Submitter : Dr. Katrina Kuzyszyn-Jones **Date:** 10/09/2007

Organization : Dr. Katrina Kuzyszyn-Jones

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-519-Attach-1.DOC

#519

October 9, 2007

To Whom It May Concern:

As a member of the North Carolina mental health community, I am appalled by the proposed rule to amend the definition of Medicaid Rehabilitative Services.

Pertaining to Section 440.130(d) (3)
Please do not cut funding or restrict rehabilitative services to Medicaid eligible individuals with severe and persistent mental illness. The Clubhouse Model is the most effective program to serve persons with mental illness in the community. Instead, develop a rule change that would truly benefit the clients served. Work to reduce the paper work demands on providers so we can focus on service delivery. Unscrupulous providers can and should be pursued without overwhelming the good providers such as Threshold Clubhouse in Durham.

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 social skills often contribute to the debilitating symptoms of one's illness and to further relapse. Activities which help individuals reintegrate into society are therapeutic and very meaningful. It is important to help people enjoy activities that were lost to them. There should be no time limit placed on rehabilitation, whether it occurs in an office, or in a social setting with peers and professionals. "Recovery goals" are unique to each person that lives with mental illness. Most people 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. Monthly progress notes would be more appropriate.

Sincerely
Katrina Kuzyszyn-Jones, Psy.D.
Psychologist

Submitter : Lucy Chaney **Date:** 10/09/2007

Organization : Lucy Chaney

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a mother of a 23 year old young woman who is suffering from sever mental illness. Please do not stop the services. She did not ask to be sick and we only ask for her to be safe and comfortable.

Thank you for you consideration

Submitter : Ms. Lauren Agoratus **Date:** 10/09/2007

Organization : Family Voices NJ

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-521-Attach-1.DOC

#521

SPAN
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4th Floor
Newark, NJ 07102
(973) 642-8100
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E-Mail address: span@spannj.org
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Statewide Parent Advocacy Network, Inc.

Family Voices comments on the CMS Proposed Guidelines on Rehabilitative Services

10/4/07

We are writing on behalf of Family Voices-NJ concerning the proposed CMS Guidelines on Rehabilitative Services. Family Voices is a national network that speaks and advocates on behalf of children with special healthcare needs and our NJ Chapter is housed at the Statewide Parent Advocacy Network, NJ's federally funded Parent Training and Information Center. In addition, SPAN is the Family-to-Family Health Information Center for the state, and a chapter of the Federation of Families for Children's Mental Health. It is from these perspectives, the perspectives of the many families we assist, and our own experiences as parents of children and youth with special needs, that we are sharing these comments.

In *Overview I Section A*, the emphasis is that services "restore an individual to his previous functional level". How will this affect EPSDT (Early Periodic Screening Diagnostic and Treatment) and EI (early intervention) services for children? It further says that some states expanded "physical rehabilitative services to also include mental health and substance abuse" which is as it should be; states should be required to include mental health and substance abuse services. Rehabilitation is rehabilitation. There is also new awareness that mental illnesses can be biologically based and there should be parity in coverage for mental health with physical illnesses. Lastly, there is mention that "some States have used Medicaid to fund services that are included in...foster care and IDEA" and we feel this is as it should be as states are given flexibility in developing programs.

In the *Overview I Section B,* mention is made that some States have provided "day habilitation services...on behalf of persons with mental retardation". The suggestion is to use Medicaid waivers, which are difficult to obtain, and there is no uniformity among states. More importantly, Medicaid funding should go towards community-based, non-segregated settings. There should be a presumption, consistent with the U.S. Supreme Court decision in Olmstead, that services are going to provided in community-based, non-segregated settings under virtually all circumstances!

Regarding *Section II Provisions of the Proposed Rule, Part B Scope of Services*, clarification is given on retaining the current definition of rehabilitation to include "maximum *reduction* of physical or mental disability" which would apply to early intervention and EPSDT; however it conflicts with the notion of "restoration of previous functional level" mentioned above for children who may not have attained skills yet because they haven't yet received necessary therapy. These discrepancies should be clarified so that it is clear that there is no requirement that children have achieved some previous functional level in order to be eligible for rehabilitation services.

