Submitter : **Date: 10/08/2007**

Organization :

Category : **Social Worker**

Issue Areas/Comments

Background

Background

Re: 441.45(b) Non-Covered Services

I am most concerned about this part of the proposed rules. They seem to conflict with federal statutory requirements and make assumptions about covered services that are not accurate in my professional experience. We are not duplicating services or double-billing services by providing MRO services to children in therapeutic foster care. The clinical services covered by MRO are NOT part of the per diem, and so children would be denied services allowed to children in other settings with this rule. If this passes, providers will be forced to increase their per diems and this expense will then move from the federal government to the counties and states.

Submitter : Rita M. Doss **Date:** 10/08/2007

Organization : Integrity Rehab Services

Category : Long-term Care

Issue Areas/Comments

Background

Background

The wording for a Speech therapy should be consistent with the CMS language for defining the practice as Speech-Language pathology. It can be confusing when at times refered to as Speech Pathologist. It suggest 2 separate therapies.

Reccommend in this section to be precises in defining when a licensed therapist needs to provide direct therapy vs supervising a Physical therapy assistant or Occupational Therapy assistant. Currently it states periodically- this is not specific enough and leaves room to argue that simply completing the a recertification 30 days later would bc "periodic" enough. Suggest a minimum amount of time/days that thc OT or PT would need to provide hands on care.

Collections of Information Requirements

Collections of Information Requirements

Under section Provisions of the Proposed Rule

The wording for a Speech therapy should be consistent with the CMS language for defining the practice as Speech-Language pathology. It can be confusing when at times refered to as Speech Pathologist. It suggest 2 separate therapies.

Reccommend in this section to be precises in defining when a licensed therapist needs to provide direct therapy vs supervising a Physical therapy assistant or Occupational Therapy assistant. Currently it states periodically- this is not specific enough and leaves room to argue that simply completing the a recertification 30 days later would be "periodic" enough. Suggest a minimum amount of time/days that the OT or PT would need to provide hands on care.

Submitter : **Date: 10/08/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Re: 441.45(b) Non-Covered Services

I urge that you eliminate this portion of the proposed rules. I believe there are very appropriate ways (that we already practice) to safeguard against any concerned duplication implied by this "intrinsic element" rule. Ask that providers clearly articulate what services are provided by a program and build those costs into the per diems, or program costs. They should clearly name what clinical and case management services ARE and ARE NOT included. Then the appropriate clinical and case management services could be billed through MRO through an un-bundled fee structure. This will ensure there is no duplication and still ensure that kids are given needed clinical services regardless of their setting (which could be considered discriminatory).

Thank you.

Submitter : **Mrs. Linda Barton** **Date: 10/08/2007**

Organization : **Mrs. Linda Barton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that CMS withdraw, revise and re-issue the regulations proposed under Section 441.45(b)(2), with greater clarity as to the implications for children and adolescents with special needs who are currently receiving necessary medical services here in Pennsylvania.

As written, these proposed regulations raise questions as to whether the federal government will use them to force Pennsylvania to restrict these vital services for our children.

It is also urged that CMS provide opportunity for public comment.

Sincerely,
Linda Barton

Submitter : Ms. Shawn McGill **Date:** 10/08/2007

Organization : SharpVisions, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Without wraparound services my son would never be able to enjoy the things that we take for granted every day - going to school, going to the playground, walking on the grass, even eating a meal and brushing his teeth. Our team has devoted so much time and energy into supporting Jack. Without this service we would feel lost. I have watched the progression - he is speaking, he has stopped biting himself and banging his head (no more trips to the ER), and his incidents of running into the streets are beginning to dwindle. He is now learning how to co-exist with other children and he finally enjoys being with them. Most importantly he is developing a bonded relationship...with me, his mother. My son is over 3 years old now. About 6 months ago he gave him my first "kiss" eveer by placing his lips against my face. Just two weeks ago he repeated "I love you" for the very first time. Wrapround has taught him language and social skills. The team has also taught him to handle very difficult and frustrating situations and environments to prevent him from uncontrollably hurting himself or other people. The potential for growth with Jack is numerous, but wrapround is a key component to his continued development.

Submitter : **Date: 10/08/2007**

Organization :

Category : **Psychiatric Hospital**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I have many concerns about several aspects of these proposed rules and am convinced it will have a severe impact on the funding available for vulnerable populations. At a minimum, please delay implementation of these rules for 12 to 18 months to allow providers and states time to secure alternate sources of funding.

