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

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

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

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

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

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

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

Submitter : Mrs. Phoebe Clark **Date:** 10/10/2007

Organization : Mrs. Phoebe Clark

Category : Individual

Issue Areas/Comments

Background

Background

As the parent of an adult child who has suffered a mental illness for more than half his lifetime, my concern is the over regulation of most processes. A written rehabilitation plan with the involvement of the family and the person with the mental illness is not always possible. There are times the mental illness is so severe that the person is incapacitated and unable to participate in his own rehabilitation. There are also times when the individual may be incarcerated or hospitalized and unable to participate in that plan. Please relax the regidity of the regulation to allow for such contingencies. Many times the illness renders the person incapable of understanding why they need treatment. This takes time and patience. The very last place that funds should be cut from is for the mentally ill. They are part of our society and can become productive citizens of the United States given the time and treatment that they deserve.

Submitter : **Ms. Jewell Vance** **Date: 10/10/2007**

Organization : **East MS State Hospital**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

People living with mental illness need treatment that has been proven to be effective. Evidence-based interventions like Assertive Community Treatment programs are needed to help them remain in the community. Please support Medicaid Rehabilitation Services!
Jewell Kay Vance, LSW

Submitter : Dr. Ron Farkas **Date:** 10/10/2007

Organization : Chester County Intermediate Unit

Category : Other Government

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule will have a seriously negative impact on children with disabilities, particularly children with autism or emotional disturbance, who will be deprived of services in their home or community (even if education implements services through their IEPs).

Has CMS determined what effect such 'cost shifting' will have on local school districts, which will no longer be able to obtain partial reimbursement for services such as Personal Care Assistant or Psychological Counseling through the School-Based ACCESS Program?

Similarly, IDEA allows that when a student with a disability needs as part of his/her free and appropriate public education (FAPE) a related service to which he/she is also entitled through Medicaid, the service is to be paid for by Medicaid. In many instances, Behavioral Health Rehabilitative Services are providing the IEP services the student requires (i.e. Therapeutic Staff Support to assist the student to achieve behavioral goals which are also medically necessary, or Mobile Therapy to deliver Psychological Counseling). If BHRS is no longer funded for these students, the school district will absorb the full cost. Has CMS studied the impact of this on local school districts?

Ron Farkas, Ph.D.
Director of Student Services
Chester County Intermediate Unit
455 Boot Road
Downingtown, PA 19335

Submitter : Dr. Lori D'Angelo **Date:** 10/10/2007

Organization : Magnolia Clubhouse, Inc.

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-2261-P-660-Attach-1.TXT

#660

Magnolia Clubhouse, Inc.
11101 Magnolia Drive
Cleveland, Ohio 44106-9808

(216) 721-3030 *Fax (216) 721-0105*

A Member of the International Center for Clubhouse Development

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October 4, 2007

Center 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:

Magnolia Clubhouse represents 300 members and staff who are in opposition to the proposed new CMS rules on Medicaid Rehabilitation services. In response to the recent request for comments on the Proposed New CMS Rules we are submitting the following opinion.

The last Surgeon's General Report and the recent New Freedom Commission on Mental Health both concluded unequivocally that the current community mental health system is fragmented, underfunded and inadequate. The reports also urged systems to provide vitally needed supports for psychosocial rehabilitation and employment in particular, and demonstrated a current emphasis on crisis oriented services. Without the recommended community support system, there is a resulting increased reliance on more expensive and time limited acute care.

In addition, research has demonstrated the effectiveness of comprehensive treatment in the promotion of recovery, including employment. Research has also demonstrated the effectiveness of early comprehensive interventions on preventing more chronic courses of mental illness. Information from all of these sources and the science of the field unanimously support the need and effectiveness of services beyond medication. Based on incident rates, we know only about 15% of those who have a mental illness are receiving any kind of treatment. The vast majority of those in treatment are primarily provided medication, and linkage with financial benefits, and even these very basic services are often in short supply and compromised by limitations and restrictions in funding for outreach and linkage.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect on an already inadequate community mental health systems, at the local level in many states and threaten to do the same

Magnolia Clubhouse, Inc.
11101 Magnolia Drive
Cleveland, Ohio 44106-9808

(216) 721-3030 *Fax (216) 721-0105*

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throughout the country. The effect of the rule changes may be well intentioned but in practice they are creating a situation where even the limited but medically necessary services and supports are being further reduced or eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes limiting rehabilitation services may be appropriate for people with very circumscribed physical rehabilitative needs, people with long term mental illness, more similar to those with traumatic brain injuries, often have long term needs, for a wide array of holistic supports.

Many of the proposed rule changes reduce access to services that more progressive communities have been able to provide. These service systems have been working effectively with CMS approved Medicaid funding for more than ten years. However, with the recent changes in CMS practice, many community support systems now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need and an already fragmented system of inadequate care is further reduced.

Vast numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future. In addition, the reduction or elimination of existing services puts individuals with severe and persistent mental illness at even greater risk of unnecessary institutionalization in our hospitals or even worse in our prison system. People who live with mental illness are tragically overrepresented in prison, among the homeless and are living shorter lives and are more frequently committing suicide.

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 services and supports.

A similar problem in the proposed changes is that although the concept of "person centered" services and rehabilitation plans would appear to be an improvement, the change seems misnamed and short sighted, as it results in the exclusion of "person centered" and vital recovery focused supports 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 and holistic support in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social

Magnolia Clubhouse, Inc.
11101 Magnolia Drive
Cleveland, Ohio 44106-9808

(216) 721-3030 *Fax (216) 721-0105*

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service providers, and have a history and network of members leading more gainful and meaningful lives due to their involvement in Clubhouse communities around the world.

Therefore it is our opinion that none of the proposed rule changes should be implemented unless 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.

We are very concerned that the proposed re-organization of funding for long approved services in an effort to reduce short term spending will result in unnecessary - and more costly emergency spending and an 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 but still fragile support networks that have allowed millions of Americans with serious mental illness to begin the long and difficult process of rebuilding their lives. We believe the proposed changes are not in the best interest of those of us who live with mental illness and urge you to reconsider.

Sincerely,

Submitter : Ms. Christina Bumgardner

Date: 10/10/2007

Organization : Ms. Christina Bumgardner

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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

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

Submitter : **Mrs. Emma G. Mullendore** **Date: 10/10/2007**

Organization : **Foster Parent for Okolahoma DDSD**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Ladies and Gentleman,

Although I support the reqirements for having TFC providers to have proper education, training in the area of their services, it is my concern that in a society where foster parents are already in short supply. By reducing the options for placements for children in Child Welfare custody, we are setting families and states up for a reduction in services options which are least restrictive, in their communities and individualised.

My husband and I are foster parents and have served over 44 children in our home since 1990. ALL foster children have suffered trauma from just being removed from their family of origin, let alone any trauma they have experienced as a result of the removal. The children in our home have used rehabilitative services, as well as habilitative services to improve their social skills, improve their self esteem and improve the quaility of their lives.

I can support part of your proposal, but the "intrinsic to" portions is quite confusing. Congress rejected adopting this in the Deficit Reduction Act, so why is it now an option? On whose authority?

The states a already stretched to try and meet the needs of their children in custody, which they are required to do. In Oklahoma there has been great support by both the state programs, buisness sectors, providers, religious community as well as families and youth to make changes in the way services are provided. We have put a great deal of work into colaborating with each other and though we still have a way to go, it is in my opinion that the proposed changes would strangulate our progress.

Thank you for allowing my comments.

Emma G. Mullendore

Submitter : **Ms. Adrienne Relyea** **Date: 10/10/2007**

Organization : **North Jersey Friendship House, Inc.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

The current rule proposed by the Center for Medicare and Medicaid Services will have a chilling effect on the ability of states and mental health providers to provide evidence based pratices, including Supported Employment Services. I feel very strongly that psychiatric rehabilitation services are extremely important to those individuals suffering from mental illness and that CMS should be working to make services more readily available to these individuals instead of working to take services away.

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

1. I do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illness. I 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. I 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. I 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.

IT SHOULD BE THE GOAL OF EVERYONE IN GOVERNMENT AND AT CMS TO DO EVERYTHING POSSIBLE TO HELP INDIVIDUALS WITH MENTAL ILLNESS ACHIEVE THEIR HIGHEST LEVEL OF FUNCTIONING. ALLOWING THESE INDIVIDUALS TO RECEIVE PSYCHIATRIC REHABILITATION SERVICES IN THE LONG RUN WILL BE COST EFFECTIVE AS THEY RETURN TO THEIR PRIOR LEVEL OF FUNCTIONING AND NO LONGER BE IN NEED OF SERVICES/BENEFITS.

Submitter : Dr. Carol Fuller Powell

Organization : Charis Youth Center

Category : Other Health Care Provider

Date: 10/10/2007

Issue Areas/Comments

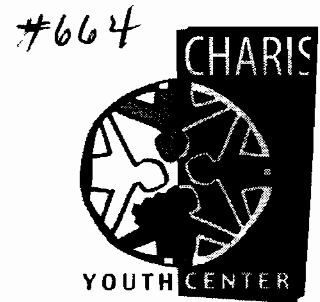
GENERAL

GENERAL

See Attachment

CMS-2261-P-664-Attach-1.DOC

#664



Changing Communities One Youth at a Time Since 1984

October 9, 2007

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

To Whom It May Concern:

I am the Executive Director of Charis Youth Center, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides Residential Treatment, Nonpublic School (Special Education), Mental Health, and Day Treatment services to emotionally challenged and troubled adolescents. We will soon begin providing Wraparound services to Nevada County children and families.

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

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.

accredited member
California Alliance
OF CHILD AND FAMILY SERVICES
www.cacfs.org

Charis Youth Center · 714 West Main Street · Grass Valley, CA 95945 · (530)477-9800
Fax (530)477-9803 · office@charisyouthcenter.org · www.charisyouthcenter.org

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

Recommendation:

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

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

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

Recommendation:

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

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

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

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

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

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

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

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental

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

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

Recommendation:

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

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

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (530) 432-9800 ext. 201.

Sincerely,

Carol Fuller Powell, Ed.D.
Executive Director

CP:vb

Submitter : Dr. Dale Klatzker

Date: 10/10/2007

Organization : The Providence Center

Category : Health Care Provider/Association

Issue Areas/Comments

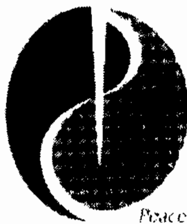
GENERAL

GENERAL

See Attachment

CMS-2261-P-665-Attach-1.PDF

#665



The Providence Center

Peace of Mind in Community Care

Mental health and substance abuse care and treatment services for adults, children, adolescents and families

October 4, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Providence Center 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.

Since 1969, The Providence Center has operated as a community mental health center in Rhode Island and neighboring southeastern Massachusetts. Our mission is to help people of all ages who are affected by psychiatric illness, emotional problems, and addiction by providing treatment and supportive services within a community setting. Last year we served over 10,000 individuals. We rely on federal, state, and City of Providence funding as well as donations from foundations, corporation and private entities.

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

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

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.

Accredited by the Joint Commission on Accreditation of Healthcare Organizations

528 North Main Street, Providence, RI 02904 • (401) 528-0123 • (800) 456-0300 • Fax (401) 528-0124
www.providencecenter.org • TDD (401) 274-2599

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

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

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

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

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

Additionally, The preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss has a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory,

as well as other communication and social skills that are neccssary 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 cxample 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 organizations serving individuals in need of rehabilitative services.

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

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

prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

We are concerned by the requirement that the plan include information on alternate providers of the same service. In Rhode Island, the number of providers willing to accept Medicaid reimbursement is small, and access is already difficult. To expect that the treating clinical team, responsible for planning with the client, to now become familiar with alternate providers is an unreal expectation, and adds significant administrative burden. What are the implications for the provider who unknowingly omits to mention a possible alternative?

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

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

<u>Recommendations</u>:

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

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated

achievement of long-range and intermediate rehabilitation goals;

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

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

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

There is little clarity in the regulation on how this provision would be applied as the regulation

provides no guidance on how to determine whether a service is an Aintrinsic element@ of another program.

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

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

Recommendation:

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

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

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

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.
It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an

especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child=s functional impairments should be a covered service.

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

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

OTHER ISSUES

Payment and Accounting for Services

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

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

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

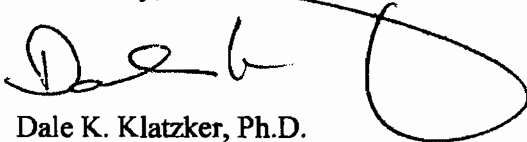
Section 441.45(b)(4), which refers to services having to be targeted under the State=s plan, should be amended to reference EPSDT for children.

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

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

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

Yours truly,



Dale K. Klatzker, Ph.D.
President/CEO
The Providence Center

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

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CMS-2261-P-666

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

Organization :

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-666-Attach-1.DOC

#666

Liberty Union High School District

20 Oak Street
Brentwood, CA 94513
Phone: (925) 634-2166 Fax (925) 634-1687
Daniel M. Smith, Superintendent

October 10, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: **CMS-2261-P Rehabilitation Services**

To Whom It May Concern:

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.

Therefore, we respectfully request that CMS retract this proposed rule to the extent that it applies to school-based rehabilitative services provided to or on behalf of children with disabilities.

Sincerely,

John Saylor
Director, Special Services

CMS-2261-P-667

Submitter : Mr. Raymond Scheppach

Organization : National Governors Association

Category : State Government

Date: 10/10/2007

Issue Areas/Comments

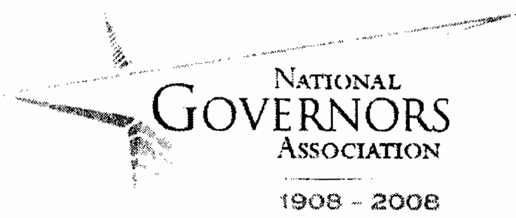
GENERAL

GENERAL

See Attachment

CMS-2261-P-667-Attach-1.PDF

#467



Tim Pawlenty
Governor of Minnesota
Chair

Edward G. Rendell
Governor of Pennsylvania
Vice Chair

Raymond C. Scheppach
Executive Director

October 10, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Mr. Weems:

On behalf of the nation's governors, we request that the Centers for Medicare and Medicaid Services (CMS) rescind the proposed rule regarding Medicaid rehabilitation services [CMS 2261-P], published in the *Federal Register* on August 13, 2007. Governors recognize the need to ensure that Medicaid reimburses for appropriate services and that enrollees are involved in developing and evaluating their plan of care. However, the proposed rule represents a significant departure from states' authority to provide necessary health-related services for Medicaid enrollees, and would unnecessarily shift costs to states by reducing federal Medicaid expenditures by $2.2 billion over five years without eliminating the need for such services.

The proposed rule would make significant changes to the definition and financing of Medicaid rehabilitation services. It seeks to create a firm distinction between rehabilitation services and habilitation services, which must be paid for by other programs. However, as proposed, this delineation does not adequately account for the complex nature and scope of these necessary services.

States have made tremendous progress in designing programs to address the needs of Medicaid enrollees. In addition, initiatives already are underway in many states to involve Medicaid enrollees in developing and reviewing their plan of care, when appropriate. Combined with other initiatives, these efforts are creating comprehensive and streamlined programs that can result in a seamless care delivery system for enrollees as well as improved quality and cost efficiencies. Rehabilitation services are an important component of such efforts.

In particular, mental health accounts for more than three-quarters of the services covered by Medicaid under existing rehabilitation plans. Implementing this rule may limit Medicaid coverage of these services and shift costs to already overburdened state mental health systems. Therefore, to avert any gaps in services resulting from the proposed changes in the definition and financing of rehabilitation services, CMS should preserve state authority to determine and cover the most appropriate services.

Hall of the States * 444 North Capitol Street * Suite 267 * Washington, D.C. 20001-1512
Telephone (202) 624-5300 * www.nga.org

The proposed rule also addresses licensure and certification requirements for Medicaid providers delivering rehabilitation related services. We strongly urge you to defer to state standards and treat as final and binding determinations regarding the medical necessity of an item or service made by state- licensed or certified providers working in an educational program or setting.

In the past, governors have worked with the Administration and the Congress to develop important Medicaid reforms. The proposed policy by CMS (2261-P) was developed without sufficient outreach and could significantly restrict access to vital rehabilitative services for Medicaid-eligible individuals. The far-reaching nature of this rule and other recent regulations requires a more thoughtful, wide-ranging and collaborative effort. We recognize the complexities of these services and would welcome an opportunity to work collaboratively with CMS to establish clearer guidelines for coverage and reimbursement.

Sincerely,

Raymond C. Scheppach
Executive Director

Submitter :

Date: 10/10/2007

Organization : **Southern Plains Behavioral Health Services**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-668-Attach-1.PDF

#668

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.

CMS-2261-P-669

Submitter : Ms. Susan Maier

Date: 10/10/2007

Organization : Center for Mental Health

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

CMS-2261-P-670

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

1. I do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. I 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. I 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. I 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 : Mr. Michael G Spennato **Date:** 10/10/2007

Organization : New York Clubhouse Coalition

Category : Consumer Group

Issue Areas/Comments

Background

Background

Rehabilitative Services

GENERAL

GENERAL

See Attachement

CMS-2261-P-671-Attach-1.DOC

CMS-2261-P-671-Attach-2.DOC

I am testifying on behalf of those consumer members who utilize ICCD Certified Clubhouses with regards to the proposed rule **file code CMS-2261-P. "PROVISIONS OF THE PROPOSED REGULATIONS" Qualified providers of rehabilitative services**

My name is Michael G Spennato I am a recipient of mental health services since 1989, have been an advocate since 1997, have been a member of Sky Light Center an ICCD (International Center for Clubhouse Development) Certified Clubhouse since 2002 preside as the Vice-President of the New York Clubhouse Coalition and sit on the Board of Directors for Sky Light Center since 2003and on the faculty of the ICCD since 2004.

The Clubhouse model is very different than the Medical Model of mental health services and does not fit into the focus of medical necessity as such. While I am in agreement that we need to have a licensed provider to request or refer a patient for services, I also believe that the medical model of treatment in mental health rehabilitation centers is not the only answer for consumers who are suffering with mental health issues. As no two people are alike, not one method of mental health rehabilitation will work for all.

An ICCD Certified Clubhouse provides recipients of mental health services with opportunities in Education and Employment that no other Medical Modeled Mental Health services provide. This is done by allowing its members to take ownership in their treatment through participation in the clubhouse and its community thus increasing the chances for long term recovery and fewer, repetitive, hospitalizations and providing the consumer with a place to return to in the event of destabilization. This participation is not a teaching device, but an experiential tool that allows the members/consumers to develop and increased the level of hope, self-esteem and functioning that is encouraged by positive reinforcement in an effort well done regardless of the productivity.

If the funding stream is relegated to a Medical Model approach, it may jeopardize the integrity the ICCD Certified Clubhouse Model and could be insufficient to sustain the current level of service that an ICCD Certified Clubhouse provide, I am not speaking about those clubhouses which are truly Drop-In Centers and do not follow a set of standards that have been Internationally accepted. In addition, if Medicaid is the primary source of income for rehabilitation services then there is a much greater chance for antiselection thus excluding members who have limited incomes but who have incomes too high to be Medicaid eligible. The current members that I speak of are those who receive Social Security Disability Income (not SSI) and are on Medicare and Veterans. These two groups may not be eligible for any form of Medicaid, such as the Medicaid Spend Down and Buy in Programs My suggestion is: for ICCD Certified Clubhouse Programs a rehabilitation program exception be a carve-out for their funding. The details of the specific requirements for the carve-out can be determined through a variety of methodologies that could be developed by experts in the field of rehabilitative services

I CCD Certified Clubhouses have a uniquely integrated program that encourages its members to return to their communities in a productive manner. An example is this

approach is the Transitional Employment Program that is exclusive to Certified Clubhouses. In this program a member /consumer is allowed the opportunity to attempt a part-time work experience for a time limited period of 6-9 months where the employer is guaranteed that there will be coverage. The member is able to try the experience in the hope of finding a position, either in a Supported or Independent Employment in the future which will possibly allow the consumer to return to a more stable work situation. A program such as this does not teach or train but aids the member/consumers attempt at work thus providing hope, increased self-esteem and in addition provides the community with a new potential self-sufficient member of society who in turn pays taxes, becomes less dependent on the community mental health services programs and may, possibly, return to a full-time employment that provides an income and insurance coverage that would allow the consumer of mental health services the ability to sustain their independence from the benefits system while at the same time continuing in their ongoing treatment. A program such as this does not teach or train but helps to. We in the clubhouse community know that it is in keeping with best practices that the program works and that while it many not seem to be medically necessary it is as the results of ICCD Clubhouse Programs have provided its members with lower relapse rates and grated employment and educational outcomes.

As you may have noticed I am sincerely concerned for the programs that are ICCD Certified as they are held to higher standards, 36 to be exact, than any other clubhouse programs. In addition they are required to maintain 25% of Average Daily Attendance in a Transitional and Supported Employment programs. Making members of ICCD Certified Clubhouse Programs who are employed contributors to the economy.

These programs were formed in New York City in 1948 with the founding of WANA {We Are Not Alone) currently known as Fountain House. Have been developed over the years and are now in over 40 Countries throughout the world.
It seems odd to me that a model that has worked for so long and has been part of our communities should now be in jeopardy of not being able to sustain itself in a country where we do believe in giving every member of our society a chance to succeed. Yes I know that there will be some clubhouses that may succeed in a new climate but for many, this new environment may be disastrous. It is with the consumers of mental health services in mind that I implore you to consider measures to provide for the clubhouse community, especially those that have been or will be ICCD certified.

#671-2

October 16, 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,

Michael G Spennato

Submitter : **David Johnson** **Date: 10/10/2007**

Organization : **NAMI**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachmcnt

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

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

CMS-2261-P-673

Submitter : Mr. Joshua Rubin **Date:** 10/10/2007

Organization : Mr. Joshua Rubin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Redefining eligibility for Medicaid rehabilitation services in such a way as to systematically exclude services for people with intellectual and developmental disabilities, including autism is a horrible idea. Decades of hard work to move peoplc out of institutions and into the community shouldn't be jeopardized just to savc a fcw dollars.

CMS-2261-P-674

Submitter : Mr. George Iadipaolo

Date: 10/10/2007

Organization : Mr. George Iadipaolo

Category : State Government

Issue Areas/Comments

Background

Background

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Collections of Information Requirements

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Provisions of the Proposed Rule

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CMS-2261-P-675

Submitter : Dr. Steven Sharfstein

Date: 10/10/2007

Organization : Sheppard Pratt

Category : Psychiatric Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-675-Attach-1.DOC

#675

Sheppard Pratt

A not-for-profit behavioral health system

Office of the President and Chief Executive Officer

6501 N. Charles Street
Baltimore, MD 21204
410-938-3401
Fax: 410-938-3450
email: ceo@sheppardpratt.org

October 10, 2007

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

RE: CMS-2261-P; PUBLIC COMMENT REGARDING PROPOSED AMENDMENT TO 42 CFR PARTS 440 AND 441: Medicaid Program- Coverage for Rehabilitative Services

To Whom It May Concern:

Sheppard Pratt Health System is a 156-year-old, not-for-profit organization in Maryland that provides comprehensive hospital and community-based mental health services to over 45,000 individuals each year, approximately 10,000 of whom are Medicaid recipients. We oppose the draft regulation amendments because we believe they could be interpreted to conflict with the recovery model and evidence-based practices in the mental health field, and they could thwart some of the recommendations of the President's New Freedom Commission on Mental Health. Furthermore, the implementation of the proposed regulation changes could have serious adverse clinical effects on countless Medicaid recipients, causing an increase in more expensive and more restrictive institutional care – with the overall costs to taxpayers being much greater than the short-term savings hoped to be gained with the regulation changes.