Also in *Section II, Part C Written Rehabilitation Plan*, a suggestion is made that "covered rehabilitative services...must be identified under a written rehabilitation plan". How does this coordinate with a child's IFSP (Individualized Family Service Plan) or IEP (Individualized Education Program)? Statements are made that the benefit is "not custodial care for...chronic conditions but should result in a change of status." This is the same rationale that insurance companies use to deny nursing to a child; a child with a vent (ventilator) or trach (tracheotomy) doesn't need a babysitter, he needs a nurse. Also this contradicts the notion of "reduction of ...disability" mentioned above. Further statements support this in that "goals are contingent on the individual's maintenance of current level of functioning". Yet later in the document it states "services provided...to maintain...functioning in the absence of a rehabilitation goal are not rehabilitation services" with which we strongly disagree. We are very concerned about this statement because many children and adults with certain conditions may not necessarily improve but would certainly deteriorate without treatment and services. Suggestion is made that the rehabilitation plan be based on a "diagnosed condition" with which we again disagree as there is a range of abilities even within the same diagnosis justifying the need that "covered rehabilitative services for each *individual* must be identified" as stated previously. We do agree that anticipated outcomes are an essential component of the rehabilitation plan. We concur that flexibility such as including recreational activities to restore social functioning and personal interaction skills are a good example of implementation.

In *Section II, Part D Impairments to be Addressed*, we agree with state flexibility on determining rehabilitative services but feel that mental health and substance abuse should be required, as people with mental illnesses should have the same level of treatment and services as "physical" illnesses. We agree that looking at "assistive devices, supplies, and equipment" is necessary and would hope this includes medical supplies, such as those post-surgery, which would allow the individual to meet his/her rehabilitation goals.

Also in *Section II, Part E Settings*, we agree that services can be provided at a "facility, home, or other setting" which allows flexibility of natural environments. Skills learned in a clinical setting are not usually generalized to the natural environment so this will allow for better outcomes. To emphasize the importance of starting with homes and community settings, we recommend that the order be changed to "home, community setting, facility, or other setting."

Section II, Part F Requirements and Limitations for Rehabilitative Services #2 specifically eliminates or limits services previously provided. The overview stated this will "prevent coverage...that could be furnished through another program, such as... education". Many states have a Medicaid initiative to cover related services under IDEA (Individuals with Disabilities Education Act). This is up to and including nursing for children to allow FAPE (free appropriate public education) under IDEA. We're concerned about the proposal to limit transportation, personal care, vocational, and patient education; all of which are essential services for rehabilitation. We're also concerned about the lack of parity with mental health services proposing exclusions for "institutions for mental disease", including residential placements. Although it says states *can* use the "psych under 21 benefit for children", states have "flexibility" whether or not to have this, which is not likely to provide equitable access for persons with mental health needs. Lastly, the habilitative vs. rehabilitative argument defining the "capability to perform an activity in the past" will exclude therapies for children. How are children going to get the new ability without therapy? Section 441.45 rehabilitation services exclusions which include "non-medical support services...teacher aides" does not consider paraprofessionals who may provide related health services that aren't necessarily considered medical under special education law (e.g., special toileting, etc.) but are mandated. The proposal also limits therapeutic foster care, which is a concern.

Thank you for the opportunity to comment on the CMS proposed Guidelines on Rehabilitative Services and considering our concerns for this vulnerable population.

Sincerely,

Lauren Agoratus, M.A.-parent
NJ Coordinator- Family Voices at the Statewide Parent Advocacy Network
Central/Southern Coordinator, Family-to-Family Health Information Resource Center
35 Halsey St., 4th Fl.
Newark, N.J. 07102
(800) 654-SPAN ext. 110
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Website www.spannj.org

Submitter : Dr. Robert E. Drake **Date:** 10/09/2007

Organization : Dartmouth Medical School

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Any movement to reduce rather than expand the rehab option for patients with severe mental illnesses would be a disaster for patients, for communities, and for costs. Supported employment is the most effective mental health treatment that we have and the only one that reduces social security and health care costs dramatically over time.

Submitter : Ms. Jennifer Colbert **Date:** 10/09/2007

Organization : Epilepsy Foundation of Long Island

Category : Intermediate Care Facility for the Mentally Retarded

Issue Areas/Comments

Background

Background

We strongly oppose the proposed rule s definition of habilitation services [?441.45(b) (2)] as including services provided to individuals with mental retardation and related conditions.