Thank you.

Submitter : **Date: 10/08/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am a recipient of MRO services. My child benefited from services provided to her while she was in therapeutic foster. The case manager from community mental health center was able to provide services that enabled her to come home more quickly. I know that the welfare caseworker would never have had time to provide those same services. Please do not take MRO services away from TFC kids. I know how important they are.

Submitter : **Dimitrios Cavathas** **Date: 10/08/2007**

Organization : **People Encouraging People, Inc.**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Please allow States to provide services on a capitated or monthly case rate plan (bundled rate) instead of incremental billing. The packaging of services into one monthly rate allows providers and States to plan properly for financial goals as well as allow multi faceted services to be provided in a bundled rate. This also allows efficiencies in financial departments for non profits and states. The monthly case rate or capitated rate has been very beneficial in the provision of Assertive Community Treatment Services. This Evidenced Based practice which is being promoted by SAMHSA & CMS would be very difficult to manage in an incremental billing system where each professional would bill different rates for each service every time they provided it. This would be very difficult to manage and would result in stacking of professions which can bill at higher rates which defeats the purpose of ACT. This also would make having paraprofessionals such as peer counselors very difficult to have on the team. This also may have a paradoxical effect by actually making the service more expensive since there would be minimal limits on what you could bill. A capitated rate allows for cost containment and easy tracking of cases by the system. PLEASE ALLOW BUNDLED RATES FOR STATES THAT WANT TO USE THEM!
IN PARTICULAR:

Section 441.45(a)(5)(iii) Specifies the methodology under which rehabilitation providers are paid.

Each state will be required to submit a state plan amendment on rehabilitation services. I strongly urge CMS to allow states maximum flexibility in payment methodology to support evidence based practices. As the preamble notes, the President s New Freedom Commission determined that more adults and children with serious mental illnesses would recover if they had access to evidence based treatment. NAMI s research indicates that there are critical shortages of these services in all states. CMS should ensure that its policies facilitate providing more access to effective services such as Assertive Community Treatment, Multi-Systemic Therapy and Therapeutie Foster Care.

Many states find it administratively efficient to combine services provided in these evidence based treatment programs, a practice commonly known as bundling. Services can be bundled into a case rate, daily rate or similar arrangement. This allows a provider to predict revenue and facilitates its ability to hire the extensive teams of individuals required to provide these services with fidelity to the model. ACT services, for example, will often be provided by a 10 member team, including nurses, a psychiatrist, a peer specialist, a substance abuse specialist and others. Numerous research studies have confirmed that good outcomes are dependent on fidelity to the model, including the active participation of a full team. States should be given the flexibility to choose the method that they believe will best allow them to ensure fidelity to the evidence based practice and replication throughout the state.

While CMS s goal of ensuring that Medicaid is not paying for non-rehabilitative services is laudable, this objective can be achieved by examining the services that are combined in the bundled rates. States should be required to explain their rate setting methodology, but they should not be arbitrarily prohibited from using bundling methodologies that are efficient and essential to significant expansion of the availability of the evidenee based services. CMS allows managed care arrangements that use similar methodologies and should be consistent in its review of state rehabilitation plan amendments.

Recommendation:

In reviewing state plan amendments, CMS should allow states flexibility in rate setting methodologies. If there are concerns about the services that are provided within a bundled rate methodology, CMS should review the state s documentation of the specific services they intend to provide within the combined rate.

Submitter : Mr. Gregory Schnepf **Date:** 10/08/2007

Organization : Oaklawn

Category : Individual

Issue Areas/Comments

Background

Background

-- elimination of Provision 441.45(b)which disallows billing MRO for kids who are in TFCs,child welfare, education, child care, vocational, probation, juvenile justice or public guardianship. It makes the assumption that these clinical services are "intrinsic elements" of these programs. This is very problematic: the rules are silent on how they made determination that these clinical and case management services are provided; it seems to discriminate against kids who happen to be places in these alternative settings; it assumes there is duplication of service provision or duplicate billing which is not true (as we carefully adhere to bundled and un-bundled billing practices; and it assumes that the clinical and case management services we provide are being provided by DCS caseworkers, probation officers, school teachers, etc.

-- consider, at least, more time to figure this out and/or secure alternate sources of funding.

--reconsideration of the 17-point rehabilitation plan which is onerous, duplicative and bureaucratic.