We propose several specific modifications to the draft regulation amendments which we believe would correct the problems, minimize the consequences, and achieve the greatest cost savings. Our comments and proposed changes are articulated in the context of the New Freedom Commission's Final Report which the CMS discussion also cites.

The Commission Report views federal funding agencies and reimbursement regulations to be part of the nation's mental health service delivery system that needs to be transformed. (*Final Report*, 1). We believe that our suggested changes will achieve the *accountability* that CMS seeks while at the same time assuring the *flexibility* that individuals with serious mental illness need – both of which the Commission noted as being critical aspects of effective public mental healthcare financing. (*Id.* at 23).

I. **Section 440.130 (d)(1)(vi) and Section 440.130 (d)(3)(xiv)**

A. **Problems.** The current language defining "restorative services" and the requirement that the reevaluation of the rehabilitation plan demonstrate a "measurable reduction of disability and restoration of functional ability" can be interpreted to prohibit reimbursement for long-term rehabilitation services for adults with serious mental illness that are provided toward the goals of living in the community without long-term or intermittent hospitalization or of managing symptoms to avoid deterioration or hospitalization. These can be important recovery-oriented goals for individuals who choose them, and for many people, avoiding or reducing hospitalizations is substantial progress in and of itself.

Unlike some other chronic illnesses, serious mental illness is often characterized by a cyclic nature that encompasses periods of gains in functioning followed by periods in which functioning decreases or remains static. It is critical that rehabilitation continues during all phases of the illness in order to keep the individual stable in the community until such time that he or she can once again show progress toward goals. Furthermore, what may look like maintenance of functioning to the untrained eye may actually be subtle but critical internalization of the recovery process. It would be a grave mistake to deny these individuals Medicaid-funded rehabilitation services simply because they fail to show linear progress.

The regulation also contradicts the New Freedom Commission's transformation principle of facilitating recovery – which it defines as "the process in which people are able to *live, work*, learn, and participate fully in their communities. (*Id.* at 5). With this definition, the regulation should unambiguously support a rehabilitation goal of living in the community without long-term or intermittent institutionalization or of reducing symptoms to avoid deterioration or hospitalization. The regulation appears to support a goal of *working* in the community, but not one of *living* in the community.

Several Sheppard Pratt consumers of services with schizophrenia and bipolar disorder exemplify this dynamic. William's psychosis and thought disorganization caused him to spend eight years in a state psychiatric hospital prior to receiving psychiatric rehabilitation services. Dorothy's intense paranoia and auditory hallucinations resulted in over 20 hospitalizations and five years of persistent homelessness. John's almost lethal combination of mania, visual hallucinations, and drug abuse spiraled him into a revolving door between institutionalization, homelessness, and incarceration. While they each ended up in different places in their recovery, the initial journey was similar, with each receiving psychiatric rehabilitation services for over ten years without any apparent progress. In fact, growth was occurring, but it was subtle and slow and it needed to be viewed in light of the potential hospitalizations that were prevented as opposed to the other goals that were not achieved.

It took ten years for William to get to the point that he could identify basic personal care needs such as a haircut and to retain a part-time job with intensive support and an employer willing to try compensatory strategies. He continues to live in the community but only because of rehabilitation services and only with growth so modest that it appears to be more maintenance than progress. The slow struggle with Dorothy was to gradually build trust in order to penetrate the paranoia and persuade her to reject homelessness and accept medication. After a decade of rehabilitation and several years of Dorothy's apparent stability which included employment, Sheppard Pratt yielded to managed care pressure to reduce rehabilitation services, and Dorothy was lost again, falling back into an escalating paranoia that was never able to be pierced. Conversely, John ended up appearing to be one of our most successful consumers – gaining a college degree, renting his own apartment, maintaining a full-time job as a substance abuse counselor, and then graduating entirely from our services. But this was only after a decade of rehabilitation with no apparent growth. Then, several years after rehabilitation services were terminated, during what appeared to be steady, linear progress, he committed suicide, evidently having begun to hear voices again – a warning sign that would have been recognized with regular rehabilitation services but which went undetected during quarterly psychiatric medication checks.

It is important to emphasize that during the first decade of rehabilitation services for these individuals, when each was asked the consumer-centered question of what he or she wanted most in life, they all said they wanted to live in an apartment in the community without the pain of their symptoms and without the restrictiveness of institutional care. Of course, they also expressed a desire to have a job at some point and to gain more education – but those were not their priorities. As a skilled rehabilitation provider, we continued to urge them toward these more aggressive goals because we knew that

evidence-based practices such as Supported Employment could be effective not only in securing a job, but also in achieving the stability they sought. However, the fundamental principle of recovery focuses on consumer choice and empowerment, and one of the most critical factors of success of many of the EBPs is supporting individuals in pursuing their personal goals, however modest. Therefore, for such individuals, while the goals of employment and education may be appropriate, the goal of living in the community without intermittent hospitalizations would also be reasonable – and extremely cost-effective for taxpayers if achieved.

B. Solution. To resolve these problems, we propose that CMS add language that it has used in other program transmittals in which it clarified how to apply the requirement of treatment improvement to individuals with serious mental illness. In two different Medicare program transmittals, CMS used this definition:

> "Reasonable Expectation of Improvement – Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning. It is not necessary that a course of therapy has as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. *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.*" (emphasis added). 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.

Adding several sentences to two parts of the proposed regulation would provide the necessary clarification.

1. Section 440.130 (d)(1)(vi) (Definition of "Restorative services").

We propose adding to the end of this section the following sentence borrowed from the CMS Medicare transmittals:

"Examples of acceptable rehabilitation goals in these instances for some individuals, such as those with serious mental illness, could include: living in the community without long-term or intermittent hospitalization; or reduction or control of symptoms to avoid further deterioration or hospitalization."

2. Section 440.130 (d)(3) (xiv) (Requirement of "Measurable Reduction of Disability").

We propose adding to the end of this section the following two sentences borrowed from the CMS Medicare transmittals:

"For some individuals such as those with serious mental illness, 'reduction of disability and restoration of functional level' may be measured by comparing the effect of continuing rehabilitation versus discontinuing it. Where there is a reasonable expectation that if rehabilitation services had been

withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion would be met."

II. Section 441.45 (b) (1) and 441.45 (b) (3)

A. Problems. We agree that FFP should not cover foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice or public guardianship services. However, when the regulation prohibits FFP for rehabilitation services that are "intrinsic elements" of these non-medical programs, CMS is making a mistake in not differentiating between: *blending of services* – which is positive because it can facilitate integration, increase transferability of skill development in natural settings, and promote a key principle of evidence-based practices; and *blending of funding* – which can be negative because it can lead to cost shifting and reimbursement of non-covered services. As a result, the regulation could be interpreted to perpetuate the obstacle of system fragmentation identified by the New Freedom Commission. In addition, it could be in conflict with the Commission's promise that states will have the "flexibility to combine federal, state and local resources in creative, innovative, and more efficient ways" and Commission's suggestion that states should not need to rely on waivers to achieve this important flexibility. (*Id.* at 8, 22).

In addition, the proposed regulation amendment could have a chilling effect on the implementation of the Commission's strong recommendation to support the advancement and utilization of evidence-based practices and best practices. (*Id.* at 12). For example, the regulation could be interpreted to prohibit FFP for mental health rehabilitation services provided as part of a Supported Employment program even though SAMHSA endorses this service protocol as an effective, evidence-based mental health practice.

Finally, the regulation's unqualified prohibition in 441.45 (b)(3) of FFP for "vocational and prevocational services" creates potential confusion about what types of employment support are successful for individuals with serious mental illness. It could also perpetuate the common misunderstanding that most employment barriers for these individuals involve cognitive limitations relative to performing the job task when in fact the barriers more often include disability-related symptoms and associated functional deficits. Using another Sheppard Pratt consumer as an example, Supported Employment staff spends most of their time helping Lee to develop interpersonal skills necessary to deal with supervisors and peers to prevent conflicts. He needs very little support in learning how to perform the tasks of his job which include washing, drying, and stacking dishes. His employment barrier is that he keeps getting fired because of angry outbursts on the job. Similarly, Jason's Supported Employment staff help him to develop strategies to manage his depression and fear in order to avoid excessive tardiness and absences – which are the reasons he keeps losing jobs.

In the discussion about this section, CMS cites as an example of a covered rehabilitation service teaching an individual to cook in order to restore living skills. The comment identifies as an example of a non-covered vocational service teaching an individual to cook as part of training to be a chef. Sheppard Pratt consumer Steve is an example of a third alternative which needs to be clarified in the regulation: Supported Employment staff assist him in securing and maintaining a job as a cook by helping him to manage his paranoia and auditory hallucinations that prevent him from interacting appropriately with co-workers and customers and assisting him in managing his compulsive behaviors that drive him to excessive hand-washing that reduces his productivity.

B. Solution. Instead of discouraging the effective blending of services in Supported Employment and other similar programs, the regulation should support FFP for rehabilitation services

provided as part of these programs as long as states can distinguish Medicaid funding for the rehabilitation services as being separate from non-Medicaid funding for non-covered services. Similarly, instead of potentially thwarting the implementation of Supported Employment services with an unqualified exclusion of vocational and prevocational services, the regulation should clarify that services geared to supporting employment by reducing disability-related symptoms and deficits that create employment barriers are covered rehabilitation services – whereas services that train the individual to perform job tasks are not. Adding several sentences to two different sections of the regulation would resolve both problems.

1. Section 441.45 (b) (1)

We propose adding the following after the first sentence:

"Services would not be considered to be intrinsic elements of these non-medical programs if they are medically necessary rehabilitation services for an eligible individual that are clearly distinct from the non-covered program services and that are provided by qualified Medicaid providers. One way to demonstrate this distinction is to clearly and reasonably distinguish the funding stream for the Medicaid rehabilitation services as being identifiably separate from that of the non-covered services."

2. Section 441.45 (b)(3)

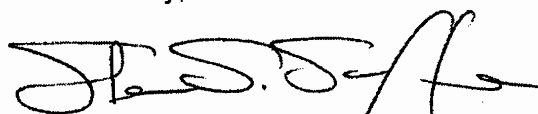
We propose adding the following clause after the phrase "vocational and prevocational services:"

"...that are not focused on reducing disability-related symptoms or deficits and not provided by a qualified Medicaid provider."

III. Conclusion

Sheppard Pratt understands the limitations of federal funding and the constraints of regulation, and appreciates CMS' desire to increase accountability in the Medicaid reimbursement system in order to save money. As Maryland's largest provider of mental health treatment and rehabilitation services to Medicaid beneficiaries, we support all effective ways to protect the supply and longevity of this funding source. However, while we share CMS' concerns, we point instead to the New Freedom Commission's recommended strategies for resolving those concerns. Simply put, a transformed mental health system will save money in the end for all funding sources, including Medicaid. Increasing accountability at the cost of decreasing flexibility will end up wasting money – and lives. We believe that the Commission's comprehensive vision addresses both the quality of life of American citizens and the financial integrity of limited government resources. Our proposed changes to the regulation amendment represent concrete ways to implement the Commission's recommendation to improve both the accountability and flexibility of public financing for mental health services as an important part of the broader system's rehabilitation and transformation. Thank you for considering our comments.

Sincerely,



Steven S. Sharfstein, M.D.
President and Chief Executive Officer

Submitter : **Mr. William Daroff** **Date: 10/10/2007**

Organization : **United Jewish Communities**

Category : **Association**

Issue Areas/Comments

GENERAL

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Please see attachment.

CMS-2261-P-676-Attach-1.DOC

#676

United Jewish Communities
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October 10, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

United Jewish Communities (UJC) 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.

UJC represents 155 Jewish community federations and 400 independent Jewish communities across North America. As the second-largest charitable network in North America our system advocates for life-saving and life-enhancing humanitarian assistance through more than 1,300 social service and healthcare institutions, community centers, schools and summer camps in nearly 800 locations in North America.

United Jewish Communities' beneficiary agencies sustain some of our nation's most vulnerable citizens: persons with HIV, struggling families, the fragile elderly, people living with co-morbid health conditions, people discharged from psychiatric hospitals and detoxification units, prison discharges and troubled children. They provide a full continuum of behavioral health services including: Assertive Community Treatment, Assisted Outpatient Treatment, case management, clinic treatment programs, community residential programs, continuing day treatment programs, crisis outreach and intervention services, drop-in centers, family support services, home and community based services, homeless outreach, mobile crisis intervention programs, on-site rehabilitation, psychosocial clubs, school based programs, supportive housing, transitional employment placement , transitional management services, vocational and social rehabilitation and vocational services for adolescents.

We are deeply concerned that the proposed regulations will pose additional barriers and prove to be more burdensome for providers of rehabilitative services, including non-profit community based organizations. We fear the new regulations will result in a decrease in both the quality and quantity of services individuals receive. With the implementation of the proposed regulations, consumers are at greater risk of depending on emergency services – including hospitalization – at a tremendous cost to individuals, communities and ultimately to federal and state governments. Below, please find United Jewish Communities recommendations and comments as they pertain to the proposed rule.

Joseph Kanfer
CHAIR, BOARD OF TRUSTEES

Kathy E. Manning
CHAIR, EXECUTIVE COMMITTEE

David Fisher
CHAIR, NATIONAL CAMPAIGN

Michael C. Gelman
TREASURER

David Steirman
ASSISTANT TREASURER

Susan K. Stern
SECRETARY

Lori Klinghoffer
CHAIR, NATIONAL WOMEN'S PHILANTHROPY

VICE CHAIRS
Robert Cutler
Ann-Louise Kleper
Robert T. Mann
Esther Polland
S. Stephen Selig III
Susan K. Stern
Toni Young
Mark Wilf

Howard M. Rieger
PRESIDENT/CEO

UJA Federation Campaign

Washington, D.C. Office
1720 I Street NW, Suite 800
Washington, DC 20006

Phone 202.785.5900
Fax 202.785.4937
www.ujc.org

Comments re: PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130: Diagnostic, screening, preventive and rehabilitative services

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

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

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

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

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

Recommendation:
We urge CMS to clarify the role of the individual and the definition of "input" and "active participation". We also urge CMS to ensure that the active participation of "collaterals" meets all of the necessary HIPAA requirements for the privacy rule.

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

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

The proposed regulations state that "services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve

a rehabilitation goal as defined in the rehabilitation plan." While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. We are concerned that states and providers will interpret the current proposed regulations as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services.

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

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

Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, some of the language in this provision is unclear and needs clarification. The proposed requirements will be burdensome, both administratively and

financially, for agencies serving individuals in need of rehabilitative services. They will also create another level of complexity for documentation compliance and audits.

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

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

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

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

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

- that the plan be written plainly in multiple languages so that it is understandable to all individuals;
- that the plan indicate the individual's level of participation, as well as his or her concurrence with the plan;

- that the plan allow for a qualified provider to sign the treatment plan when the client or their representative is unable to do so or has no family or designated representative;

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

- that the plan include intermediate rehabilitation goals;

- that the plan include, if necessary, provisions for crisis intervention;

- that the plan include individualized anticipated review dates that correspond with the anticipated achievement of long-range and intermediate rehabilitation goals;

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

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

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

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

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

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

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

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

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

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

Section 441.45: Rehabilitative Services

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

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

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

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

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

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

effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

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

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

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

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

The final rule should list therapeutic foster care as a covered rehabilitation service for children with serious mental disorders.

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

The proposed regulations deny payment for therapeutic foster care as a single program, requiring instead that each component be billed separately. If states are not able to provide and bill for services as a package, the effectiveness of treatment will decrease while administrative costs rise.

Recommendation:
We strongly urge CMS to list therapeutic foster care as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

We also urge CMS to include language in Section 441.45(b)(1)(i) to clarify that mental health rehabilitation providers are eligible to provide and bill for rehabilitation services for children in therapeutic foster care.

<u>441.45(b)(2)</u>

The final rule should clarify the difference between "exclusion for habilitation services as opposed to the exclusion from Federal Financial Participation (FFP) for rehabilitative services."

The Omnibus Reconciliation Act of 1989 (OBRA 89) prohibited CMS (the HCFA) from disallowing claims for day habilitation services until CMS issued a new regulation that specified the types of habilitation services that would only be covered. Therefore, the provision in the proposed regulations that would exclude coverage for habilitation services for persons with mental retardation and related conditions is unprecedented, inconsistent with Congressional intent, and not justified.

It should be noted that the exclusion of habilitation services does and should not equal exclusion from FFP for any rehabilitative services provided to persons with mental retardation or related conditions (i.e. cerebral palsy and epilepsy) that would gain functionality from rehabilitative services. Individuals with serious mental illness may experience periods of cognitive impairment as a result of their illness. If they do experience cognitive impairment, will the rehabilitation services they receive be covered?

If CMS approves this change, it is going to require a considerable amount of time and planning to transfer coverage of habilitation services from the rehabilitation option into another appropriate Medicaid authority. The proposed rule does not specify how CMS will provide technical assistance during the transition period.

<u>Recommendation</u>:

We urge CMS to provide clarification as to the difference between exclusion for habilitation services as opposed to the exclusion from FFP for rehabilitative services provided to persons with mental retardation and related conditions.

<u>441.45(b)(3)</u>

The final rule should clarify when recreational and/or social activities are a covered rehabilitation service.

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

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are a covered

rehabilitative service. The proposed regulations are unclear regarding when personal care services are covered rehabilitation services.

Recommendations:
We urge CMS to include language in section 441.45(b)(3) that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation service. The final rule should also clarify how personal care furnished as an integral part of personal care skills training is covered and how it is to be documented.

Individuals in Secure Custody and Residing in Public Institutions
The final rule should not include the phrase "in secure custody" and "system".

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

Recommendation:
We urge CMS to delete the phrase "in secure custody" and "system".

441.45(b)(7) Services for individuals who are not Medicaid eligible
The final rule should clarify when services for individuals who are not Medicaid eligible are a covered rehabilitation service.

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered rehabilitation services. In the preamble (page 45207) there is an explanation of when services may be provided to non-Medicaid eligible individuals if it is directed exclusively toward the treatment of the Medicaid-eligible child or adult. No such explanation, however, is included in this section of the proposed regulations.

Recommendation
We urge CMS to include language in Section 441.45(b)(7), similar to that in the preamble, explaining when services may be provided to non-Medicaid eligible individuals if it is directed exclusively toward the treatment of the Medicaid-eligible child or adult.

OTHER ISSUES

Payment and Accounting for Services
Although not specifically described in this regulation, the language used supports recent efforts by CMS to require providers to account and bill for services through 15-minute increments and the denial of payment through daily rates, case rates and similar arrangements.

This new shift in rate setting methodology is inconsistent with evidence-based mental health practices that are based on delivering services together in a flexible and coordinated way. The shift in documentation and billing procedures significantly increases the amount of time that clinicians must spend completing paperwork, thus reducing the amount of time available to

spend with clients. Furthermore, if providers are asked to bill services individually, they will be moving away from the evidence-based model (i.e. therapeutic foster care). Current evidence-based practices include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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

Recommendation:
We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support best practices and the most successful outcomes for children and adults with mental disorders. We strongly urge CMS NOT to require providers to bill for services separately that are part of a "package of services".

EPSDT Mandate
The proposed regulations 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.

Recommendation:
We strongly urge CMS to do the following:

- Insert a new paragraph to Section 441.45(a) that will make clear 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.

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

- To reference the federal EPSDT mandate in Section 441.45(b)(4), which refers to services having to be targeted under the State's plan.

CONCLUSION

We would like to thank CMS for the opportunity to submit comments on the provisions of the proposed rule for the Coverage for Rehabilitative Services.

A reduction in federal support for rehabilitation services would force States to make a choice between continuing service provision at the same level at a greater cost in state/local dollars; decreasing the amount and quality of essential services individuals receive; reducing eligibility,

benefits, or payments to providers; cutting back on other state programs and using those funds to replace federal Medicaid dollars lost; or a combination of all of the above.

If funding for rehabilitation services is eliminated, overall expenditures for both the Federal Government, States and localities may actually increase because consumers will be re-directed

into more costly Medicaid-funded settings, including in-patient psychiatric beds. Other individuals may end up in homeless shelters or in jail, settings which are exorbitantly expensive for taxpayers and personally debilitating for consumers. We are deeply concerned that the proposed rule will harm vulnerable beneficiaries with severe mental illnesses.

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

Sincerely,

William Daroff
Vice President for Public Policy &
Director of the Washington Office
United Jewish Communities

CMS-2261-P-677

Submitter : **Mr. Carlos and Jean Richardson, Jr.** **Date: 10/10/2007**

Organization : **San Diego Chapter of NAMI**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As citizens who have experienced family mental illnesses, we urge the passage of any legislation that will ensure that mentally ill persons will be able to receive adequate health care, including mental health rehabilitation services.

Submitter : **Mrs. Melinda Berry** **Date: 10/10/2007**

Organization : **Mrs. Melinda Berry**

Category : **Individual**

Issue Areas/Comments

Background

Background

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by Melinda Berry, LCSW.

Non-covered services: 441.45(b)

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There is little clarity in the regulation on how this provision would be applied, as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

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

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

Recommendation:

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

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

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

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

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

Therapeutic Foster Care: 441.45(b)(1)(i)-

The regulation denies payment for therapeutic foster care as a single program, requiring instead that each component

CMS-2261-P-679

Submitter : Mrs. Kristin Carpenter

Date: 10/10/2007

Organization : Center for Mental Health

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-679-Attach-1.DOC

#679

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:

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

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,

Kristin Carpenter
BSW

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

CMS-2261-P-680

Submitter : Lisa Hamill **Date:** 10/10/2007

Organization : National Alliance on Mental Illness-Orange County

Category : Other Association

Issue Areas/Comments

Background

Background

CMS proposed regulations would withdraw services to some of our nation's most vulnerable citizens. Disallowing long term supportive services for individuals with a severe mental illness will only increase Medicaid costs in the long run with more expensive psychiatric hospitalizations. Time limited services vs. longer term support services will disallow sustaining and maintaining aspects of psychosocial rehabilitation. This will not work for the majority of persons with a severe mental illness. How can you address a long term, chronic illness with a short term solution?

The focus on documentation per contact for rehabilitation puts the focus on paperwork and not people work. The documentation requirements are too strict and therefore greatly impact the delivery of needed services. There should be great care taken in the new rules to prevent state and providers from requiring unnecessary and overly burdensome paperwork and administrative procedures to document billable services.

GENERAL

GENERAL

I m concerned that Medicaid requirements and an overstressed authorization system are threatening the survival of Psychosocial Rehabilitation Services, also known as Club Houses!

I personally know what a positive difference they can make for those suffering from severe, persistent mental illnesses.

My 25 year old son was diagnosed with a severe, persistent mental illness over 7 years ago. I almost lost him when he was really ill and I live with the ongoing concern of him dying as a result of his illness.

Club Nova, a Club House located in Carrboro, NC, has played a huge role in providing support for my son that has helped to stabilize his well-being enough to prevent more expensive treatment through hospitalization that would have cost more in Medicaid expenses. They were instrumental in helping him to obtain a job where he has been a valued employee for the 18 months.

The clubhouse is an intentional community offering cost effective, comprehensive community supports ranging from support with daily living to housing, education, and jobs, as well as assistance with obtaining entitlements and quality medical care and providing crisis prevention. Providing these services are integral to preventing the higher costs of hospitalizations.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Re: Non-covered services 441.45(b)(1) where regulations refer to services intrinsic to other program.
The definition of "intrinsic" is unclear and this will probably lead to misuse of this rule to eliminate and deny medically necessary services that have been funded for a long time through Medicaid. Including but not limited to rehabilitation services like employment, education and housing. It is necessary to better define "intrinsic elements and to insure that any services determined at the local level to be non-reimbursable due to this rule be readily available, effective, funded and accessible at another program before current funding is discontinued. It would be better to drop this section altogether.

