Submitter : **Katherine Smeal** **Date: 10/02/2007**

Organization : **Katherine Smeal**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am the parent of a child with autism. My child needs BHRS services which I cannot afford on my own and private insurance does not cover. This is the only way I can get him the services he needs. Please do not take away this coverage unless you have first made other provisions for helping families afford this.

Submitter : Dewayne Long **Date:** 10/02/2007

Organization : NAMI Southwest Missouri

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

It is our belief that the proposed rule will negatively impact individuals with Mental illness with the potential loss of funding for Assertive Community Treament and rehabilitative services for disabled individuals.

These changes would result in a loss of services that help individuals to maintain some normalcy of routine and structure in their lives.

These provided services are evidence based and are contradictory to the Presidents New Freedom Commission finding which promotes the use of evidence based practices in providing service to our most at-risk citizens.

I would urge that the proposed rule not be adopted until you review the potential losss of funding to states to help pay for these much needed services.

Submitter : **Ms. faith pyne** **Date: 10/02/2007**

Organization : **Road to Responsibility**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#235

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

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

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

Submitter : Mr. **Date:** 10/02/2007

Organization : Mr.

Category : Congressional

Issue Areas/Comments

Background

Background

Dictator Bush at it again in the name of the law

Submitter : Mrs. Natalie Swanson **Date:** 10/02/2007

Organization : Autism Help Network

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-237-Attach-1.DOC

237

Dear Sir or Madam:

I am writing to you in regards to the CMS regulations and the SCHIP bill. As cofounder of the Autism Help Network and a parent of a child with Autism, I can tell you that Wraparound Therapy is one of the few therapies that children with Autism are practically guaranteed to receive currently in PA and other states regardless of the parent's income. If the CMS regulations take that away from children with Mental Retardation or an Autism Spectrum Disorder, that will allow only the parents that can afford to pay for it themselves to receive therapy for their child. In other words, if you are not financially secure then "too bad for your child". On one hand, the government is now allotting monies for research and awareness but on the other hand they are taking away therapies that are currently allowed. I can not imagine that someone high up on the food chain of government politics has stood back and looked at the big picture and thought "OK that's what we will do.....give money for research but take away a key therapy that helps the kids now". I am asking you to please make them stand back and look at what is in the process of being done to these kids. My son has made great strides with his wraparound therapy, and I can tell you now that if the wraparound is taken away, he will regress. My son is in a regression right now simply because of a large change in his routine and therapists. I can only imagine how it will affect him if his wraparound is removed entirely!

We as a country are doing good right now. The CDC is taking Autism more seriously. The government is now seeing the trend and concern of Autism. Do we really have to take 2 strides forward and then 1 large step backwards? All I ask is that the SCHIP bill be passed and allow the current regulations to continue for another year, and in that year, have the government rewrite the regulations to clearly define all regulations of coverage and not leave the current broad statement that would allow all children with mental retardation and Autism to be excluded from the REQUIRED care that they need to simply function.

Sincerely,

Natalie Swanson
President of the Autism Help Network

Submitter : **Mrs. Ruth Cromwell** **Date: 10/02/2007**

Organization : **NAMI**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Background

Background

Re: File Code CMS-22261-P Please follow NAMI recommendations for revision to make it clear that the federal government encourages any state systems to do all they can to provide efective treatments to people with serious mental illnesses. IE: To allow payment for outreach and emergency services; to allow payment for rehabiltative services to prevent deterioration as well as to restore functioning.

GENERAL

GENERAL

My comments are above under: "Provisions of the Proposed Rule".

Thanks for your consideration which I believe is most important for the best service for those with serious mental illness.

Submitter : **Date: 10/02/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-239-Attach-1.DOC

The problem is with the proposed federal definition of "habilitation services" which cannot be covered under the rehabilitation service category of Medical Assistance. Under the proposed federal regs, "Habilitation services include services provided to individuals with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.)

- Does this mean that wraparound services provided to children and adolescents with mental retardation or autism (which is a "related condition") are "habilitation services" and therefore totally excluded from coverage?
- Autism is also considered a mental illness by psychiatrists (in the DSM IV). Does that mean it is "not included in the scope of related conditions so rehabilitation services may be appropriately provided"?
- Does the proposed definition of habilitation mean that the state will have to deny wraparound for children with mental retardation for autism spectrum disorders whose treatment goals are to assist the child in learning new social skills or other positive behaviors the child never had before (which might be excluded as "habilitation services")?
- Will each child's treatment plan or psych eval need to show that the child had "a functional loss and has a specific rehabilitative goal toward regaining that function" (part of the definition of rehabilitation services)?

The proposed regulations fail to answer any of these key questions. Adoption of these proposed regulations would leave PA with the unenviable choice of either keeping wraparound the same and risk losing federal funds if the feds later decide the new regulations limit our wraparound program or restricting wraparound in hopes of avoiding loss of federal funds. We believe it is irresponsible for the federal agency ("CMS") to adopt these proposed regulations as written as they fail to clarify the potential impact on the thousands of Pennsylvanian children with autism spectrum disorders and mental retardation who currently receive wraparound services. We

recommend that CMS withdraw the proposed regulations and republish them again for further comment only after they have clarified how the proposed regulations would impact wraparound services for children and adolescents with autism spectrum disorders and those with mental retardation.

Submitter : Mr. Emmett Reeder **Date:** 10/02/2007

Organization : NAMI

Category : Consumer Group

Issue Areas/Comments

Background

Background

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

Please modify the rules as requested by the National Alliance for the Mentally Ill.

