Submitter : Ms. Verena Wessel **Date:** 10/09/2007

Organization : NWHS Homeless Outreach and Advocacy Project

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

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. Lorie Morris **Date:** 10/09/2007

Organization : Alaska Baptist Family Services

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2261-P-574-Attach-1.PDF

#574

abha & aahc

Alaska Behavioral Health Association

Alaska Association of Homes for Children

March 13, 2007

Karleen Jackson, Commissioner
Department of Health and Social Services
P. O. Box 110601
Juneau, Alaska 99811-0601

Dear Commissioner Jackson,

We are writing to request the Commissioner's office to establish a standard for the use of extrapolation in Medicaid audits that is consistent with the verbal position set forth by representatives from your office in recent ABHA and AAHC meetings.

As you know, many service providers throughout the state have received Medicaid audits conducted by Myers and Stauffer over the past three years. As part of their protocol, Myers and Stauffer selects a sample of Medicaid claims to review for each provider that receives an audit. Based on the findings for the sample claims, the auditors then extrapolate the findings across the full extent of the provider's Medicaid claims during the period being reviewed. In this way, a relatively minor payback attributable to the sample claims often translates to a major repayment for providers once extrapolation is applied. While extrapolation may be statistically valid when considered across all providers, it often does not result in a fair and equitable analysis when applied to the claims of individual providers.

For some time now, ABHA and AAHC has been advocating for a policy change regarding the use of extrapolation in Medicaid audits. We have suggested that the department establish a standard which represents an acceptable performance level in a Medicaid audit. Under our proposed framework, those providers who scored within a predefined acceptable range for the audit sample being reviewed would not be subjected automatically to payback penalties based on extrapolation. This method is currently being used by the state of Oklahoma. The Oklahoma Health Care Authority's policy is to apply extrapolation only in those cases where the error rate for the sample claims exceeds 10%. Those providers who score 90% or higher are not subject to extrapolation; they are only responsible for payback on any overpayments for the sample claims.

We have proposed the above framework to representatives of your office at ABHA and AAHC meetings. We were informed that when the audit contract was rebid, the department would establish a standard for acceptable audit findings that would not be subject to extrapolation. We understand that the bidding process for the audit contract is

currently underway. At the Division of Behavioral Health's recent change agent meeting, we were disappointed to learn that no apparent progress has been made on this issue. Leo Blas, Chief Auditor for your office, informed us that the extrapolation standard has not yet been addressed in the new contract award process for the next round of Medicaid audits. While Mr. Blas acknowledged that this issue could be addressed as an operational protocol once the contract award is made, we received no assurance that an extrapolation standard would in fact be established.

We are now asking the Commissioner's Office to establish a formal policy position on acceptable error rate for Medicaid audits that is consistent with the verbal stance presented to us at the past ABHA and AAHC meetings. In addition, we request that this position be integrated as quickly as possible in the current contract development process for the next round of Medicaid audits.

Thank you Commissioner for your attention to this important issue.

Sincerely,

Steve Horn, Excutive Director
Alaska Behavioral Health Association

Walter Majoros, President
Alaska Association of Homes
for Children

cc. Bill Hogan, Deputy Commissioner
Tammy Sandoval, Deputy Commissioner
Stacy Toner, Acting DBH Director

Submitter : Mrs. Kym Grosso **Date:** 10/09/2007

Organization : n/a

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a mother of a child with autism, I am requesting that CMS not 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.

CMS should 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.

Thank you.

Submitter : Mr. Michael Cohen **Date:** 10/09/2007

Organization : National Alliance on Mental Illness, NH

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Rehabilitation services can positively change the course of a person's life. Many of our families have seen that happen to their child. 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, in pareticular return to work and manage their own illness effectively.

We know what works. But we also know that too many people can't access these treatments; in NH we are working to bring evidence based practices to our consumers and the Medicaid is vitally important to assure that this continues. Yet the terrible consequences are seen in every jail and prison in America if our familiy members do not get these rehab services.
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 see the potential in our loved ones and we see the benefits of rehab services.

We ask that you revise these regulations to make it clear that the federal government encourages any state system, including NH, to do all they can to provide effective treatments to people with serious mental illnesses and utilize the rehab services to the fullest. Thank you.
Michael J. Cohen, Executive Director,
NAMI NH

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

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-577-Attach-1.DOC

#577

HORIZON HUMAN SERVICES
210 E. Cottonwood Lane
Casa Grande, AZ 85222-2514
(520) 836-1688 *FAX (520) 421-2708*

Norman E. Mudd, MA, LMFT
Chief Executive Officer

October 9, 2007

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

Re: File Code CMS-2261P

To Whom It May Concern:

Horizon Human Services 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.

Horizon Human Services has extensive experience providing behavioral health services to residents in Pinal and Gila Counties, including habilitation services in Cochise, Gila, Maricopa, Pinal and Santa Cruz counties. Horizon was incorporated as an Arizona nonprofit corporation in 1975 as the Behavioral Health Agency of Central Arizona. In July of 2000, the agency changed its name to better reflect its expanding role as a full service human services agency. We provide crisis intervention (24-hour services), outpatient counseling, adult residential and partial care, children and family services, vocational rehabilitation and habilitation programs. Additionally, our services extend to prevention and domestic violence services that offer programs including community education, awareness and prevention activities targeting youth and adults.

As a non profit 503c organization, our primary funding source is the Federal government passed through the State Department of Health Services and Cenpatico Behavioral Health of Arizona. In calendar year 2006, we provided over 174,000 services to more than 4,000 participants.