Re: Rehabilitation Services 441.45(a)
The issue is the change in providing services to maintain current level of functioning only when it is necessary to help an individual achieve a rehabilitation goal. Continuation of rehabilitation services is at times essential to retain a person's functional level. Failure to provide such services could lead to further deterioration which might lead to reinstatement of intensive services including hospitalization. It is very important that this section include language that determines when and how to determine if a rehabilitation service or services is/are necessary to maintain a desired functional level.

Re: Restorative Services 440.130 (d) (1) (vi)-
Similar to the Rehabilitation Services section are concerns that this definition focuses on achieving a rehabilitation goal and not maintaining a functional level necessary to avoid the need for more intensive and expensive medically necessary and covered services. It is our understanding the CMS had both the authority and obligation to fund needed "rehabilitation and other services" for helping covered individuals "retain" improved functioning and that allows for independence from more intensive and expensive services. There should be clear language in this section that allows for funding services that are determined through approved rehabilitation plans to be necessary to achieve and maintain the least intensive service level and most independence possible.

CMS-2261-P-681

Submitter : Ms. Janet Alexander **Date:** 10/10/2007

Organization : Infinity Counseling Services

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

sce attachment

#681

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..

CMS-2261-P-682

Submitter : Evelyn Driskel

Date: 10/10/2007

Organization : Center for Mental Health

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-682-Attach-1.DOC

#682

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.

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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

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- 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,

Evelyn Driskel
Employment Specialist

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

Submitter : **Dr. Farrel Klein** **Date: 10/10/2007**

Organization : **Newport County Community MHC**

Category : **Physician**

Issue Areas/Comments

Background

Background

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.

Collections of Information Requirements

Collections of Information Requirements

I have worked with the chronically mentally ill for decades. Many are not going to "get better," but need intensive services to keep them from getting "sick" and getting hospitalized, losing housing, and having higher morbidity and mortality. Cutting these funds hurts people and shifts costs to inpatient and prison facilities, but does not save costs or improve systems.

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 : **Mrs. Nita Bradford** **Date: 10/10/2007**

Organization : **NAMI Colorado**

Category : **Individual**

Issue Areas/Comments

Background

Background

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

GENERAL

GENERAL

Please see attachment.

CMS-2261-P-684-Attach-1.DOC

#684

October 10, 2007

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

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

Dear Sir or Madam:

I appreciate the opportunity, as a person who has a family member with a serious mental illness, to comment on the proposed rule changes regarding rehabilitative services under the Medicaid program. I am a founding member of the Colorado NAMI and therefore have had a great deal of experience with mental illnesses and so believe I can comment through that experience.

I know from personal experience how necessary and beneficial rehabilitative services can be in the life of a person with a mental illness. My son, who has a diagnosis of schizo-affective disorder, was terribly ill for 10 years. He was on SSI and Medicaid, was hospitalized several times and was incarcerated twice. Later he was able to take advantage of many rehabilitative services offered in Colorado during the 1990s, which included: training to be a peer specialist; receiving supported employment; housing in a cooperative setting; employment in a consumer run program; advocacy leadership; and leadership of a statewide consumer group. As a result of this training and subsequent opportunities, my son now owns his own successful tree cutting and trimming business, is married and has three healthy children. He now receives no federal or state assistance and, instead, adds to the productivity of our state and nation. In addition, he pays for his own insurance. Recovery can happen, but not through medicine alone. Medicine is a vital and necessary tool; rehabilitative services are the vehicle to recovery.

Colorado no longer offers all of the rehabilitative services that my son was privileged to receive. However, there are other services that are just as important and helpful, although not nearly enough to serve all who need them, especially in our rural areas. In our state, as in every state in the country, many people with serious mental illnesses are not getting the help that they need. Therefore, I'm very concerned about the rule change proposals that could reduce even further the vital services that people need. And this will NOT SAVE money! It is counterproductive for the rehabilitation rules to be changed in order to attempt to save money. Only the reverse will happen: costs will increase. The need for hospital beds and the number of juveniles and adults in our state prison are growing every year and costing our state money that could be used to provide needed mental illness services.

I understand and appreciate the movement toward recovery; my soon is a prime example of the ability of a seriously ill persons achieving recovery. I like and value the emphasis on individual and family involvement in recovery plans. However, recovery does not happen quickly and is not linear. My son had a serious relapse only 5 years ago and had to start all over in his recovery, although it happened within a few months, instead of a few years due to heavy family support and encouragement. Not everyone has family support. We need a wide range of community and state rehabilitative services so that everyone can achieve whatever level of recovery they are able to achieve. This means flexibility in services and the ability to reach out to those who need extra assistance and support. Acknowledging one's illness and accepting treatment is often a slow process and requires many visits and a variety of types of service options. Just as NAMI has found that families need time to accept our services, even more do people who have a mental illness need help in accepting and planning their treatment, especially if they have been civilly committed to a hospital or have been incarcerated due to their illness. Please retain this kind of outreach for people in crisis. I cannot overstate how important this is.

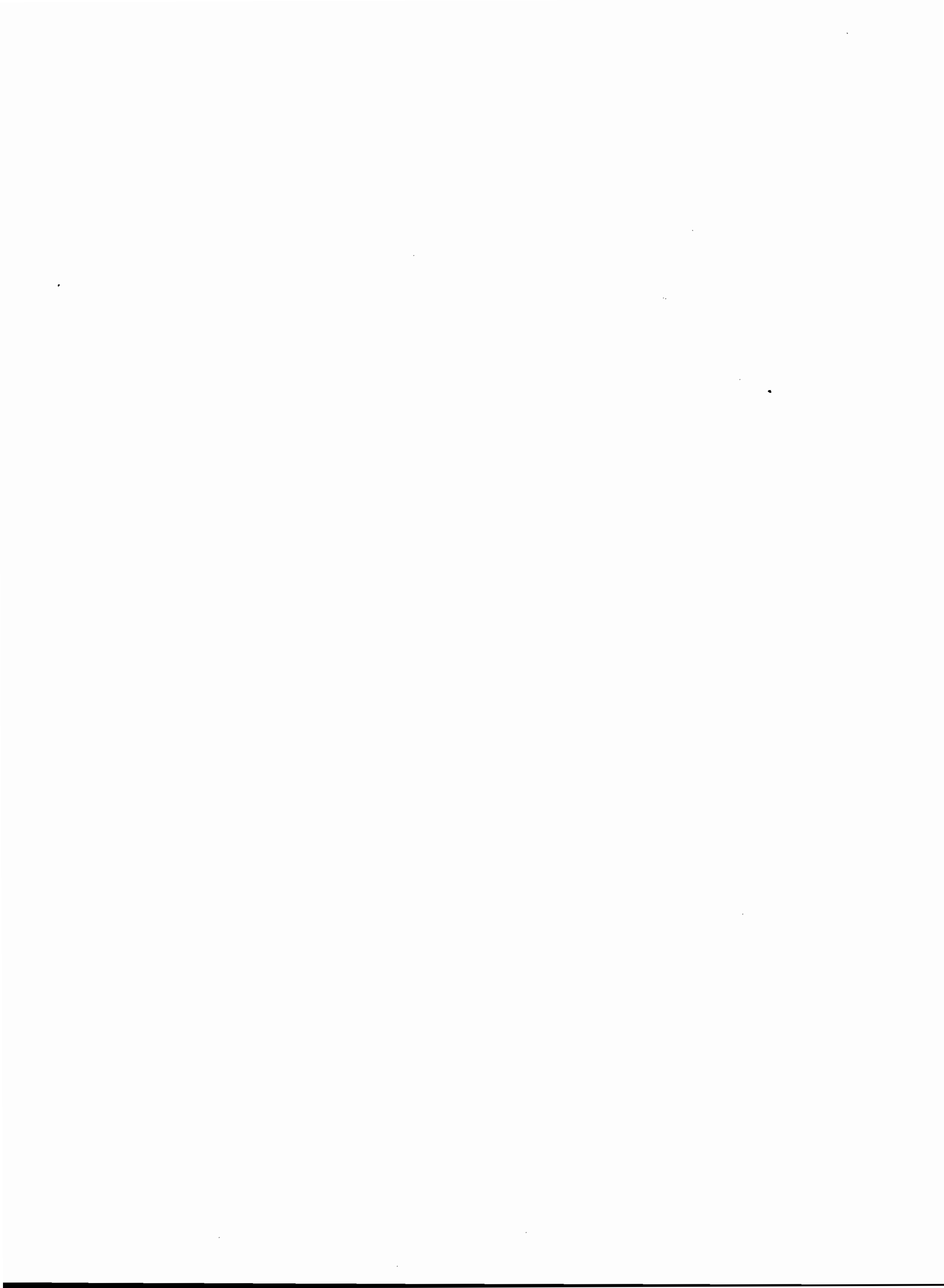
Please also understand and reflect in the rules the reality that people with a mental illness do not heal in a linear fashion. Their illness is not like a wound that closes slowly but surely. The nature of these illnesses of the brain are to advance and relapse, sometimes for a number of months or years. Progress builds upon progress, but not in a steady manner for many, or even most. PLEASE DO NOT add the stress of the need to show steady and consistent progress to the terrible burden of the disease itself. I understand that this change is imbedded in the new rules.

As an advocate for one vulnerable population, I can not condone removing these services from other vulnerable populations. This is inhumane and it appears beyond the scope of any reform or changes that your agency has been asked to make.

Finally, a person who has a mental illness often finds him or herself in another system, either due to drug or alcohol use or actions that require contact with the juvenile or criminal justice system. In fact, these are often the systems that first reveal the illness. In addition schools, child welfare and housing systems must often be involved. Please do not limit the role of various systems that make discovery and recovery possible. Medicaid has saved countless lives and has been responsive to changes in treatment and services. It is not in the best interest of the government, and certain not in the best interest of patients and families, to begin to restrict the payment for any rehabilitative service that can prevent deterioration or that can promote increased functioning and ultimate recovery to the extent possible for each individual.

Thank you for listening. I beg you to rethink some of the proposed rules.

Most sincerely,



Submitter : **Yvonne Clerico** **Date: 10/10/2007**

Organization : **Yvonne Clerico**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that the services given to this program remain in as it is. These individuals need all the services that are now in progress.

Submitter : **Mr. Gregory Carlson** **Date: 10/10/2007**

Organization : **NAMI Alabama**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

The families of NAMI Alabama are very concerned about the proposed language in the regulations on the Rehab option that are non-specific in nature but seems to indicate that maintenance services are not be allowed. Persons with serious mental illness have chronic illnesses in that there is no cure and they are very cyclical from stabilization to acute phases. It would be a serious flaw if the interpretation of this language would prevent continued treatment and supports during those stabilization phases. It would harm the consumer, the family and cost more in the long run especially if hospitalization is the result.

Serious mental illness is a chronic condition like heart disease and diabetes. The logic of these regulations if applied to the physician services section would remove coverage of insulin and other support services for persons with diabetes when they are stabilized. This will lead to serious consequences and ultimately death. A heart patient whose blood pressure is under control with medications would be blocked from other services such stress tests, and continued maintenance doctor visits resulting in more expensive care or even death. It makes no sense. The language in these regulations needs to be changed to prevent exacerbation of all chronic illnesses as a means of actually reducing costs.

A letter dated August 15, 2007 from CMS encourages states to implement peer-support services while at the same time CMS, via these regulations, apparently will not cover services that are provided for persons who are stable and trying to reach higher levels of recovery or rehabilitation of their psychiatric illnesses. The inherent contradictions within the CMS policy making machine needs to be reconciled so that these regulations reflect letters of guidance issued from time to time.

Another example of this inherent contradiction is illustrated with the language that would seem to remove bundling of services such as ACT team services. CMS has on many instances encouraged the states to implement ACT services. NAMI Alabama is opposed to the removal of bundling of Assertive Community Treatment services since it would prevent providers from individualizing the service to each consumer served by the team. Research has shown that ACT reduces inpatient costs and saves money while improving the quality of lives of this consumer group that accounts for the heaviest use of care without intensive care. If unbundled, consumers will receive whatever enables the provider to recoup its costs. In other words, rather than providing what is needed, the team will provide that configuration of services that is economically the best. Bundling of services into a single cost rate enables the teams to be innovative and based on patient need rather than economic need. This section of the regulations should encourage bundling in the name of cost containment and best practice.

Finally, NAMI Alabama questions the legal basis for these regulations. It seems to be without Congressional direction and in fact seems to fly in the face of Congressional Intent. Cost data is revealing that targeting those who consume the most services can actually reduce costs to Medicaid and to the tax payer in other areas (ER Visits, Local and State Hospitalization Jails, Prisons, etc.) These regulations, coupled with other recent events, have ironically instilled a sense of paranoia in mental health system that disabled citizens in this country are not perceived as equal to other American citizens. These regulations are not consistent with President Bush s New Freedom Commission on Mental Health Report and, in fact, continues the discrimination and stigma that it cited in its report. We are spending exorbitant amount of money in all of the wrong places and once again, these regulations perpetuate that practice.

Please let me know if we can provide additional information on these regulations.

Greg Carlson
President

CMS-2261-P-687

Submitter : Mr. Aaron Dupuis **Date:** 10/10/2007

Organization : Mr. Aaron Dupuis

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am afflicted with Bi-Polar disorder and havc lost a high paying job because of it. I am on Social security and barely make ends meet, while many of my co-workers gct Disability Insurance for life for such things as bad backs, injured knees, and other"physical afflictions". The mentally ill arc already being discriminated against, please don't continue this unfair and ugly spiral. Those with mcntal illnesscs already have a tough enough time making it through the day without having to worry about finances. Please don't make it harder for us to receive Medicare or Medicaid- we desperately need all the resources we can get, and private insurance is pricing itself out of our reach. Don't leave us behind, for you may have this affliction happen to a loved one of your own one day.Thank You for your time.

Aaron Dupuis

Submitter : **Daleen O'Dell** **Date: 10/10/2007**

Organization : **Daleen O'Dell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am the mother of a seriously mentally ill son who currently receives FACT Services. I realize we have a national crisis with the economy but our mental health crisis needs to out way any other financial commitments. If we do not allow the mentally ill the right to adapt into society they will continue to utilize crisis units, state mental hospitals and spend repeated times incarcerated. This will I promise you be a lot more expensive in the long run.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

It is critical that the existing day hab. program remain as it is in thc hands of Mcdicaid.

Submitter : **Joseph Durante** **Date: 10/10/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-690-Attach-1.DOC

#690

October 16, 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,

Joseph M. Durante Jr.
252 Awapuhi Place
Wailuku, Hawaii 96793

Submitter : Ms. Angie Thompson **Date:** 10/10/2007

Organization : Mental Health Association of Middle Tennessee

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-691-Attach-1.DOC

CMS-2261-P-691-Attach-2.DOC

#691

October 3, 2007

Centers for Medicare and 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:

The Public Policy Committee of the Mental Health Association of Middle Tennessee fears that the recent changes in the rules proposed by CMS to govern Medicaid's rehabilitation service category could restrict access to intensive community mental health services for Medicaid's children and adults struggling with disabilities. Access to these rehabilitative services is crucial to help these individuals avoid institutionalization.

Consequently, the Public Policy Committee is submitting the following comments and suggestions on the Proposed Rule for Coverage and Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

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

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

Providers should also be encouraged to be flexible in response to the individual's needs. Serious mental illness is often a cyclical disorder and, in the course of their recovery, individuals may suddenly deteriorate, requiring a change in services. Service planning

and goal setting should anticipate this need and crisis plans need to be developed as part of the rehabilitation plan.

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

Recommendation:

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

440.130(viii)(3) Written Rehabilitation Plan

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

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

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

accountability. The regulation does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

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

<u>Recommendations</u>:

<u>We recommended inclusion of the following requirements regarding the written rehabilitation plan:</u>

- The plan be written in plain English so that it is understandable to the individual.
- The plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan.
- The plan of services be based on a strengths-based assessment of needs;
- Tηε plan include intermediate rehabilitation goals;
- Where indicated, the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- Certification that the individual has been informed about their rights regarding advance directives;
- 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.)

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

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

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

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

Recommendation:

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.

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.

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)(1)(i) Therapeutic foster care

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

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

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

Recommendation:

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

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

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

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

Sincerely,

Angie Thompson, Executive Director
Mental Health Association of Middle Tennessee

Submitter : Lynn Thomas **Date:** 10/10/2007

Organization : PARENT

Category : Individual

Issue Areas/Comments

Background

Background

The draft federal regs (section 441.45(b)(2)) exclude habilitation
> services from the definition of rehabilitation services that can be
> covered under Medical Assistance. The problem is with the proposed
> federal definition of habilitation services which cannot be covered > under the rehabilitation service category of Medical Assistance. > Under the proposed federal regs, Habilitation services include > services provided to individuals with mental retardation or related > conditions. (Most physical impairments, and mental health and/or > substance related disorders, are not included in the scope of related> conditions, so rehabilitation services may be appropriately
> provided.) Does this mean that wraparound services provided to
> children and adolescents with mental retardation or autism (which is a > related condition) are habilitation services and therefore totally > excluded from coverage? Autism is also considered a mental illness by> psychiatrists (in the DSM IV). Does that mean it is not included in > the scope of related conditions so rehabilitation services may be > appropriately provided ? Does the proposed definition of habilitation > mean that the state will have to deny wraparound for children with > mental retardation for autism spectrum disorders whose treatment goals > are to assist the child in learning new social skills or other > positive behaviors the child never had before (which might be excluded > as habilitation services). Will each child s treatment plan or > psych eval need to show that the child had a functional loss and has > a specific rehabilitative goal toward regaining that function (part > of the definition of rehabilitation services)?

GENERAL

GENERAL

Please know that if nothing is done when they are younger, if services are not provided, it will cost the state 100 times that when they are older, if not more. The words 'rehabilitation' or 'habilitation' don't apply in the case of AUTISTIC individuals.

Destroying the futures of many autistic children is NOT in the best interests of the state. You need to answer the questions in the first paragraph - in the CHILD'S best interest - before you pass anything that destroys wraparound. Or is PA not about what is in the best interest of the CHILD? I didn't think tyranny of the weak was in our state constitution.

My son has no siblings. When we are gone, there is no one to take care of him. If we are able to ENABLE him to be a productive member of society he will be on the streets - IF he is able to get services to help him, he stands a chance to live on his own. IF PA thwarts that, then they deserve to be financially responsible for him for the rest of his adult life.

Response to Comments

Response to Comments

d

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Individuals at these daytime therapeutic rehabs critically need the
services rendered to them and would be at risk of losing the nursing benefits which they receive at the present time. Many of these adults have medical problems, need many services such as OT, PT. etc.
It is mandatory that they not loose these benefits.

CMS-2261-P-694

Submitter : Ms. Diane Johnson **Date:** 10/10/2007

Organization : Independent Advocate for MH

Category : Individual

Issue Areas/Comments

Background

Background

Hi my name is Diane Johnson and I'm not to familiar with legislative Acts and so on, but I do know as a consumer of both Mental Health & Drug & Alcohol Community that Rehabilitation Services are extremely important. If it wasn't for those services I would not have had 10 years of sobriety nor would I have been Recovering from Mental Illness for the past 10 years. If these facilities hadn't been available to me, I would have been either been Dead or in some State Hospital with no future in sight. In stead I am a individual with a lot of self-esteem & I believe to have a very lucrative future in front of me. So please do not cut these services for me and especially for the children of our future who are and some who will be in desperate need for them. To cut these services would be not only damaging but in humane.

Thank you for listening,
Diane Johnoson
Allegheny County

Collections of Information Requirements

Collections of Information Requirements

I am an Independent Advocate for both the Mental Health & Drug & Alcohol Community. I am an In Our Own Voice Presenter for the National Alliance for the Mentally Ill, I am a Board member for Peer Support & Advocacy Network in Pgh., I work as a secretary for ACCR's Public Awareness Committee, I am a committee member for Consumer Support Program in Pgh, former Board member of the Pa Mental Health Association out of Harrisburg and more. But none of these things would have been possible if I hadn't got help from Rehabs. My goal is to become more & more active for MH&D&A and eventually help run a Rehab myself someday.

GENERAL

GENERAL

See above remarks!

CMS-2261-P-695

Submitter : Mr. Scott Rose

Date: 10/10/2007

Organization : Way Station, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-695-Attach-1.DOC

#695

October 10, 2007

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

RE: CMS-2261-P; PUBLIC COMMENT REGARDING PROPOSED AMENDMENT TO 42 CFR PARTS 440 AND 441: Medicaid Program- Coverage for Rehabilitative Services

TO WHOM IT MAY CONCERN:

Way Station is a 30 year-old not-for-profit organization in Maryland that provides comprehensive community-based mental health services to over 7,000 individuals each year, approximately 4,000 of whom are Medicaid recipients. We thank you for the opportunity to give input, and we submit the following comments which we believe will achieve the *accountability t*hat CMS seeks while at the same time assuring the *flexibility* that individuals with serious mental illness need – both of which the New Freedom Commission noted as being critical aspects of effective public mental healthcare financing. (*Final Report*, at 23). Attached to this letter is a red-lined version of the regulation and preamble, showing our proposed modifications in the yellow highlighted sections.

I. <u>Section 440.130 (d) (1)(vi) and Section 440.130 (d) (3) (xiv)</u>

We are concerned that the proposed language defining "restorative services" and the rehabilitation plan requirement for reevaluation of "measurable reduction of disability and restoration of functional ability" could be misinterpreted to prohibit coverage for long-term rehabilitation services for adults with serious mental illness that are provided toward goals of living in the community without intermittent hospitalization or of reducing symptoms to avoid hospitalization. While such individuals may choose the type of goals that involve positive outcomes such as employment or formal education, others may choose the type that involve reducing symptoms and avoiding negative outcomes such as hospitalization. The New Freedom Commission views both types of goals as being recovery-oriented as both are included in the Commission's definition of "recovery." (*Id.* at 5) Furthermore, for many individuals with serious mental illness and histories of multiple hospitalizations, the latter type of goal can be just as ambitious as the former, and avoiding hospitalization can be substantial progress in and of itself.

To provide the necessary clarification, we propose that CMS add language that it has used in other program transmittals in which it clarified how to apply the requirement of treatment improvement to individuals with serious mental illness. In two different Medicare program transmittals, CMS used this definition:

PO Box 3826 / Frederick, Maryland 21705-3826 / 301-662-0099 / Toll Free 888-549-0629 / Fax 301-694-9932
9030 Route 108, Suite A / Columbia, Maryland 21045 / 410—740-8262 / Toll Free 877-381-5482 / Fax 410-740-8237
25 East North Avenue, Hagerstown, MD 21740 / 301-733-6063 / Fax 301-733-6220

www.waystationinc.org

"Reasonable Expectation of Improvement – Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning. It is not necessary that a course of therapy has as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. *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.*" (emphasis added) 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.

Our proposed highlighted changes in the attached red-lined version incorporate this CMS language.

II. Section 441.45 (b) (1) and 441.45 (b) (3)

We agree that FFP should not cover foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice or public guardianship services. However, when the regulation prohibits FFP for rehabilitation services that are "intrinsic elements" of these non-medical programs, we are concerned that this could be misinterpreted as prohibiting the positive blending of Medicaid-covered and nón-covered services even though such blending can yield important clinical benefits such as facilitating integration, increasing the transferability of skill development in natural settings, and promoting a key principle of evidence-based practices. In addition, the regulation could be misinterpreted to prohibit FFP for mental health rehabilitation services provided as part of a Supported Employment program even though SAMHSA endorses this service protocol as an effective, evidence-based mental health practice. Finally, the regulation's prohibition in 441.45 (b)(3) of FFP for "vocational and prevocational services" could be misinterpreted to prohibit coverage for rehabilitation services that are focused on reducing disability-related symptoms or deficits which create employment barriers. Those types of services are quite different from services which train the individual to perform a job task, but the language does not clarify that important distinction.

