**Submitter :** Ms. Mary Anderson **Date:** 10/04/2007

**Organization :** Cambridge Elementary School

**Category :** Academic

**Issue Areas/Comments**

**GENERAL**

GENERAL

Loss of Mediciad revenue to schools will directly and severely impact existing preventative programming for our youngest students. At our preK-6 elementary school, we utilize Medicaid funding generated by our special education students to contract with a licensed school social worker who provides a variety of important services to our students and families. As a society, should we pay now or pay later when some of these students are involved withthe corrections system? I choose to pay now knowing that these services will ultimaltely help keep some of our students from failing socially, emotionally, and academically. Let's invest early! Haven't we learned this lesson already time and time again?

CMS-2261-P-354

**Submitter :** Mr. Paul Lindeman **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

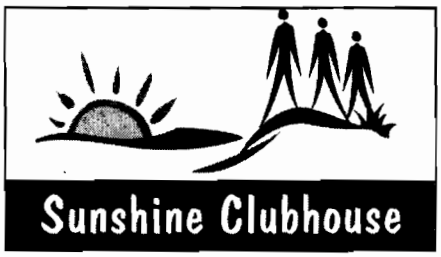
**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-354-Attach-1.DOC

#354




October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com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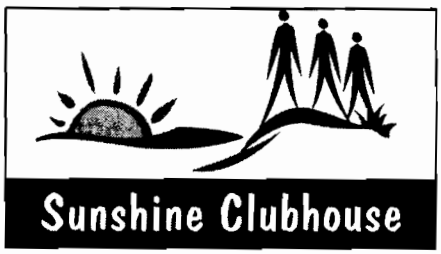
Sincerely,

Paul Lindeman
3017 Northside Blvd.
South Bend, Indiana 46615

#355

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Sincerely,

Karen Ware
1031 Patty Lane
South Bend, Indiana 46615

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.

For instance, providing adequate mental health services for individuals with psychiatric disorders in the prison system costs approximately $50,000 per person per year. As an agency, Pacific Clinics has 4 ACT Program sites that serve 335 members with an annual budget of about $4.5 million. This averages to just over $13,430 per member per year for services that include medication & medication support, psychotherapy, case management, rehabilitation/skill development, vocational counseling, substance abuse counseling, self help programs and a Wellness Center (Clubhouse).

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. Medicaid should cover medications and other treatment options required for this to occur. 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,

James Wainwright, MFT
Program Director
Pacific Clinics
El Monte ACT/ Wellness Center

**Submitter :** Ms. Bridget Bennet-Lewis **Date:** 10/04/2007

**Organization :** Children's Services Committee of RICCMHO

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2261-P-357-Attach-1.PDF

coordinated services that are individualized for each client. These models have been proven to be most effective for people with trauma histories who have lost function in a number of areas. Funding each service separately (unbundling) destroys the coordination of integrated services and undermines their effectiveness.

Lastly, we would be remiss if we did not applaud the rules on several points.

- First, we are heartened to see the Federal government's willingness to allow States to develop their own plans with regard to the licensing and credentialing of workforce.
- Second, we appreciate the acknowledgment of the importance of the family in treatment and the acknowledgement of the validity of family treatment.
- And third, it is heartening to see that the Federal government recognizes that for individuals suffering from mental illness, what may appear to be a social activity, may in fact be an intervention addressing the rehabilitation goal of social skill development which is identified in the rehabilitation plan.

This attention to the special needs of individuals with behavioral health issues is appreciated.

Thank you for providing the opportunity to offer comment.

Sincerely,

**The Children's Services Committee of the RI Council of Community Mental Health Organizations**

Bridget Bennett-Lewis, LICSW,
Vice President
Child & Family Services
NRI Community Services

Susan E. Stevenson, Director
ASD Connections
Gateway Healthcare

Katherine Powell, LICSW
Vice President
Children's Services
Gateway Healthcare

Jim Szabo, LICSW, Director
Children's Intensive Services &
Family Outpatient Services
Gateway Healthcare

Judith Strickland, LMFT
Clinical Manager
Child, Adolescent & Family Services
South Shore Mental Health Center