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 services. 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 rehabilitation and other services to help individuals retain capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain an individual's functional level.

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

> *For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.*

"Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met." Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

Additionally, the preamble and section 441.45 (b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss. 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 unrealistic expectation.

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

First, severe mental illness is episodic, and it is not always possible to determine when an exacerbation of the illness may occur. There may be instances in which a person, because of the symptoms of their illness, may not believe they are sick or comply with the signing the treatment plan, and it is also true, that at this point in the individual's life, retention of services are critical to prevent hospitalization, incarceration, or other public or personal safety consequences. 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 the state licensed provider to document reasons that the client, or their representative is not able to sign the treatment plan.

Recommendations:

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

- That this plan be written in plain English so that it is understandable to the individual.
- That the plan includes an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow the state licensed provider to document reasons that the client, or their representative is not able to sign the treatment plan.
- That the plan of services be based on a strengths-based assessment of needs.
- That the plan includes intermediate rehabilitation goals.
- That, as indicated, the plan includes provisions for crisis intervention.
- That the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals.
- Remove the requirement that the plan list the potential alternate providers of the same service. Instead, have 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, and 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,

Norman E. Mudd
Chief Executive Officer

CC: Members of the Arizona State Congressional Caucus
The Honorable Janet Napolitano, Governor of the state of Arizona

Submitter : Ms. Julie Reiskin **Date:** 10/09/2007

Organization : Colorado Cross-Disability Coalition

Category : Consumer Group

Issue Areas/Comments

Background

Background

We would ask first that you revisit the issue of precluding room and board. In some select instances it might be the best way to provide services to include room and board. Psychiatric rehabilitation is one such instance. The patient might need to be in a residential facility while medications are adjusted with simultaneous teaching of social skills. In some cases the patient can pay for room and board with their SSI check, but in other cases that is not possible. This is particularly true for shorter term rehabilitation programs (6 months or less) where the person may need to maintain housing. We support the INTENTION behind the written rehabilitation plan but it will not acheive your purpose of transparancy and accountability without greater reform of the public mental health system. This will become one more piece of paper that is shoved in front of a client at intake or at some annual or care planning meeting. The client will be ordered to sign it, as we are ordered to sign numerous documents in order to get care. If we question or ask that we have true input into our plan, in most mental health settings, we are labeled as troublemakers and often denied services altogether. The way to get to real accountability is to require that all Medicaid funded services have clients on the governing boards, have open board meetings and have an affirmative action hiring process to hire former patients. There are already numerous written plans of care in our lives, most of which folks have no clue what is in the plans even though they have signed that they helped to develop the plan. The regulations say that the plans should have "recovery goals" but do not define what that means. There should also be a requirement that each recipient is asked if they want family, friends or advocates participating. We get regular complaints that recipients who want/need an advocate or a family member to help them with the mental health centers are denied that access. The review about whether or not goals are met should include all factors. Often the client does everything in his or her power but other factors prevent progress. For example if the client cannot get transportation to appointments, or if the clients medication regime is disrupted by the implementation of a preferred drug list the client should not have services cut off because of lack of progress. If rehabilitation is not going to be at all custodial, some sort of psychosocial program for custodial maintanence should be implemented. One does not need highly trained professionals to run these programs but programs like drop in centers where mental health clients can show up and hang out are very important to some of our more seriously ill clientele. Perhaps these services could be added onto the HCBS menu of services. We urge you to keep the setting flexible. Some services will need to be provided on site--for example teaching someone with an anxiety disorder to use a public bus will need to be done on the bus with a trained rehabilitation provider. Similarly, teaching someone with schizophrenia problem solving may need to be done in a variety of settings including the home. It is also important that we balance accountability and flexibility. Many people with psychiatric conditions have accompanying cognitive limitations and may not learn as quickly as non-disabled persons. Therefore they may need significantly more time and lots of repetition to learn or regain a skill. We are concerned about the wording of the limitations and concerned that this is going to create discriminatory practices. You say that these services cannot be provided in the school setting, however for other Medicaid services in the school setting that are part of an IEP or provided through a school based health center Medicaid does pay. Why should this be different?

Collections of Information Requirements

Collections of Information Requirements

It appears as if CMS is casting a wide net and responding with over-regulation to what is likely a serious misuse of funds in a few states. Rehabilitation services are very specific services and should not be used as a catch all. They should be medically necessary. Medicaid is a population that is different from the privately insured population--if the same rules worked for our population we would not need for Medicaid to be there. One main difference historically is that Medicaid covers (or always has covered) services to allow those of us with disabilities to maintain our functional abilities and sometimes even to prevent deterioration. Many of us cannot attain decreased levels of disability no matter how hard we try or no matter how good the care. However many can benefit from Rehabilitation services --both for physical and psychiatric disabilities. The proposed rules constitute a dramatic reduction in services and places Medicaid in a new position that more closely imitates the private sector. These limitations almost always create a greater level of disability and overall dependence. Habilitation should be a central part of rehabilitation. For many people the difference is not as black and white as they appear in your analysis. For example someone with childhood onset schizophrenia could definately benefit from psychiatric rehabilitation as a young adult or even as a teen. However this person would not have previous capacity. This is just one example. By drawing a dramatic distinction that one cannot penetrate one is precluding a needy and deserving population from receipt of these critical services.