The modification we have proposed in the attached red-lined version states that distinguishing funding streams is one concrete way of demonstrating how Medicaid rehabilitation services are not "intrinsic elements" of non-covered programs. As such, services can be blended (which is critical to *flexibility*) as long as funding is "braided" (which is important for *accountability*). In addition, our language clarifies the distinction between vocational services that train individuals to perform job tasks versus rehabilitation services that reduce symptoms which create employment barriers.

III. 440.130 (d) (3)

The more minor suggestions included in the attached red-lined version relate to clarifying potential confusion around the requirement in (3) (xi) to list "anticipated providers of services" and allowing providers to document reasons if an individual refuses to sign the plan.

In conclusion, we hope that our proposed changes to the regulation represent concrete ways to implement the Commission's recommendation to improve both the accountability and the flexibility of public financing for mental health services as an important part of the broader system's rehabilitation and transformation. We thank

you for considering our comments, and offer to assist in any way in providing additional information or answering any follow-up questions.

Sincerely,

Scott Rose
President/CEO

SUMMARY: EPA proposes to approve the State Implementation Plan (SIP) revision submitted by the Commonwealth of Virginia for the purpose of establishing a variance for the International Paper, Franklin Paper Mill facility located in Franklin, Virginia. The variance provides regulatory relief from compliance with state regulations governing new source review for the implementation of the International Paper, Franklin Paper Mill innovation project. In lieu of compliance with these regulatory requirements, the variance requires the facility to comply with site-wide emission caps. In the Final Rules section of this **Federal Register**, EPA is approving the Commonwealth's SIP submittal as a direct final rule without prior proposal because the Agency views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this action, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time.

DATES: Comments must be received in writing by September 12, 2007.

ADDRESSES: Submit your comments, identified by Docket ID Number EPA- R03-OAR-2006-0060 by one of the following methods:

A. *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.

B. E-mail: cam pbell.dave@epa.gov.

C. *Mail:* EPA-R03-OAR-2006-0060, David Campbell, Chief, Permits and Technical Assessment Branch, Mailcode 3AP11, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103.

D. *Hand Delivery:* At the previously-listed EPA Region III address. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information. *Instructions:* Direct your comments to Docket ID No. EPA-R03-OAR-2006- 0060. EPA's policy is that all comments received will be included in the public docket without change, and may be made available online at *http:// www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http:// www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an anonymous access system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http:// www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov index.* Although listed in the index, some information is not publicly available, *i.e.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http:// www.regulations.gov* or in hard copy during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Virginia Department of Environmental Quality, 629 East Main Street, Richmond, Virginia, 23219.

FOR FURTHER INFORMATION CONTACT: Sharon McCauley, (215) 814-3376, or by e-mail at *mccauley.sharon@epa.gov.*

SUPPLEMENTARY INFORMATION: For further information, please see the information provided in the direct final action, with the same title, that is located in the Rules and Regulations section of this **Federal Register** publication. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not subject of an adverse comment.

Dated: July 31, 2007.

William T. Wisniewski,

Acting Regional Administrator, Region II. [FR Doc. E7-15585 Filed 8-10-07; 8:45 am]

BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 440 and 441

[CMS 2261 -P] RIN 0938-A081

Medicaid Program; Coverage for Rehabilitative Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the definition of Medicaid rehabilitative services in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services and programs include, but

are not limited to, foster care, child welfare, education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and any other non-Medicaid services from Federal, State, or local programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 12, 2007.

ADDRESSES: In commenting, please refer to file code CMS–2261–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2261– P, P.O. Box 8018, Baltimore, MD 21244– 8018.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2261–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786– 3685 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Maria Reed, (410) 786–2255 or Shawn Terrell, (410) 786–0672.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2261–P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable (for example, names, addresses, social security numbers, and medical diagnoses) or confidential business information (including proprietary information) that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

A. Overview

Section 1905(a)(13) of the Social Security Act (the Act) includes rehabilitative services as an optional Medicaid State plan benefit. Current Medicaid regulations at 42 CFR 440.130(d) provide a broad definition of rehabilitative services. Rehabilitative services are defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." The broad general language in this regulatory definition has afforded States considerable flexibility under their State plans to meet the needs of their State's Medicaid population.

Over the years the scope of services States have provided under the rehabilitation benefit has expanded from physical rehabilitative services to also include mental health and substance abuse treatment rehabilitative services. For example, services currently provided by States under the rehabilitative benefit include services aimed at improving physical disabilities, including physical, occupational, and speech therapies; mental health services, such as individual and group therapy, psychosocial therapy services; and services for substance-related disorders (for example, substance use disorders and substance induced disorders). These Medicaid services may be delivered through various models of care and in a variety of settings.

The broad language of the current

statutory and regulatory definition has, however, had some unintended consequences. It has also led to some confusion over whether otherwise applicable statutory or regulatory provider standards would apply under the rehabilitative services benefit.

As the number of States providing rehabilitative services has increased, some States have viewed the rehabilitation benefit as a "catch-all" category to cover services included in other Federal, State and local programs. For example, it appears some States have used Medicaid to fund services that are included in the provision of foster care and in the Individuals with Disabilities Education Improvement Act (IDEA). Our audit reviews have recently revealed that Medicaid funds have also been used to pay for behavioral treatment services in "wilderness camps," juvenile detention, and similar facilities where youth are involuntarily confined. These facilities are under the domain of the juvenile justice or youth systems in the State, rather than Medicaid, and there is no assurance that the claimed services reflect an independent evaluation of individual rehabilitative needs.

This proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers. This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused on social or educational development goals in programs other than Medicaid.

This proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are in fact rehabilitative out-patient services, are furnished by qualified providers, are provided to Medicaid eligible individuals according to a goal-oriented rehabilitation plan, and are not for services that are included in programs with a focus other than that of Medicaid.

B. Habilitation Services

Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) prohibits us from taking adverse action against States with approved habilitation provisions pending the issuance of a regulation that "specifies types of day habilitation services that a State may cover under paragraphs (9) (clinic services) or (13) (rehabilitative services) of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions." We believe that issuance of a final rule based on this proposed rule will satisfy this condition. We intend to work with those States that have habilitation programs under the clinic services or rehabilitative services benefits in their State plans to transition to appropriate Medicaid coverage authorities, such as section 1915(c) waivers or the Home and Community-Based Services State plan option under section 1915 (i) of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 107–171), enacted on February 8, 2006.

II. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption "PROVISIONS OF THE PROPOSED REGULATIONS" at the beginning of your comments.]

A. Definitions

In 440.130(d)(1), we propose to define the terms used in this rule, as listed below:

- Recommended by a physician or other licensed practitioner of the healing arts.
- Other licensed practitioner of the healing arts.
- Qualified providers of rehabilitative services.
- Under the direction of.
- Written rehabilitation plan.
- Restorative services.
- Medical services.
- Remedial services.

In § 440.130(d)(1)(iii), we would define "qualified providers of rehabilitative services" to require that individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories. Further, the provider qualifications must be set forth in the Medicaid State plan. These qualifications may include education, work experience, training, credentialing, supervision and licensing, that are applied uniformly. Provider qualifications must be reasonable given the nature of the service provided and the population being served. We require uniform application of these qualifications to ensure the individual free choice of qualified providers, consistent with section 1902(a)(23) of the Act.

Under this proposed definition, if specific provider qualifications are set forth elsewhere in subpart A of part 440, those provider qualifications take precedence when those services are provided under the rehabilitation option. Thus, if a State chooses to provide the various therapies discussed at § 440.110 (physical therapy, occupational therapy, speech, language and hearing services) under § 440.130(d), the requirements of § 440.110 applicable to those services would apply. For example, speech therapy is addressed in regulation at § 440.110(c) with specific provider requirements for speech pathologists and audiologists that must be met. If a State offers speech therapy as a rehabilitative service, the specific provider requirements at § 440.110(c) must be met. It should be noted that the definition of Occupational Therapy in § 440.110 is not correct insofar as the following—Occupational Therapists must be certified through the National Board of Certification for Occupational Therapy, not the American Occupational Therapy Association.

We are proposing a definition of the term "under the direction of" because it is a key issue in the provision of therapy services through the rehabilitative services benefit. Therapy services may be furnished by or "under the direction of" a qualified provider under the provisions of § 440.110. We are proposing to clarify that the term means that the therapist providing direction is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuming professional responsibility for services provided, and ensuring that all services are medically necessary. The term "under the direction of" requires each of these elements; in particular, professional responsibility requires face-to-face contact by the therapist at least at the beginning of treatment and periodically thereafter. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing

and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.

B. Scope of Services

Consistent with the provision of section 1905(a)(13) of the Act, we have retained the current definition of rehabilitative services in § 440.130(d)(2) as including "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." We would, however, clarify that rehabilitative services do not include room and board in an institution, consistent with the longstanding CMS interpretation that section 1905(a) of the Act has specifically identified circumstances in which Medicaid would pay for coverage of room and board in an inpatient setting. This interpretation was upheld in *Texas* v. *U.S. Dep't Health and Human Servs.,* 61 F.3d 438 (5th Cir. 1995).

C. Written Rehabilitation Plan

We propose to add a new requirement, at § 440.130(d)(3), that covered rehabilitative services for each individual must be identified under a written rehabilitation plan. This rehabilitation plan would ensure that the services are designed and coordinated to lead to the goals set forth in statute and regulation (maximum reduction of physical or mental disability and restoration to the best possible functional level). It would ensure transparency of coverage and medical necessity determinations, so that the beneficiary, and family or other responsible individuals, would have a clear understanding of the services that are being made available to the beneficiary. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health. The Medicaid goal is to deliver and pay for the clinically-appropriate, Medicaid-covered services that would contribute to the treatment goal. It is our expectation that, for persons with mental illnesses and substance-related disorders, the rehabilitation plan would include recovery goals. The rehabilitation plan would establish a basis for evaluating the effectiveness of the care offered in meeting the stated goals. It would provide for a process to involve the beneficiary, and family or other responsible individuals, in the overall management of rehabilitative care. The rehabilitation plan would also document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. It is our expectation that the reevaluation of the plan would involve the beneficiary, family, or other responsible individuals and would include a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods. It is important to note that this benefit is not a custodial care benefit for individuals with chronic conditions but should result in a change in status. However, it is also important to note that for some individuals such as those with serious mental illness, "reduction of disability and restoration of functional level" may be measured by comparing the effect of continuing rehabilitation versus discontinuing it. Where there is a reasonable expectation that if rehabilitation services had been withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion would be met. The rehabilitation plan should identify the rehabilitation objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities. We recognize, however, that rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. Acceptable rehabilitation goals in these instances could include avoidance of negative outcomes such as hospitalization or achievement of positive outcomes such as community participation. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services.

It is our further expectation that the rehabilitation plan be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative services to an individual with the individual's condition(s). The rehabilitation plan is not intended to limit or restrict the State's ability to require prior authorization for services. The proposed requirements state that the written rehabilitation plan must:

- Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living;
- Be developed by qualified provider(s) working within the State scope of practice acts with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing;
- Ensure the active participation of the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review and modification of these goals and services;
- Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders;
- Specify the physical impairment, mental health and/or substance related disorder that is being addressed;
- Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder, and identify the individuals or agencies responsible for providing

these services;

- Identify the methods that would be used to deliver services;
- Specify the anticipated outcomes;
- Indicate the frequency, amount and duration of the services;
- Be signed by the individual responsible for developing the rehabilitation plan, or if the individuals [illegible] sign the plan, document the reason(s);
- Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service;
- Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year;
- Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and
- Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

We believe that a written rehabilitation plan would ensure that services are provided within the scope of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. In order to determine whether a specific service is a covered rehabilitative benefit, it is helpful to scrutinize the purpose of the service as defined in the care plan.

For example, an activity that may appear to be a recreational activity may be rehabilitative if it is furnished with a focus on medical or remedial outcomes to address a particular impairment and functional loss. Such an activity, if provided by a Medicaid qualified provider, could address a physical or mental impairment that would help to increase motor skills in an individual who has suffered a stroke, or help to restore social functioning and personal interaction skills for a person with a mental illness.

We are proposing to require in § 440.130(d)(3)(iii) that the written rehabilitation plan include the active participation of the individual (or the individual's authorized health care decision maker) in the development, review, and reevaluation of the rehabilitation goals and services. We recommend the use of a person-centered planning process. Since the rehabilitation plan identifies recovery-oriented goals, the individual must be at the center of the planning process.

D. Impairments to be Addressed

We propose in § 440.130(d)(4) that rehabilitative services include services provided to an eligible individual to address the individual's physical needs, mental health needs, and/or substance-related disorder treatment needs. Because rehabilitative services are an optional service for adults, a State has flexibility to determine whether rehabilitative services would be limited to certain rehabilitative services (for example, only physical rehabilitative services) or will include rehabilitative treatment for mental health or substance-related disorders as well.

Provision of rehabilitative services to individuals with mental health or substance-related disorders is consistent with the recommendations of the New Freedom Commission on Mental Health. The Commission challenged States, among others, to expand access to quality mental health care and noted that States are at the very center of mental health system transformation. Thus, while States are not required to provide rehabilitative services for treatment of mental health and substance-related disorders, they are encouraged to do so. The Commission noted in its report that, "[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs."

Under existing provisions at § 440.230(a), States are required to provide in the State plan a detailed description of the services to be provided. In reviewing a State plan amendment that proposes rehabilitative services, we would consider whether the proposed services are consistent with the requirements in § 440.130(d) and section 1905(a)(13) of the Act. We would also consider whether the proposed scope of rehabilitative services is "sufficient in amount, duration and scope to reasonably achieve its purpose" as required at § 440.230(b). For that analysis, we will review whether any assistive devices, supplies, and equipment necessary to the provision of those services are covered either under the rehabilitative services benefit or elsewhere under the plan.

E. Settings

In §440.130(d)(5), consistent with the provisions of section 1905(a)(13) of the Act, we propose that rehabilitative services may be provided in a facility, home, or other setting. For example, rehabilitative services may be furnished in freestanding outpatient clinics and to supplement services otherwise available as an integral part of the services of facilities such as schools, community mental health centers, or substance abuse treatment centers. Other settings may include the office of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings. The State has the authority to determine in which settings a particular service may be provided. While services may be provided in a variety of settings, the rehabilitative services benefit is not an inpatient benefit. Rehabilitative services do not include room and board in an institutional, community or home setting.

F. Requirements and Limitations for Rehabilitative Services

1. Requirements for Rehabilitative Services

In § 441.45(a), we set forth the assurances required in a State plan amendment that provides for rehabilitative services in this proposed rule. In § 441.45(b) we set forth the expenditures for which Federal financial participation (FFP) would not be available.

As with most Medicaid services, rehabilitative services are subject to the requirements of section 1902(a) of the Act. These include statewideness at section 1902(a)(1) of the Act, comparability at section 1902(a)(10)(B), and freedom of choice of qualified providers at section 1902(a)(23) of the Act. Accordingly, at § 441.45(a)(1), we propose to require that States comport with the listed

requirements.

At § 441.45(a)(2), we propose to require that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.

In § 441.45(a)(3) and (a)(4), we propose to require that providers of the rehabilitative services maintain case records that contain a copy of the rehabilitation plan. We also propose to require that the provider document the following for all individuals receiving rehabilitative services:

- The name of the individual;
- The date of the rehabilitative service or services provided;
- The nature, content, and units of rehabilitative services provided; and
- The progress made toward functional improvement and attainment of the individual's goals.

We believe this information is necessary to establish an audit trail for rehabilitative services provided, and to establish whether or not the services have achieved the maximum reduction of physical or mental disability, and to restore the individual to his or her best possible functional level.

A State that opts to provide rehabilitative services must do so by amending its State plan in accordance with proposed § 441.45(a)(5). The amendment must (1) describe the rehabilitative services proposed to be furnished, (2) specify the provider type and provider qualifications that are reasonably related to each of the rehabilitative services, and (3) specify the methodology under which rehabilitation providers would be paid.

2. Limitations for Rehabilitative Services

In § 441.45(b)(1) through (b)(8) we set forth limitations on coverage of rehabilitative services in this proposed rule.

We propose in § 441.45(b)(1) that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. We also propose in § 441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid.

It should be noted however, that enrollment in these non-medical programs does not affect eligibility for Title XIX services. Rehabilitation services may be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. One way to demonstrate that Medicaid rehabilitation services are not intrinsic elements of non-covered programs is to clearly and reasonably distinguish the funding [illegible] being [illegible] that of the non-covered services. Medicaid rehabilitative services must be coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals and are available as part of other services or programs. Further, Medicaid rehabilitation services must be available for all participants based on an identified medical need and otherwise would have been provided to the individual outside of the foster care, juvenile justice, parole and probation systems and other non-Medicaid systems. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

For instance, therapeutic foster care is a model of care, not a medically necessary service defined under Title XIX of the Act. States have used it as an umbrella to package an array of services, some of which may be medically necessary services, some of which are not. In order for a service to be reimbursable by Medicaid, states must specifically define all of the services that are to be provided, provider qualifications, and payment methodology. It is important to note that provider qualifications for those who furnish care to children in foster care must be the same as provider qualifications for those who furnish the same care to children not in foster care. Examples of therapeutic foster care components that would not be Medicaid coverable services include provider recruitment, foster parent training and other such services that are the responsibility of the foster care system.

In § 441.45(b)(2), we propose to exclude FFP for expenditures for habilitation services including those provided to individuals with mental retardation or "related conditions" as defined in the State Medicaid Manual § 4398. Physical impairments and mental health and/or substance related disorder are not considered "related conditions" and are therefore medical conditions for which rehabilitation services may be appropriately provided. As a matter of general usage in the medical community, there is a distinction between the terms "habilitation" and "rehabilitation." Rehabilitation refers to measures used to restore individuals to their best functional levels. The emphasis in covering rehabilitation services is the restoration of a functional ability. Individuals receiving rehabilitation services must have had the capability to perform an activity in the past rather than to actually have performed the activity. For example, a person may not have needed to drive a car in the past, but may have had the capability to do so prior to having the disability.

Habilitation typically refers to services that are for the purpose of helping persons acquire new functional abilities. Current Medicaid policy explicitly covers habilitation services in two ways: (1) When provided in an intermediate care facility for persons with mental retardation (ICF/MR); or (2) when covered under sections 1915(c), (d), or (i) of the Act as a home and community-based service. Habilitation services may also be provided under some 1905(a) service authorities such as Physician services defined at 42 CFR 440.50, Therapy services defined at 42 CFR 440.110 (such as, Physical Therapy, Occupational Therapy, and Speech/Language/Audiology Therapy), and Medical or other remedial care provided by licensed practitioners, defined at 42 CFR 440.60. Habilitative services can also be provided under the 1915(i) State Plan Home and Community Based Services pursuant to the Deficit Reduction Act of 2005. In the late 1980s, the Congress responded to State concerns about disallowances for habilitation services provided under the State's rehabilitative

services benefit by passing section 6411(g) of the OBRA 89. This provision prohibited us from taking adverse actions against States with approved habilitation provisions pending the issuance of a regulation that ''specifies types of day habilitation services that a State may cover under paragraphs (9) [clinic services] or (13) [rehabilitative services] of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions.'' Accordingly, this regulation would specify that all such habilitation services would not be covered under sections 1905(a)(9) or 1905(a)(13) of the Act. If this regulation is issued in final form, the protections provided to certain States by section 6411(g) of OBRA 89 for day habilitation services will no longer be in force. We intend to provide for a delayed compliance date so that States will have a transition period of the lesser of 2 years or 1 year after the close of the first regular session of the State legislature that begins after this regulation becomes final before we will take enforcement action. This transition period will permit States an opportunity to transfer coverage of habilitation services from the rehabilitation option into another appropriate Medicaid authority. We are available to States as needed for technical assistance during this transition period.

In § 441.45(b)(3), we propose to provide that rehabilitative services would not include recreational and social activities that are not specifically focused on the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan, and provided by a Medicaid qualified provider recognized under State law. We would also specify in this provision that rehabilitative services would not include personal care services; transportation; vocational and prevocational services that are not specifically focused on reducing disability-related symptoms or deficits and that are not provided by a qualified Medicaid provider; or patient education not related to the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan. The first two of these services may be otherwise covered under the State plan. But these services are not primarily focused on rehabilitation, and thus do not meet the definition of medical or remedial services for rehabilitative purposes that would be contained in § 440.130(d)(1).

It is possible that some recreational or social activities are reimbursable as rehabilitative services if they are provided for the purpose allowed under the benefit and meet all the requirements governing rehabilitative services. For example, in one instance the activity of throwing a ball to an individual and having her/him throw it back, may be a recreational activity. In another instance, the activity may be part of a program of physical therapy that is provided by, or under the direction of, a qualified therapist for the purpose of restoring motor skills and balance in an individual who has suffered a stroke. Likewise, for an individual suffering from mental illness, what may appear to be a social activity may in fact be addressing the rehabilitation goal of social skills development as identified in the rehabilitation plan. The service would need to be specifically related to an identified rehabilitative goal as documented in the rehabilitation plan with specific time-limited treatment goals and outcomes. The rehabilitative service would further need to be provided by a qualified provider, be documented in the case record, and meet all requirements of this proposed regulation.

When personal care services are provided during the course of the provision of a rehabilitative service, they are an incidental activity and separate payment may not be made for the performance of the incidental activity. For example, an individual recovering from the effects of a stroke may receive occupational therapy services from a qualified occupational therapy provider under the rehabilitation option to regain the capacity to feed himself or herself. If during the course of those services the individual's clothing becomes soiled and the therapist assists the individual with changing his or her clothing, no separate payment may be made for assisting the individual with dressing under the rehabilitation option. However, FFP may be available for optional State plan personal care services under § 440.167 if provided by an enrolled, qualified personal care services provider.

Similarly, transportation is not within the scope of the definition of rehabilitative services proposed by this regulation since the transportation service itself does not result in the maximum reduction of a physical or mental disability and restoration of the individual to the best possible functional level. However, transportation is a Medicaid covered service and may be billed separately as a medical assistance service under § 440.170, if provided by an enrolled, qualified provider, or may be provided under the Medicaid program as an administrative activity necessary for the proper and efficient administration of the State's Medicaid program.

Generally, vocational services are those that teach specific skills required by an individual to perform tasks associated with performing a job. Prevocational services address underlying habilitative goals that are associated with performing compensated work. To the extent that the primary purpose of these services is to help individuals acquire a specific job skill, and are not provided for the purpose of reducing disability and restoring a person to a previous functional level, they would not be construed as covered rehabilitative services. For example, teaching an individual to cook a meal to train for a job as a chef would not be covered, whereas, teaching an individual to cook in order to re-establish the use of her or his hands or to restore living skills may be coverable. Furthermore, rehabilitative services in support of an individual employed as a chef may be coverable if those services teach the individual how to manage disability-related symptoms or deficits that create employment barriers such as paranoia that causes conflicts with co-workers or depression that causes absences or tardiness. While it may be possible for Medicaid to cover prevocational services when provided under the section 1915(c) of the Act, home and community based services waiver programs, funding for vocational services rests with other, non-Medicaid Federal and State funding sources.

Similarly, the purpose of patient education is one important

determinant to whether the activity is a rehabilitative activity covered under § 440.130(d). While taking classes in an academic setting may increase an individual's integration into the community and enable the individual to learn social skills, the primary purpose of this activity is academic enhancement.

Thus, patient education in an academic setting is not covered under the Medicaid rehabilitation option. On the other hand, some patient education directed towards a specific rehabilitative therapy service may be provided for the purpose of equipping the individual with specific skills that will decrease disability and restore the individual to a previous functioning level. For example, an individual with a mental disorder that manifests with behavioral difficulties may need anger management training to restore his or her ability to interact appropriately with others. These services may be covered under the rehabilitation option if all of the requirements of this regulation are met.