GENERAL

GENERAL

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

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

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

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

Recommendation:

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

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

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

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

Recommendation:

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

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

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

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

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

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

Submitter : Ms. denise Gundel **Date:** 10/02/2007

Organization : n/a

Category : Congressional

Issue Areas/Comments

Background

Background

Please allow parents of mentally disabled children to have a free access to take care of the persons affairs in the event they cannot and that could very well be most of the time.

((((Guardianship Rights needed))))

There is a cost of $3,000.00 to $5,000.00 to get guardianship rights now, and I cannot afford it.

Please help. Denise Gundel

631 W. Patterson St.
Lakeland, Fl. 33803

863 868-5173

Collections of Information Requirements

Collections of Information Requirements

Mental Illness is widespread in POLK county florida. We need help.

Since 1995 this has not been addressed properly, by congress or states who are causing students and family's to suffer severe emotional, financial, and economical drain.

These families have no way out of the horror they are experiencing, even the counseling limitations for family counseling are too strict.

GENERAL

GENERAL

Wake up and help us, unless you have been here you will never know what it is really like to deal with mental illness. Some of this if you trace it back leads to Vietnam and the war we had with them.

The government needs to take ownership of this growing problem and stop allowing it to continue on. We need assistance in the mental illness remedy's.

Talk about what you can do for us, just like your ad- from the war campaigns previously...

'Ask not what you can do for your country...but ask what can your country do for you. ' (unknown presidental speech)

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please give free counseling to family members of a mentally ill person, and guardenship to a responsible parent.

Thank you.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Look at my sons medical records.

Regulatory Impact Analysis

Regulatory Impact Analysis

No comment.

Response to Comments

Response to Comments

Read the statistics for this county yourself.

Submitter : **Ms. Vinnie Allbritton** **Date: 10/02/2007**

Organization : **Intermountain Centers for Human Development**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:

The purpose of this letter is to express concerns related to the proposed rule changes (CMS-2261-P) by the Centers for Medicare and Medicaid Services (CMS) as it relates to therapeutic foster care.

The proposed changes by CMS are a threat to the well being of seriously emotionally and behaviorally disturbed children and adolescents who have benefited from the service of therapeutic foster care. Therapeutic foster care provides an intensive level of service that provides an environment which allows for individuals to learn new ways to manage their emotional and behavioral challenges in the context of a family environment. This environment also teaches the skills necessary to become productive members of society. The act of prohibiting the use of Medicaid funds to pay for therapeutic foster care will result in the institutionalization of children and adolescents who are currently successful in community based placements, and will create a significant barrier to the process of transitioning children from hospital or acute care facilities, via therapeutic foster care, to community based settings.

We urge you to reconsider the proposed rule changes (CMS-2261-P), as they are a significant threat to the well being of children and youth.

Submitter : **Jay Berlin** **Date: 10/02/2007**

Organization : **Alternative Family Services**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-243-Attach-1.DOC

#243

The Honorable Arnold Schwarzenegger
ATTN: Ana Matasantos
State Capitol
Sacramento, CA 95814
Via Facsimile: 916-445-4633

September 17, 2007

RE: **SB 785 (Steinberg)**
Position: **Support**

Dear Governor Schwarzenegger:

I am the Executive Director of Alternative Family Services, a non-profit, community-based child welfare agency serving California's vulnerable foster youth. Our organization provides care, adoptions, mental health and transitional services to California foster children and youth . I am also an active member of the California Alliance of Child and Family Services, which represents more than 140 nonprofit agencies similar to my own, and they are proud to be the co-sponsor of SB785 (Steinberg). I urge your signature on this measure.

This bill is an important piece of legislation that will improve access to medically necessary, mental heath services for adopted youth and California's most vulnerable youth in foster care. The bill received unanimous, bi-partisan support throughout the legislative process, and the State cost affiliated with implementation of the provisions of this bill would be minimal.

Foster children and children adopted from the foster care system represent two of the most vulnerable populations served by California's public human service systems, and due to their history, which includes abuse, neglect, and trauma, they typically have a more substantial need for mental health services. These youth often have difficulty accessing medically necessary, specialty mental health services due in part to a series of administrative barriers faced by county mental health plans and community-based providers.

Last year, the Zellerbach Family Foundation funded a grant to the California Institute for Mental Health (CIMH) and The Child and Family Policy Institute of California (CFPIC) to lead a project in which they have worked with a large and diverse group of stakeholders to identify these barriers and develop solutions to address the barriers the youth face when trying to access mental health services.

The stakeholders, led by CIMH, CFPIC, and content-expert consultants, are developing all of the products required in the legislation; these include the standardized contract, the standardized documentation forms, inter-county collaboration/communication procedures, as well as foster care giver and social worker informing materials. The Department's workload will be to facilitate the Administration's final review and approval of the materials created by the workgroup, of which they are a current, active member.

This legislation will help children access federally entitled, medically necessary, specialty mental health services. I urge your signature on this important piece of legislation, and direct the Department of Mental Health to actively work with stakeholders to facilitate implementation. If I may provide you with any additional information regarding this measure, please do not hesitate to contact me at (707) 576-7700, ext. 314.