GENERAL

GENERAL

Rehabilitation can be critical to the long term independence of the disabled. True psychiatric rehabilitation can be the difference between an independent life and a life bouncing in and out of hospitals. Quality control is definately needed and it is important for the patient/client to be the central driver of the plan, when able. Accountability is important. These regulations do not increase accountability or deal with the serious quality of care problems we have in the area of mental health rehabilitation.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

WE should not be excluding services simply because they may be integral to something else, such as school or a vocational program. If the service is primarily vocational, for example, but has a rehabilitation component, then Medicaid should pay for the medical rehabilitation piece and vocational rehabilitation services or the appropriate entity should be for the vocational aspect. In a situation with something like work hardening, there may be medical, psychiatric and vocational elements that need to be addressed simultaneously. You could make that argument for services that occur in some criminal justice settings as well as some foster care settings. We STRONGLY oppose cutting people with mental retardation out of this service. We can separate the endless costly habilitation from the rehabilitation benefit and have appropriate limitations without engaging in disability discrimination. People with mental retardation are not immune to suffering from strokes, from acquiring schizophrenia, or having other conditions that require comprehensive and quality rehabilitation. Again, the focus on rehabilitation should be on gain or in some cases maintanence or prevention of deterioration. It should not be a bottomless pit with no goals or accountability but you also

cannot pigeonhole people with various disabilities into a hole where you must prove that you previously had the capacity to do something. Rules like this lead to arbitrary enforcement by mental health centers, particularly in states like Colorado where there is little regulation or control over the mental health industry. Personal care should be allowed to be provided during the service. The example you used about an OT having to help a patient change who soiled his clothes during a session is limiting. A more realistic example would be someone is going to day long rehabilitation with various groups. The person needs assistance going to the bathroom and eating. If we do not allow that person to have his assistant come it will exclude that person from participating. We have had complaints in Colorado from people with disabilities who have been denied care in mental health settings for this precise reasons. Mental health provider staff either cannot or will not provide personal care of any kind.

Response to Comments

Response to Comments

We disagree with the regulatory impact analysis. This seems to be a response to poor quality and low accountability that permeates the mental health system. Addressing real problems rather than creating another layer of bureacracy would be a more efficient way to address the problems. We do not agree that this will save $2.2 billion in four years. First, there is not much rehabilitation services going on in general. Any savings from reducing these services will immediately be eaten by criminal justice or higher acute care costs. For example a person might be going to a drop in center and hanging out all day. This might be funded with rehabilitation dollars. Perhaps now it is overfunded and should be funded as an unskilled service but if you take it away at least some of the clients who now have nowhere to go will be showing up in the emergency room. Another example is that if you make rehabilitation so administratively difficult to offer that no provider wants to offer the service you will be creating lifelong dependency. We should be increasing not decreasing rehabilitation. When someone can get high quality intensive psychiatric rehabilitation following onset of a serious illness like schizophrenia they will be more independent forever. We have many people in the Denver area who never received proper rehabilitation services. These individuals are as sick now as they were 30 years ago when they entered the system. They need a significant amount of services. Others with diagnosis just as severe who were able to receive high quality rehabilitation are able to stay out of the hospital and can manage in the community with relatively few services. The fiscal analysis did not take any effects into consideration.

Submitter : Mr. Jeff Yarbrough **Date:** 10/09/2007

Organization : Mr. Jeff Yarbrough

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#579

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 : Dr. Susan Taccheri **Date:** 10/09/2007

Organization : Dr. Susan Taccheri

Category : Individual

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Recommend elimination of Provision 441.45(b)- these services are NOT intrinsic elements of the listed programs- Ther. Foster care, child welfare, education, child care, probation, juvenile justice involvement or public guardianship. If you do not eliminate this provision, the kids in the above programs will be discriminated against and these children would be adversely affected- yet these are our most vulncrable kids!
Please reconsider the 17-point rehabilitation plan which is onerous, duplicative and bureaucratic.

Submitter : Mrs. Alberta Longacre **Date:** 10/09/2007

Organization : Mesa Public Schools

Category : Individual

Issue Areas/Comments

Background

Background

I respectfully request that CMS retratct proposalCMS-2261-P.

GENERAL

GENERAL

Please retract the proposed rule CMS-2261-P

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

Organization : Hale o Lanakila

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-582-Attach-1.DOC

#582

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 15, 2007

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

To Whom It May Concern:

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

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

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

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

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

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

1765 Wili Pa Loop Wailuku Maui Hawaii 96793 Tel 808.984.2156 Fax 808.984.2159 Email: haleolanakila@hawaii.rr.com

Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

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

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

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

Sincerely,

Theresa L. DeCambra
P.O. Box 1827
Makawao, Hawaii 96768

Submitter : **Ms. Marjorie McKisson** **Date: 10/09/2007**

Organization : **California Alcohol and Drug Programs**

Category : **State Government**

Issue Areas/Comments

Background

Background

The proposed regulations as published in the August 13, 2007 Federal Register section 440.130 would require significant and sudden changes in the substance abuse treatment service system. Although the California Medicaid plan for substance abuse services already requires documentation from a licensed physician of medical necessity for services and updated treatment plans (or rehabilitation service) more frequently than once per year, some of the proposed changes are deleterious to persons suffering from substance dependence.