--further clarification of "restorative services" when we're working with kids (who are still developing) and chronically mentally ill adults where the continuation of services is at time essential for functioning.

Submitter : Mrs. Gladys Disbrow **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Medication is expensive. More people will be in the hospital, some will kill themselves without their medication. Families will be destroyed. Please don't make any changes.

Submitter : Mrs. Victoria Covey **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I come to a clubhouse 3 days a week, the rest of the time I'm at home sleeping. Medicaid cuts mean I can't come to the clubhouse/LightHouse at all. When I'm not on my medication,
I get physically aggressive towards other people and more depressed.

Submitter : Miss. Josephine Ayo **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I can not pay for my medications. Therefore, I will be hospitalized and cost the government more money. I am finally at a place where I am doing great, but because of your cuts to medicaid, life will get worse for all of us with mental illness. We will all be unhappy and hospitalized. Please do not do this to all of us that need help. PS I have tried to kill myself in 2001, and if it happens again most will succeed.

Submitter : Mr. David Maasch **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Without medicaid to pay for my medication, after two to three days I won't be able to function and will end up in the hospital.

Submitter : Miss. Paige White **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

If you mess with medicaid, it will effect my medication. My medication costs $600.00 per shot and I have to get it every two weeks. I can't afford that!!! Also, I live out in the middle of nowhere and I take DASH Transportation, without my medicaid how will I get to my appointments, be able to get a job or come to the LightHouse?

Submitter : Dr. Fran Edelstein **Date:** 10/08/2007

Organization : California Alliance of Child and Family Services

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-485-Attach-1.PDF

#485

California Alliance
OF CHILD AND FAMILY SERVICES

V. 916.449.2273
F. 916.449-2294

2201 K STREET
SACRAMENTO, CALIFORNIA 95816

WWW.CACFS.ORG

October 8, 2007

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

To Whom It May Concern:

The California Alliance of Child and Family Services appreciates the opportunity to comment on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register August 13, 2007.

The California Alliance is a statewide association of more than 140 private non-profit child-serving agencies. Our member organizations serve tens of thousands of at-risk and in-need children and their families including some of California's most challenging children. To accomplish the outcomes Californians want for these children and their families, our member agencies provide a range of high quality, well coordinated, effective and efficient programs and services in mental health, child welfare, education, housing and other human service areas. Alliance agencies serve children in the mental health, foster care, juvenile justice and other child-serving systems.

The California Alliance's commitment to high quality programs and services is demonstrated in many ways including our requirement that all members be accredited by either a nationally recognized accrediting body or by our association's own rigorous accreditation process.

GENERAL COMMENT

Our association agrees and supports the comments provided by the following national organizations of which we are a member:

1. National Council for Community Behavioral Healthcare
2. Child Welfare League of America

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.

CMS AUTHORITY FOR THE PROPOSED RULE

During the development of the Deficit Reduction Act Congress rejected the Administration's proposal to amend the definition of rehabilitative services and to include the intrinsic element concept. With this clear congressional intent it is unclear that CMS has the authority to proceed with this rule making process.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This language is also 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. The long-term clinical course of these conditions is difficult to determine.

Given this clinical fact, 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.

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.

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. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR 438.210(a)(4)(ii)(B)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

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

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

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

signs and symptoms (such as hallucinations). They are insufficient for preparation of a rehabilitation plan and do not provide a good basis for measuring change.

This definition also includes the word "care" after "treatment," but that term is not defined anywhere. The word "rehabilitation" should be inserted here to clarify that the term "medical services" includes rehabilitation. This is important because the term medically necessary is used in this proposed rule to indicate necessary rehabilitation services.

Recommendation:

1. In section (viii) add the word "assessment" before the word "diagnosis" and replace the word "care" with the word "rehabilitation."

440.130(3) Written Rehabilitation Plan

Some aspects of this section of the rule are unclear and others are not addressed. 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.

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

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.

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the child's family, or other responsible individuals. However, 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:

Include the following written rehabilitation plan requirements:

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, and mobile crisis vehicles.

Section 441.45: Rehabilitative Services

441.45(a)(2) Covered services requirements

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

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

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.

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

441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to 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 or when an agency has already received a federal payment to meet a specific non-medical need of a particular person.

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.

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

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

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

The 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

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

It should be noted that the exclusion of habilitation services does 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.