Gary P. Cournoyer, MSW, LICSW
Adminstrator, Children's Intensive Services
Newport County Community Mental Health Center

Christopher M. Reidy, MSW, LICSW
Administrator
Child & Adolescent Treatment Services
Newport County CMHC

James S. Pinel, LCMHC
Director of Children's Services
The East Bay Center

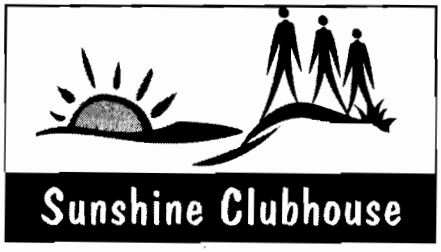
Alan S. Jacobson, Psy.D.
Licensed Psychologist
Director of Child & Family Programs
The Providence Center

David C. Savitsky, M.D.
Child & Adolescent Psychiatrist
Associate Medical Director
Gateway Healthcare

Barbara Lamoureux, MSW
Youth & Family Services
The Kent Center

Louise LaMountain, M. Ed., Director
Local Coordinating Council (CASSP)
NRI Community Services

#358




October 3, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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Sincerely,

Bernie Dolezal
437 North Niles Avenue
Apartment 122
South Bend, Indiana 46617

**Submitter :** Mrs. Linda Kemp **Date:** 10/04/2007

**Organization :** First Step, Inc.

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Arkansas has habilitation program under the clinic services or rehabilitative services benefits. The proposed change to waiver services will not be cost producctive for anyone. The habilitation program in place now has caps and parameters that contain costs and limit billing procedures. Waiver services costs run much higher for individuals.
Please allow persons with mental retardation/develomental delays to continue to attend Developmental Day Treatment Clinic Services for habilitation in order to get more service for dollar spent.
Thank you for your consideration.

#360


# Intermountain Centers for Human Development

## Intermountain Youth Centers

P.O. Box 1089 • SANTA FE, NEW MEXICO 87504-1089 • (505) 986-8481 • IYC-SF@ICHD.NET




October 4, 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,

Robin Edwards

Robin Edwards
Operations Manager


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Sincerely,

Mark Gosser
437 North Niles Avenue
Apartment 109
South Bend, Indiana 46617

#363

Sunshine Clubhouse

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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Sincerely,

Leonard Palmer
1301 Jackson
South Bend, Indiana 46614

**Submitter :** Ms. Heather McCall **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attached"

CMS-2261-P-364-Attach-1.DOC

#364


October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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Sincerely,

Heather McCall
15639 Hamilton St.
Granger, Indiana 46530

**Submitter :** Mr. Kevin Toth **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attached"

CMS-2261-P-365-Attach-1.DOC

#365


October 10, 2007

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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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com


Our example of the inappropriateness of theses 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 an supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective will and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such a 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 Clubhouse more than 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 governmental) has a plan in place to provide the necessary recovery focused services that would 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 Clubhouse.

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 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,

Kevin Toth
801 Riverside Court
South Bend, Indiana 46616

**Submitter :** Ms. Karen Scott **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-366-Attach-1.DOC

#366

Sunshine Clubhouse

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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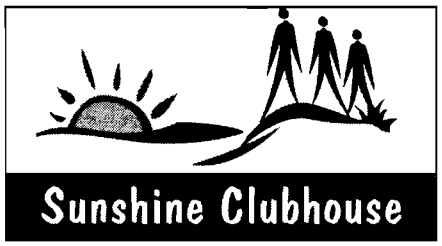


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Sincerely,

Karen Scott
801 Riverside Court
South Bend, Indiana 46616

**Submitter :** Ms. Margaret Ripple **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

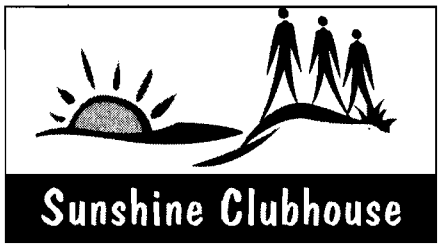
**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-367-Attach-1.DOC

#367




October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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Sincerely,