The proposed Regulation 440.130(d)(3)(xiv) appears to require measurable reduction in disability and restoration of functional level on an annual basis. If measurable results are not achieved, a new strategy is required in the treatment plan. This change ignores scientific evidence that substance abuse is a chronic, relapsing illness characterized by observable changes in brain chemistry, according to the federal Substance Abuse and Mental Health Services Agency, the American Society of Addiction Medicine, and other prominent organizations. Acute care is not sufficient to effectively treat substance dependence and the proposed regulations would deny continued Medicaid funding for all patients who achieve the best possible functional level and wish to maintain their hard-earned health improvements through continued services. Denying effective ongoing treatment is likely to result in costs to other health care services.

The proposed Regulations 440.130(d)(3)(v) and 440.130(d)(3)(xiii) requires the service plan to be developed and reevaluated with the active participation of the individual and the individual s family, the individual s authorized decision maker, and/or the person of the individual s choosing. Requiring the participation of another individual would conflict with federal confidentiality regulations for alcohol and other drug services (42 CFR Part 2). Inclusion of another person in the development of an individual s treatment plan may be permissive under 42 CFR if consent is given by the individual. As the proposed regulation is written, this can cause conflict for all states. The proposed regulation does not contain a provision for individuals to waive other individual s involvement.

Substance abuse services are often not distinguished from mental health services, yet many fundamental differences exist. One area where federal statute and regulations considers the two service systems together is within the limit on the number of beds in an institute for mental disease. If this exclusion no longer applied to persons with a primary diagnosis of substance dependence, significant cost efficiencies to state and the federal government could be realized in the delivery of Medicaid substance abuse services.

No provision is made in the regulations for transition to the new requirements. Given the significance of some of the proposed changes, a thoughtful, no-harm transition is necessary to protect the health of beneficiaries impacted by the changes.

For these reasons, the California Department of Alcohol and Drug Programs disagrees with some of the proposed changes and would be very concerned with the resulting reduction in services to Medicaid-eligible patients. If you should have any concerns regarding these comments please contact me at (916) 327-4178 or mmckisson@adp.ca.gov.

Submitter : **Dr. Bruce Romney** **Date: 10/09/2007**

Organization : **Dr. Bruce Romney**

Category : **Individual**

Issue Areas/Comments

Background

Background

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

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

I also urge the CMS to provide opportunity for public comment.

Sincerely,
Bruce Romney

Submitter : **Mr. John Cirillo** **Date: 10/09/2007**

Organization : **Above The Line**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-585-Attach-1.TXT

#585

Above the Line

A community based not-for-profit serving at-risk teens and children since 1976

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

October 9, 2007

To Whom It May Concern:

I am the Executive Director of Above The Line, 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 comprised of a 9-bed teen girl group home and Homes For Kids Foster Care Program. We serve girls 13-18 in our group home and children from 2-18 in our foster care program.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

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

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

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

Recommendation:

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

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically

necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

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

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

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

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

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

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

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

home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

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

Recommendation:

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

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

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Above the Line

A community based not-for-profit serving at-risk teens and children since 1976

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 (831) 724-3077 X201.

Sincerely,

John Cirillo
Executive Director

Above The Line – Group Home Society
2716 Freedom Blvd. Corralitos, CA 95076 831-724-3077
www.abovetheline.org

Submitter : Mr. David `Isaacson **Date:** 10/09/2007

Organization : Compass Rose

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

"see attatchment

#586

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 : **Andrew Adams** **Date: 10/09/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-587-Attach-1.DOC

#587

October 15, 2007

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

To Whom It May Concern:

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

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

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

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

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

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

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment,

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

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

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

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

Sincerely,

Andrew P. Adams
355 Mahalani St. #6
Wailuku, Hawaii 96793

Submitter : Mrs. Sally Linder **Date:** 10/09/2007

Organization : Parent

Category : Individual

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

My daughter has a rare seizure disorder and PDD/NOS (Pervasive Developmental Disorder- Not otherwise specified) Mentally Retarded and my daughter. She will be 16 years old soon. She has utilized the Wraparound Program twice during her life. Her frustration with her disabilities have caused her to become aggresive and difficult to manage at home. The behavior therapists and the TSS (therapeutic support staff workers) have been our salvation. I am a special education teacher and social worker. My husband is a PhD Chemist. We needed this help. It has helped to keep our family safe and has also helped to keep our family together.

GENERAL

GENERAL

If people in my position with experience, education, and support need and can benefit from this wraparound service, just imagine how its continuation can help those without this background. This program can benefit the child, the family, and the community. It will help to support families and prevent possible abuse of at-risk children. It may also help to hold families together and to avoid the high risk of abuse. The Wraparound services may also reach to the school system to support the child within that environment to facilitate his/her success. Please preserve this Wraparound Program.

Submitter : **Dr. Patricia Donoghue** **Date: 10/09/2007**

Organization : **Dr. Patricia Donoghue**

Category : **Individual**

Issue Areas/Comments

Background

Background

This provision would be extremely harmful to many who need services. It should NOT be supported.

GENERAL

GENERAL

THis provision would be very harmful to many. It should not be passed.

Regulatory Impact Analysis

Regulatory Impact Analysis

This provision would be very harmful to many and should not be passed.

Submitter : Mrs. Lisa Mongiello **Date:** 10/09/2007

Organization : Devereux

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

It is so important that parents have Wraparound services. The impact that these services can have on Autistic children are profound, and I cannot describe them in words. Please keep our service. Thank you.