Sincerely,

Jay A. Berlin,
Executive Director

The Honorable Arnold Schwarzenegger
ATTN: Ana Matasantos
State Capitol
Sacramento, CA 95814
Via Facsimile: 916-445-4633

September 17, 2007

RE: **Assembly Bill 1453 (Soto)**
Position: **SUPPORT**

Dear Governor Schwarzenegger:

I am the Executive Director of Alternative Family Services, a non-profit, community-based child welfare agency serving California's vulnerable foster youth. Our organization provides care, adoptions, mental health and transitional services to California foster children and youth . I am also an active member of the California Alliance of Child and Family Services, which represents more than 140 nonprofit agencies similar to my own, and they are proud to be the sponsor of AB 1453 (Soto). I urge your signature on this measure.

In order to achieve better outcomes and reduce lengths of stay in residential programs for foster youth, AB 1453 would transform California's current system of foster care group homes into a new system of Residentially-based service (RBS) programs. The bill would require a workgroup of stakeholders to develop an operational plan for implementing this reform effort, and would allow individual counties and private nonprofit group homes to enter in voluntary agreements to offer alternative program designs and funding models. The new alternative models will be subject to approval by the Department of Social Services (DSS). The bill stipulates that any waivers or alternative funding models approved by DSS would have to be cost-neutral in terms of State General Fund costs.

Much of the workload tasks outlined in this bill will be paid for by a private foundation, Casey Family Programs. Casey has made a multi-year commitment to provide financial support for the RBS reform administrative costs, starting with $500,000 for the remainder of 2007. Casey-funded consultants will provide support to the stakeholder workgroup and additional consultants will work directly with counties to provide training and technical assistance for the development and implementation of the county-provider agreements. Casey will also fund positions to work directly in DSS to provide statewide administrative support. DSS responsibilities authorized by AB 1453 should create only minor costs.

This is a true "public-private partnership" with private nonprofit group homes and a private foundation collaborating with counties and the state on program innovation and financing. There is no better approach to making fundamental reforms in the foster care system with such a minimal impact to DSS workload and ensure cost-neutrality for the state's general fund.

For these reasons, I urge your signature on this important piece of legislation. Please feel free to contact me for any additional information at (707) 576-7700 ext. 314.

Sincerely,

Jay A. Berlin,
Executive Director

Submitter : **Ms. Chris Koyanagi** **Date: 10/02/2007**

Organization : **Bazelon Center for Mental Health Law**

Category : **Individual**

Issue Areas/Comments

Background

Background

HARD COPY HAS BEEN SENT

October, 1, 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 Bazelon Center for Mental Health Law 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.

OVERVIEW (PREAMBLE)

There is an incorrect statement in the preamble with respect to the availability of FFP for a Medicaid-covered service furnished to a child that is included in the child=s special education program under IDEA. Under the statute, Section 1903(c), Medicaid is not prohibited or restricted from paying for services that are included in the child=s individualized education program.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. We applaud CMS for including requirements that are designed to ensure the individual=s participation in this process, but believe the wording could be improved. There is a real difference between an individual providing Ainput@ and an individual having Aactive participation.@ By including both terms in different places, the regulation confuses this issue. Further, by requiring the plan to be developed by the provider significantly diminishes the role of the individual. In mental health service delivery, it is a better and far more common practice to have a service planning team working with the active participation of the individual than to have a single provider develop the plan.

In the preamble, CMS recommends the use of a person-centered planning process. There is, however, no reference to person-centered planning in the regulation itself.

Providers should also be encouraged to be flexible in response to the individual=s needs. Serious mental illness is often a cyclical disorder and, in the course of their recovery, individuals may suddenly deteriorate, requiring a change in services. Service planning and goal setting should anticipate this need and crisis plans need to be developed as part of the rehabilitation plan.

Rehabilitation providers should also be encouraged to inform individuals that they have the right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated. All Medicaid providers are required under federal law to inform individuals about advance directives, although state law governs how those directives are to be developed and implemented.

Recommendation:

Revise the language under paragraph (v) so as to require the plan to be developed by a team that is led by a qualified provider working within the State scope of practice act, with the active participation of the individual (unless it is documented that the individual is unable to actively participate due to their medical condition), the individual=s family (if a minor or as the individual desires), individual=s authorized decision maker and/or of the individual=s choosing and following the guidanee of the individual (or authorized decision-maker), in the development, review and modification of the goals and services.

This change should also be made to section 440.130(d)(3)(ii) and (xiii).

Add language to Section 440.130(d)(1)(v) to the effect that CMS encourages the use of person-centered planning processes.

Encourage providers to take into account the possibility of relapse, and incorporate within individuals rehabilitation plans provisions for how they will respond should crises arise.

When developing a rehabilitatio

Submitter : Ms. Elizabeth Earls **Date:** 10/02/2007

Organization : RICCMHO

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-245-Attach-1.PDF

#245

40 Sharpe Drive
Suite 3
Cranston, RI 02920-4485
Voice 401-228-7990
Fax 401-228-7979
www.riccmho.org

Rhode Island Council of Community Mental Health Organizations, Inc.

October 2, 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 Rhode Island Council of Community Mental Health Organizations 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 Council is a private, not-for-profit, organization, representing ten (10) not-for-profit, behavioral health treatment organizations in Rhode Island. Each organization, in addition to having state licensure, is nationally accredited. They include:

Butler Hospital
The East Bay Center
Fellowship Health Resources
Gateway Healthcare
The Kent Center
NRI Community Services
Newport County Community Mental Health Center
The Providence Center
Riverwood Mental Health Services
South Shore Mental Health Center

Collectively, these organizations serve an estimated 15,000 Rhode Islanders annually through an array of programs that serve all ages, and cover a range of intensity from office-based, outpatient care, to intensive services offered in home and community settings, to inpatient psychiatric treatment. The Council provides education and training to its members, and advocates on their behalf and on behalf of the consumers, whom they serve.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. Rhode Island's mental health treatment system has long endorsed family and consumer participation in treatment planning, and we applaud CMS for including requirements that are designed to ensure the individual's participation in this process, as well.