441.45(b)(3) Recreational or social activities

The Preamble includes examples of recreational or social activities that are covered services due to a focus on skill building or other rehabilitative needs. However, the rule does not include any examples or specific language explaining when these activities are covered services. This is a serious omission, as the rule alone may be interpreted as denying any recreational or social activities no matter how therapeutic and how focused they are on restoring functioning.

Recommendations:

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

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

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

Recommendation:

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

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

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered. However, the preamble (page 45207) clarifies that services furnished through contacts with non-eligible individuals, but which are exclusively for the treatment of Medicaid-eligible individuals, are covered. The rule should also include that clarification.

Recommendation

1. Include, in the rule, the language in the preamble that explains that services furnished through contacts with relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services.

OTHER ISSUES

Payment and Accounting for Services

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

These changes in rate setting methodology are administratively and clinically inefficient. They 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, please contact me at (916) 449-2273 ext. 18.

Sincerely,

Fran Edelstein PhD

Fran Edelstein PhD
Consultant for Mental Health Public Policy

Submitter : Mr. Wesley Bunyon **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I take several medications, one alone is $500.00 which I can't afford without medicaid. If I am not on medication, I will be hospitalized, if I don't committ suicide.

Submitter : Mrs. Grace Bunyon **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

If I can't get my medication, I won't remain stable, my heart will be affected and I will end up in the hospital. I will either be in for my heart and the psychiatric unit or the psych unit.

Submitter : Mr. Henry Blanchard **Date:** 10/08/2007

Organization : LightHouse, the Centers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The "Government" in the long run won't save money because, those who take medications and can't afford them, will end up in prison, jail or hospitalized. The money will come from another "government" souee to take care of our citizens.

Submitter : Dorothy Flynn **Date:** 10/08/2007

Organization : NAMI

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

My family member, who has schizophrenia, is a prime example. She is currently in the IHIP-A program. But, there have been many times that she is unable to actively participate in a treatment plan even though she desperately needs help. Please don't let her slip through the cracks.

Recommendation:

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

Submitter : **Ms. Karen Mann** **Date: 10/08/2007**

Organization : **NAMI**

Category : **Nurse**

Issue Areas/Comments

Background

Background

GENERAL

GENERAL

I write to you as a consumer, a nurse ho is a provider of services for the clients that would be hurt if this legislation passe. Please consider my comments. I am also a member of NAMI and feel that they need to have a voice in this as well.

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

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

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

Thank you,

Submitter : Valerie Fox **Date:** 10/08/2007

Organization : Valerie Fox

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-491-Attach-1.DOC

#491

October 3, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

I am a graduate student in Occupational Therapy at the University of North Carolina in Chapel Hill. For the last 3 months I have been placed at Threshold Clubhouse in Durham, NC for my fieldwork. This fieldwork opportunity was sponsored by a grant to determine the possibilities for Occupational Therapists working in community-based mental health sites. Among the many things that I learned this summer, I realized the barriers that finances and excessive documentation plays in the treatment of individuals with mental illness. Threshold is a clubhouse model organization that provides an amazing service to their clients. Their dedicated staff work for rather low wages and do it because they value the opportunities they have to facilitate pre-vocational training to the members of Threshold to get them 'on their feet again' and actively participating in life. Instead of spending their time with the members during the day, most of the staff were overwhelmed with the amount of documentation that was being forced on them. While I understand that documentation is needed, there is a certain point at which documentation is out of hand and is actually harming the individuals that the documentation was put in place to serve. The system is becoming more focused on paperwork and not people work.

It is clear from the published "Summary" of this proposed Rule that the intent of CMS is to severely restrict rehabilitative services to Medicaid eligible individuals with long term Mental Illness, through increased documentation requirements for already overburdened Providers and through extremely restrictive service definitions. CMS appears to want to cut funding for medically necessary services to the most vulnerable segment of this country's citizens- those with long term Mental Illness. The majority of Threshold's members rely on Medicaid as their only health insurance and are alarmed by the degree to which their coverage could be reduced by the proposed Rule change. Like it or not, Medicaid has become the single largest funding source for Mental Health services in this country. If CMS truly wants to cut Medicaid funding, the agency needs to stop blaming the states for viewing rehabilitation benefits as a "catch-all category" and accept responsibility for their approval of all state plans. CMS should then begin

working with other federal, state and local agencies to develop alternative funding sources and develop a transition plan that will prevent the disruption of vital services to adults with severe Mental Illness. For CMS to proceed with their current strategy of a "Rule change," will result in precious funding being wasted on challenging the creative writing skills of Mental Health Professionals to document needed services in a manner that Medicaid will pay for. Or, worse yet, the funds will be misused to provide specific, time limited, and ineffective interventions to adults with Mental Illness in a misguided effort to at least offer them something, rather than abandoning them to isolation in the community, only to decompensate. Much more intensive and expensive services will then be needed to stabilize the individual only to again be abandoned.