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

Organization : **Lorraine Small**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I have a 46 year old daughter currently receiving services at Road to Responsibility. I strongly oppose the provisions related to excluded FFP for habilitation services and urge you to vote against the proposed SCHIP bill, File Code CMS-2261-P. Please keep day habilitation under the current Medicaid state plan, as the proposed change would not be cost-effective due to increased administrative costs and inefficiencies. It could adversely effect all the current and future people who desperately need these services.
Bi-annual rate review is essential to having well-qualified staff.
We must protect access to day habilitation services for people with developmental disabilities. Please do all you possibly can to prevent File Code CMS-2261-P from being enacted.

My daughter, Michelle, has made tremendous progress in her day program. The various therapies she has received have dramatically improved her life and she thoroughly enjoys the time she spends at her RTR Day-Habilitation program. The nurse on staff has been involved in Michelle's daily life and has been extremely helpful in crucial health matters.

It would be devastating to Michelle and all the other people serviced in day-hab programs if the proposed changes sere made.

I would be deeply appreciative if File Code CMS-2261-P was defeated.

Sincerely yours,

Lorraine Small

Submitter : Mr. Ed Contaldi **Date:** 10/09/2007

Organization : Mr. Ed Contaldi

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:

I 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.
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.
Sincerely yours,
Ed Contaldi
1215 Fitzgerald St.
Phila., PA 19148

Submitter : Ms. Susan Connors **Date:** 10/09/2007

Organization : Brain Injury Association of America

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-593-Attach-1.PDF

#593

Brain Injury Association of America

1608 Spring Hill Dr., Suite 110
Vienna, VA 22182

phone: (703) 761-0750
fax: (703) 761-0755
website: www.biausa.org

October 9, 2007

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

Re: Comments on the Medicaid Rehabilitation Services Option (CMS-2261-P) from the Brain Injury Association of America

Dear Acting Administrator Weems:

These comments are submitted on behalf of the Brain Injury Association of America ("BIAA"). Founded in 1980, BIAA is the leading national organization serving and representing individuals, families and professionals who are touched by a life-altering, often devastating, traumatic brain injury (TBI). Together with its network of more than 40 chartered state affiliates, as well as hundreds of local chapters and support groups across the country, BIAA provides information, education and support to assist the 5.3 million Americans currently living with traumatic brain injury and their families. BIAA strongly supports policies that ensure access to rehabilitative care so that individuals with disability, injuries or chronic conditions - including those with traumatic brain injury (TBI) – may regain and/or maintain their maximum level of independent function and community participation.

On August 13, 2007, the Centers for Medicare and Medicaid (CMS) issued a Notice of Proposed Rule Making (NPRM) that would save $2.2 billion over five years by restricting access to services provided under the Medicaid Rehabilitative Services Option. BIAA strongly opposes this NPRM because it will restrict the ability of state Medicaid programs to provide important community rehabilitative services which many Medicaid recipients with traumatic brain injury rely on to improve and maintain their health and ability to function as independently as possible. **BIAA strongly urges CMS to withdraw the proposed rule.**

Despite the NPRM's stated intent in the preamble – to ensure provision of services in the "best interests" of the recipients – these proposed changes will dramatically decrease access to community-based rehabilitation services for individuals with traumatic brain injury, and, ultimately, result in decreased access to home- and community-based living. This harmful proposal stands in stark contrast to goals associated with President Bush's New Freedom Initiative, the Americans with Disabilities Act and its Olmstead Supreme Court decision,

Medicaid's Money Follows the Person grants, and other government initiatives aimed at improving independent, community living outcomes.

BIAA opposed a similar proposal in 2005 as legislative language sent from the Secretary of the Department of Health and Human Services (HHS) to Congress. HHS offered this legislative proposal as a potential means of achieving savings in the Deficit Reduction Act of 2005 (DRA). However, the proposal was ultimately rejected by Congress due to serious concerns regarding its impact on access to community living for individuals with disabilities and the financial strains it would place on state and local governments. BIAA remains unclear as to why CMS continues to push these harmful changes when there is such widespread concern regarding their impact from Members of Congress, states, providers, clinicians, and advocates. If changes to this benefit are needed, the legislative process is the appropriate process and BIAA therefore requests that CMS withdraw this proposed rule to make substantial changes to the Medicaid Rehabilitative Services Option without Congressional directive.

BIAA would like to provide the following comments on specific provisions with in the NPRM:

Written Rehabilitation Plan((§440.130 (d)(3))

The NRPM would require a written rehabilitation plan to be developed for each individual receiving services under the Rehabilitative Services Option. This section states that the rehabilitation plan would establish a basis for evaluating the effectiveness of care offered in meeting the stated goals, provide a process to involve the beneficiary and other stakeholders in the management of the rehabilitation care, and document that the services are allowable under the regulations. The rehabilitation plan would include a timeline based on anticipated rehabilitative "progress" to be revaluated yearly and if no progress is determined upon evaluation, it appears that a new plan would have to be drafted.

BIAA does not oppose the implementation of a written rehabilitation plan and supports the NPRM's requirement that virtually all stakeholders be involved in the process of establishing the written plan including the individual receiving services and their family and/or guardian. However, BIAA is concerned that the written plan could be used as a basis for termination of services when sufficient "progress" is not achieved according to the plan, leading to exacerbation of the individual's condition and requiring a higher level of support.

Given the variability of mental illness, developmental disabilities and cognitive impairments – including those caused by a traumatic brain injury - it would be difficult for many providers, clinicians, consumers and other stakeholders to develop written rehabilitation plans that accurately predict the functional progress to be made by most individuals with these disabilities. In addition, some of these conditions are episodic in nature and change dramatically

over time. We encourage CMS to ensure that determinations of appropriate rehabilitative "progress" (and any termination of services based on these determinations) are made on a case-by-case basis by qualified experts.