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

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

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

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that our state leaders and providers will, out of an abundance of caution, 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, and we believe it promotes discriminatory treatment to persons living with psychiatric disorders.

Section 1901 of the statute specifically authorizes funds for "rehabilitation and other services" to help individuals "retain" capability for independence and self-care. This provides authority for

CMS to allow states to furnish services that will maintain an individual's functional level.

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
>
> Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

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

Recommendation:

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

Secondly, revise the definition of when services may be furnished to maintain functioning 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(d)(1)(vii) Definition of medical services

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person's functional capacity - clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change. This definition also includes the word "care" after treatment, but that term is nowhere else defined. Does it mean clinical care? The word rehabilitation should be inserted here to make clear the term "medical services" includes rehabilitation. This is important because the term "medically necessary" is used in this regulation to indicate necessary rehabilitation services.

Recommendation:

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

440.130(d)(1)(viii)(2) Scope of Services

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

Language is included in the preamble to the effect that services are to be provided at the least intrusive level to sustain health. Coupled with states' obligations to furnish care in the least restrictive setting, this wording can encourage providers to focus on delivery of the most effective community services that can improve the individual's functioning within a reasonable time frame and discourage provision of restrictive levels of care that are unacceptable to the individual.

Recommendation:

Insert the word "restorative" after "medical" in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

Insert into this section a requirement that rehabilitation services be delivered in a coordinated manner.

The preamble phrase "services are to be provided at the least intrusive level to sustain health and ensure the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level" should be added to the definition of the scope of services, and additionally, services should also be required to be provided in the most integrated, appropriate setting.

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 administrative burden, especially when services are delivered to a group, and will result in reduced availability of treatment. 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 concerned by the requirement that the plan include information on alternate providers of the same service. In Rhode Island, the number of providers willing to accept Medicaid reimbursement is small, and access is already difficult. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation, adds administrative burden, and could well add a layer of confusion to the treatment planning process. Providers cannot help but question whether or not rules such as these have the desired goal of tripping up clinicians. Will there be penalties if a practitioner, out of ignorance, fails to list all potential alternate providers?

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals, a practice already endorsed and followed by Rhode Island's community mental health organizations; however, requiring the signature of the client or representative in some rare cases may prove to 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 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 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.

440.130(4) Impairments to be addressed

The regulation states that services may address an individual's physical impairments, mental health impairments and/or substance-related disorder treatment needs. In describing this section in the preamble, the agency also states that because rehabilitative services are an optional service for adults, states have the flexibility to determine whether they will be limited to certain services for specific populations.

Limiting services to only one group, based on diagnosis or disability violates Medicaid's requirement that services be furnished in sufficient amount, duration and scope to reasonably achieve their purpose. Excluding coverage of rehabilitative services needed by individuals with mental illnesses would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:

Section 440.130(4) should be changed to delete "/or" after the word "and" in this sentence.

440.130(5) Settings

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

Recommendation:

Add to the list of appropriate settings for rehabilitation services "schools, therapeutic foster care homes, and mobile crisis vehicles."

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 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 his/her family may have specific issues directly stemming from the mental disorder which impact upon the reunification process. Mental health rehabilitation services to address these problems (as distinct from generic reunification services) should be covered.

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

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

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

The regulation makes no acknowledgment that therapeutic foster care is a mental health service, provided through mental health systems to children with serious mental disorders who need to be removed from their home environment for a temporary period and furnished intensive mental health services. This mental health intervention is designed for children both in and outside of

the foster care system; it is not a service exclusively for children in the foster care system.

Recommendation:

Therapeutic foster care should be listed as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

Language should also be included in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care.

441.45(b)(2)

The Omnibus Reconciliation Act of 1989 (OBRA 89) prohibited CMS (the HCFA) from disallowing claims for day habilitation services until such time as a regulation was issued by the Agency that specified the types of habilitation services that would be covered. Therefore, CMS' action to categorically exclude coverage for Habilitation services for persons with mental retardation and related conditions is unprecedented, inconsistent with Congressional intent, and not justified.

It should be noted that the exclusion of habilitation services does and should not equal exclusion from FFP for any rehabilitative services provided to persons with mental retardation or related conditions. Related conditions include such illnesses as cerebral palsy, and epilepsy and it is clear that individuals with these illnesses can gain and lose functionality and would benefit from rehabilitative services. Some individuals with serious mental illnesses may also experience periods of extreme cognitive impairment as a result of their illnesses.

Recommendation:

Clarification should be provided as to the difference between exclusion for habilitation services as opposed to the exclusion from FFP for rehabilitative services provided to persons with mental retardation and related conditions.

441.45(b)(3)

The Preamble includes examples of when recreational or social activities may be covered services due to a focus on skill building or other rehabilitative needs. However, the regulation

does not include any examples or any specific language explaining when these activities are covered services. This is a serious omission, as the regulation alone may be interpreted in the field as denying any recreational or social activities no matter how therapeutic and how focused they are on restoring functioning.

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are covered rehabilitative services. It would be helpful if CMS would clarify this and also explain to providers how they document that a service was personal care skill building, even though the provider may have had to demonstrate (and therefore provide) personal care in the process.