Margaret Ripple
3001 Hope Avenue
South Bend, Indiana 46615

**Submitter :** Mr. William McCormick **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-368-Attach-1.DOC

#368


October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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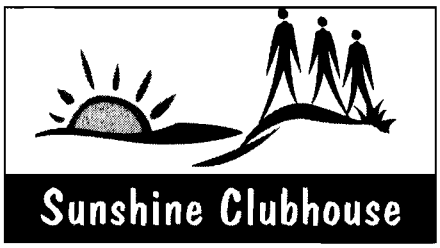


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Sincerely,

William McCormick
809 S. Walnut
South Bend, Indiana 46619

**Submitter :** **Ms. Pamela Bland** **Date: 10/04/2007**

**Organization :** **Ms. Pamela Bland**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

B. Habilitation.
The proposed rule does not satisfy the condition of issuance of a regulation that "specifies types of day habilitation that a state may cover." To eliminate day habilitation is not to satisfy this prohibition. Day Habilitation is an extremely effective necessary medically service for children with disabilities in Arkansas. The proposed rule states that CMS will work with states with this option to convert services to a waivered service.
All home and community waiver services are unavailable for children and adults with developmental disabilities. Until CMS no longer reimburses the six institutions in Arkansas that provide day habilitation during the day no matter what they call, then day habilitation would only be less costly if compared to their reimbursement. Day Habilitation in Arkansas is for a maximum of 5 hours, based on individual need and all services are coordinated with other agencies.

When a child is born with a developmental delay, disability or acquires a disability during childhood it is a medical emergency to intervene.

Please consider the adverse cost to place children and adults in an institution just so they can receive their specialized day habilitation.

Sincerely submitted,

Pam Bland

**Submitter :** **Ms. Christine Stoner-Mertz** **Date: 10/04/2007**

**Organization :** **Lincoln Child Center**

**Category :** **Other Health Care Provider**

**Issue Areas/Comments**

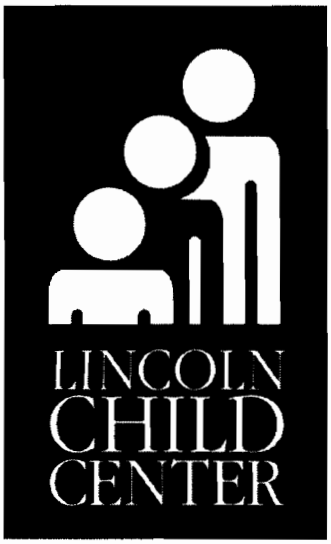
**GENERAL**

GENERAL

See Attachment

CMS-2261-P-370-Attach-1.DOC

#370




October 4th, 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 President/CEO of Lincoln Child Center a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides residential, mental health and educational services to severely emotionally disturbed children in the San Francisco Bay area.

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



4368 Lincoln Avenue
Oakland, CA 94602
Tel: 510-531-3111
Fax: 510-531-8968
www.lincolncc.org

## 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 510-485-7100.

Sincerely,

Christine Stoner-Mertz, LCSW
President/CEO

**Submitter :** Mr. Korelli Morris **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-371-Attach-1.DOC

#371


October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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.

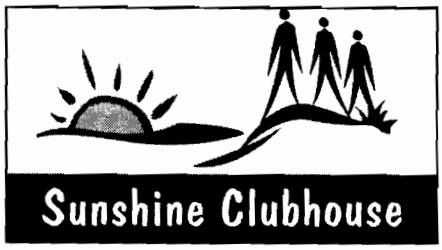
The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice 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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com




Our example of the inappropriateness of theses 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 an supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective will and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such a 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 Clubhouse more than 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 governmental) has a plan in place to provide the necessary recovery focused services that would 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 Clubhouse.

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 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,

Korelli Morris
1922 South Warren Street
South Bend, Indiana 46613

**Submitter :** Mr. Daniel Johansson **Date:** 10/04/2007

**Organization :** Ass'n for Rehabilitative Case Mgt. and Housing

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-372-Attach-1.PDF

CMS-2261-P-372-Attach-2.PDF

The Association for Rehabilitative
ACMH
Case Management & Housing



October 4, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Association for Rehabilitative Case Management and Housing, Inc. (ACMH) 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.

