get him the habilitation services and he is responding very well. We see improvement every day. We were told a few times that we should quit our jobs and go on welfare. I told them that option was not for my husband and I. We are able to work, and we don't mind paying our taxes. That is all we want our son to be able to do...live a normal life, work, have a family, and pay taxes too. Is that too much to ask? The only way that these children can become viable members of society is to get them the help and support they need while they are children. We have jails full of people; who might not be there if they would have gotten help and support when they were children. We parents of autism spectrum children only want our children to be on the normal spectrum. We can't do it without the habilitation services.

Please don't regulate SCHIP without looking at the impact it would have on these children. We don't need to punish the families or these children...don't you think they have been punished enough? Isn't this the country of opportunity? Well give us the opportunity to let our children lead normal lives!

Submitter :

Date: 10/12/2007

Organization : **County of San Bernardino, Behavioral Health**

Category : **Local Government**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

#1327

RTMENT OF HEALTH AND HUMAN SERVICES
ERS FOR MEDICARE AND MEDICAID SERIVICES
CE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : Ms. Kathleen Whelan-Ulm **Date:** 10/12/2007

Organization : Rushford Center Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2261-P-1328-Attach-1.DOC

#1328

ushford

HARTFORD HEALTHCARE

Administrative Offices
384 Pratt Street
Meriden, CT 06450
Phone: (203) 235-1792
Fax: (203) 634-2799

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

As Vice President of Behavioral Health Services at Rushford Center, I am 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.

Rushford Center is a private, non-profit organization providing community mental health and substance abuse treatment and prevention services in Central Connecticut. We serve more than 6,000 individuals and families each year through a comprehensive system of residential, outpatient, community support and educational services. As the state-designated lead mental health agency for our catchment area, Rushford is responsible for assessing the needs of persons with serious and persistent mental illness, two-thirds of whom are enrolled in Medicaid, and delivering or arranging for the delivery of services that meet those needs. Our organization also provides a range of residential and outpatient services for children and youth with serious emotional disturbance and substance use disorders.

I am writing to express concern with the proposed regulations, as they will create barriers to the recovery process for the children and adults whom our agency serves. My concerns fall in four areas:

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

  This section should make clear that 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.

  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.

Centers for Medicare & Medicaid Services
Reference: File code CMS-2261-P
October 8, 2007

- 440.130(viii)(3) Written Rehabilitation Plan

  Substitute for the requirement that the plan list alternative 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 existing providers).

- 441.45: Rehabilitative Services

  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

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

In closing, to the extent that any of these proposals become final, I urge CMS to 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,

Kathleen Whelan Ulm
Vice President of Behavioral Health Services

Submitter : **Ms. Crystal McMahon** **Date: 10/13/2007**

Organization : **Options for Southern Oregon**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Center for Medicare and Medicaid Services,

As a treatment provider for persons with serious mental illness, I have seen the value of supported employment as a treatment intervention that promotes, encourages and fosters recovery. It also makes sense fiscally to encourage work for people with disabilties. Please take these comments into consideration, as NAMI has endosed the following points.

1. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.
2. 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.
3. We ask that you revise these regulations to make it clear that the federal government encourages any state system to do all they can to provide effective treatments to people with serious mental illnesses.
4. Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.
5. Revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning.

Thank you for your consideraation of this important matter.

Sincerely,
Crystal McMahon
Research Assistant
Options for Southern Oregon