Recommendations:

Language that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation services should be included in the regulation at section 441.45(b)(3).

The regulation should clarify how personal care furnished as an integral part of personal care skills training is covered and how it is to be documented.

Individuals in Secure Custody and Residing in Public Institutions

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

Recommendation:

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

441.45(b)(7) Services for individuals who are not Medicaid eligible

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered. In the preamble (page 45207) there is an explanation of how services that are furnished through contacts with non-eligible individuals, but which are exclusively for the treatment of Medicaid-eligible individuals, are covered. No such explanation, however, is included in this section.

Recommendation

The language in the preamble explaining when services may be furnished through contacts with

relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services should be included in the regulation.

OTHER ISSUES

Payment and Accounting for Services

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

These new shifts in rate setting methodology are not efficient and are moreover extremely detrimental to the provision of evidence-based mental health services which are more and more frequently being offered as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multi-systemic therapy, therapeutic foster care and others. As proposed, these rules would effectively eliminate the ability to provide these highly effective, evidence-based therapies.

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

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

Recommendation:

We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support the best practice and the most successful outcomes for children and adults with mental disorders. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

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

Recommendation:

Section 441.45(a), insert a new paragraph clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

Section 441.45(b)(4), which refers to services having to be targeted under the State's plan, should be amended to reference EPSDT for children.

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

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,

Elizabeth V. Earls
President/CEO
RICCMHO
40 Sharpe Drive, Suite 3
Cranston, RI 02881
(401)228-7990

CC: U.S. Senator Jack Reed
U.S. Senator Sheldon Whitehouse
U.S. Representative Patrick J. Kennedy
U.S. Representative James R. Langevin
RI Governor Donald L. Carcieri
RI Lieutenant Governor Elizabeth Roberts
RI DMHRH Director Ellen Nelson
RI DHS Director Gary Alexander

RI DCYF Director Patricia Martinez
RICCMHO Member Organizations

Submitter : Mr. Matt Madaus **Date:** 10/02/2007

Organization : Victor Community Support Services, Inc.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#246

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

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

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

Submitter : Carla Sanders **Date:** 10/02/2007

Organization : Gryphon House

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

October 1, 2007

To Whom It May Concern:

The purpose of this letter is to express concerns related to the proposed rule changes (CMS-2261-P) by the Centers for Medicare and Medicaid Services (CMS) as it relates to therapeutic foster care.

The proposed changes by CMS are a threat to the well being of seriously emotionally and behaviorally disturbed children and adolescents who have benefited from the service of therapeutic foster care. Therapeutic foster care provides an intensive level of service that provides an environment which allows for individuals to learn new ways to manage their emotional and behavioral challenges in the context of a family environment. This environment also teaches the skills necessary to become productive members of society. The act of prohibiting the use of Medicaid funds to pay for therapeutic foster care will result in the institutionalization of children and adolescents who are currently successful in community based placements, and will create a significant barrier to the process of transitioning children from hospital or acute care facilities, via therapeutic foster care, to community based settings.

We urge you to reconsider the proposed rule changes (CMS-2261-P), as they are a significant threat to the well being of children and youth.

Respectfully,

Carla Sanders
Theraputic Foster Parent

Submitter : Mr. Tom Gordon **Date:** 10/02/2007

Organization : Mr. Tom Gordon

Category : Individual

Issue Areas/Comments

Background

Background

Overall comment on the regulation

Collections of Information Requirements

Collections of Information Requirements

I believe that the regulation change does not go to the core of the issue. For many of these BHRS providers in Philadelphia, they have gone out of their way to keep the behavioral health case open- even when the families actions have demonstrated that they do not want the service continued. They contact the family repeatedly and give chance after chance to come in. This was a problem especially with placcs like CATCH. People make choices and dccisions - behavioral health providers need to accept them. It is unfortunate that in Philadelphia especially, it seems that the children exist for the providers to make money instead of thc provider existing to help the children and their families. Help has its limits and discharge is good.

Submitter : **Ms. Koren Crisovan** **Date: 10/02/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

Background

Background

October 2nd, 2007

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

To Whom It May Concern:

The recent changes in practice by CMS and the associated proposed rule changes published on August 13th, 2007 are having a negative effect in the services provided to people with long term and/or permanent mental health issues such as myself and over 100 other people associated with the Sunshine Clubhouse, an accredited member organization affiliated with the International Center of Clubhouse Development (ICCD), in South Bend, IN alone; let alone the whole state or the nation.
The idea in many instances of state and local programs to emphasis returning to previous levels of functioning is naive at best and ruinous at worst. In my case, as well as many others, there is no previous level of functioning anybody would in their right mind want me. I have been struggling with being bipolar all of my life, and have been in and out of mental hospitals for the past 15 years. Currently, I am at one of the most stable periods in my life. And, along with therapy and medication, it is largely due to the Sunshine Clubhouse. Without a program such as this to provide a stable environment for socialization, advocacy, and support, I would probably be spiraling in a destructive state of isolation and depression that could culminate in yet another attempted suicide. And, believe me, I am far from being an isolated case.
Funding for programs such as this is being severely threatened by the federal, state, and local agencies looking to reduce costs by reorganizing the rules and regulations for them. This must not be allowed to continue. I urge you to reconsider these changes, and to provide even more resources to such rehabilitation type services and support programs.