Please note ACMH's recommendations and comments as they pertain to the proposed rule.

Comments re:
PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130: Diagnostic, screening, preventive and rehabilitative services

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

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

584 Broadway • Suite 806 • New York, NY 10012
212-274-8558 • 212-925-7958 (Fax) • www.acmhnyc.org

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

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

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

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

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

The proposed regulations state that "services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan." While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. We are concerned that states and providers will interpret the current proposed regulations as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level. Failure to

provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services.

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

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

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

Recommendation:
We urge CMS to indicate in the final rule that a child does not have to demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually have performed the activity in the past. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR 438.210(a)(4)(ii)(B)). An example of the above point may be a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for every encounter will become a major burden, especially when services are delivered to a group.) We would recommend that progress notes be required at least monthly, leaving it to states to require, or providers to make, more frequent notes in cases where that may be appropriate. The guiding factor should be that the service record include information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

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

The proposed regulations recommend the use of "person-centered planning", which requires the active participation of the individual, involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative can be problematic. There may be instances in which a person, because of the symptoms of their illness, may not believe they are sick or comply with the treatment plan. There is also no guarantee that the individual will appoint a representative, or that the consumer when in crisis could identify this person.

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

- that the plan be written plainly in multiple languages so that it is understandable to all individuals;
- that the plan indicate the individual's level of participation, as well as his or her concurrence with the plan;
- that the plan allow for a qualified provider to sign the treatment plan when the client or their representative is unable to do so or has no family or designated representative;
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that the plan include, if necessary, provisions for crisis intervention;
- that the plan include individualized anticipated review dates that correspond with the anticipated achievement of long-range and intermediate rehabilitation goals;

- provide certification that the individual has been informed about their rights regarding advance directives;

- that the plan allow providers to provide information on potential alternate providers of the same service instead of listing all of the alternative providers in the treatment plan.

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

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

**440.130(4) Impairments to be addressed**
**The final rule should state that all individuals are eligible for coverage of rehabilitation services.**

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

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

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

**440.130(5) Settings**
**The final rule should include a more extensive list of settings where rehabilitative services can be provided.**

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

**Section 441.45: Rehabilitative Services**

**441.45(a)(2)**
**The final rule should clarify the definition of a rehabilitative service.**

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level, as defined in the law.

Recommendation:
We urge CMS to insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning (see previous comments). We also urge CMS to include the language in the preamble (page 45204) regarding how to determine whether a particular service is a rehabilitation service, based on its purpose.

**441.45(b) Non-covered services**
**The final rule should not deny Medicaid coverage for services provided to Medicaid-covered individuals if such services are furnished through another program.**

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

how to determine whether a service is an "intrinsic element" of another program or how it would be applied.

Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r)). The result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other programs due to lack of resources (i.e. therapeutic foster care, foster care or child care institutions for a foster child). What is the legal basis for denying federal financial participation (FFP) for the Medicaid-covered individual? Thus, the rule effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

Recommendation:
We strongly urge CMS to remove this entire section, because it conflicts with Medicaid statute. Alternatively, the section should be clarified and narrowed so as to specifically focus on situations where an entity (e.g. an insurer) has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded from this provision.

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

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

**441.45(b)(1)(i) Therapeutic foster care**
**The final rule should list therapeutic foster care as a covered rehabilitation service for children with serious mental disorders.**

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved

Thank you for the opportunity to submit comments on the provisions of the proposed rule for the Coverage for Rehabilitative Services.

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

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

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

Sincerely,

Daniel K. Johansson
Executive Vice President/CEO

**Submitter :** Dr. B. Joseph Ho **Date:** 10/04/2007

**Organization :** Pacific Clinics

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

CMS-2261-P-373-Attach-1.DOC

#373

Pacific Clinics
ADVANCING BEHAVIORAL HEALTHCARE

October 4, 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 ten years in my current position as Divisional Director, Family Specialty Services Division 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 contract management, program administration and development, strategic planning, interagency liaison, community relations, quality improvement and assurance, staff recruitment, and clinical supervision. My total experience of 18 years also includes being a provider of clinical psychological services for public insurance (such as MediCal, MediCare), and private insurance companies and HMO's (such as U.S. BehavioralHealth, PacificCare).