In § 441.45(b)(4), we propose to exclude payment for services, including services that are rehabilitative services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offense in, or confined involuntarily to, State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

We also propose to exclude payment for services that are provided to residents of an institution for mental disease (IMD), including residents of a community residential treatment facility of over 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illness, and that does not meet the requirements at § 440.160. It appears that in the past, certain States may have provided services under the rehabilitation option to these individuals. Our proposed exclusion of FFP for rehabilitative services provided to these populations is consistent with the statutory requirements in paragraphs (A) and (B) following section 1905(a)(28) of the Act. The statute indicates that "except as otherwise provided in paragraph (16), such term [medical assistance] does not include—

(A)Any such payments with respect to care or services for any individual who is an inmate of a public institution; or
(B)any such payments with respect to care or services for any individual who has not attained 65 years and who is a patient in an IMD." Section 1905(a)(16) of the Act defines as "medical assistance" "* * * inpatient psychiatric hospital services for individuals under age 21 * * *". The Secretary has defined the term "inpatient psychiatric hospital services for individuals under age 21" in regulations at § 440.160 to include "a psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State." Thus, the term "inpatient psychiatric hospital services for individuals under age 21" includes services furnished in accredited children's psychiatric residential treatment facilities that are not hospitals. The rehabilitative services that are provided by the psychiatric hospital or accredited psychiatric residential treatment facility (PRTF) providing inpatient psychiatric services for individuals under age 21 to its residents would be reimbursed under the benefit for inpatient psychiatric services for individuals under age 21 (often referred to as the "psych under 21" benefit), rather than under the rehabilitative services benefit.

In § 441.45(b)(6), we propose to exclude expenditures for room and board from payment under the rehabilitative services option. While rehabilitative services may be furnished in a residential setting that is not an IMD, the benefit provided by section 1905(a)(13) of the Act is primarily intended for community based services. Thus, when rehabilitative services are provided in a residential setting, such as in a residential substance abuse treatment facility of less than 17 beds, delivered by qualified providers, only the costs of the specific rehabilitative services will be covered.

In § 441.45(b)(7), we propose to preclude payment for services furnished for the rehabilitation of an individual who is not Medicaid eligible. This provision reinforces basic program requirements found in section 1905(a) of the Act that require medical assistance to be furnished only to eligible individuals. An "eligible individual" is a person who is eligible for Medicaid and requires rehabilitative services as

defined in the Medicaid State plan at the time the services are furnished. The provision of rehabilitative services to non-Medicaid eligible individuals cannot be covered if it relates directly to the non-eligible individual's care and treatment. However, effective rehabilitation of eligible individuals may require some contact with non-eligible individuals. For instance, in developing the rehabilitation plan for a child with a mental illness, it may be appropriate to include the child's parents, who are not eligible for Medicaid, in the process. In addition, counseling sessions for the treatment of the child might include the parents and other non-eligible family members. In all cases, in order for a service to be a Medicaid coverable service, it must be provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.

Thus, contacts with family members for the purpose of treating the Medicaid eligible individual may be covered by Medicaid. If these other family members or other individuals also are Medicaid eligible and in need of the services covered under the State's rehabilitation plan, Medicaid could pay for the services furnished to them.

In § 441.45(b)(8), we propose that FFP would only be available for claims for services provided to a specific individual that are documented in an individual's case record.

We will work with States to

implement this rule in a timely fashion using existing monitoring and compliance authority.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 440.130 Diagnostic, Screening, Preventative, and Rehabilitative Services

This section outlines the scope of service for rehabilitative services provided by States. The services discussed in this section must be provided under a written rehabilitation plan as defined in § 440.130(d)(1)(v). Specifically, § 440.130(d)(3) states that the written rehabilitation plan must meet the following requirements:

(i) Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing.

(iii) Ensure the active participation of the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review, and modification of these goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved including recovery goals for persons with mental illnesses or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder.

(vii) Identify the methods that will be used to deliver services.

(viii) Specify the anticipated outcomes.

(ix) Indicate the frequency and duration of the services.

(x) Be signed by the individual responsible for developing the rehabilitation plan.

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the beneficiary, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

The burden associated with the requirements in this section is the time and effort put forth by the provider to gather the information and develop a specific written rehabilitation plan. While these requirements are subject to the PRA, we believe they meet the exemption requirements for the PRA found at 5 CFR 1320.3(b)(2), and as such, the burden associated with these requirements is exempt.

Section 441.45 Rehabilitative Services

Section 441.45(a)(3) requires that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

The burden associated with these requirements is the time and effort put forth by the provider to maintain the case records. While these requirements are subject to the PRA, we believe they meet the exemption requirements for the PRA found at 5 CFR 1320.3(b)(2), and as such, the burden associated with these requirements is exempt.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: Melissa Musotto [CMS–2261–P], Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244– 1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Katherine Astrich, CMS Desk Officer, [CMS–1321–P], *katherine_astrich@omb.eop.gov*. Fax (202) 395–6974.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the DATES section of this preamble, and, when we proceed with a final document, we will respond to the comments in that document.

V. Regulatory Impact

Analysis *A. Overall Impact*

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This is a major rule because of the size of the anticipated reduction in Federal financial participation that is estimated to have an economically significant effect of more than $100 million in each of the Federal fiscal years 2008 through 2012.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6.5 million to $31.5 million in any 1 year. The Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule. CMS is unable to determine the percentage of providers of rehabilitative services that are considered small businesses according to the Small Business Administration's size standards with total revenues of $6.5 million to $31.5 million or less in any 1 year. Individuals and States are not included in the definition of a small entity. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 (proposed documents) of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicaid payment regulations and has fewer than 100 beds. The Secretary certifies that this major rule would not have a direct impact on small rural hospitals. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule.

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. Since this rule would not mandate spending in any 1 year of $120 million or more, the requirements of the UMRA are not applicable.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this rule would not impose any costs on State or local governments, preempt State law, or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

B. Anticipated Effects

FFP will be available for rehabilitative services for treatment of physical, mental health, or substance-related disorder rehabilitation treatment if the State elects to provide those services through the approved State plan. Individuals retain the right to select among qualified providers of rehabilitative services. However, because FFP will be excluded for rehabilitative services that are included in other Federal, State and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This reduction in spending is expected to occur because FFP for rehabilitative services would no longer be paid to inappropriate other third parties or other Federal, State, or local programs.

The estimated impact on Federal Medicaid spending was calculated starting with an estimate of rehabilitative service spending that may be subject to this rule. This estimate was developed after consulting with several experts, as data for rehabilitative services, particularly as it would apply to this rule, is limited. Given this estimate, the actuaries discounted this amount to account for four factors: (1) The ability of CMS to effectively identify the rehabilitative services spending that would be subject to this proposal; (2) the effectiveness of CMS's efforts to implement this rule and the potential that some identified rehabilitative services spending may still be permissible under the rule; (3) the change in States' plans that may regain some of the lost Federal funding; and (4) the length of time for CMS to fully implement the rule and review all States' plans.

The actual impact to the Federal Medicaid program may be different than the estimate to the extent that the estimate of the amount of rehabilitative services spending subject to this rule is different than the actual amount and to the extent that the effectiveness of the rule is greater than or less than assumed. Because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services, particularly as it relates to this rule, there is a significantly wide range of possible impacts.

Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government agencies or geographic regions under Executive Order 12866. We invite public comment on the potential impact of the rule.

C. Alternatives Considered

This proposed rule would amend

the definition of rehabilitative services to provide for important individual protections and to clarify that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. We believe this proposed rule is the best approach to clarifying the covered rehabilitative services, and also because all stakeholders will have the opportunity to comment on the proposed rule. These comments will then be considered before the final document is published.

In considering regulatory options, we considered requiring States to license all providers as an alternative to only requiring that providers to be qualified as defined by the State. However we believe that giving States the flexibility to determine how providers are credentialed allows for necessary flexibility to States to consider a wide range of provider types necessary to cover a variety of rehabilitation services. We believe this flexibility will result in decreases in administrative and service costs.

We also considered restricting the rule to only include participant protections but not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs. Had we not prohibited FFP for services that are intrinsic elements of other programs, States would continue to provide non-Medicaid services to participants, the result would have been a less efficient use of Medicaid funding because increased Medicaid spending would not result in any increase in services to beneficiaries. Instead, increased Medicaid funding would have simply replaced other sources of funding.

D. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in the table below, we have prepared an accounting statement showing the classification of the savings associated with the provisions of this proposed rule. This table provides our best estimate of the savings to the Federal Government as a result of the changes presented in this proposed rule that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.24 billion between FY 2008 and FY 2012. All savings are classified as transfers from the Federal Government to State Government. These transfers represent a reduction in the federal share of Medicaid spending once the rule goes into effect, as it would limit States from claiming Medicaid reimbursement for rehabilitation services that could be covered through other programs.

ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED SAVINGS, FROM FY 2008 TO FY 2012

[In millions]

Category	Primary estimates	Year dollar	Units discount rate	Period covered
Federal Annualized Monetized ($millions/year)	443.4	2008	7%	2008–2012
	441.6	2008	3%	2008–2012
	448	2008	0%	2008–2012
From Whom to Whom?	Federal Government to State Government			

Column 1: Category—Contains the description of the different impacts of the rule; it could include monetized, quantitative but not monetized, or qualitative but not quantitative or monetized impacts; it also may contain unit of measurement (such as, dollars). In this case, the only impact is the Federal annualized monetized impact of the rule.

Column 2: Primary Estimate—Contains the quantitative or qualitative impact of the rule for the respective category of impact. Monetized amounts are generally shown in real dollar terms. In this case, the federalized annualized monetized primary estimate represents the equivalent amount that, if paid (saved) each year over the period covered, would result in the same net present value of the stream of costs (savings) estimated over the period covered.

Column 3: Year Dollar—Contains the year to which dollars are normalized; that is, the first year that dollars are discounted in the estimate.

Column 4: Unit Discount Rate—Contains the discount rate or rates used to estimate the annualized monetized impacts. In this case, three rates are used: 7 percent; 3 percent; 0 percent.

Column 5: Period Covered—Contains the years for which the estimate was made.

Rows: The rows contain the estimates associated with each specific impact and each discount rate used.

"From Whom to Whom?"—In the case of a transfer (as opposed to a change in aggregate social welfare as described in the OMB Circular), this section describes the parties involved in the transfer of costs. In this case, costs previously paid for by the Federal Government would be transferred to the State Governments. The table may also contain minimum and maximum estimates and sources cited. In this case, there is only a primary estimate and there are no additional sources for the estimate.

Estimated Savings—The following table shows the discounted costs (savings) for each discount rate and for each year over the period covered. "Total" represents the net present value of the impact in the year the rule takes effect. These numbers represent the anticipated annual reduction in Federal Medicaid spending under this rule.

ESTIMATED SAVINGS, FROM FY 2008 TO FY 2012
[In millions]

Discount rate (percent)	2008	2009	2010	2011	2012	Total
0	180	360	520	570	610	2,288
3	175	339	476	506	526	2,069
7	168	314	424	435	435	1,822

E. Conclusion

For these reasons, we are not preparing analyses for either the RFA or section 110 2(b) of the Act because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services. Accordingly, there is a significantly wide range of possible impacts due to this rule. As indicated in the Estimated Savings table above, we project an estimated savings of $180 million in FY 2008, $360 million in FY 2009, $520 million in FY 2010, $570 million in FY 2011, and $610 million in FY 2012. This reflects a total estimated savings of $2.240 billion dollars for FY 2008 through FY 2012. We invite public comment on the potential impact of this rule.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 440

Grant programs—health, Medicaid.

42 CFR Part 441

Family planning, Grant programs— health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 440.130 is amended by revising paragraph (d) to read as follows:

§ 440.130 Diagnostic, screening, preventative, and rehabilitative services.

* * * * *

(d) *Rehabilitative Services—(1) Definitions.* For purposes of this subpart, the following definitions apply:

(i) *Recommended by a physician or other licensed practitioner of the healing arts* means that a physician or other licensed practitioner of the healing arts, based on a comprehensive assessment of the individual, has—

(A) Determined that receipt of rehabilitative services would result in reduction of the individual's physical or mental disability and restoration to the best possible functional level of the individual; and

(B) Recommended the rehabilitative services to achieve specific individualized goals.

(ii) *Other licensed practitioner of the healing arts* means any health practitioner or practitioner of the healing arts who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.

(iii) *Qualified providers of rehabilitative services* means individuals who meet any applicable provider qualifications under Federal law that would be applicable to the same service when it is furnished under other Medicaid benefit categories, qualifications under applicable State scope of practice laws, and any additional qualifications set forth in the Medicaid State plan. These qualifications may include minimum age requirements, education, work experience, training, credentialing, supervision and licensing requirements that are applied uniformly. Provider qualifications must be documented in the State plan and be reasonable given the nature of the service provided and the population served. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

(iv) *Under the direction of* means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see § 440.110, ''Inpatient hospital services, other than services in an institution for mental diseases'') the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the supervision of services and ongoing involvement

in the treatment. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.

(v) *Rehabilitation plan* means a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals. The plan is developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing and also ensures the active participation of the individual, individual's family, individual's authorized decision maker and/or of the individual's choosing in the development, review, and modification of the goals and services. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition. The plan must have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. The plan must be reasonable and based on the individual's condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individual's condition(s).

(vi) *Restorative services* means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past. For example, a person may not have needed to take public transportation in the past, but may have had the ability to do so prior to having the disability. Rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Acceptable rehabilitation goals in these instances could include avoidance of negative outcomes such as hospitalization or achievement of positive outcomes such as community participation. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services.

(vii) *Medical services* means services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care of a physical or mental disorder and are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Medical services may include physical therapy, occupational therapy, speech therapy, and mental health and substance-related disorder rehabilitative services.

(viii) *Remedial services* means services that are intended to correct a physical or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.

(2) *Scope of services.* Except as otherwise provided under this subpart, rehabilitative services include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a individual to the best possible functional level. Rehabilitative services may include assistive devices, medical equipment and supplies, not otherwise covered under the plan, which are determined necessary to the achievement of the individual's rehabilitation goals. Rehabilitative services do not include room and board in an institution or community setting.

(3) *Written rehabilitation plan.* The written rehabilitation plan shall be reasonable and based on the individual's condition(s) and on the standards of practice for provision of rehabilitative services to an individual with the individual's condition(s). In addition, the written rehabilitation plan must meet the following requirements:

(i)Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing.

(iii) Follow guidance obtained through the active participation of the individual, and/or persons of the individual's choosing (which may include the individual's family and the individual's authorized health care decision maker), in the development, review, and modification of plan goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder, and identify the individuals or agencies responsible for providing these services.

(vii)Identify the methods that will be used to deliver services.

(viii) Specify the anticipated outcomes.

(ix) Indicate the frequency, amount and duration of the

services.

(x) Be signed by the individual responsible for developing the rehabilitation plan, and if the individual refuses to sign the plan, document the reason(s).

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the individual, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods. For some individuals such as those with serious mental illness, "reduction of disability and restoration of functional level" may be measured by comparing the effect of continuing rehabilitation versus discontinuing it. Where there is a reasonable expectation that if the rehabilitation services had been withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion would be met.

(xiv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xv) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

(xvi) Include the individual's relevant history, current medical findings, contraindications and identify the individual's care coordination needs, if any, as needed to achieve the rehabilitation goals.

(4) *Impairments to be addressed.* For purposes of this section, rehabilitative services include services provided to the Medicaid eligible individual to address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs.

(5) *Settings.* Rehabilitative services may be provided in a facility, home, or other setting.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

1. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—General Provisions

2. A new § 441.45 is added to subpart A to read as follows:

§441.45 Rehabilitative services.

(a) If a State covers rehabilitative services, as defined in § 440.130(d) of this chapter, the State must meet the following requirements:

(1) Ensure that services are provided in accordance with § 431.50, § 431.51, § 440.230, and § 440.240 of this chapter.

(2) Ensure that rehabilitative services are limited to services furnished for the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level.

(3) Require that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

(4) For all individuals receiving rehabilitative services, require that providers maintain case records that include the following:

(i) A copy of the rehabilitative plan.

(ii) The name of the individual.

(iii) The date of the rehabilitative services provided.

(iv) The nature, content, and units of the rehabilitative services.

(v) The progress made toward functional improvement and attainment of the individual's goals as identified in the rehabilitation plan and case record.

(5) Ensure the State plan for rehabilitative services includes the following requirements:

(i) Describes the rehabilitative services furnished.

(ii) Specifies provider qualifications that are reasonably related to the rehabilitative services proposed to be furnished.

(iii) Specifies the methodology under which rehabilitation providers are paid.

(b) Rehabilitation does not include, and FFP is not available in expenditures for, services defined in § 440.130(d) of this chapter if the following conditions exist:

(1) The services are furnished through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. Services would not be considered to be intrinsic elements of these non-medical programs if they are medically necessary rehabilitation services for an eligible individual [illegible] the [illegible] and [illegible] Medicaid [illegible] to demonstrate this distinction is to clearly and reasonably distinguish the funding stream for the Medicaid rehabilitation services as [illegible] from that of the non-covered services. Examples of services that are intrinsic elements of other programs and that would not be paid under Medicaid include, but are not limited to, the following:

(i) Therapeutic foster care services furnished by foster care providers to children, except for

medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers.

(ii) Packaged services furnished by foster care or child care institutions for a foster child except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers.

(iii) Adoption services, family preservation, and family reunification services furnished by public or private social services agencies.

(iv) Routine supervision and non-medical support services provided by teacher aides in school settings (sometimes referred to as "classroom aides" and "recess aides").

(2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include "services provided to individuals" with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.)

(3) Recreational or social activities that are not focused on rehabilitation and not provided by a Medicaid qualified provider; personal care services; transportation; vocational and prevocational services that are not focused on reducing disability-related symptoms or deficits and not provided by a qualified Medicaid provider; or patient education not related to reduction of physical or mental disability and the restoration of an individual to his or her best possible functional level.

(4) Services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offence in, or confined involuntarily to, public institutions such as State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit; or over which a governmental unit exercises administrative control. Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

(5) Services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of community residential treatment facilities with more than 16 beds that do not meet the requirements at § 440.160 of this chapter.

(6)Room and board.

(7) Services furnished for the treatment of an individual who is not Medicaid eligible.

(8) Services that are not provided to a specific individual as documented in an individual's case record.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: March 22, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 12, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–3925 Filed 8–8–07; 4:00 pm] BILLING CODE 4120–01–P

CMS-2261-P-696

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

Organization :

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

As a Nurse and a mother of a developmental disabled son, I have
personally seen tremendous progress while at the day habilitation
program. These wonderful, patinet staff hold college degrees and are entitled tobe financially rewarded for their work. It would be a tremendous loss if the would
to loose the medicaid benefits.

Submitter : **Mrs. ELAINE SCHNEEGURT** **Date: 10/10/2007**

Organization : **NAMI**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am writing as a member of the National Alliance on Mental Illness,(NAMI) about the proposed rule regarding coverage for rehabilitative services under the Medicaid Program.

Our son, from childhood to adulthood has fought to get the best amount of recovery that he can from the devastating illness of schizoprenia. My family and I have fought for him all the way and we have seen first hand that being able to get rehabilitative serviecs helped him to recover sufficiently enough to enable him to live very well in the community.

Since there is no way, (unless you are wealthy) that a family can fund necessary services, untreated, he would have had to be hospitalized on a regular basis, even incarcerated, (G-D forbid) or had some other bad outcome which would inevitably have put a financial drain on the system.

There are still gaps in services and our son was not always able to get the help that he needed and still needs if he should start to deteriorate. Treatment works, if you can get it.

We are very troubled by the estimate in the proposed regulation that these rules would save the feder fovernment 2.2 billion dollars. Creating barriers to vital services will not save money in the long run.

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

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

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

Thank you,
Mrs. Elaine Schneegurt & family
francis4242@go.com

Submitter : **Mark Matsunaga** **Date: 10/10/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-698-Attach-1.DOC

#698

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 16, 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,

Mark H. Matsunaga
325 Mahalani St. #3B
Wailuku, HI 96793

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

Submitter : Mr. Ken Berrick

Date: 10/10/2007

Organization : Seneca Center for Children and Families

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Plcasc scc attachment

CMS-2261-P-699-Attach-1.PDF

#699

A Non-profit Agency for Children and Families

October 10, 2007

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

To Whom It May Concern:

I am the CEO of Seneca Center for Children and Families, a California non-profit agency serving our state's most seriously troubled children and their families. Seneca offers a continuum of innovative programs in the areas of residential care, education, and community-based services, including non-public schools, therapeutic programs within public schools, intensive treatment foster care, short and long term residential care, mobile response teams, receiving centers, and wraparound.

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

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

2275 Arlington Drive • San Leandro, California 94578 • (510) 481-1222 • FAX (510) 481-1605
40950 Chapel Way • Fremont, California 94538 • (510) 226-6180

proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

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

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

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

Recommendation:

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

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

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (510) 317-1444.

Sincerely,

Ken Berrick
President and CEO

Submitter : **Ms. Mala Spivack** **Date: 10/10/2007**

Organization : **NJ Friendship House**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

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.

Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged,

Revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning. People with mental illness can function well in the community and be productive citizens if given the proper treatment!!

Submitter : **Ms. Sue Bergeson** **Date: 10/10/2007**

Organization : **Depression and Bipolar Support Alliance**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-701-Attach-1.DOC

701

Depression and Bipolar
Support Alliance

Medicaid Program: Coverage for Rehabilitative Services
Comments by
The Depression and Bipolar Support Alliance

The Depression and Bipolar Support Alliance (DBSA), the nation's leading patient-directed organization focusing on depression and bipolar disorder, would like to comment on behalf of the more than 20 million Americans living with a mood disorder, on the recent proposed rule making on the Coverage for Rehabilitative Services in the Federal Register (72 FR 45201).

As a consumer-directed organization that provides hope, help and support to more than 5 million people each year, DBSA supports the new requirement for a written rehabilitation plan, developed and approved by consumers that will exemplify their strengths and their ability to make decisions. It also strengthens the system's commitment to ensure consumer control of their own lives through their own recovery process. We commend the Centers for Medicare and Medicaid Services (CMS) for including these values within the plan and requesting that these values be included throughout other Medicaid-provided services.

We also are pleased with the report's recognition of the value of consumer-driven psychosocial rehabilitation as an essential element in an individual's recovery plan. As we move towards a system focused increasingly on recovery- driven outcomes, DBSA believes that a recovery model must go beyond the treatment of symptoms and engage individuals in managing their own care, adhering to treatment and moving towards wellness.

Because many individuals have faced the devastation of stigma throughout their lives, they may benefit from peer coaching to prepare them to participate in a formal documented rehabilitation plan. As a result, DBSA is recommending that these individuals be presented with options, such as self-help and peer-support services, as an interim short-term reimbursable expense. Such options would instill the empowerment needed to set goals and examine and evaluate a treatment plan. To meet CMS' requirement, these short- term services would include documentation of the revised approaches; steps taken to set goals; and any related activities used to involve the individual in a self-directed course of action. Examples of these short-term options could include educating the individual about the recovery process and possible outcomes, their rights and responsibilities and/or relationship building through participation in peer-directed support groups.

DBSA is also pleased that the new regulations would continue to provide states with flexibility in terms of how rehabilitative services would be compensated. Allowing states to continue to identify the methods of payment would greatly benefit and help maintain

We've been there. We can help.
730 N. Franklin Street, Suite 501 Chicago, IL 60610-7224
(312) 642-0049 Toll Free (800) 826-3632 Fax (312) 642-7243 www.DBSAlliance.org

many successful programs such as consumer-centered and led treatment and crisis and transitional residential treatment
programs – activities that are billed using a single daily rate or by a case rate. These programs are crucial because they focus on improvement and achievement of goals that are specific to the rehabilitation plan without duplicating services that would be "intrinsic" to programs outside of Medicaid.