Sincerely,
Koren R. Crisovan

Submitter : Dr. Randy Cima **Date:** 10/02/2007

Organization : LodgeMakers of California

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#250

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

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

Submitter : Mr. Matt Madaus **Date:** 10/02/2007

Organization : Victor Community Support Services, Inc.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-251-Attach-1.PDF

#251

Date October 2nd, 2007

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

To Whom It May Concern:

I am the Executive Director of Victor Community Support Services, Inc. a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization delivers community-based mental health and family support services to children and their families struggling with a wide range of behavioral and emotional problems.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

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

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

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

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

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

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

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

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

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

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

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

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (530) 671-3427
Sincerely,

Matt Madaus
Executive Director

Submitter : Mr. David Repath **Date:** 10/02/2007

Organization : Mr. David Repath

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-252-Attach-1.DOC

#252

October 2, 2007

To Whom It May Concern:

The purpose of this letter is to express concerns related to the proposed rule changes (CMS-2261-P) by the Centers for Medicare and Medicaid Services (CMS) as it relates to therapeutic foster care.

The proposed changes by CMS are a threat to the well being of seriously emotionally and behaviorally disturbed children and adolescents who have benefited from the service of therapeutic foster care. Therapeutic foster care provides an intensive level of service that provides an environment which allows for individuals to learn new ways to manage their emotional and behavioral challenges in the context of a family environment. This environment also teaches the skills necessary to become productive members of society. The act of prohibiting the use of Medicaid funds to pay for therapeutic foster care will result in the institutionalization of children and adolescents who are currently successful in community based placements, and will create a significant barrier to the process of transitioning children from hospital or acute care facilities, via therapeutic foster care, to community based settings.

We urge you to reconsider the proposed rule changes (CMS-2261-P), as they are a significant threat to the well being of children and youth.

Respectfully,

David Repath

Submitter : **Ms. Syrondia Garner** **Date: 10/02/2007**

Organization : **Hinds Behavioral Health Services**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-253-Attach-1.DOC

#253

October 4, 2007

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

To Whom It May Concern:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

Some of the proposed rule changes simply reduce this population's access to needed services - without any back up plan to fund services or programs. Many of these services have been working effectively with CMS approved Medicaid funding for more than ten years, However, with the recent changes in CMS practice, they now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need. The net result is that vast numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.

To create, or suddenly start enforcing, bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial cut in services for people who already have more than their fair share of burdens. A reduction or elimination of services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse in our prison system.

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of functioning.' Because recovery from mental illness is often a long term process, this definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse

Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

Therefore it is my opinion that none of the proposed rule changes should be implemented until each state (or the federal government) has a plan actively in place to provide the necessary recovery focused services that would no longer be "covered" by Medicaid. The plan must not exclude people with mental illness from psychosocial services needed to maintain their recovery progress, such as ICCD Certified Clubhouses.

It is a mistake to re-organize funding for long approved services in an effort to reduce short term spending. A poorly developed strategy will result in unnecessary - and more costly emergency spending and over-reliance on emergency services.

Most importantly, these changes will have a tragic impact on the lives and futures of millions of people struggling to recover from the long term effects of serious mental illness. In the interest of short term spending cuts, these changes will quickly erode the essential support networks that have allowed Americans with serious mental illness to begin the long and difficult process of rebuilding their lives. In my opinion, that would be an unconscionable mistake.

Sincerely,

Syrondia Garner
Day Treatment Specialist II
Hinds Behavioral Health Services
3450 Highway 80 West
Jackson, MS 39209
601-969-7505

Submitter : **Dr. Corrine Donley** **Date: 10/02/2007**

Organization : **Association for Behavior Analysis International**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Services not covered for HABILITATION, only for REHABILITATION!

Collections of Information Requirements

Collections of Information Requirements

As a behavior analyst who treats children and adults with autism, I am concerned that individuals who may speak in the future, will never be able to, because they can not receive "rehabilitation" for language under this new law.

GENERAL

GENERAL

I contend that there are numerous medical conditions and mental health issues that are rehabilitative, whether or not the condition was present before the therapy was begun or not. For instance, most often speech and language are dormant in persons with elective mutism or autism before the treatment is begun. In other words, the person may NEVER have spoken before, but with therapy will speak. There is an abundance of excellent studies in Applied Behavior Analysis that demonstrate this case. Therefore, I request that you delete any notion of contrast between habilitation and rehabilitation in this bill, especially as it relates to speech therapy! In addition, there may be other therapies with which I am unfamiliar that pose the same scenario!

Submitter : Tasneem Patni **Date:** 10/02/2007

Organization : NAMI Washtenaw County

Category : State Government

Issue Areas/Comments

Background

Background

Please continue to provide medicaid rehabilitation services to current and prospective recipients of medicaid/medicare. Do not cease these services. A cessation will cause great financial and emotional hardships to those who are in current receipt as well as those who qualify for medicare/medicaid.

Sincerely,
Tasneem Patni
(734)673-0640

Submitter : Mr. William Martone **Date:** 10/02/2007

Organization : Hathaway-Sycamores Child and Family Services

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-256-Attach-1.PDF

#256

October 2, 2007

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

To Whom It May Concern:

I am the President/CEO of Hathaway-Sycamores Child and Family Services, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides an array of services including mental health, child welfare, education, and housing, for children and youth and their families.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

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

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

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

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

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

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

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

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

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

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

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

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at 626-395-7100.