Defining clinical service eligibility by excluding individuals with mental retardation is discriminatory and is based on false presumptions of individual needs, abilities, etc.

Collections of Information Requirements

Collections of Information Requirements

Scope of Issue

Unofficial estimates: in 2006, roughly $800 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities.

In the same year, it has been estimated that approximately 52,000 people with intellectual and other developmental disabilities received necessary habilitation services through the clinic and rehab options that are being eliminated by these regs

Regulatory Impact Analysis

Regulatory Impact Analysis

(1) strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. Urge that this proposed rule be withdrawn.

The proposed rule would severely harm people with intellectual and other developmental disabilities in two major ways:
(1) it eliminates longstanding programs for providing habilitation services to people with developmental disabilities, and
(2) it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with intellectual disabilities/mental retardation and related conditions.

We take issue with the assertion that there are more appropriate coverage authorities (i.e. waiver services, etc.) In particular, waiver programs operate as discretionary alternatives to our State's core Medicaid program under the state plan. We believe that states should have the flexibility to continue operating habilitation services under the longstanding state plan options in addition to having the waiver options, but should not be forced to utilize only one option.

(2) The definition creates a discriminatory and arbitrary exclusion from receiving rehabilitative services for people with mental retardation and related conditions

Submitter : Ron Keebler **Date:** 10/09/2007

Organization : YAI NIPD

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : Lee Burns **Date:** 10/09/2007

Organization : National Alliance on Mental Illness (NAMI)

Category : Individual

Issue Areas/Comments

Background

Background

Recommendation:

Amend the language of restorative services to add: In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to prevent regression based on a documented history and severity of illness or to help an individual achieve a rehabilitation goal defined in the rehabilitation plan.

Secondly, amend the language to add bolded language: Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. For children, this can include services to achieve age appropriate skills and development.

Collections of Information Requirements

Collections of Information Requirements

Various Medicare and Medicaid services are critical to my son's mental and physical stability as he struggles with schizoaffective disorder.

GENERAL

GENERAL

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

I applaud the discussion in the preamble recognizing that effective rehabilitation of eligible individuals may require some contact with non-eligible individuals. The preamble further explains that counseling sessions for the treatment of the child may include the parents or other non-eligible family members and concludes that contacts with family members for the purpose of treating the Medicaid eligible individual may be covered under Medicaid.

I appreciate this recognition of the importance of family relationships in supporting recovery. Recent research studies have confirmed that family support leads to better outcomes from treatment. I urge CMS to amend the rule to add language from the preamble to be clear on this point.

Recommendation:

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

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Recommendation:

Amend the proposed rule to revise the language to read:

(xi) indicate the anticipated provider(s) of the service and when feasible document that the individual was informed of any available resource for identifying alternate providers of the same service.

(xiv) & if it is determined that there has been no measurable reduction of disability, prevention of regression, or restoration of functional level, any new plan&

(xv) document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan or document the exigent circumstances which prevented such participation in the development of the plan, signing of the plan and/or receipt of a copy of the plan. Such circumstances may include, but are not limited to, the need to provide services to allow an individual to begin the planning process or to receive services in the event of an emergency or crisis.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Recommendation:
Delete section of the preamble granting states the authority to determine the setting.

Add to the list of settings: & school, workplace, foster home, group home, mobile crisis vehicle, community mental health center, substance abuse treatment setting, community setting and other settings.

Regulatory Impact Analysis

Regulatory Impact Analysis

Recommendation:
Strike Section 441.45(b)(1).

If CMS is unwilling to strike this section, add:

including services that are intrinsic elements of programs other than Medicaid [list of programs], except for services which are medically necessary rehabilitation services for an eligible individual.

And add: This exclusion will only apply if the programs other than Medicaid are legally liable to provide the services to a specific Medicaid eligible individual. Discretionary appropriations do not constitute legal liability to a specific individual.

Response to Comments

Response to Comments

Recommendation:

Revise these sections to read:

(i) Services that are packaged as part of therapeutic foster care services which are not medically necessary rehabilitation services for an eligible child. States are permitted to package medically necessary rehabilitation services to provide therapeutic foster care to an eligible individual child.