Nevertheless, DBSA is concerned over the adoption of and use of the term, "intrinsic" element, throughout the proposed regulations. We understand that an intrinsic test would be conducted to ensure that Medicaid does not pay for a service already provided by another program. However, CMS needs to keep in mind that in 2005, Congress enacted a new third-party liability provision and rejected an intrinsic element test for rehab option services. Implementation of new third-party liability restrictions and the addition of an "intrinsic element" test raises some important questions. Certainly, an "intrinsic element" needs to be clearly defined and answers are needed for questions such as how the test would be devised; what services would be excluded from coverage and what the impact would be on Medicaid beneficiaries.

DBSA would also like to comment on the states' current flexibility to define providers' qualifications. Currently, rehab option services can be provided by a broad range of professionals that include both community paraprofessionals and Certified Peer Specialists. DBSA would like to propose that these rules clearly state that this practice will continue and that Certified Peer Specialists (Peer Coaches and Recovery Specialists) continue to be accepted as key providers of essential services. DBSA has a proven record of successful Peer Specialist training and certification, facilitated by nationally recognized trainers who deliver a foundation in recovery principles, intervention techniques, and ethical practice.

DBSA remains hopeful that states will be allowed to continue to operate innovative programs while also responding to the legitimate concerns to protect Medicaid from abuse or waste of resources. Policy clarifications are needed in some areas of the rules. Additionally, questions need to be answered regarding CMS' authorization to engage in new rulemaking in light of the fact that Congress has not enacted any new restrictions to the rehab option, and has also rejected many of the proposed changes to Medicaid. Clearly, there needs to be clarification of whether rulemaking is the most effective way of achieving federal policy objectives.

DBSA is optimistic that there will be a collaborative dialogue between federal officials, states, service providers and those served in order to reach an understanding of many of the issues raised by DBSA and others in the advocacy community. We would like to offer our participation in these dialogues and the opportunity to help with the resolution of the proposed rulings.

DBSA

DBSA

Submitter : **Mr. Johnathan Mitchell** **Date: 10/10/2007**

Organization : **Mr. Johnathan Mitchell**

Category : **Individual**

Issue Areas/Comments

Background

Background

The rule seems to be not well thought out. It will have a negative impact on children with autism who receive home based services through the medicare system. The rule should be evaluated for its impact and a report should be presented showing that it will not have disparate impact.

Submitter : **Lisa Kopko** **Date: 10/10/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-2261-P-703-Attach-1.DOC

#703

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 16, 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,

Lisa A Kopko
111 Kahului Beach Rd
Apt D411
Kahului, HI
96732

Submitter : **Ms. Janet Davis** **Date: 10/10/2007**

Organization : **NAMI**

Category : **Consumer Group**

Issue Areas/Comments

Background

Background

Medicaid Proposal

Collections of Information Requirements

Collections of Information Requirements

I've been denied Medicaid twice, at the city level. Now I am Appealing it at the County Level.

Submitter : **Thomas Bradfield** **Date: 10/10/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-705-Attach-1.DOC

#705

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 16, 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

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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,

Thomas Bradfield
35 Naniluna Place Apt. K
Wailuku HI. 96793

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

CMS-2261-P-706

Submitter : **Dr. Robert Smith** **Date: 10/10/2007**

Organization : SWVTC

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that Medicaid and Medicare implement procedures that adequately fund evidence-based practices. It is imperative that Medicaid and Medicaid do not restrict funding for existing programs. As the war lingers on and the federal government doesn't pay for it, the states are becoming increasingly responsible. As such, many states in more dire financial circumstances reduce services to the most desperate and indigent individuals in our society. Too bad they all can't afford to buy a few shares of Halliburton ...

CMS-2261-P-707

Submitter : Mr. Luis Gutierrez

Date: 10/10/2007

Organization : St. Luke's House, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Mr. Luis Gutierrez** **Date: 10/10/2007**

Organization : **St. Luke's House, Inc.**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-708-Attach-1.PDF

#708

Luis T. Gutierrez, Jr.
9212 Beech Hill Drive
Bethesda, MD 20817
(301) 767-9751

October 10, 2007

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

To Whom It May Concern:

Reference: File Code CMS-2261-P
Comments on 42 CFR Parts 440 and 441: Medicaid Program: Coverage for Rehabilitative Services

I am submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. My interest stem from two sources. First, for the past 16 years, I have worked for research organization, Covance Inc., that is intimately involved such areas as the analysis of health economics, health policy, and the comparative effectiveness of a wide variety of treatment modalities. This experience has brought the extent to which even seemingly small nuances in CMS policy can have a dramatic effect on what care is, and isn't, available in the United States.

In addition, I serve on the board of directors of St. Luke's House, Inc., a private, non-profit, non-sectarian organization that helps people live, learn and work successfully in their communities by offering integrated mental health services and resources. St. Luke's House serves adults who have serious and persistent mental illness and youth who have been identified as seriously emotionally disturbed through a wide array of community based services, such as psychiatric and residential rehabilitation, supported employment, supported living, case management, outpatient mental health clinics and crisis residential services. St. Luke's House is certified to provide two of the SAMHSA Evidence Based Practice models, Supported Employment and Family Psychoeducation, as well as integrates other evidence based models, like DBT into its programs. Most of the funding upon which St. Luke's House depends comes from Medicaid, Medicare and state and local government.

It is critical that the proposed regulations support the people we serve in maximizing their functioning in the community. I am seriously concerned that the proposed regulations, as written, may create significant obstacles to the recovery process for adults and children. Therefore, we respectfully submit these comments in hopes of eliminating these potential

barriers and promoting the well being of these individuals. I ask that you consider changing the following specific areas:

<u>440.130(d)(1)(vi) Definition of Restorative Services and 3(xiv) Measurable Reduction of Disability</u>

It is critical that these regulations fully recognize the nature of mental illnesses and the recovery process. The regulatory language must reflect the flexibility needed to help children grow and develop and to support adults in dealing with relapse and the challenges in sustaining levels of functioning. Therefore the following changes to language are recommended:

Section 440.130 (d)(1)(vi) Definition of "restorative services"

Recommendations:

- Include language that states 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.

- Add the following language to the end of section:

  "Examples of acceptable rehabilitation goals in this context would include: living in the community without long-term or intermittent hospitalization; reduction or control of symptoms to avoid further deterioration or hospitalization."

440.130 (d)(3) (xiv) Requirement of "Measurable Reduction of Disability"

Recommendation: Add the following language to the end of the section:

> *"For some individuals, particularly those with serious mental illness, 'reduction of disability' and 'restoration of functional level' may be measured by comparing the effect of continuing rehabilitation versus discontinuing it. Where there is reasonable expectation that if rehabilitation services had been withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion is met."*

<u>440.130 (3) preamble, (3)(xi), (xv), (xvi) Written Rehabilitation Plan</u>

There are four specific areas we would like this section to address. First, the preamble of this section refers to a written rehabilitation plan. While it does not prohibit an integrated treatment and rehabilitation plan, it also does not specifically allow for one. Since integrated planning and service delivery is in the consumer's best interest, we feel that the regulations should support an integrated plan. Second, (re: 3xi) while there is great value in consumers knowing their options for alternate providers, we think that information should be shared earlier in the process than during rehabilitation planning, at any time the consumer expresses a desire to consider other options or at specific progress review periods. The rehabilitation planning process is an important time of partnership. The routine inclusion of information about alternate providers during this process may disrupt the therapeutic bond, may cause confusion and anxiety for the consumer and also places an unnecessary burden on the provider. Third, (re: 3 xv) due to the

episodic nature of serious mental illness and sometimes due to specific symptoms, some consumers may not be able or willing to sign the treatment/rehabilitation plan at a given time. The need for the services is still likely to be critical. The individual may not have appointed a representative who could sign on behalf of him/her. Therefore, CMS should allow for documentation of efforts of the provider to secure the signature and the reasons that the consumer or his/her representative is not able to sign the plan. Finally, (re: 3xvi) since the provider is already bound by Medicaid requirements, the inclusion of the statement in the last bullet below seems unnecessary and inappropriate for inclusion in the service plan and seems to add no real value. In the interest of time and clarity, we recommend it be deleted from this section.

Recommendations:

- Specifically clarify that a single integrated treatment and rehabilitation plan is acceptable (3 preamble)
- Delete the section that reads "Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." (3xi)
- Allow providers to document attempts to involve consumers in the development of their treatment/rehabilitation plans and to secure their signatures. (3xv)
- Delete the section that reads "Document that the services have been determined to be rehabilitative services consistent with the regulatory definition." (3xvi)

441.45 (a) (2) : Rehabilitative Services

This recommendation serves to reinforce what has been said regarding restorative services and "measurable reduction of disability."

Recommendation: Reiterate here when services may be provided to retain or maintain functioning.

441.45 (b) (1) Non-Covered Services

In order to strongly support the concept of integrated and coordinated services and to ensure that consumers have access to covered rehabilitation services, the following clarifications are recommended.

Recommendations:

- Add the following to the end of the first paragraph in Section 441.45(b) (1):

  "...except for medically necessary rehabilitation services for an eligible individual that are clearly distinct from these non-covered program services and are provided by qualified Medicaid providers. One way to demonstrate this distinction is by clearly and reasonably distinguishing the funding stream for the rehabilitation services as being distinct from that of non-covered services."

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

Thank you for this opportunity for commenting and for your consideration of these recommendations.

Sincerely,

Luis T. Gutierrez, Jr.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

This bill is harmful to families and children with autism. Autistic children can improve, but many need the behavioral help available through Wrap Around. This bill will imprison families and keep many children with autism from growing into productive adults. The adult system cannot handle an influx of untreated, behaviorally disorded adults with autism.

Submitter : **Mr. Andrew nakagawa** **Date: 10/10/2007**

Organization : **Hale Oluea Clubhouse**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Hale Oluea Clubhouse
1045 B Kilauea Ave.
Hilo, HI 96720
(808) 974-4320

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

To Whom It May Concern:

In regards to the CMS proposed rule change on Medicaid Rehabilitation Services, I am submitting the following opinion:

The proposed changes published on August 13, 2007 will negatively affect mental illness services across the county. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and support will be eliminated for some of this country s most vulnerable citizens those with severe and persistent mental illness.

Mental illness rehabilitation programs have an exclusive set of long term needs that are distinct from the needs of other services requiring rehabilitative services. Because recovery from mental illness is often a long term process, the new rules that define rehabilitation, one of which emphasizes returning a person to previous levels of functioning, will exclude psychosocial rehabilitation type services that are vital for people with persistent mental illness.

In regards to proposals that bolster person centered rehabilitative plans, I wholeheartedly support them, however it would prove ineffective and ultimately cost-defective to provide an individual driven plan without concomitant support and funding sustained for focused community based services. The International Center for Clubhouse Development (ICCD) is one such program that would be negatively affected by this new emphasis. ICCD Clubhouses have a long and rich history of providing a cost-effective array of community based services such as education, employment, housing, and pre-vocational services. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers. Shifting funds from this absolutely vital community based service to individual based services, when in fact the two types of services are interdependent, will do very little to help the individual or community in need.

Therefore it is my opinion that none of the proposed rule changes should be implemented until each state (or federal government) has a plan actively in place to provide the necessary recovery focused services that would no longer be covered by Medicaid.

It would be 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 mental illness. 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, and that would be an unconscionable mistake.

Sincerely,

Members and Staff of Hale Oluea Clubhouse

Submitter : **Judith Solomon** **Date: 10/10/2007**

Organization : **Center on Budget and Policy Priorities**

Category : **Other**

Issue Areas/Comments

Background

Background

See attachment

Collections of Information Requirements

Collections of Information Requirements

See attachment

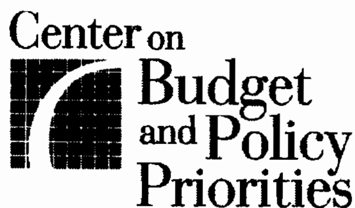
Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

CMS-2261-P-711-Attach-1.DOC

#711



820 First Street NE ▪ Suite 510 ▪ Washington DC 20002
(202)408-1080▪ fax (202)408-1056 ▪ center@cbpp.org ▪ www.cbpp.org

October 10, 2007

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

Re: File Code CMS-2261

To Whom It May Concern:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, DC. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting low- and moderate-income families and individuals. We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007.

The Consortium for Citizens with Disabilities and the National Health Law Program have submitted detailed and extensive comments on the proposed rules, and we generally support the points they raise. Rather than repeat their comments on specific provisions of the proposed rule, our comments focus on one aspect of the proposed regulations – the exclusion at section 441.45(b)(1) of services "furnished through a non-medical program as either a benefit or administrative activity." We focus on this exclusion to show that it conflicts with Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children and should therefore be withdrawn from the proposed rule.

Under EPSDT, states must make sure that all children enrolled in Medicaid receive regular check-ups, including vision, dental, and hearing exams, as well as necessary immunizations and laboratory tests and all medically necessary follow-up testing and treatment. When a health care service is medically necessary for an eligible child, the service must be covered through Medicaid regardless of whether the state where the child lives has chosen to cover the service for adults. Thus, medically necessary rehabilitative services must be covered for children even though rehabilitative services are optional for adults.[1]

[1] Even though rehabilitative services are optional for adults, nearly every state (47 states plus the District of Columbia) provides rehabilitative services for Medicaid beneficiaries.

Rehabilitative services are defined in the Medicaid statute in a provision that also includes the definition of screening, diagnostic, and preventive services. These services are defined as "other diagnostic, screening, preventive, and rehabilitative services, including 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 the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[2]

The broad definition of rehabilitative services has allowed states to cover a number of services for children with mental illness as alternatives to more costly care in a residential treatment program or psychiatric hospital. These services include therapeutic foster care, in which children are placed in a private home with foster parents who are specially trained to help them improve their condition, and intensive in-home psychiatric services, in which a team of mental health workers provide an array of services such as evaluation, treatment, and parent training in a child's home, school and in other community settings.

Rehabilitative services for children are often delivered in coordination with other agencies that are involved with the child and family. As noted in a report from the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services:

> Many youth with SED [serious emotional disturbance] are first identified in the schools, child welfare or juvenile justice systems, and they often claim a great deal of public attention because of the wide gap between their need for intensive treatment and the availability of appropriate services, including home-based counseling, respite care, family-to-family support, treatment foster care, and school-based mental health care. More and more studies indicate that these services are effective not only in improving mental health outcomes for youth with SED, but also in reducing or preventing stays in residential care and other out-of-home settings.[3]

The report identified rehabilitative services as one way states could offer services such as "assessment, in-home services, school-based services, behavioral management, skills training, and crisis intervention."

The proposed rule directly conflicts with the EPSDT guarantee for children by establishing new conditions of coverage for Medicaid services that ignore how states organize and deliver services for children in foster care and other programs. Section 441.45(b)(1) of the proposed rule states that federal financial participation would not be available if "services are furnished through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid." The rule goes on to provide examples of non-medical programs, which include foster care, child welfare, education, and child care programs, the precise programs where children with mental illness are most often identified and cared for.

---

[2] Section 1905(a)(13) of the Social Security Act.

[3] *Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies*, U.S. Department of Health and Human Services, June 2006.

The rule would have a devastating impact on the provision of services to children in foster care. Children in foster care are more likely to suffer from mental health problems than other children, even when they are compared only to poor children.[4] In fiscal year 2001, only 3.7 percent of non-disabled children enrolled in Medicaid were in foster care, but they accounted for 12.3 percent of all expenditures for this group of children. Children in foster care accounted for 46 percent of expenditures for inpatient psychiatric services for non-disabled children and 28 percent of such expenditures for all children. Foster children accounted for 35 percent of state expenditures on rehabilitative services for non-disabled children and 13 percent of expenditures on rehabilitative services for all children enrolled in Medicaid.[5]

Children in foster care are in the custody of state child welfare systems that have responsibility for their health and well-being. They also go to school, and some are involved with the juvenile justice system. At the same time that they are involved with these programs, most children in foster care are also eligible for Medicaid, and Medicaid provides a way to finance the health and mental health services they need. About half of foster children who are eligible for federally-funded child welfare services are automatically eligible for Medicaid. Almost all of the remaining children are eligible under Medicaid categories developed for low-income children or children with disabilities.

As children eligible for Medicaid, these foster children are entitled to EPSDT services. However, under the proposed rule federal matching funds would not be available for rehabilitative services "furnished through" the foster care or child welfare system, "including services that are intrinsic elements of programs other than Medicaid."

This restriction on coverage for rehabilitative services is clearly in conflict with the EPSDT guarantee that children get medically necessary health care services. The fact that a service is "furnished through" another system such as the foster care or child welfare system has nothing to do with whether it should be covered by Medicaid. The reference to services "that are intrinsic elements of programs other than Medicaid" is also meaningless when considering whether a service should be covered for a Medicaid-eligible child. The proposed rules do not define "intrinsic element," and this lack of definition is likely to lead to confusion and uncertainty for beneficiaries, their families, and health care providers as states grapple with figuring out what can and cannot be covered under this vague test.

By making children in foster care eligible for Medicaid, Congress has shown a clear intent that Medicaid provide the financing for the health care services they need regardless of whether the health care services are "furnished through" the state's child welfare system. Federal funds that directly support the child welfare system do not provide support for health care services. This is the role of the Medicaid program.

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[4] See studies cited in N. Halfon, et al., "Child Health Agency Roles in Health Services for Children in Foster Care," UCLS Center for Healthier Children, Families and Communities, September 2002.

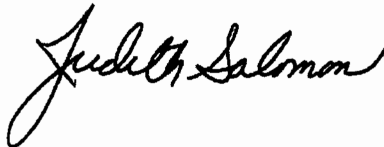
[5] R. Geen, et al., "Medicaid Spending on Foster Children," The Urban Institute, August 2005.

The proposed rule singles out therapeutic foster care as a service that would not be covered, but the restriction would have a broader impact and likely affect many more services that states provide to children with mental illness and other disabilities or chronic conditions. As noted in the Surgeon General's report on Mental Health, "the field of children's mental health has witnessed a shift from institutional to community-based interventions" since the 1980s.[6] With this shift, the ability to provide rehabilitative services in a child's home, school or other community setting has grown in importance particularly for children in foster care.

The proposed rule attempts to distinguish services that are "packaged" from services that can be covered as rehabilitative services, stating that services that are "clearly distinct" from the packaged services can be covered. This distinction is also in conflict with EPSDT as it would eliminate coverage for the very services such as therapeutic foster care and intensive in-home psychiatric services that have been found effective in treating children with mental illness, simply because these services encompass a number of elements such as assessment, evaluation, and treatment. The definition of rehabilitative services in the Medicaid statute clearly allows for the coverage of these services, which have been shown to be effective in keeping children out of psychiatric hospitals and residential treatment facilities.

We urge that you withdraw section 441.45(b)(1) from the proposed rule so that states can continue to receive federal matching funds to cover the rehabilitative services guaranteed to children by the EPSDT program. .

Sincerely,



Judith Solomon
Senior Fellow

[6] *Mental Health: A Report of the Surgeon General,* 1999 at
http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec7.html#newer

Submitter : **Mrs. Elizabeth Carlson** **Date: 10/10/2007**

Organization : **Mrs. Elizabeth Carlson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

This will reduce the intensity and duration of treatment of kids with autism. My 2 boys with autism, Kevin and Ryan, will be affected.

By limiting the duration and intensity of speech and occupational therapy, Ryan may not become self-sufficient. The more help Ryan has, the more self-sufficient he becomes. Right now, Ryan has a few words and can do many things. He won't become self-sufficient without more therapy. If his therapy is cut, then he won't learn to speak in 2-word sentences...and will probably remain on public assistance for his whole life. Ryan is only 8, but the therapy he is getting right now will determine whether or not he will be able to live independently.

His brother, Kevin, 10, is non-verbal. The therapy he receives does help, but will only mitigate how much assistance he will need.

Reducing the intensity and duration of speech and occupational therapy will only increase the probability that they will remain on public assistance for a lifetime. Please consider the long-term effects of reducing therapy to autistic kids.

Thank you.

Submitter : Miss. PEGGY FREELAND **Date:** 10/10/2007

Organization : OUACHITA INDUSTRIES INC.

Category : Individual

Issue Areas/Comments

Background

Background

THE BILL THAT HAS BEEN VETOED BY PRESIDENT BUSH
CONCERNS 'THE CENTERS OF MEDICAID& MEDICAID SERVICES
THAT ARE PROVIVED FOR CHILDREN AND ADULTS WHO ARE
DEPENDENT ON SERVICES WHO HAVE DEVELOPMENT DISABILITIES.

Collections of Information Requirements

Collections of Information Requirements

THE NAME OF THE BILL IS CALLED CALLED S-CHIP AND THE MANY
CHILDREN WHO ARE DEPENDENT ON THIS PROGRAM WILL BE
WITOUT HELP AND SO WILL THERE PARENTS BE WITHOUT HELP.
FOR THE FIRST TIME THE FEDERAL GOVERNMENT HAS THREATENED
TO SHUT DOWN THE INDUSTRIES THAT HELPS OLDER ADULTS.

GENERAL

GENERAL

THE CHILDDREM OF THE CHILD-ENRICHMENT CENTER,
THE ABC PROGRAM AND THE OLDER ADULTS OF OUACHITA
INDUSTREIES WILL APPRICIATE YOUR HELP IN KEEPING
US OPEN.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

IF THE SERVICES ARE NO LONGER BY MEDICAID MANY PEOPLE WILL
SUFFER FROM THIS RULE.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

OUACHITA INDUSTRIES IS LOCATED IN CAMDEN ARKANSAS
AND PROVIDES A DAILY HABILITATION PROGRAM FOR
ADULTS WHO HAVE DISABILITIES.
I HAVE A DISABILITY AND WORK THERE ALSO.
I WORK AS A PART-TIME SWITCHBOARD OPERATOR
I AM ONLY ABLE TO WORK THERE FOR 4 HOURS 5 DAYS A WEEK.

Regulatory Impact Analysis

Regulatory Impact Analysis

PLEASE SAVE THE CHILDREN OF THE CHILD ENRICHMENT CENTER
AND ABC PROGRAM AND THE OUACHITA INDUSTRIES.
THANK YOU.

CMS-2261-P-714

Submitter : **Mr. Leland Dickerman** **Date: 10/10/2007**

Organization : **cciu #24**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

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

I find it unconsciousionable for you to consider your proposals WITHOUT any impact statement.. This smacks of our PA lawmakers "midnight pay raise" action.

Submitter : Phoebe Norton **Date: 10/10/2007**

Organization : NAMI Colorado

Category : Individual

Issue Areas/Comments

Background

Background

I strongly support the goals of rehabilitation and recovery. However I know that the road to rehabilitation and recovery for someone with mental illness can have a number of steps forward and some steps back with the overall picture being one of progress. Often progress is demonstrated by maintaining independent living, participating in the life of the community and working at least part time. Often this kind of progress takes continued rehabilitation services to maintain.

I strongly urge you to make the definitions and regulations flexible enough to address helping people to maintain their progress and not to deteriorate.

Collections of Information Requirements

Collections of Information Requirements

We have seen great success in helping people to recover from mental illness when we help them achieve vocational goals and maintain employment in the community. Specialized pre-vocational and vocational services for people with mental illness are extremely important to achieve recovery. Governmental vocational services are not epuipped or funded to provide these specialized vocational services for people with mental illness. Moreover, if the prevocational and vocational services are provided as an integral part of the person's rehabilitation treatment along with other psychiatric services, the continuity of care is much better and the outcomes are much better.