Sincerely,

William P. Martone

William P. Martone
President/CEO

Submitter : **Josh Leonard** **Date: 10/02/2007**

Organization : **Bay Area Youth Centers**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-257-Attach-1.DOC

#257

October 2, 2007

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

To Whom It May Concern:

I am the Executive Director of Bay Area Youth Centers a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides housing, case management and mental health services to current and former foster youth, aged 15-21.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

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

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

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

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

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

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

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

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

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

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

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

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (510) 727-9401.

Sincerely,

Josh Leonard
Executive Director

Submitter : Mr. Charles Rich **Date:** 10/02/2007

Organization : David & Margaret Youth and Family Services

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-258-Attach-1.PDF

#258

David & Margaret
Youth and Family Services
1350 Third Street, La Verne, CA 91750 • (909) 596-5921 • Fax: (909) 596-7583 • www.dmhome.org

October 2, 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:

I am the Executive Director of David & Margaret Youth and Family Services, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides a range of both residential and community-based intervention programs for foster and at-risk children, youth and families.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

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

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

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

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by

qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

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

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

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

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

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

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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

agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (909) 596-5921, ext. 3140.

Sincerely,

Charles C. Rich, LCSW
Executive Director

Submitter : Mrs. Marilyn Owen **Date:** 10/02/2007

Organization : Hathaway-Sycamores Child and Family Services

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-259-Attach-1.DOC

CMS-2261-P-259-Attach-2.DOC

#259

Date

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

To Whom It May Concern:

I am a licensed Marriage and Family Therapist working for Hathaway-Sycamores Child and Family Services, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides a wide range of mental health services to children and families, including residential, intensive-community based (Therapeutic Behavioral Services, Wraparound, in home family therapy) , and outpatient services. We have been operating in the LA County area for over 100 years.

Below, you will find comments submitted by Hathaway-Sycamores on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries. I would like to go on record as being in complete agreement and support of these comments and suggestions.

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their

functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

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

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

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

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered

individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.

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

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

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

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

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

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at 626-395-7100 ext. 5334.

Sincerely,

Marilyn J. Owen, MFT
Clinician, Therapeutic Behavioral Services
Hathaway-Sycamores Child and Family Services

Submitter : Mr. Bradley Loveland **Date:** 10/02/2007

Organization : Breakthrough

Category : Other Association

Issue Areas/Comments

Background

Background

The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. I am concerned that the proposed rules may have a negative impact on the ability of states to pay for these services.

Collections of Information Requirements

Collections of Information Requirements

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GENERAL

GENERAL

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Provisions of the Proposed Rule

Provisions of the Proposed Rule

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Regulatory Impact Analysis

Regulatory Impact Analysis

The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. I am concerned that the proposed rules may have a negative impact on the ability of states to pay for these services.

Response to Comments

Response to Comments

The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systcmic therapy for children and adolescents (MST), and other important evidence-based services. I am concerned that the proposed rules may have a negative impact on the ability of states to pay for these services.

Submitter : Ms. Carolyn Davis **Date:** 10/02/2007

Organization : NAMI of Prince George's

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

The Centers for Medicare and Medicaid Services have issued proposed rules on the Medicaid Rehabilitation Services option. The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services.

GENERAL

GENERAL

NAMI is concerned that the proposed rules may have a negative impact on the ability of states to pay for these services.

Submitter : **Date: 10/02/2007**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-262-Attach-1.DOC

#262

EMQ *Children & Family Services®*

October 2, 2007

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

To Whom It May Concern:

I work with EMQ Children and Family Services, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides a broad range of individual and family based mental health services throughout the community based and residential services continuum.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as

maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

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

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

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

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

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

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

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

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

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

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define

therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at 408-379-3790.

Sincerely,

Susan Denison
Fund Development Department
EMQ Children and Family Services
251 Llewellyn Ave.
Campbell, CA 95008
(408) 379-3790
www.emq.org

Submitter : **Dr. Michi Fu** **Date: 10/02/2007**

Organization : **Pacific Clinics**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-263-Attach-1.DOC

CMS-2261-P-263-Attach-2.DOC

#263

October 5, 2007

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

Reference: File code CMS-2261-P

I write to comment on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

My professional background includes 1 year in my current position as API Child Collaborative Coordinator at Pacific Clinics in Los Angeles, California, a nonprofit behavioral healthcare agency providing services to clients/members in five counties in Southern California. My current responsibilities include program development, supervision/consultation, crisis intervention, and other administrative functions. My total experience of 5 years also includes clinical and administrative positions such as Staff Counselor, Staff Psychologist and Team Supervisor a University of Hawaii, Kapiolani Women and Children's Hospital, and Asian Pacific Family Center respectively.

My comments concern the definition of restorative/rehabilitative services and proposed rule changes regarding written rehabilitation plans. My colleagues and I will appreciate your careful review and consideration of these remarks.

The behavioral health community has, during the last several decades, focused on providing services to persons in the least restrictive treatment alternative. The result of innovative, research-based service programs has been the reduction of populations in jails and institutes for mental disease, which were often the last refuges of those with serious mental illness. Most people with mental illness were thereby enabled to live productive lives in their communities, while receiving outpatient treatment. Surveys of the results of this approach have shown, repeatedly, that treatment of mentally ill clients in the community, outside of jails or hospitals, improves quality of life for these individuals and provides a substantial saving to taxpayers.

My colleagues and I believe that the new CMS regulations to change the rehabilitation option will threaten these principles by raising concerns about so-called "maintenance" treatment. Since one of the premiere responsibilities of mental healthcare administrators is designing and implementing low-cost solutions that benefit all in the community, we feel strongly that proposed rule changes should not include any suggestion that medication and other services should be denied to a person with mental illness because of lack of Medicaid coverage.