Submitter : **Date: 10/09/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachemnt

Submitter : Dr. Bonita Bowman **Date:** 10/09/2007

Organization : Dr. Bonita Bowman

Category : Individual

Issue Areas/Comments

Background

Background

see attachment

Collections of Information Requirements

Collections of Information Requirements

see attachment

GENERAL

GENERAL

I have attached the comments distributed by NAMI regarding the impact on lives of people with Mental Illness. But, I would like to emphasize that my family would be adversely impacted by these changes. My sister has not experienced any miracle return to normalcy through the newer medications. Hence she remains feeling medicated rather than feeling better, and hence she is difficult to keep in any program. We are having some success right now with ACT. But too often she runs away and we need to start from the beginning. And... then we hear that she does not qualify because our mental health system is turning into a system that tries NOT to serve those in need. So what happens when she doesn't qualify? The criminal justice system gets involved, there are long term hospitalizations and more. She has two young children. We can provide respite and many outside positive and normal experiences for them and they do well as long as she is staying put and has treatment providers continually reaching into their bag of tricks to keep "one of her feet" in the doorway of our world as much as possible. I know from conversations with other families that our struggle is not unique. Please read these NAMI comments and know they are true. We as families can and many of us will pick up a lot of expenses and support required for the care of our mentally ill loved ones - but only if the system will help us. We need easier access not more barriers.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

CMS-2261-P-527-Attach-1.DOC

#527

September 27, 2007

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

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

Dear Sir or Madam:

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

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

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.

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

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

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

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

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

Recommendation:

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

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

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

For some of us and our family members who have been hospitalized or in jail, staying stable and in housing is not easy and is an achievement. It also requires services so we

do not deteriorate and get worse. We hope the agency will adjust its regulations to take into account the nature of our illnesses and those of our family members and allow services to prevent deterioration of the illnesses.

Recommendation:

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

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

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

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

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

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

Recommendation:

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

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

Many children with mental illnesses rely upon therapeutic foster care. This is a service that works well and creates good outcomes such as going to school more, staying out of trouble with law enforcement, and living in a stable place. The proposed regulations

should give states the ability to get federal resources to support this effective service as long as the services are rehabilitative.

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

Recommendation:

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

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

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

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

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

Recommendation:

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

Conclusion:

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 : Mr. Richard Leclerc **Date:** 10/09/2007

Organization : Gateway Healthcare, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2261-P-528-Attach-1.PDF

#528

GATEWAY
HEALTHCARE, INC

www.gatewayhealth.org

ADMINISTRATIVE OFFICES
249 Roosevelt Avenue, Suite 205 Pawtucket, RI 02860-2134
tel (401) 724-8400 fax (401) 724-8488

October 5, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

Gateway Healthcare, Inc. 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.

Gateway Healthcare, Inc. (GHI) is a non-profit behavioral health care organization that provides a wide array of services to adults, children and families in Rhode Island. Our Mission is to promote resiliency and to assist people in their recovery from behavioral health and emotional disorders. Gateway provides services to people of all cultural and economic backgrounds, who may not otherwise have access to the services they need. To further support the mission of promoting resiliency and assisting individuals in their recovery, Gateway Healthcare offers a continuum of services that include around-the-clock psychiatric emergency services, psychiatric medication therapy services, outpatient counseling for individuals and families, specialized residential care for children and adolescents, permanent affordable housing for adults, supervised adult residential services, adult supported housing services, mental health services for adults with persistent mental health issues, a licensed school for children with emotional and behavioral difficulties, nationally recognized vocational and occupational rehabilitation services, a therapeutic outdoor recreation program for children and adolescents, a homeless shelter for families, residential substance abuse services, individual and management services for adults and children.

Established in 1995, GHI has grown to include more than 23 locations across Rhode Island, including Pawtucket, Central Falls, Johnston, Cranston, Middletown, Lincoln, Smithfield and West Greenwich. Gateway's tenure in the Rhode Island community boasts of providing services annually to over 14,000 men, women and children.

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

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

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

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

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that our state leaders 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.

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

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 Rhode Island; however, requiring the signature of the client or representative in some rare cases may be problematic. There are two factors to consider.

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

Recommendations:

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

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the

provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.

- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers.