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,

B. Joseph Ho, Ph.D., MBA
Divisional Director, Family Specialty Services Division
Pacific Clinics
2550 E. Foothill Blvd.
Pasadena, CA 91107
(626) 744-5230
jho@pacificclinics.org

**Submitter :** Mr. Robert Gamble **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-374-Attach-1.DOC

#374


October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

To Whom It May Concern:

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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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com


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Therefore it is my opinion that none of the proposed rule changes should be implemented until each state (or the federal governmental) has a plan in place to provide the necessary recovery focused services that would 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 Clubhouse.

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 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,

Robert Gamble
629 South Carroll
Apartment 28
South Bend, Indiana 46601

**Submitter :** Dr. Amanda Bolbecker **Date:** 10/04/2007

**Organization :** Mental Health America of Indiana

**Category :** Consumer Group

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#375



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 :** **Mrs. Kathy Fager** **Date: 10/04/2007**

**Organization :** **Sunshine Clubhouse**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

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"See Attached"

CMS-2261-P-376-Attach-1.DOC

#376


October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
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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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

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Our example of the inappropriateness of theses 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 an supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective will and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such a 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 Clubhouse more than 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 governmental) has a plan in place to provide the necessary recovery focused services that would 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 Clubhouse.

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 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,

Kathy Fager
803 North Main Street
Mishawaka, Indiana 46545

**Submitter :** Mr. Joseh Dziobek **Date:** 10/04/2007

**Organization :** Fellowship Health Resources, Inc.

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-2261-P-377-Attach-1.DOC

CMS-2261-P-377-Attach-2.DOC

CMS-2261-P-377-Attach-3.DOC

CMS-2261-P-377-Attach-4.DOC

#377

# Fellowship Health Resources, Inc.

Creative Solutions for Rebuilding Lives and Restoring Hope

October 4, 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

Fellowship Health Resources, Inc.(Fellowship) 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 Fellowship is a private, not-for-profit behavioral healthcare agency which provides community based services for adults with major mental illnesses, addictions, and other co-occurring disorders. Established in 1975, it now services over 3,000 clients daily in the following seven states: Delaware, Maine, Massachusetts, North Carolina, Pennsylvania, Rhode Island, and Virginia. Clients range in age from 18 – 80 with the majority between the ages of 30-55. Over 80% of Fellowship clients have histories of multiple psychiatric hospitalizations, close to 50% have co-occurring disorders and approximately 15% have had forensic involvement. Service models include: outpatient mental health and substance abuse services, crisis stabilization and hospital diversion, intensive residential services, psychiatric day rehabilitation programs, Assertive Community Treatment Teams, clubhouse programs, intensive case management, supportive apartments, and re-entry services for mentally ill inmates. The primary source of program funding is Medicaid for those clients who are Medicaid eligible and county and state funding for those who are not. A small percentage have dual coverage (Medicaid/Medicare) and private insurance.

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

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Web: http://www.fellowshi

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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. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services that are 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 will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest, and it discriminates against persons with severe mental illness. One would not consider terminating a drug therapy for a cancer patient who was not improving from the treatment but able to maintain medical stability. Likewise a reasonable outcome might be for a person with mental illness to achieve a level of stability in their mental status with continuing support.

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

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

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

Additionally, The preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss has a specific rehabilitation goal toward regaining that

functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

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

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

440.130(viii)(3) Written Rehabilitation Plan

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

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for every encounter will become a major burden, especially when services are delivered to a group.) We would recommend that progress notes be required at least monthly, leaving it to states to require, or providers to make, more frequent notes in cases where that may be appropriate. The guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

We are 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. To expect that the treating clinical team, responsible for planning with the client, to now become familiar with alternate providers is an unreal expectation, and adds significant administrative burden. What are the implications for the provider who unknowingly omits to mention a possible alternative?

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. This practice is already in place in all of the states that we operate; however, requiring the signature of the client or representative in some rare cases may be problematic. There are two factors to consider.

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

Recommendations:

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

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

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. 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 Aintrinsic element@ of another program.

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396?? (1396d(r)). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.
It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child=s functional impairments should be a covered service.