Requirements and Limitations for Rehabilitative Services – Limitations for Rehabilitation Services

The Intrinsic Element Standard (§441.45 (b)(1)):

The NPRM would disallow Federal Financial Participation (FFP) for services under the rehabilitative services option that are considered an "intrinsic element" of another federal, state or local program. *Section V "Regulatory Impact Analysis," Subsection C "Alternatives Considered,"* of the NPRM states that, in drafting this regulation, the agency considered "not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs." However, the rule also states that the absence of this provision would result in a "less efficient use of Medicaid funding because.... increased Medicaid funding would have simply replaced other sources of funding." BIAA strongly disagrees with these assumptions.

Implementation of the intrinsic element standard would essentially remove the Medicaid safety net, a defining characteristic of this entitlement program. Medicaid coverage is already subject to third party liability – a standard which establishes Medicaid as the "payor of last resort" without harming the beneficiary. BIAA feels that this proposed "intrinsic element" standard is not only unnecessary in light of third-party liability standards already in place, but will have the unfortunate impact of reducing access to vital rehabilitative services for many individuals with traumatic brain injury currently receiving them under this option. Without these rehabilitative services, many individuals with TBI are at grave risk of 'falling through the cracks' and/or will eventually require higher level, less community integrated and far more costly levels of care, including emergency room over utilization, skilled nursing facilities, psychiatric settings, incarceration and homelessness.

As written, the new policy appears to exempt federal Medicaid from covering its share of the cost of rehabilitative services that may be *allowable* under vocational, prevocational, educational, substance-abuse, mental health, foster care, and assisted living programs. However, the rule does not indicate that the services *must* be provided by these other programs or received by the beneficiary in order for Medicaid to withhold FFP. As a result, the onus is taken off Medicaid to ensure access to these services and placed instead on the Medicaid recipient who, in cases where traumatic brain injury results in significant cognitive impairment, will often be unable to navigate the bureaucracy that limits access to rehabilitation.

Denial of FFP does not simply render important Medicaid rehabilitative services unnecessary. State and local governments may attempt to help ensure that individuals maintain access to these services at substantial costs to their governments. However, state and local governments face significant, and sometimes severe, budgetary constraints. The ability of these governments to absorb this cost-shift will vary widely and significant access problems will result. While there indeed may be discretionary federal, state, and local programs that allow provision of rehabilitative services similar to those currently being provided under Medicaid, there is no indication that these other programs will be able to provide such services to a large influx of Medicaid recipients. This disruption in the continuum of care for some of that nation's most vulnerable individuals, including those with traumatic brain injury, will ultimately lead to greater institutionalization and less independent living, likely costing Medicaid more in the long-term. More clarity is needed regarding implementation of this new language; however, it appears to establish a very dangerous standard.

Exclusion of Habilitative Services (§441.45 (b)(2)):

The NPRM also proposes to exclude FFP for all rehabilitative services that assist individuals in attaining and/or maintaining function (as opposed to *regaining* function) under section 1905(a)(9) or 1905(a)(13) of the Social Security Act. CMS refers to such services as "habilitative" and proposes to include services provided to individuals with "mental retardation or related conditions" in this habilitation exclusion.

BIAA is very concerned that CMS is trying to force a medical model onto a benefit clearly designed to provide psychosocial rehabilitation services to individuals with complex disabilities, such as those caused by traumatic brain injury. A narrowed focus on short-term medical rehabilitation, which one might complete initially following an injury or accident and likely involves time-limited services, leaves out the important concept of post-acute rehabilitation, which is a critical aspect of the continuum of care for individuals with traumatic brain injury. For such individuals, maintenance and attainment of function years after the initial injury is as important as – and often contributes to – the regaining of function.

For example, multiple studies have documented demonstrated functional gains in individuals who have participated in Community Integrated Rehabilitation (CIR) programs, delivered in the post-acute phase of recovery, (i.e. many years following the initial injury).[1] In particular, one study found that participation in a Comprehensive Holistic Day Treatment CIR

[1] Trudel, T.M., Nidiffer, F.D. & Barth, J.T. (in press). Community integrated brain injury rehabilitation: Treatment models and challenges for civilian, military and veteran populations. *Journal of Rehabilitation Research and Development.*

program significantly improved societal participation and social functioning even among individuals with a long history of limited participation after brain injury.[2]

The regulation points out that while habilitation services may not be allowable under the rehabilitative services option, Medicaid will cover such services in two ways - in an ICF/MR or under the home-and-community-based services (HCBS) waiver/HCBS option. CMS seems to imply in the proposed rule that this habilitation provision will not deny access to such services, but, rather, simply shift services from coverage under one benefit to another. However, BIAA does not believe that solely providing habilitation services under these alternatives benefits will reach all of the individuals in need of such care. Clearly, if this were the case, there would be no budgetary savings associated with this provision.

For example, an ICF/MR would not be an appropriate setting for many individuals to receive habilitative services, specifically when such habilitative services may prevent them from reaching the institutional level of care required by the ICF/MR benefit.

Additionally, the HCBS waiver has much stricter eligibility requirements than the Medicaid Rehabilitative Services Option (as does the new HCBS option, although regulations implementing this option have yet to be published). BIAA urges CMS to refrain from pushing states onto waivers to provide appropriate rehabilitation services when, for many years, states have been successful in using the flexibility currently allowed by the Rehabilitative Services Option to best serve the needs of their populations, including individuals with traumatic brain injury.