Even as a student, I quickly saw the many "flaws" in the system. I am still in awe at the fact that our government and funding entities have yet to realize the devastating effect that all of these changes are having on these individuals, the organizations trying to serve them, and the mental health system as a whole; the system is in complete disarray and yet CMS is calling for more and more documentation and less and less actual client-centered service being offered to help the clients. I sincerely hope that you take a strong look at the damage that the proposed changes can, and most likely, will cause. Disallowing long term supportive services for individuals with a severe mental illness will only increase Medicaid costs in the long run with more expensive psychiatric hospitalizations. There are no short-term, easy solutions to this crisis; you cannot address a long term, chronic illness with a short term solution.

Sincerely,

Valerie Fox
vfox@med.unc.edu

Submitter : Mr. Ken Norman **Date:** 10/08/2007

Organization : Mr. Ken Norman

Category : Social Worker

Issue Areas/Comments

Background

Background

For the sake of kids, please allow continued billing of MRO for kids and chronically mentally ill adults. Provision 441.45(b)disallows billing MRO for kids and adults who are in TFCs, child welfare, education, child care, vocational, probation, juvenile justice or public guardianship.
It makes the assumption that these clinical services are "intrinsic elements" of these programs. This is very problematic: these rules are silent on how they made determination that these clinical and case management services are provided; it really seems to discriminate against kids in these places and services; Where will they get these services? This provision assumes there is duplication of service or duplicate billing which is not true. DCS caseworkers probation officers, school teachers, etc. will not have the time to take on this extra burden.
I've been a professional in Indiana for over 20 years and understand how time consuming and complex case managing is. The needs of these kids must be addressed if they are to have a chance at enjoying the freedoms and US way of life and pursuit of happiness.

Please, strike this provision and/or give us more time to find alternate funding so we can get this right. Cannot afford to make a mistake in this. The kids already have enough facing them.
sources of funding.

Collections of Information Requirements

Collections of Information Requirements

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sources of funding.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please reconsider this 17-point rehabilitation plan which is onerous, bureaucratic and seems duplicative.

Please, one example. A child seeing a DCS caseworker is going to initially be provided with a safe place, food, referrals to various services and "monitored" but not case managed from there on out. They don't have time to do further case management. That's why they make the referrals. Then, the provider has to do the case management. If you burden DCS caseworkers and probation officers with more, someone's safety is going to slip through the cracks. Continued services are essential at this time for functioning.

Submitter : **Date: 10/08/2007**

Organization :

Category : **Social Worker**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

A comment about 441.45(b)-- I'm not a lawyer but it seems unfair -- and discriminatory to eliminate whole groups of kids from receiving medically necessary services just because of where they happen to be living (eg., TFC) and because they happen to be under the jurisidiction of the state welfare system or probation.

Please eliminate this part of the proposed rule.

Submitter : Nancy Cummings **Date:** 10/08/2007

Organization : CCIU

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As someone who has worked in wrap-around as a para-professional and now a clinician, it is my firm belief that these services are vital to promote independence, growth in skills, and development of meaningful relationships for children with Autism and other Axis I diagnoses. Please support this work through funding.