Creating bureaucratic barriors to services will not save money in the long run but instead will increase the numbers of mentally ill youths and adults in prisons.

GENERAL

GENERAL

Please consider the overall negative effect that these proposed rules will have on the progress that has been made in helping people with mental illness to recover and maintain their recovery.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Make the definitions and rules flexible enough to address helping persons with mental illness maintain progress and not deteriorate.

Include specialized prevocational and vocational services for people with mental illness as essential services to help people achieve their rehabilitation and recovery goals.

Include specialized school based services provided by qualified providers for children with serious emotional disturbance and/or mental illness.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Adding to the already burdensome documentation requirements and making providers spend even more time justifying each service will not improve the quality or outcomes of these services. We should be trying to reduce the administrative requirements not increasing them. Each requirement requires specialized forms, people to check and collate the information at each level of government (local, regional, state, and federal). Hence we spend a huge proportion of our public Medicaid service dollars on administration of these rules and regulations at the federal, state, regional, local and provider levels. Too many documentation requirements diminish the creative and caring spirit of the actual providers. Too many documentation requirements result in less choice for individuals, since most private, qualified providers will not accept Medicaid clients because of the burdensome documentation required for each client.

Response to Comments

Response to Comments

I do not think this an adequate analysis of the added administrative costs at the federal, state, regional, local, and provider levels. The administrative and documentation and justification costs are not negligible and will result in a smaller percentage of the available service dollars "trikling down" to the actual provision of services.

I do not think that this analysis has adequately looked at the increased costs to our justice systems, detention facilities, jails, and prisons as a result of the diminished services and monetary savings in the Medicaid system. Do we really want to trade expenditures for evidence-based, community-based services for mentally ill children and adults for increased costs in our prisons for youths and adults with mental illness?

Submitter : Mrs. Coreen Gonzalez **Date:** 10/10/2007

Organization : Students against Substance abuse

Category : Individual

Issue Areas/Comments

Background

Background

Plcasc continuc to hclp our community with mcdicare carc for the mentally disabled.

CMS-2261-P-716-Attach-1.PDF

#716

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 : Mrs. Ruth Pacheco

Date: 10/10/2007

Organization : Mrs. Ruth Pacheco

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-2261-P-717-Attach-1.DOC

CMS-2261-P-717-Attach-2.TXT

#717

October 10, 2007

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

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

Dear Sir or Madam:

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

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

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

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

We appreciate the emphasis on recovery in the rules. All individuals with mental illness and their families want the system to make it easier to recover. We also like the provisions about the participation of the individual and their family in the rehabilitative

plan and receiving copies of the plan so we can hold the system accountable. We would like to see some flexibility to make sure that providers can still do outreach and provide crisis care, but we very much appreciate the agency's intent to encourage communication between providers, the individual and family members.

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

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

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

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

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

Recommendation:

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

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

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

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

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

Recommendation:

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

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

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

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

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

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

Recommendation:

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

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

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

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

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

Recommendation:

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

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

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

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

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

Recommendation:

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

Conclusion:

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

We know what works. But we also know that too many people can't access these treatments. And the terrible consequences are seen in every jail and prison in America.

The federal government should be doing everything possible to encourage states to provide better and more effective services for people living with mental illnesses. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

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

Thank you,

Ruth E. Pacheco
Pembroke Pines, FL

Submitter : Mr. Darrel Wilson **Date:** 10/10/2007

Organization : Opportunity Foundation

Category : Intermediate Care Facility for the Mentally Retarded

Issue Areas/Comments

Background

Background

I support the comments by ANCOR, submitted Oct 11, 2000.

Submitter : Marlene Geiger **Date:** 10/10/2007

Organization : NAMI

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

Background

Background

PLEASE DO NOT CUT THE FUNDING FOR REHABILITATION SERVICE OPTION

Collections of Information Requirements

Collections of Information Requirements

I AM A MOTHER WHO HAS A SON WHO HAS HAD MENTAL ISSUES MOST OF HIS LIFE AND IS NEED OF THE FUNDING THAT THE STATE IS HELPING WITH, AFTER 45 YEARS I AM RETIRED NOW AND NEED THE HELP FOR HIM.I CAN NO LONGER FUND IT.

GENERAL

GENERAL

PLEASE DO NOT CUT FUNDING FOR THE MENTALLY ILL, IT IS NOT THEIR FAULT THEY ARE SICK.

Submitter : **Ms. Lorna Simon**

Date: 10/10/2007

Organization : **Ms. Lorna Simon**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-720-Attach-1.DOC

CMS-2261-P-720-Attach-2.DOC

#720

October 10, 2007

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

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

Dear Sir or Madam:

The National Alliance on Mental Illness (NAMI) is grateful for the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program. With 1100 affiliates, NAMI is the nation's largest grassroots organization representing individuals living with serious mental illnesses and their families. Many of our members have personally experienced the effectiveness of rehabilitation services and have been able to live, work and participate in their communities as a direct result of these services.

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 and their families.

NAMI conducted a survey of the 50 state mental health agencies and found that evidence-based practices funded by Medicaid under the rehabilitation services option were woefully inadequate in the states. In our 2006 *Grading the States* report, the average state grade was a D. For every poor grade NAMI gave, we know that there are hundreds of thousands of individuals who are being jailed, living on the streets or dropping out of school because they were unable to access the services that we know work. For this reason, we are particularly concerned that any new regulations governing rehabilitation services facilitate the provision of these services and in no way discourage systems and providers from increasing the availability of these critical services. Many of our members are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars from an already under-resourced service system.

NAMI is very appreciative of the effort in the proposed rules to encourage states to use rehabilitative services to meet the goals of the New Freedom Commission. We particularly agree with the quote from the Commission referenced in the preamble to the rules, "[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs."

We believe that the emphasis on recovery and person-centered planning and the inclusion of the individual, their families and other individuals in treatment planning is a very positive development that will further improve access to treatment. However, other sections of the proposed regulations have the potential to frustrate the ability to engage individuals in the process of recovery and provide evidence based and tailored services. We are particularly concerned about the prohibition on billing for services that may maintain a person's functioning and the broad exclusion of services that are "intrinsic" to other programs. We will describe these concerns in greater detail below.

Overall, NAMI believes that a system of rehabilitative services must follow these principles:

- Services should attain a high degree of accessibility and effectiveness in engaging and retaining persons in care.
- The effects of these services shall be sustained rather than solely crisis-oriented or short-lived.
- Services must be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery.
- Whenever possible, services should be provided within the person's home and/or community, using the person's natural supports.

Specific comments on sections of the preamble and regulations follow:

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

Section 440.130(d)(1)(iii) – Definition of qualified providers of rehabilitative services

This section provides general requirements for providers of rehabilitative services. While NAMI fully supports choice for consumers of services, we request clarification that schools and other systems could be reimbursed under Medicaid for services provided by employees of that system who meet Medicaid provider requirements. For example, it is often most efficient for schools to hire a therapist or behavioral aide rather than contract with an outside provider. This also allows for proper training and accountability.

Our members report great barriers to coordinating their services and supports so we would like to ensure that the burden is not shifted to consumers and their families to find service providers who will accept Medicaid because other systems such as education are no longer providing someone to give the service. Nothing in the current regulations prohibits schools and other systems from using their own employees, but CMS should clarify in the preamble that such practices are permissible as long as individuals are informed of their choice to seek another Medicaid provider if they wish to do so.

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

NAMI commends CMS for the emphasis on a person-centered planning process including the individual, the individual's family and others of the individual's choosing. The active participation of the individual is an essential part of the recovery process. In addition, research indicates that recovery is greatly facilitated by support from an individual's family.

NAMI also applauds the requirement that the plan include goals for the rehabilitation services, the services to be provided, and a timeline for assessment of the effectiveness of the provided services. It is important that individuals and their families have clear information about the services that are being made available so they can ensure that the services are actually received. It is also necessary for a treatment plan to have clear goals and for providers and the individual to periodically review whether goals and services need to be altered.

Several of our members have raised concerns, however, about the relationship between a rehabilitation plan and other service plans. CMS should clarify that plans produced by other entities, such as an individualized education plan or provider treatment plan, can be the rehabilitation plan as long as they meet the requirements of Section 440.130(d)(3).

Recommendation:

Add: **The requirement for a rehabilitation plan may be met by a treatment plan, individualized educational plan or other plan if the written document meets the requirements in Section 440(d)(3).**

Section 440.130(d)(vi) Definition of Restorative Services:

The proposed regulation and the preamble indicate that services that provide assistance in maintaining functioning may only be reimbursed as a rehabilitative service when necessary to help an individual achieve a rehabilitative goal. They further clarify that rehabilitative goals must be designed to assist with the regaining or restoration of functional loss. We have received overwhelming feedback from our members regarding their concern with the exclusive emphasis on restoring functioning rather than maintaining functioning. Many of our members describe their personal recovery process as varied, with periods of maintenance as well as periods of restoration. As one NAMI member stated, "recovery is not a linear process trending upward." Instead, consumers and family members describe their illnesses as up, down and stable depending on the period of time. In addition, many times these fluctuations did not depend on the rehabilitation services, but rather on outside events, changes in the course of the illness, or changes in medication effectiveness.

Moreover, our members noted that a person's history and severity of illness could be such that a period where the person is not regressing is meeting a rehabilitative goal. For example, an individual with schizophrenia who has experienced multiple hospitalizations and contacts with law enforcement and who has gained sufficient living skills to maintain

stable housing may need services to continue those skills. Withdrawing services as soon as the person's living skills were sufficiently restored to allow him or her to live in home for a brief period is inadvisable because the person's history and severity of illness indicate that he or she is likely to regress without further support.

Requiring that a person deteriorate before services can be provided is not cost effective For individuals with serious mental illnesses, a break in services and support can lead to a downward spiral and long period of acute illness. Thus, NAMI recommends that the proposed rule be amended to allow provision of rehabilitative services if the rehabilitation plan documents that based on the individual's history and severity of illness, such services are needed to prevent regression. The provider would be required to periodically review whether the history and severity of illness continue to merit rehabilitative services to prevent regression as part of the review of the rehabilitation plan.

Moreover, NAMI recognizes the value of consumer run services such as clubhouses and peer support services. Many of our members find these services to be instrumental in their recovery. These programs also recognize that progress is not always linear and prohibiting services to prevent regression can be a barrier to their ability to serve people in need of services.

CMS has full authority to allow rehabilitation services which will prevent regression or deterioration. Section 1901 of the Medicaid Act clearly authorizes expenditures for rehabilitation and other services to help families and individuals "attain and **retain** capability for independence and self-care."(emphasis added).

In addition, NAMI commends CMS for specifying that rehabilitative services enable an individual to perform a function, but the individual is not required to demonstrate that they actually performed the function in the past. This is particularly true for children, who will not necessarily have had the ability to perform a function in the past due to their level of development and acquisition of age appropriate skills. It would be helpful for CMS to further clarify that rehabilitation services may be provided to children to achieve age appropriate skills and development.

Medicaid is a critical funding source for evidence based practices for children with serious mental illnesses. For example, multi-systemic therapy has been funded under Medicaid and has been proven in multiple clinical trials to produce good outcomes for children, including reduced psychiatric symptoms, decreased substance use and abuse, decreased hospitalizations and out of home placements, less contact with law enforcement, and increased school attendance. However, NAMI hears from many of our members regarding their inability to access MST and other services. The proposed regulations should encourage the further dissemination of evidence based services for children by clarifying that rehabilitative services are available to allow children to gain age appropriate skills and development.

Recommendation:

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

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

Section 440(d)(1)(vii) Definition of Medical Services

The proposed regulations provide that medical services are those required for the diagnosis, treatment or care of a physical or mental disorder. It would be helpful to clarify that rehabilitation services include a functional assessment of the individual. It is critical for a provider to attain the correct diagnosis, but our members experiences indicate that individuals with the same diagnosis may have very different rehabilitative goals and services based on their current functional level and their stage of recovery from the illness. Accordingly, we recommend that CMS amend this section to specifically include functional assessment or to indicate in the preamble that such an assessment is part of the meaning of diagnosis. This would provide consistency with later requirements in the proposed regulation for a rehabilitation plan which must be "based on a comprehensive assessment... including diagnosis and presence of a functional impairment in daily living."

Recommendation:

Add bolded language: services that are required for the "diagnosis**, assessment**, treatment or care of a physical or mental disorder..."

Section 440.140(d)(3) Definition of Written Rehabilitation Plan

NAMI commends CMS for requiring a written rehabilitation plan to guide treatment. We support the inclusion of the individual and the individual's family in the development of the rehabilitation plan.

However, NAMI strongly urges additional language to provide needed flexibility to address the nature of mental illness and the current practices in mental health service delivery.

For example, as indicated in our prior comments on restorative services, NAMI encourages language which allows the reevaluation process to determine whether services were effective in preventing regression or deterioration as well as achieving reduction of disability and restoration of functional ability.

We further note that while individuals should always be encouraged to actively participate in treatment planning, rehabilitative services are often required to assist an individual in acquiring the skills necessary to understand the benefits of treatment and begin a recovery process. Assertive community treatment teams (ACT) for example, is an evidence based practice based on an outreach model and a team approach to providing services to individuals with serious mental illness who also have a history of multiple hospitalizations and/or involvement with law enforcement. ACT teams report that they often will need to provide services for a period of time before an individual is ready to sign a treatment plan. However, they can develop the plan and provide services with the goal of developing social and living skills such that the individual is able to more actively participate and sign a treatment plan.

Moreover, the mental health service delivery system is not always coordinated and individuals with serious mental illnesses can move into new communities. It is not uncommon for an individual with serious mental illness to lack sufficient linkages to the community provider system. An individual with a serious mental illness who has been released from jail or the hospital without continuity of care or someone who has recently moved to a new community may experience a crisis and require rehabilitation services such as mobile crisis services. At the point of service, the provider of mobile crisis may not have a treatment plan signed by the individual on file, particularly if that individual was not a previous resident of that community. In addition, an individual in a psychiatric crisis may not be able to actively participate in a treatment plan at that time. If the individual has Medicaid coverage, they should be able to get coverage for this intervention regardless of the fact that these requirements for a written treatment plan could not be met. The proposed regulations should have sufficient flexibility to allow Medicaid financing for crisis stabilization services.

Of course, it is preferable to have a planning process and a crisis plan included in the rehabilitation plan. However, the regulations should have sufficient flexibility to recognize that this will not always be possible.

In addition, a mental health provider does not always have knowledge of alternate providers of the same service and it may be confusing to the individual being served if the provider attempts to give this information. However, the rehabilitation plan should indicate that the person has been given information about any available resource listing alternative providers. We suggest adding language that clarifies this obligation and recognizes that in some circumstances, such as an emergency intervention, it may not be feasible to do so.

Recommendation:

Amend the proposed rule to add bolded language:

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

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

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

Section 440.130(d)(4) Impairments to be Addressed

The regulation states that services "may address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs." NAMI appreciates the express inclusion of mental health and substance-related treatment needs. However, NAMI is concerned about the explicit omission of developmental disabilities from the list of impairments to be addressed in this section and in other parts of the rule and preamble. NAMI believes that a categorical exclusion of a particular disability is disability-based discrimination and should not be included in the proposed regulations. We urge CMS to allow all individuals regardless of disability to be eligible to receive rehabilitative services if the requirements for provision of the service are met.

Recommendation:

Amend to add bolded language: may address the individual's physical **or mental** impairments, mental health impairments, and/or substance-related disorder treatment needs."

Section 440.130(d)(5) Settings

This section of the regulation can be very helpful in reinforcing that rehabilitative services may be provided in natural settings and build upon natural supports. However, NAMI urges CMS to revise the preamble language which gives states the authority to determine the setting for the service. Rehabilitation services should be available in whatever setting will yield the best results and the appropriate setting should be determined as part of the rehabilitation planning process with input from the individual with mental illness and his or her family.

We also recommend adding to the settings listed in the proposed regulations to clarify that rehabilitative services can be provided in setting such as schools, workplaces and in the community. Assertive community treatment and mobile crisis, for example, often take place in the community and outside of a home or facility. The preamble includes some of these settings, but it would be helpful to also have them in the regulation itself.

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

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

Section 441.45 Rehabilitative Services

<u>Section 441.45(a)(1) – Assurance of compliance with other federal regulations</u>

NAMI appreciates the specific inclusion of these regulatory requirements. However, it would be helpful to also include the regulatory and statutory requirements of Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), which mandate that Medicaid beneficiaries under the age of 21 must receive all medically necessary services to ameliorate or correct a physical or mental condition regardless of whether the services are included in a state's Medicaid plan. 42 U.S.C. Section 1396d(r)(5) and 42 C.F.R. Section 440.40(b).

EPSDT is a critical requirement for children with mental illness who require rehabilitative services to facilitate their recovery and full participation in their schools and communities. States should be required to ensure that nothing in their implementation of these regulations will compromise the mandate in the EPSDT provisions.

Recommendation:

Add bolded language: **and 440.40(b)** of this chapter and **42 U.S.C. Sections 1396d(r)(5) and 1396a(a)(43).**

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

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

Many states find it administratively efficient to combine services provided in these evidence based treatment programs, a practice commonly known as "bundling." Services can be bundled into a case rate, daily rate or similar arrangement. This allows a provider to predict revenue and facilitates its ability to hire the extensive teams of individuals

required to provide these services with fidelity to the model. ACT services, for example, will often be provided by a 10 member team, including nurses, a psychiatrist, a peer specialist, a substance abuse specialist and others. Numerous research studies have confirmed that good outcomes are dependent on fidelity to the model, including the active participation of a full team. States should be given the flexibility to choose the method that they believe will best allow them to ensure fidelity to the evidence based practice and replication throughout the state.

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

Recommendation:

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

Section 441.45(b)(1) Services that are excluded from rehabilitation, including those that are intrinsic elements of other programs

NAMI strongly urges CMS to strike this section of the regulation because these provisions create an ambiguous standard that states and beneficiaries will be unable to apply. The preamble and the regulation give no guidance on how to determine if a service is an intrinsic element of programs other than Medicaid. Individuals with mental illnesses, their families, and state policymakers will not be able to determine what is intrinsic to other programs and this lack of clarity undermines the integrity of the Medicaid program.

Moreover, the ambiguity of the proposed regulations places states in an untenable position. They can either forego federal funds that they may be entitled to or they can bill Medicaid and risk an audit and the eventual loss of state dollars. For Medicaid to operate successfully as a state-federal program, the terms and conditions of the relationship and what can be provided must be clear and readily applied by states.

Furthermore, the current language in the proposed rule can be read to disallow rehabilitative services that are furnished through a non-medical program as either a benefit or an administrative activity, including those that are intrinsic elements of other programs. However, under the Medicaid statute, a Medicaid eligible individual who resides in a state that has chosen the rehabilitation option is entitled to rehabilitative services paid for by Medicaid regardless of their participation in another program. The

proposed language in Section (b) (1)(i) regarding therapeutic foster care acknowledges this distinction and provides an exception for "medically necessary rehabilitation services for an eligible child." This language should be included in Section (b)(1) to clarify the agency's intent.

Clarifying language is particularly important for children, who are entitled to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). As previously noted, this mandate requires that children receive all necessary services to correct or ameliorate a physical or mental condition, regardless of whether the service is covered under the state Medicaid plan. *See* 42 U.S.C. Section 1396d(r)(5). Thus, Medicaid eligible children are entitled to all rehabilitative services necessary to ameliorate a physical or mental condition such as mental illness. This clear mandate also applies regardless of whether the rehabilitative service is intrinsic to another program or is furnished as a benefit or administrative activity of another program.

Finally, third party liability rules under Medicaid have recognized that states have an obligation to determine if another entity is legally liable for payment of the services. If CMS is unwilling to strike the language, the proposed regulations should be clarified such that services are only excluded if the other program has a specific legal obligation to pay for services to a specific Medicaid recipient. Programs that are financed by capped or discretionary appropriations from state or local entities should be specifically excluded from these provisions.

NAMI believes that if this language is unchanged, it will have a devastating effect on the ability and willingness of other programs to provide quality treatment to adults and children with serious mental illnesses. These other programs are often operating with little resources and growing need. If they are denied Medicaid resources to pay for the treatment for individuals with mental illnesses, some are likely to fail to provide needed services and others may refuse to serve individuals with mental illnesses.

Moreover, the ambiguity inherent in the language of the proposed rule will discourage the dissemination of evidence based practices in these other programs. NAMI is just beginning to see child welfare, juvenile justice and corrections programs that serve large numbers of adults and children with serious mental illnesses recognize the value of these mental health interventions and coordinate with the mental health system to adopt such practices. Research clearly shows that this coordination leads to better outcomes. The proposed rule should facilitate and not impede such progress.

Finally, the President's New Freedom Commission report decried a fragmented service system that denied hope and opportunity to adults and children with serious mental illnesses. They wrote:

> The promise of the New Freedom Initiative-a life in the community for everyone-can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity

for recovery. Today's mental health care system is a patchwork relic-the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

NAMI strongly urges CMS to reconsider the current language in this section of the proposed rule which furthers fragmentation by discouraging other systems from offering treatment to individuals with serious mental illnesses. NAMI is deeply concerned that this provision will move us in the wrong direction at a time when states are showing progress in moving toward systems' coordination.

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

If CMS is unwilling to strike this section, add:

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

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

<u>Sections 445(b)(i) and (ii) Exclusion of Therapeutic Foster Care Services</u>

Therapeutic foster care, also known as treatment foster care (TFC), has a strong evidence base supporting its effectiveness for children with serious mental illness. Trained parent/providers work with youth in the treatment home to provide a structured and therapeutic environment while enabling the youth to live in a family setting. These services are effectively used to avoid out of home placement and more trauma to the child and family. Moreover, this intervention has been proven in multiple clinical trials to improve functional behavior, reduce contact with law enforcement, and decrease hospitalization and out of home placements.

As part of the President's Executive Order on Community Based Alternatives for People with Disabilities, the President ordered federal agencies to review their policies and regulations "to improve the availability of community-based services for qualified individuals with disabilities" and promote the integration of adults and children with disabilities in their local communities. The proposed language in these sections should be altered to facilitate the provision of treatment foster care so children with mental illnesses can continue to live in the community, rather than in more costly residential and hospital settings.

The preamble to the regulation indicates that CMS is promulgating this regulation because some states have packaged services within therapeutic foster care which are not

medically necessary rehabilitative services. CMS should clarify in the regulation that states may only provide medically necessary rehabilitative services as part of any bundling of services, but should allow states to use a case rate, daily rate or other arrangement as long as the services included in that rate are medically necessary rehabilitation services.

Recommendation:

Revise these sections to read:

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

Section 445(b)(1)(iv): Exclusion for Teacher Aides

NAMI urges CMS to clarify that the language regarding school services does not apply to behavioral health aides and other mental health providers who address a child's functional impairments which interfere with his or her ability to learn. Mental health providers in the schools play an essential role in allowing children to develop into productive, independent adults and the proposed regulations should encourage the provision of these services. The New Freedom Commission called for schools to play a far greater role in effectively addressing the mental health needs of students and NAMI recommends amending this provision to ensure consistency with that call to action.

Recommendation:

Add: Routine supervision and non-medical support services provided by teacher aides in school setting (sometimes referred to as "classroom aides" and "recess aides"), **however this exception shall not apply to behavior aides and other related service providers in the classroom that are designated to address a specific child's functional impairments and to provide rehabilitative services for that child**.

Section 445(b)(2): Exclusion of habilitation services

As previously noted, NAMI is concerned about policies that exclude a particular disability or group of disabilities from eligibility for a Medicaid service. Individuals with mental retardation and related conditions, such as cerebral palsy, appear to be categorically excluded in this proposed regulation from rehabilitation services.