Several states currently provide important habilitation services to Medicaid recipients with disabilities through adult day habilitation programs. Section 6411(g) of the Omnibus Budget and Reconciliation Act of 1989 (OBRA 89) placed a moratorium on elimination of coverage of day habilitation services for people with mental retardation/developmental disabilities, including persons who sustained traumatic brain injuries prior to age 18, in states that included such services in their state Medicaid plan prior to enactment. The statute states that CMS may issue a proposed rule outlining the specific types of day habilitation and related services that a state may cover under the rehabilitative services option and CMS contends that the NPRM issued on August 13, 2007 serves as the NPRM referenced by OBRA 89. However, BIAA argues that the terms set forth in this proposed rule would completely *eliminate* day habilitation services from coverage under the Medicaid rehabilitative services option and, thus, are inconsistent with the terms set out in OBRA 89 which explicitly permit CMS to specify the *types* of day habilitation and related services covered under this option.

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[2] Malec, J. "Impact of comprehensive day treatment on societal participation for persons with acquired brain injury." *Archives of Physical Medicine and Rehabilitation*, Vol. 82, July 2001.

Conclusion

In conclusion, BIAA strongly supports increased utilization of community rehabilitative services, not only for the millions of civilians who live with the life-long effects of TBI, but also the thousands of brave men and women who sustain traumatic brain injuries while serving in Iraq and Afghanistan. Our nation has moved beyond institutionalization as an acceptable standard of care and efforts to slow or block the shift to community-based care, as is the case with this NRPM, represent poor public policy. **BIAA strongly urges CMS to withdraw the proposed rule.**

Thank you for this opportunity to comment.

Sincerely,

Susan H Connors

Susan H. Connors
President/CEO

Submitter : **Mrs. Susan F. Rzucidlo** **Date: 10/09/2007**

Organization : **Mrs. Susan F. Rzucidlo**

Category : **Individual**

Issue Areas/Comments

Background

Background

I would like to ask CMS to Withdraw, Revise and Republish proposals with clarification of impact to children with ASD and MR

Also I would ask you to allow sufficient a sufficient comment period so that individuals and families impacted may respond as needed.

Submitter : Mrs. Susan Healy **Date:** 10/10/2007

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

This change would severely impact the day hab program our daughter currently goes to. To maintain her physical and mental wellbeing and to prevent regression this program is critical and essential, any cuts to these services for these kids is criminal. Our daughter lives with us and without this program in place for her to receive these srvices on a daily basis she would become impossible to manage at home. If it's all about the money you are very short sighted, keeping her as healthy as possible is the least expensive way to go.

Submitter : Joan Pierce **Date:** 10/10/2007

Organization : Club Nova

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

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

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by (insert your name, address and affiliation)

Dear Sir or Madam:

We appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. Commenting as the Executive Director of Club Nova, a certified clubhouse model program, the clubhouse model is one of the most comprehensive, cost effective, successful programs in the nation working with individuals living with severe and persistent mental illness. Our members have personally experienced the effectiveness of rehabilitation services offered through the clubhouse and have been able to participate in their communities as a direct result of these services.

The changes in the rules proposed by the Centers for Medicare and Medicaid (CMS) to govern Medicaid s rehabilitation service category set forth exclusion, after exclusion, after exclusion. Individuals living with mental illness already experience enough exclusion without having their most basic mental health care coverage excluded . The proposed rules will restrict access to necessary intensive community mental health services needed by children and adults with disabilities who rely on Medicaid for their health care. We need changes for individuals living with mental illness that are inclusive, not exclusive.

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

Access to rehabilitative services can make all the difference in a person s life. We have seen people utilize services to help them recover from their illness. With services and support, individuals with serious mental illness can and do live meaningful lives in the community. We have also seen those who can t get help and the pain and trauma that results from untreated mental illness for the individual, his or her family, and the community.

Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better outcomes, such as stable housing and employment. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses.

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

For every poor grade NAMI gave, we know that there are hundreds of thousands of individuals who are being jailed, living on the streets, dropping out of school, and dying because they were unable to access the necessary services that we know work. These services not only work, these services save lives.

For this reason, we are particularly adamant that any new regulations governing rehabilitation services include and facilitate the provision of these services and in no way discourage and exclude systems and providers from increasing the availability of these critical services. We are very t

Submitter : Dan Coleman **Date:** 10/10/2007

Organization : Carrboro Board of Aldermen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

CMS proposed regulations would withdraw services to some of our nation's most vulnerable citizens. We have an invaluable service agency operating in our downtown. It would be a great loss to our community were their ability to deliver services compromised by the proposed rule changes. Continuing current funding levels without compromise is essential to maintaining their operations.

In particular, I ask that you not time limit the provision of services to clients who depend upon them and that you do not overly burden service agencies with increased documentation and paperwork.