We feel that the proposed rule change should stress that an important goal for the mentally ill is the acquisition of all basic, age-appropriate functions necessary for living successfully in the

community. Activities related to such acquisition, and medications and other treatment options required for this to occur, should be covered by Medicaid. This is a relatively small expenditure, given what can be extraordinary benefits for each client, as well as the long-term savings afforded to the community when its residents with mental illness are able to work and live there outside of government-operated facilities.

We are also concerned about rule changes in the area of written rehabilitation plans. The proposed rule change, as our agency reads it, requires monthly progress notes by the agency's practitioners. We foresee a substantial increase in administrative tasks for our staff if such a requirement is implemented. Many of our staff members have large caseloads, and Pacific Clinics operates several programs for large groups. A required monthly progress note for each client will consume staff time which can be more cost-efficiently devoted to treatment. A required period of 90 days, rather than 30 days, will provide the detailed documentation that CMS requires, while not overburdening staff members with duties unrelated to treatment of mental illness.

We must also express concern over the recovery orientation and strengths-based model that has been recommended by the President's New Freedom Commission on Mental Health, by SAMHSA, by the Institute of Medicine, and by others as a best practice for treatment of persons with mental health and substance abuse issues. A strengths-based rehabilitation option is one that empowers consumers and family members to develop coping mechanisms and develop techniques that allow effective function maintenance entirely in a community setting. The recovery orientation for persons with mental illness is different from the recovery orientation for persons with a physical disability, i.e., stroke, amputation, etc. The proposed rule change seems to be written designed for persons with physical disabilities. We feel that the needs of those with serious and persistent mental illness should be more adequately represented.

Thank you very much for this opportunity to comment on CMS's proposed rule changes. I am confident that through its close work and cooperation with the mental healthcare community, CMS will continue to see mental health services that are truly effective and fair to all.

Sincerely,
Michi Fu, Ph.D.
API Child Collaborative Coordinator, Pacific Clinics

Submitter : **Dr. John Tanner** **Date: 10/02/2007**

Organization : **Dr. John Tanner**

Category : **Individual**

Issue Areas/Comments

Background

Background

I am particularly concerned that the proposed rule allows billing only for restoration of function, and not also for maintenance of function. Response to treatment for mental illness is not a matter of steady improvement, but rather has relapses and periods when no progress seems to be made. A person needs assistance through these periods as well as when he seems to be making progress. He shouldn't be allowed to go back down hill during these times because of lack of support.

Submitter : Mr. Robert Wirtz **Date:** 10/02/2007

Organization : Mr. Robert Wirtz

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am the parent of an individual who suffers from a mental illness. My son receives some necessary services from an ACT service. Without those services my son will become unstable, and may no longer be able to live outside of a hospital.

Re: Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan
Please clarify the provisions in the regulation to allow payment for outreach and emergency services.

Re: Section 440.130(d)(1) Rehabilitation and Restorative Services
Please revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning.

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

Re: Section 441.45(b) Exclusions for therapeutic foster care and classroom aides
Please amend the proposed rule to allow therapeutic foster care and let states combine the services in one rate if that works best for them. The federal government can meet its goals by making sure that the rate only includes rehabilitative services.

Re: Section 441.45(b)(2) Exclusion for Mental Retardation and other conditions and Habilitation Services
Please amend the proposed rules so that they do not exclude people with mental retardation and related conditions from habilitation services.

Submitter : Mr. Steven Kossor **Date:** 10/02/2007

Organization : The Institute for Behavior Change

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

If I understand the proposed rule-making correctly, a child with a diagnosis of Autism would still be eligible for payment of treatment services under Medicaid's revised Rehabilitation Option if the treatment services were intended to rehabilitatate the child's lost skills (in communication, socialization, etc) provided that the child had developed age-appropriate skills in those areas at some point in the past. In other words, the exclusion of children with a particular diagnostic label (e.g., 'Autism') would not occur. They would not be made ineligible for treatment under the revised Rehabilitation Option as a population based on diagnosis, but the revised rules would restrict the kinds of services that could be funded -- to only those that provide REhabilitation of lost skills, rather than HAbilitation (the creation of 'new' skills that did not formerly exist). Is that correct?

Submitter : Mr. Steven Kossor **Date:** 10/02/2007

Organization : The Institute for Behavior Change

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

If a child has a mental illness diagnosed on Axis I of the DSM-IV system (e.g., "Autism"), would that exempt the child from the revisions to the Rehabilitation Option? Do the changes to the Rehabilitation Option refer to the kinds of services that will be funded (REhabilitation) and not funded (HAbilitation), so that regardless of the child's diagnosis, the determination of what will be funded via Medicaid under the Rehabilitation Option is based on the nature of the treatment, and not based on the child's diagnosis?
Doesn't EPSDT prohibit denial of treatment based solely on diagnosis?
Isn't the Rehabilitation Option part of the EPSDT program?

GENERAL

GENERAL

The EPSDT section of the Medicaid statute indicates that services that are determined to be "medically necessary" (e.g., prescribed by a state-licensed practitioner of the healing arts for the amelioration of a condition identified during the screening process) must be delivered regardless of whether or not the services are part of any "state plan." Is the Rehabilitation Option covered by this clause, or does it exist separately from the EPSDT regulations?

Submitter : **Date: 10/03/2007**

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#268

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

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

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