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

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

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. In Delaware we operate a program which has three levels of intensity from intensive case management to outpatient. Clients are placed according to a standardized assessment tool and the agency is reimbursed by a monthly rate. However, were the agency to be reimbursed just for that specific encounter in the least restrictive level in 15 minute units the cost to deliver the service would be prohibitive. That is why managed care companies such as Community Care Behavioral Health in Pennsylvania have been willing to convert from unit rates to per member per month for Assertive Community Treatment programs because it caps funding without limiting the level of service.

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,

Joseph F. Dziobek
President/CEO
Fellowship Health Resources, Inc.

**Submitter :** **Mrs. Debra Austin** **Date: 10/04/2007**

**Organization :** **LCSW/Psychotherapist**

**Category :** **Comprehensive Outpatient Rehabilitation Facility**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I work as a psychotherapist in an adult, acute, psychiatric hospital. I have read through all sections of the proposed regulations and I am shocked with how little reserach was done when drafting these proposals. Every patient I have ever worked with will be adversely affected by these adjustments. Especially in Arkansas where additional mental health resources are scarce. I see patients that have multiple hospital stays and the rest of their life circumstances are stacked against them. How can you take away the little crumb of assistance they now receive. If these regulations pass it can only mean disaster for each and every community because the burden of service delivery will be placed on the individual and once again the government will have created another population of "throw-away" people.

Respectfully yours,

Debra A. Austin, LSCW
Psychotherapist
St. Vincent's Behavioral Health
Little Rock, AR 72205
(501) 552-6827

**Submitter :** Mrs. kay keesaer **Date:** 10/04/2007

**Organization :** Mrs. kay keesaer

**Category :** Congressional

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please reconsider eliminating day habilitation services to children and adults with developmental disabilities and their families. We have a 37 year old son that has disabilities and works at Ouachita Industries Sheltered Workshop. He is able to go to work every day and come home with a feeling of accomplishment and pride in himself. If funds are cut he would have nothing to do everyday but sit in front of the tv because he isn't able to work in a regular work situation. The workshop he attends serves many people in our area that are in the same situation he is in. Please reconsider befor eliminating these wonderful services. Thank you. Kay Keesaer

**Submitter :**

**Date: 10/04/2007**

**Organization :**

**Category : Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#380



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 :** **Mrs. Kathy Humphrey** **Date: 10/04/2007**

**Organization :** **Mrs. Kathy Humphrey**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I would like for those who impose rulings and want to make such ridiculous changes to have to live as so many of us; with children with disabilities. You cannot fully understand ones' view of how rehabilitation services affect our lives, unless you experience it as we do. It is easy for lawmakers to make proposals to take budget cuts in programs--much needed programs for individuals WHO NEED IT--because you are not affected. I would LOVE to see you take a trip to a mental health facility where individuals are confined to 4 walls and need 24 hour care. You wouldn't last very long in there because it might make you uncomfortable. Well, how about thinking about that individual's comfort for a change. You have the option and ability to walk out of that situation. The individual who needs that care does not have the same option. What will happen if you take those services away? Who will take care of those individuals? How about you? Why don't you try doing it for a week. I bet that would change your mind real fast on whether you should take away services from people who need it. Just pray you don't need these type services in the future!! Because once you take them away, they're gone. There's nothing more sickening than to hear of lawmakers taking away services from people who cannot live without them. I wonder how you sleep at night?!?

**Submitter :** **Date: 10/05/2007**

**Organization :**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Non-covered services: 441.45(b)
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 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.
There appear to be only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service B, in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or CMS is concerned that non-medical programs are furnishing Medicaid-covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. ? 1396d(a). See 42 U.S.C. ?? 1396a(a)(10), 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:
It is 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 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.
The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.
It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.
Similarly, a child with a serious mental disorder being reunified with its family may have specific issues directly stemming from the mental disorder. Mental health rehabilitation services to address these problems (as distinct from generic reunification services) should be covered.
Therapeutic Foster Care: 441.45(b)(1)(i)-
The regulation denies payment for therapeutic foster care as a single program, requiring instead that each component 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 evidenee-based practice with more than half a dozen con