Submitter : Ms. Linda Burkhart **Date:** 10/08/2007

Organization : NAMI Durham

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Pertaining to Section 440.130(d)(3)
Please do not restrict rehabilitative services to Medicaid eligible individuals with severe and persistent mental illness. Also please don't cut the funding
The Clubhouse Model is the most effective program to serve persons with mental illness in the community
Develop a rule change that would truly benefit the clients served. Develop fines short of full paychecks and work to reduce the paper work demands on providers so that they can focus on service delivery. Unscrupulous provides can and should be persued without overwelming the good providers such as Threshold Clubhouse in Durham.
NAMI Durham is supportive of this clubhouse as they do an excellent job as a psychosocial rehabilitative service. The clubhouse is also a site visit for our local law enforcement officers who choose to become trained in the Crisis Intervention Team model. Threshold clubhouse members also print our monthly newsletters and 2 of it's members sit on our board.
Pertaining to section 440.130(d)(l)(vi)
Many persons with severe and persistent mental illness need the clubhouse setting to work on their social skills. Lack of such skills is sometimes but not always just onc of the debilitation symptons that a person may suffer from especially after a relapse. Even an activity like playing a hand of cards might seem effortless to us but for a person trying to come back from a psychotic episode, relapse or even put on new/different medications; a social game IS THERAPY and very meaningful at that if the client can once again enjoy an activity that was lost to them. There is no time limit, nor should one be placed on clients who need a social setting with their peers in which to rehabilitate. I speak from experience in watching my daughter live with bipolar disorder for the past 6 years. There were times when she was hospitalized, then to residential treatment, then thrust back into the community with no supports such as a clubhouse. It was not a good thing and I believe no community support greatly hindered her recovery. "Recovery goals" are unique to each person that lives with mental illness. Most people when in recovery will go on to live productive lives and leave the clubhouse model when they are ready.

Pertaining to Section 440.130(vii)(3)

Requiring progress notes for every encounter with a client is truly daunting for staff. Clients are urged to take part in their own recovery and write a plan with staff. That should be sufficient in itself. Monthly progress notes would be appropriate.

Sincerely
Linda Burkhart, President-Elect
NAMI Durham

Submitter : **Mr. Tim Graham** **Date: 10/08/2007**

Organization : **United States of America**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

October 8, 2007

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

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

Thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. The Livingston county CMH (Michigan) Has A LONG COLORFUL history of vulnerable patient exploitation. I have tried repeatedly to get funding cut for this horrible abusive criminal mockery of psychiatry . I have no desire to see funding cut for those professionals who are WILLING to help the disabled in my community. HOWEVER Livingston county CMH is in DESPERATE need of a comprehensive TOP DOWN ELIMINATION of unscrupulous staff. The corruption and cover-ups go right to the highest levels of authority. Please clean this sordid mess up asap. Thank you! Tim Graham

Submitter : **Date: 10/08/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Date: 10/08/2007**

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : Mrs. Janet Edelman **Date:** 10/08/2007

Organization : NAMI

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My brother became ill with schizophrenia in 1970, when he was 16 years old. He remains disabled and is served by a residential and psychosocial program in Maryland. For the past 5 years he has lived in a home that is part of the residential program with two other men. We are very proud that he was able to make the shift away from living with my parents who are now 91 and 86 years old. He has shown some growth in that in the past year he has been able to ride the bus to do some of his shopping. He has not been able to work since despite all of the medications, he still hears voices most of the time and has very low motivation as a symptom of his illness.

Please do not implement regulations that will affect my brother's ability to live in the community. He is not well enough to live on his own, since he needs help taking his medications, and could not handle many of the aspects of living independently. Even if my husband agreed to take him in to our home, I could not duplicate the services or supervision provided to him through the program that he is now a member. It would be a tragedy for us if he could not receive services and deteriorated to the point where he would need to be hospitalized again. Today he is stable, happy, and making slow progress (over many years) in being able to handle the tasks that the rest of us take for granted.

Thank you for providing opportunities for individuals living with mental illness and their family members to provide comments on the proposed rule regarding coverage for rehabilitative services under the Medicaid program. I am writing as a member of The National Alliance on Mental Illness (NAMI), the nation s largest grassroots organization representing individuals living with serious mental illnesses and their families. As members of NAMI, we have lived experience with mental illness and bring that unique perspective to our comments on these rules.

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

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

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

In conclusion, please do not take away services from some of the sickest members of our country who are not able to take care of themselves. Those that are receiving services now could deteriorate and wind up in jails, prisons or on the street or dead if they lose the services that they now have. As a family member, I do not want my loved one to suffer or be neglected.

Thank you very much for the opportunity to share my concerns with the proposed regulations.

Submitter : **Date: 10/08/2007**

Organization :

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-501-Attach-1.DOC

#501

October 8, 2007

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

To Whom It May Concern:

I am the Executive Director of Success in Recovery, Inc a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides residential care and counseling to male adolescent 602 Wards with various sexual, drug and alcohol issues.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

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

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

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

Recommendation:

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

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

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

Recommendation:

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

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

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (559) 635-4780.

Sincerely,

Michelle Weintz
Executive Director