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals

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

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

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

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

Recommendation:

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

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

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

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

Similarly, a child with a serious mental disorder being reunified with 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.

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,

Richard H. Leclerc
President
Gateway Healthcare, Inc.

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

Submitter : Mrs. Pamela Clay **Date:** 10/09/2007

Organization : A.C.S.W., Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#529

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. Pamela Clay **Date:** 10/09/2007

Organization : ACSW, inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-530-Attach-1.RTF

#530

October 5, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services Attn:
CMS-2261-P, Mail Stop C4-26-05 7500 Security
Boulevard Baltimore, MD 21244-1850

To Whom It May Concern:

A.C.S.W., Inc., a non-profit DDTCS serving developmental^ disabled adults in Ashley and Chicot counties in rural southeast Arkansas, is submitting the following comments on the Proposed Rule [CMS 2261-P] for Coverage for Rehabilitative Services under the Medicaid program as published in the Federal Register, August 13, 2007.

First, in Section 441.45(b)(2), the proposed rules states, "we propose to exclude FFP for expenditures for habilitation services including those provided to individuals with mental retardation or related conditions". If this regulation is issued in its final form, the protection provided to States by section 6411(g) of OBRA 89 for day habilitation services will no longer be in force. Our center would be in grave danger of closing if reimbursement funds for adult development, transportation, waiver, diagnosis and evaluation, and rehabilitative services were eliminated. The state of Arkansas provides only $1.00 for every $3.00 we receive in federal funds for the covered services we offer. If our center had to rely on state funds alone, we would not be able to continue serving these developmentally disabled adults and their families who have depended on our services for decades. Many of our individuals have parents who work to stay off of welfare, food stamps, and other government programs, and they depend on us to have our doors open to serve their adult children so that they can have the opportunity to hold jobs and contribute to the community. Several of our individuals also have aging parents or have lost one parent, and their ability to care for their developmentally disabled adult child over long, extended periods of time becomes increasing difficult for them. We ask that you seriously consider the negative impact that the passage of this rule would create for the lives of many rural Arkansans; the impact would adversely affect one of the most vulnerable populations in our society (developmentally disabled adults) as they would have no place to receive services that enable them to live productive lives outside their homes. While we realize that waiver services are presented in the rule as an option, this is not a viable option for those in the state of Arkansas who are not presently receiving waiver services. The "waiting period" in our state from time of application to possibly receiving services is about two years.

Secondly, in Section 441.45(b)(l), the rule states that coverage of rehabilitative services would not include services that are "intrinsic elements" of programs other than Medicaid. Little to no clarity is provided as to how this provision would be applied.

In summary, we oppose the passage of Proposed Rule 2261-P as it stands. To pass this as it is currently written would basically eliminate the support services that our consumers need in order to be functional, contributing members of our community and to continue to lead quality lives. There are no other programs or agencies that would be able to provide these services should our center have to close due to lack of funding. The individuals we serve primarily need habitation, not rehabilitation, thus Medicare does not cover the services. To eliminate a place that provides life skills training and maintenance of social and cognitive skills would only increase the risk of injury or deterioration of health and mental well-being to those we serve; this would ultimately lead to increased medical costs for these Medicaid-covered individuals due to the increased risk they would be exposed to by not having a safe haven with qualified staff to interact with on a daily basis.

We respectfully request that you reconsider funding for programs that promote independence and self-worth in this most vulnerable population of our society. Everyone deserves a chance to lead a productive, independent life and make as many choices as possible for themselves.

Sincerely,

Pamela Clay
Executive Director, A.C.S.W., Inc.
P.O. Box 900
Crossett, AR 71635

Submitter : Mr. Charles Harles **Date:** 10/09/2007

Organization : I-NABIR

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

Re: File Code CMS 2261 P http://www.cms.hhs.gov/eRulemaking

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the Federal Register on August 13, 2007. These comments are being submitted on behalf of the Inter-National Association of Business, Industry and Rehabilitation (I-NABIR).