Submitter : Mr. J.T. Knoll **Date:** 10/10/2007

Organization : Pesciluna Center

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

I SUPPORT 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 : **Date: 10/10/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Background

Background

Withdraw, Revise and Republish proposals with clarification of impact to children with ASD and MR

Allow sufficient comment period so that individuals and families impacted may respond

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

Organization :

Category : **Speech-Language Therapist**

Issue Areas/Comments

GENERAL

GENERAL

We believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: 'Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.' The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Submitter : Dr. Paul Yoder **Date:** 10/10/2007

Organization : Oaklawn Psychiatric Center, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I strong urge elimination of Provision 441.45(b)which disallows billing MRO for kids who are in Therapeutic Foster Care programs, child welfare, education, child care, vocational, probation, juvenile justice or public guardianship. It makes the assumption that these clinical services are 'intrinsic elements' of these programs. This is very problematic: the rules are silent on how they made determination that these clinical and case management services are provided; it seems to discriminate against kids who happen to be places in these alternative settings; it assumes there is duplication of service provision or duplicate billing which is not true (as we carefully adhere to bundled and un-bundled billing practices; and it assumes that the clinical and case management services we provide are being provided by DCS caseworkers, probation officers, school teachers, etc. At the very least, more time and clarification is needed to figure this out and/or secure alternate sources of funding. As proposed it has the potential to decimate true mental health medical services for these populations.

I urge reconsideration of the 17-point rehabilitation plan. This requirement is unduly burdensome, duplicates treatment plan requirements already in place (e.g. Joint Commission)and simply adds more bureaucratic costs, further reducing funds available to actually deliver services to our most vulnerable citizens.

I urge further clarification of 'restorative services' when we're working with kids (who are still developing) and chronically mentally ill adults where the continuation of services is at times essential for functioning. You don't stop paying for insulin because today the diabetics blood sugar is in the normal range. Don't stop paying for mental health services because today the schizophrenic is not hearing voices.

Collections of Information Requirements

Collections of Information Requirements

Re: "restorative services." When the decision was made in the 1960's and 70's to "deinstitutionalize" the severely and persistently mentally ill, community mental health services were established to provide care needed in the communities. As courts made it increasingly difficult to force treatment compliance in the communities, the prison system has become the new psychiatric state hospital. This proprosed rule change would only further accellerate that process. We will pay for caring for and treating these vulnerable citizens WHO ARE ILL. Please don't further shift the costs of medical care to REinstitutionalization through the criminal justice system.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Regulatory Impact Analysis

Regulatory Impact Analysis

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

we should keep day hab under the state plan because indviduals will be at risk to the loss of nursing care and therapy services ,a cap could be put on the number of individuals in a program,the new program will not cover developmental disabilities,and would also create a increase in administrative inefficienies and would not be cost -effective. leave it as is ,it is working for the state plan and will continue to be a sucess if left alon,thank you

Submitter : Mr. Joe Greene **Date:** 10/10/2007

Organization : Mr. Joe Greene

Category : Individual

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

Clarify that rehabilitation services should be covered in any setting permitted by state law, including schools.
Add the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to ? 440.130(d).

Submitter : Mr. Mark Combs **Date:** 10/10/2007

Organization : Center for Mental Health, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-604-Attach-1.DOC

#604

October 10, 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 an employee of The Center for Mental Health, Inc. (CMH) and 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.

CMH is a private, not-for-profit community mental health center serving 7,000 children, adolescent and adult residents of East Central Indiana annually with serious mental illness and substance use disorders. CMH provides a full continuum of services to include psychiatry and medication, inpatient, outpatient, residential, therapeutic foster care and community-based services including Assertive Community Treatment and case management. CMH also provides specialty services such as HIV Care Coordination, housing services, and Supported Employment. CMH is a managed care provider for the Indiana State Division of Mental Health and Addictions as well as an Indiana Health Care Provider serving Medicare and Medicaid eligibles. CMH also is a provider for other third party payers and serves uninsured individuals under a sliding scale fee. CMH has been a certified community mental health center for 40 years and has been continuously Joint Commission accredited since 1986.

I have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that my agency serves. Below are my recommendations relative to four specific areas of the proposed rule:

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

Please 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

Please include 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)

Please 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

Please drop this entire section 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,

Name
Mark Combs, Program Coordinator

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

Submitter : Mrs. Tiffany Sherwood **Date:** 10/10/2007

Organization : The Center for Mental Health

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-605-Attach-1.PDF

#605

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-606-Attach-1.DOC

#606

October 10, 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 an employee of The Center for Mental Health, Inc. (CMH) and 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.

CMH is a private, not-for-profit community mental health center serving 7,000 children, adolescent and adult residents of East Central Indiana annually with serious mental illness and substance use disorders. CMH provides a full continuum of services to include psychiatry and medication, inpatient, outpatient, residential, therapeutic foster care and community-based services including Assertive Community Treatment and case management. CMH also provides specialty services such as HIV Care Coordination, housing services, and Supported Employment. CMH is a managed care provider for the Indiana State Division of Mental Health and Addictions as well as an Indiana Health Care Provider serving Medicare and Medicaid eligibles. CMH also is a provider for other third party payers and serves uninsured individuals under a sliding scale fee. CMH has been a certified community mental health center for 40 years and has been continuously Joint Commission accredited since 1986.

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

Please 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

Please include 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)

Please 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

Please drop this entire section 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.

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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,

Stephan D. Deering
Applications Programmer/Analyst

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

Submitter : Mr. Gary Scott **Date:** 10/10/2007

Organization : Center for Mental Health

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#607

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 : **Date: 10/10/2007**

Organization : **The Center for Mental Health**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-608-Attach-1.PDF

#608

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
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Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : Dr. Jonathan Gransee **Date:** 10/10/2007

Organization : Jonathan M. Gransee, Psy.D. and Associates, P.C.

Category : Other Practitioner

Issue Areas/Comments

GENERAL

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Response to Comments

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