We are very much opposed to the proposed rules and we ask that they be withdrawn. I-NABIR supports the comments submitted by the Consortium for Citizens with Disabilities (CCD). In addition to CCD s comments we are especially concerned that the proposed rules shift the burden of paying for many services needed to achieve and maintain employment to state resources such as the vocational rehabilitation program. The basic state grant program for vocational rehabilitation has received no more than cost of living increases for several years and the Administration has tried to deny the program even this meager increases in its budget for 2008. The Administration has attempted to defund other programs such as Projects with Industry and supported employment that help many Medicaid recipients become employed and self-sufficient.

The added burden of paying for services heretofor reimbursed by Medicaid will only make a bad situation worse. Please withdraw the proposed rules.

Sincerely,
u
Charles Harles, Executive Director

CMS-2261-P-531-Attach-1.PDF

#531

Inter-National Association of Business, Industry and Rehabilitation

PROVIDING KEYS TO EMPLOYMENT FOR PERSONS WITH DISABILITIES

October 10, 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 http://www.cms.hhs.gov/eRulemaking

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. These comments are being submitted on behalf of the Inter-National Association of Business, Industry and Rehabilitation (I-NABIR).

We are very much opposed to the proposed rules and we ask that they be withdrawn. I-NABIR supports the comments submitted by the Consortium for Citizens with Disabilities (CCD). In addition to CCD's comments we are especially concerned that the proposed rules shift the burden of paying for many services needed to achieve and maintain employment to state resources such as the vocational rehabilitation program. The basic state grant program for vocational rehabilitation has received no more than cost of living increases for several years and the Administration has tried to deny the program even this meager increases in its budget for 2008. The Administration has attempted to defund other programs such as Projects with Industry and supported employment that help many Medicaid recipients become employed and self-sufficient.

The added burden of paying for services heretofor reimbursed by Medicaid will only make a bad situation worse. Please withdraw the proposed rules.

Sincerely,

Charles L Harles

Charles Harles, Executive Director

PO Box 15242
202-543-6353
inabir@harles.com

Washington, DC 20003
fax 202-546-2854
www.inabir.org

Submitter : Mr. Walter Grubbs **Date:** 10/09/2007

Organization : FamiliesFirst, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-532-Attach-1.PDF

#532

FAMILIESFIRST

2100 Fifth Street Davis, CA 95618-6591
Tel 530/753-0220 Fax 530/753-3390
www.familiesfirstinc.org

October 3, 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

To Whom It May Concern:

FamiliesFirst 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.

FamiliesFirst is a non-profit, community-based child welfare agency serving California's vulnerable foster youth. Our organization provides treatment services to more than 10,000 children and family members annually throughout Northern and Central California through programs such as foster care, residential treatment, transitional housing for emancipated youth, school programs and community based services.

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

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

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

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to

retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and remission, and the long-term clinical course of these conditions is difficult to determine. As an illustration, *Mental Health: A Report of the Surgeon General*, notes that for people living with schizophrenia, "..a small percentage (10 percent or so) seem to remain severely ill over long periods of time (Jablensky et al., 1992: Gerbaldo et al., 1995). While these individuals can significantly improve, "most do not return to their prior state of mental function." (Mental Health: Report of the Surgeon General, 1999, pg. 274).

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

Section 1901 of the statute specifically authorizes funds for Arehabilitation and other services@ to help individuals 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:

Further clarify that a child need not demonstrate that he or she was once capable of performing a

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

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

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

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

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

providers is an unreal expectation.

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

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

Recommendations:

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

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.

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

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

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

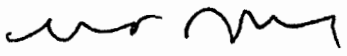
Similarly, a child with a serious mental disorder being reunified with its family may have specific issues directly stemming from the mental disorder. Mental health rehabilitation services

to address these problems (as distinct from generic reunification services) should be covered.

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

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

Sincerely,



Walter Grubbs
President & CEO

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

Submitter : Mrs. Linda Franklin **Date:** 10/09/2007

Organization : Mrs. Linda Franklin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

We believe it is irresponsible for the federal agency ("CMS") to adopt their proposed regulations as written as they fail to clarify the potential impact on the thousands of Pennsylvanian children with autism spectrum disorders and mental retardation who currently receive wraparound services.
We recommend that CMS withdraw the proposed regulations and republish them again for further comment only after they have clarified how the proposed regulations would impact wraparound services for children and adolescents with autism spectrum disorders and those with mental retardation.
My son is currently receiving wraparound services. Without this help, he would not be able to go to school and would certainly wind up in residential services, costing the taxpayers more money than wraparound.

Submitter : **Date: 10/09/2007**

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Dear Mental Health Colleagues,

People with mental illness, family members, and mental health services providers need your help immediately.

A current rule proposed by the Center for Medicare and Medicaid Services (CMS) will have a chilling effect on the ability of states and mental health providers to provide evidence based practices, including Supported Employment services.

Please let CMS know strongly and loudly that psychiatric rehabilitation services are important and CMS should be working to make those services more readily available to people with mental illness.

WE RECOMMEND THE FOLLOWING SPECIFIC NAMI-ENDORSED CHANGES RELATED TO WORK FOR PEOPLE WITH SEVERE MENTAL ILLNESS

1. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

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

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

4. Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

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

Submitter : Mrs. Megan Taylor **Date:** 10/09/2007

Organization : individual

Category : Individual

Issue Areas/Comments

Background

Background

We who are the recipients of this valuable service speak to the essential nature of this intervention for our children. Without it, there will be a greater cost to society with crime,costs of lifelong mental health issues for the children,families who will be broke and broken unable to care for their children. We need more child intervention for the autistic children.

GENERAL

GENERAL

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Regulatory Impact Analysis

Regulatory Impact Analysis

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Submitter : Joanne Connors **Date:** 10/09/2007

Organization : NAMI

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am in complete agreement with NAMIs interpretation of the rehabilitation plan and its needed modifications. While I could copy and paste their letter here, I'm sure you have plenty of those. What I can tell you, is that my illness has had a total cost at a minimum of over a million dollars, and I am just one person. That cost is due to the lousy rehabilitation programs and a complete lack of understanding of these issues by individuals with authority to enact budget changes. Their comments are so on target, and with the help of a directive to replace the ineptitude of psychiatrists, that cost could be down to probably $50,000. It's ridiculous and the system needs to be understood before silly recommendations that reflect the lack of comprehension of the consumers' experiences and needs are placed in black and white permanently for all to see.

Submitter : Jeffrey Walter **Date:** 10/09/2007

Organization : Rushford Center Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-537-Attach-1.DOC

CMS-2261-P-537-Attach-2.DOC

#537

Rushford

HARTFORD HEALTHCARE

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

October 8, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

As President and Chief Executive Officer of Rushford Center, I am submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

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

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

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

  This section should make clear that that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

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

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

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

- 440.130(viii)(3) Written Rehabilitation Plan

  Substitute for the requirement that the plan list alternative providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of existing providers).

- 441.45: Rehabilitative Services

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

- 441.45(b) Non-covered services

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

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

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

Sincerely,

Jeffrey Walter
President and CEO

Submitter : Ms. Regina Bette **Date:** 10/09/2007

Organization : Five Acres

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-538-Attach-1.PDF

#538

five acres

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

October 8, 2007

To Whom It May Concern:

I am the Assistant Executive Director of Five Acres the Boys and Girls Aid Society of Los Angeles County a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization is dedicated to helping families raise children to become caring and productive adults by building on their strengths and those of their communities.

Five Acres 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.

760 West Mountain View Street, Altadena CA 91001-4996
626.798.6793 | *fax* 626.797.7722 | www.5acres.org

Recommendation:

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

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

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

Recommendation:

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

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

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

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (626) 798-6793 ext. 2245.

Sincerely,

Regina Bette, MFT
Five Acres Assistant Executive Director

Submitter : **Ms. Sarah Ranzau** **Date: 10/09/2007**

Organization : **Ms. Sarah Ranzau**

Category : **Individual**

Issue Areas/Comments

Background

Background

See Attachment

Collections of Information Requirements

Collections of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Response to Comments

Response to Comments

See Attachment

CMS-2261-P-539-Attach-1.DOC

#539

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Burnsville, MN 55337
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October 9, 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

I am writing to you today out of great concern about the changes in the rules proposed by the Centers for Medicare and Medicaid to govern Medicaid's rehabilitation service category and how the changes could restrict access to intensive community mental health services needed by children and adults with disabilities who have come to depend on Medicaid for their healthcare, including my own children. The proposed regulations I am referring to are those that were published in the Federal Register on August 13, 2007 (Vol. 72, No. 155, 45201-45213).

As the single most significant source of financing for the public mental health system, Medicaid provides much needed access to community-based care through the rehabilitative services option to help children and adults avoid institutionalization. The proposed new rules could have a profound effect on Medicaid services needed by other vulnerable populations, including people with physical and developmental disabilities.

The Bazelon Center for Mental Health Law submitted 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. As a parent of three children with developmental, physical, and mental health needs that require Medicaid covered services for their rehabilitation; I strongly support and recommend that the submitted comments should be incorporated into the Rule for Coverage for Rehabilitative Services. I have included their comments for your review below.

OVERVIEW (PREAMBLE)

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

restricted from paying for services that are included in the child=s individualized education program.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

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

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

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

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

Recommendation:

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

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

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

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

When developing a rehabilitation plan with the individual, providers should inform the person of their right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated.

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

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

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Recommendation:

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

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

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

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person=s functional capacity B clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

This definition also includes the word Acare@ 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 Amedically necessary@ is used in this regulation to indicate necessary rehabilitation services.

Recommendation:

Add to section (vii) the word Aassessment@ before the word Adiagnosis@ and replace the word Acare@ with the word Arehabilitation.@

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

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

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

Recommendation:

Insert the word Arestorative@ after Amedical@ in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

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

The preamble phrase Aservices are to be provided at the least intrusive level to sustain health and ensure the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level@ should be added to the definition of the scope of services,

and additionally, services should also be required to be provided in the most integrated, appropriate setting.

440.130(viii)(3) Written Rehabilitation Plan

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, we do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed.

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.

Finally, there should be documentation that the provider has provided the individual with information on advance directives.

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.

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

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 encourage a single treatment and rehabilitation plan and a single planning team and service planning meetings.

440.130(4) Impairments to be addressed

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

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

Recommendation:

Section 440.130(4) should be changed to delete A/or@ after the word Aand@ in this sentence.

440.130(5) Settings

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

Recommendation:

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

Mental Health from the U.S. Surgeon General). The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

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

The regulation makes no acknowledgment that therapeutic foster care is a mental health service, provided through mental health systems to children with serious mental disorders who need to be removed from their home environment for a temporary period and furnished intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system; it is not a service exclusively for children in the foster care system.

Recommendation:

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

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

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

441.45(b)(3)

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

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

Recommendations:

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

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

Individuals in Secure Custody and Residing in Public Institutions

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

Recommendation:

Delete the phrase "in secure custody."

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

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

Recommendation

The language in the preamble explaining when services may be furnished through contacts with relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services should be included in the regulation.

OTHER ISSUES

Payment and Accounting for Services

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

These new shifts in rate setting methodology are not efficient and are moreover extremely detrimental to the provision of evidence-based mental health services which are more and more frequently being offered as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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.

Thank you in advance for considering my comments on the proposed regulations.

Sincerely,

Sarah J. Ranzau

Submitter : Dr. Maureen Barber-Carey **Date:** 10/09/2007

Organization : Dr. Gertrude A. Barber National Institute

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I believe it is irresponsible for the federal agency (CMS) to adopt these proposed regulations as written as they fail to clarify the potential impact on the thousands of Pennsylvania children with autism spectrum disorders and mental retardation who currently receive wraparound services. I recommend that CMS withdraw the proposed regulations and republish them again for further comment only after they have clarified how the proposed regulations would impact wraparound services for children and adolescents with autism spectrum disorders and those with mental retardation.

Submitter : Meri-de Mercado **Date:** 10/09/2007

Organization : Monroe County School District

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

8,000 or more students will be negatively impacted by the proposed rule changes. These reimbursement dollars fund some of the cost to provide school health services. Healthy students make better learners. Please feel free to call me with any questions, comments or concerns that you may have. 305.293.1400 x 53360. Respectfully submitted on behalf of the students in Monroe County Florida

Response to Comments

Response to Comments

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Submitter : **Date: 10/09/2007**

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

WE RECOMMEND THE FOLLOWING SPECIFIC NAMI ENDORSED CHANGES RELATED TO WORK FOR PEOPLE WITH SEVERE MENTAL ILLNESS

1. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

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

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

4. Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

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

Submitter : **Ms. Alexandra Gibson** **Date: 10/09/2007**

Organization : **Youth Focus, Inc.**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

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