In addition, in Section 6411(g) of the Omnibus Reconciliation Act of 1989 (OBRA 89), Congress required that a final regulation specify the type of habilitation services to be covered. This Congressional directive does not contemplate complete exclusion of the services from coverage under the rehabilitation option.

Recommendation:

Delete the categorical exclusion for habilitation services. Additionally, delete the categorical exclusion of people with mental retardation and related conditions from eligibility for rehabilitation services.

Section 445(b)(3): Exclusion for recreation or social activities that are not focused on rehabilitation.

NAMI applauds CMS's statements in the preamble that specifically note that "for an individual with a mental illness, what may appear to be a social activity may in fact be addressing the rehabilitative goal of social skills development as identified in the rehabilitation plan." We also appreciate earlier clarification that an activity that may appear to be recreational may be rehabilitative if it is addressing a particular impairment and functional loss. NAMI urges CMS to include this clarifying language in the regulation itself in addition to the discussion in the preamble.

We also urge CMS to clarify that personal care services that are performed to teach the individual some independent living skills are coverable services. For individuals with mental illness, modeling and cuing are often used to teach these skills and personal care services may be provided as part of the process in furtherance of the rehabilitation goal. The purpose of the service is to achieve a rehabilitative goal, rather than to provide personal care to the individual. The preamble recognizes this distinction by specifying that teaching an individual to cook a meal to re-establish the use of her or his hands or to restore living skills may be a coverable rehabilitation service. It would be helpful to provide that clarification in the regulation as well.

NAMI further urges CMS to clarify that supportive services furnished to address rehabilitative goals may be provided in community settings, including employment and academic settings or in the context of preparing to enter employment or academic settings as long as the primary purpose of the services is to achieve a rehabilitative goal rather than to assist the person with gaining employment or education. Employment and education settings or contexts can be therapeutic because the individual must interact or prepare to interact with others and manage symptoms in an increasingly challenging environment. As long as the service is directed at achieving the rehabilitative goal rather than retaining a job or furthering an education, the services should be reimbursable as rehabilitation services.

Recommendation:

Add: **Recreational and social activities that are addressing a particular impairment or functional need, such as social activities addressing a goal of social skills development, are reimbursable as rehabilitation services.**

Add: **Services, however, that are directed at achieving a rehabilitative goal may be provided in the context or setting for work or education if the purpose of the service**

is to address a functional impairment rather than to assist with employment or academic enhancement.

Add bolded language: Personal care services, **except for those which are furnished to teach a skill in furtherance of a rehabilitative goal.**

<u>Section 441.45(b)(4): Exclusion of services provided by public institutions.</u>

This section of the proposed rules restates current law with respect to public institutions. NAMI appreciates the language stating that "rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement..."

The language, however, also states that such community services cannot be "part of the public institution system." NAMI strongly urges CMS to strike the word "system" to be clear that community services which are rehabilitative are reimbursable regardless of whether a child or adult remains part of the juvenile justice or correctional system. This is particularly important for rehabilitation services that are provided in the community while the youth or adult with mental illness is still under the auspices of the correctional system, such as mental health services in a group home for children who are under juvenile court jurisdiction or forensic assertive community treatment for adults who are still in the corrections system. This clarification is very important given the large numbers of youth and adults with mental illnesses who come under the jurisdiction of these systems. It is consistent with other sections of the preamble and regulation which recognize that involvement in other programs does not affect Medicaid eligibility for services.

NAMI also strongly urges deletion of language indicating that community services can only be reimbursable if they are not used in the administration of other non-medical programs. This language is ambiguous and the preamble gives no guidance to determine whether services are used in the administration of a non-medical program. NAMI believes that a Medicaid eligible individual should receive rehabilitative services if medically necessary to address a functional impairment regardless of any involvement in another program. This point is included in the preamble language noting "enrollment in these non-Medicaid programs does not affect eligibility for Title XIX services." NAMI seeks similar language in the final regulation.

Recommendation:
Strike the following language: ... that are not part of the public institution ~~system~~, when the services are identified due to a medical condition targeted under the State's Plan, ~~are not used in the administration of other non-medical programs.~~

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

NAMI applauds the discussion in the preamble recognizing that "effective rehabilitation of eligible individuals may require some contact with non-eligible individuals." The

preamble further explains that counseling sessions for the treatment of the child may include the parents or other non-eligible family members and concludes that "contacts with family members for the purpose of treating the Medicaid eligible individual may be covered under Medicaid."

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

Recommendation:

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

Thank you for the opportunity to comment on the proposed regulations. We appreciate your consideration of our recommendations.

Sincerely,

Lorna J. Simon
8 Grafton St., #20
Shrewsbury MA 01545

CMS-2261-P-721

Submitter : Laura Thweatt

Organization : Laura Thweatt

Category : Individual

Date: 10/10/2007

Issue Areas/Comments

GENERAL

GENERAL

Please support Docket: CMS-2261-P - Rehabilitation Services: State Plan Option

CMS-2261-P-722

Submitter : Mrs. gloria morello **Date:** 10/10/2007

Organization : parent of handicalpped child

Category : Individual

Issue Areas/Comments

Background

Background

I strongly oppose provisionsrelated to excluding fed financial particpation for havilitation service lease withdraw proposed rule

GENERAL

GENERAL

strongly oppose the provisions related to excluding federal financial participation for habilitation services. I urge you to withdraw proposed rule

Submitter : **Anne Hathaway**

Date: 10/10/2007

Organization : **Anne Hathaway**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I disagree

Submitter : Nicole Burton **Date:** 10/10/2007

Organization : Nicole Burton

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The federal agency that overseas the Medical Assistance Program (called CMS) has issued proposed regulations that could potentially and significantly limit wraparound (formerly know as Behavioral Health Rehabilitation Services or BHRS) services for children and adolescents with Autism Spectrum Disorders and Mental Retardation.

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 THOUSANDS of Pennsylvania children with Autism and MR who currently receive wrap around 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 wrap around services for children and adolescents with Autism and MR.

Submitter : Mr. Robert Lyon

Date: 10/10/2007

Organization : Mr. Robert Lyon

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I concur with the comments submitted by St Luke's House (and/or Community Behavioral Health Association of Maryland; National Council on Community Behavioral Health).

Robert R. Lyon
17728 Overwood Drive
Olney, Maryland

CMS-2261-P-726

Submitter : Mrs. Kirsten Cochran

Date: 10/10/2007

Organization : Mrs. Kirsten Cochran

Category : Individual

Issue Areas/Comments

Background

Background

Please reconsider making any changes to the behavioral health/wrap-around program that would negatively impact children with Autism Spectrum Disorders and their families. As you probably know, the number of people effected by Autism has risen significantly, and these individuals need and deserve services such as wrap-around. There are many families who rely on such services to help their children. Please do not do a huge disservice to the children and families in Pennsylvania by cutting back on these much-needed services. Thank you.

Submitter : Mr. james ensley

Date: 10/10/2007

Organization : NAMI StTammany

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : **Pam Hinrichs** **Date: 10/10/2007**

Organization : **American Speech/Language Hearing Association (ASHA**

Category : **Speech-Language Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Please protect any and all legislation supporting help for those with mental illnesses....they are incredible contributors to research, leadership, business when they have medications and therapy. Thank you.

Submitter : **Cheryl Turney** **Date: 10/10/2007**

Organization : **NAMI**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2261-P-729-Attach-1.RTF

#729

October 10, 2007

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

To Whom It May Concern:
Reference: File code CMS-2261-P

Please read my comments and recommendations concerning the proposed rule to amend the definition of Medicaid Rehabilitative Services. I am the mother of a young woman diagnosed with Bipolar Disorder 8 years ago. It is heartbreaking to see how she and others like her struggle to reclaim their lives, with little help from the system of fragmented care in our country. The Clubhouse Model offers the most effective program I have found.

Pertaining to Section 440.130(d) (3)
Please do not restrict rehabilitative services to Medicaid eligible individuals with severe and persistent mental illness. Also please don't cut the funding.
The Clubhouse Model is the most effective program to serve persons with mental illness in the community.
Develop a rule change that would truly benefit the clients served. Work to reduce the paper work demands on providers so that they can focus on service delivery.

Pertaining to section 440.130(d) (I) (vi)
Many persons with severe and persistent mental illness need the clubhouse setting to work on their social skills and to develop structure for their lives. Lack of such skills is often one of the debilitating symptoms that a person may suffer from that hinders functioning and employment. There is no time limit, nor should one be placed on clients who need a social setting with their peers and professionals in which to rehabilitate. "Recovery goals" are unique to each person that lives with mental illness. Most people when in recovery will go on to live productive lives and leave the clubhouse model when they are ready.

Pertaining to Section 440.130(vii) (3)

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

Sincerely,
Cheryl Turney
NAMI Durham volunteer teacher

Submitter : **Fran Gulino** **Date: 10/10/2007**

Organization : **Fran Gulino**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Wraparound services are an important part of keeping autistic kids in the community as much as possible. With the help of such services, children can go from being children with disabilties to adults that can make a meaningful contribution to society. Please do not restrict these services.

Submitter : **Mrs. Linda Miller** **Date: 10/10/2007**

Organization : **Mrs. Linda Miller**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

October 10, 2007

Re: CMS-2261-P
Draft federal regs (section 441.45(b)(2))

To Whom It May Concern:

I received this email (below) from the AutismLink Website on which I am currently an email subscriber. My son Ben, who just turned 11, has ASD/PDD and currently receives wraparound services (Mobile Therapist) covered by Medicaid without which, he would not be able to function in school or in society. I am very concerned about the proposed regulations which could significantly affect my son s life. Please note my disapproval, and that I am opposed to the proposed regulatory changes as they have been issued and strongly suggest that they be modified to clarify the issues noted below.

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 who currently receive wraparound.

Thank you for your consideration in this very serious matter.

Linda M.. Miller
Pittsburgh, PA

Attached email:

The proposed regulations are aimed at clarifying the definition of a particular category of Medical Assistance services known as rehabilitation services . PA covers wraparound under this category of rehabilitation services (hence the formal name: Behavioral Health Rehabilitation Services or BHRS) for purpose of Medical Assistance coverage. Unfortunately for Pennsylvania, although these services have been in place since 1994 with little controversy as to their allowability under the federal category of rehabilitation services, these proposed regulations raise questions as to whether the federal government will force PA to restrict wraparound services for children and adolescents with autism spectrum disorders and those with mental retardation.

The draft federal regs (section 441.45(b)(2)) exclude habilitation services from the definition of rehabilitation services that can be covered under Medical Assistance. The problem is with the proposed federal definition of habilitation services which cannot be covered under the rehabilitation service category of Medical Assistance. Under the proposed federal regs, Habilitation services include services provided to individuals with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.) Does this mean that wraparound services provided t! o children and adolescents with mental retardation or autism (which is a related condition) are habilitation services and therefore totally excluded from coverage? Autism is also considered a mental illness by psychiatrists (in the DSM IV). Does that mean it is not included in the scope of related conditions so rehabilitation services may be appropriately provided ? Does the proposed definition of habilitation mean that the state will have to deny wraparound for children with mental retardation for autism spectrum disorders whose treatment goals are to assist the child in learning new social skills or other positive behaviors the child never had before (which might be excluded as habilitation services). Will each child's treatment plan or psych eval. need to show that the child had "a functional loss andhas a specific rehabilitative goal toward regaining that function" (part of the definition of rehabilitation services)?

The proposed regulations fail to answer any of these key questions. Adoption of these proposed regulations would leave PA with the unenviable choice of either keeping wraparound the same and risk losing federal funds if the feds later decide the new regulations limit our wraparound program or restricting wraparound in hopes of avoiding loss of federal funds.

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

Organization :

Category : **Nurse Practitioner**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am a professional that works with kids and families. I see every day how important MRO funding is for these at-risk families. Please consider the ELIMINATION of the intrinsic element rule that assumes that kids in therapeutic foster care or other welfare, probation, etc. programs are receiving these services. Without MRO, I know they WILL NOT get these necessary services. How can these at-risk kids be treated differently from other kids? How can they be denied the medically necessary kids.

Thank you for considering my concerns.

Submitter : **Ms. Patti Bedics** **Date: 10/10/2007**

Organization : **private citizen**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I understand that there are changes that are proposed to helping and aiding individuals with disabilities that are in need of provider 50 services and that these services may be cut from future budgets and that medicaid will not be sponsoring the reimbursement of these services. I feel that I need to voice my opinion on this subject. I have quite a few friends with children that fall in the autism spectrum of disabilities and they are still fighting to get these services that are much needed for the child to aid in their development and provide a tool for the parents that otherwise would not be available. I have also provided these services in past employment with agencies within my community that are contracted to go out into the community and help with children with special needs. These parents would be lost with out these services and the ones that are seeking the services and some being met with huge road blocks at every corner, what are they to do, where will these kids be when they are adults and who will ultimately be responsible for them? If we can help them now, that will save expense by the tax payer later to house,feed and cloth these individuals later. Perhaps the help they get now, will help them to be productive later. Don't cut these programs.

Thank you for your time

Patti Bedics
Catasauqua, PA

Submitter : Dr. Luis Baerga **Date:** 10/10/2007

Organization : Dr. Luis Baerga

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Diagnosis and treatment of a patient requires understanding of all medical conditions a co-morbidity a patient may have, and the effects the treatments may have on all these conditions. Only a medical doctor (physician) is qualified to do this. Physical and Occupational Therapists are not trainned to do this. Their diagnosis and tratments may affect other conditions in ways thay are not aware, which could be harmful to the patient. Also arriving to a diagnosis requires a full differential diagnosis which may fall outside the realm of physical medicine and rehabilitation, and only a medical doctor (physician) has the required knowledge base to take into account the full differential diahnosis. Allowing non-physicians to DIAGNOSE and TREAT could be HARMFUL to the patient.

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

Organization :

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

There are not enough funds available for Americans that need rehabilitation services, and the states can serve as an example to the Federaal Government.

I hope the following: Docket: CMS-2261-P - Rehabilitation Services: State Plan Option is not canceled or the money needed for it to continue increases as much as needed rather than be decreased.

Submitter : **Lucia Paparelli** **Date: 10/10/2007**

Organization : **Lucia Paparelli**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sce Attachment

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 : Amy Wendel

Date: 10/10/2007

Organization : JFCS

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

scc attachmcnt

CMS-2261-P-737-Attach-1.WPD

#737

October 10, 2007

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

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

Dear Sir or Madam:

The National Alliance on Mental Illness (NAMI) is grateful for the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program. With 1100 affiliates, NAMI is the nation's largest grassroots organization representing individuals living with serious mental illnesses and their families. Many of our members have personally experienced the effectiveness of rehabilitation services and have been able to live, work and participate in their communities as a direct result of these services.

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 and their families.

NAMI conducted a survey of the 50 state mental health agencies and found that evidence-based practices funded by Medicaid under the rehabilitation services option were woefully inadequate in the states. In our 2006 Grading the States report, the average state grade was a D. For every poor grade NAMI gave, we know that there are hundreds of thousands of individuals who are being jailed, living on the streets or dropping out of school because they were unable to access the services that we know work. For this reason, we are particularly concerned that any new regulations governing rehabilitation services facilitate the provision of these services and in no way discourage systems and providers from increasing the availability of these critical services. Many of our members are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars from an already under-resourced service system.

NAMI is very appreciative of the effort in the proposed rules to encourage states to use rehabilitative services to meet the goals of the New Freedom Commission. We particularly agree with the quote from the Commission referenced in the preamble to the rules, "[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs."

We believe that the emphasis on recovery and person-centered planning and the inclusion of the individual, their families and other individuals in treatment planning is a very positive development that will further improve access to treatment. However, other sections of the proposed regulations have the potential to frustrate the ability to engage individuals in the process of recovery and provide evidence based and tailored services. We are particularly concerned about the prohibition on billing for services that may maintain a person's functioning and the broad exclusion of services that are "intrinsic" to other programs. We will describe these concerns in greater detail below.

Overall, NAMI believes that a system of rehabilitative services must follow these principles:

- Services should attain a high degree of accessibility and effectiveness in engaging and retaining persons in care.
- The effects of these services shall be sustained rather than solely crisis-oriented or short-lived.
- Services must be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery.
- Whenever possible, services should be provided within the person's home and/or community, using the person's natural supports.

Specific comments on sections of the preamble and regulations follow:

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

Section 440.130(d)(1)(iii) – Definition of qualified providers of rehabilitative services

This section provides general requirements for providers of rehabilitative services. While NAMI fully supports choice for consumers of services, we request clarification that schools and other systems could be reimbursed under Medicaid for services provided by employees of that system who meet Medicaid provider requirements. For example, it is often most efficient for schools to hire a therapist or behavioral aide rather than contract with an outside provider. This also allows for proper training and accountability.

Our members report great barriers to coordinating their services and supports so we would like to ensure that the burden is not shifted to consumers and their families to find service providers who will accept Medicaid because other systems such as education are no longer providing someone to give the service. Nothing in the current regulations prohibits schools and other systems from using their own employees, but CMS should clarify in the preamble that such practices are permissible as long as individuals are informed of their choice to seek another Medicaid provider if they wish to do so.

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

NAMI commends CMS for the emphasis on a person-centered planning process including the individual, the individual's family and others of the individual's choosing. The active participation of the individual is an essential part of the recovery process. In addition, research indicates that recovery is greatly facilitated by support from an individual's family.

NAMI also applauds the requirement that the plan include goals for the rehabilitation services, the services to be provided, and a timeline for assessment of the effectiveness of the provided services. It is important that individuals and their families have clear information about the services that are being made available so they can ensure that the services are actually received. It is also necessary for a treatment plan to have clear goals and for providers and the individual to periodically review whether goals and services need to be altered.

Several of our members have raised concerns, however, about the relationship between a rehabilitation plan and other service plans. CMS should clarify that plans produced by other entities, such as an individualized education plan or provider treatment plan, can be the rehabilitation plan as long as they meet the requirements of Section 440.130(d)(3).

Recommendation:

Add: The requirement for a rehabilitation plan may be met by a treatment plan, individualized educational plan or other plan if the written document meets the requirements in Section 440(d)(3).

Section 440.130(d)(vi) Definition of Restorative Services:

The proposed regulation and the preamble indicate that services that provide assistance in maintaining functioning may only be reimbursed as a rehabilitative service when necessary to help an individual achieve a rehabilitative goal. They further clarify that rehabilitative goals must be designed to assist with the regaining or restoration of functional loss. We have received overwhelming feedback from our members regarding their concern with the exclusive emphasis on restoring functioning rather than maintaining functioning. Many of our members describe their personal recovery process as varied, with periods of maintenance as well as periods of restoration. As one NAMI member stated, "recovery is not a linear process trending upward." Instead, consumers and family members describe their illnesses as up, down and stable depending on the period of time. In addition, many times these fluctuations did not depend on the rehabilitation services, but rather on outside events, changes in the course of the illness, or changes in medication effectiveness.

Moreover, our members noted that a person's history and severity of illness could be such that a period where the person is not regressing is meeting a rehabilitative goal. For example, an individual with schizophrenia who has experienced multiple hospitalizations and contacts with law enforcement and who has gained sufficient living skills to maintain

stable housing may need services to continue those skills. Withdrawing services as soon as the person's living skills were sufficiently restored to allow him or her to live in home for a brief period is inadvisable because the person's history and severity of illness indicate that he or she is likely to regress without further support.

Requiring that a person deteriorate before services can be provided is not cost effective For individuals with serious mental illnesses, a break in services and support can lead to a downward spiral and long period of acute illness. Thus, NAMI recommends that the proposed rule be amended to allow provision of rehabilitative services if the rehabilitation plan documents that based on the individual's history and severity of illness, such services are needed to prevent regression. The provider would be required to periodically review whether the history and severity of illness continue to merit rehabilitative services to prevent regression as part of the review of the rehabilitation plan.

Moreover, NAMI recognizes the value of consumer run services such as clubhouses and peer support services. Many of our members find these services to be instrumental in their recovery. These programs also recognize that progress is not always linear and prohibiting services to prevent regression can be a barrier to their ability to serve people in need of services.

CMS has full authority to allow rehabilitation services which will prevent regression or deterioration. Section 1901 of the Medicaid Act clearly authorizes expenditures for rehabilitation and other services to help families and individuals "attain and retain capability for independence and self-care."(emphasis added).

In addition, NAMI commends CMS for specifying that rehabilitative services enable an individual to perform a function, but the individual is not required to demonstrate that they actually performed the function in the past. This is particularly true for children, who will not necessarily have had the ability to perform a function in the past due to their level of development and acquisition of age appropriate skills. It would be helpful for CMS to further clarify that rehabilitation services may be provided to children to achieve age appropriate skills and development.

Medicaid is a critical funding source for evidence based practices for children with serious mental illnesses. For example, multi-systemic therapy has been funded under Medicaid and has been proven in multiple clinical trials to produce good outcomes for children, including reduced psychiatric symptoms, decreased substance use and abuse, decreased hospitalizations and out of home placements, less contact with law enforcement, and increased school attendance. However, NAMI hears from many of our members regarding their inability to access MST and other services. The proposed regulations should encourage the further dissemination of evidence based services for children by clarifying that rehabilitative services are available to allow children to gain age appropriate skills and development.

Recommendation:

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

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

Section 440(d)(1)(vii) Definition of Medical Services

The proposed regulations provide that medical services are those required for the diagnosis, treatment or care of a physical or mental disorder. It would be helpful to clarify that rehabilitation services include a functional assessment of the individual. It is critical for a provider to attain the correct diagnosis, but our members experiences indicate that individuals with the same diagnosis may have very different rehabilitative goals and services based on their current functional level and their stage of recovery from the illness. Accordingly, we recommend that CMS amend this section to specifically include functional assessment or to indicate in the preamble that such an assessment is part of the meaning of diagnosis. This would provide consistency with later requirements in the proposed regulation for a rehabilitation plan which must be "based on a comprehensive assessment… including diagnosis and presence of a functional impairment in daily living."

Recommendation:

Add bolded language: services that are required for the "diagnosis, assessment, treatment or care of a physical or mental disorder…"

Section 440.140(d)(3) Definition of Written Rehabilitation Plan

NAMI commends CMS for requiring a written rehabilitation plan to guide treatment. We support the inclusion of the individual and the individual's family in the development of the rehabilitation plan.

However, NAMI strongly urges additional language to provide needed flexibility to address the nature of mental illness and the current practices in mental health service delivery.

For example, as indicated in our prior comments on restorative services, NAMI encourages language which allows the reevaluation process to determine whether services were effective in preventing regression or deterioration as well as achieving reduction of disability and restoration of functional ability.

We further note that while individuals should always be encouraged to actively participate in treatment planning, rehabilitative services are often required to assist an individual in acquiring the skills necessary to understand the benefits of treatment and begin a recovery process. Assertive community treatment teams (ACT) for example, is an evidence based practice based on an outreach model and a team approach to providing services to individuals with serious mental illness who also have a history of multiple hospitalizations and/or involvement with law enforcement. ACT teams report that they often will need to provide services for a period of time before an individual is ready to sign a treatment plan. However, they can develop the plan and provide services with the goal of developing social and living skills such that the individual is able to more actively participate and sign a treatment plan.

Moreover, the mental health service delivery system is not always coordinated and individuals with serious mental illnesses can move into new communities. It is not uncommon for an individual with serious mental illness to lack sufficient linkages to the community provider system. An individual with a serious mental illness who has been released from jail or the hospital without continuity of care or someone who has recently moved to a new community may experience a crisis and require rehabilitation services such as mobile crisis services. At the point of service, the provider of mobile crisis may not have a treatment plan signed by the individual on file, particularly if that individual was not a previous resident of that community. In addition, an individual in a psychiatric crisis may not be able to actively participate in a treatment plan at that time. If the individual has Medicaid coverage, they should be able to get coverage for this intervention regardless of the fact that these requirements for a written treatment plan could not be met. The proposed regulations should have sufficient flexibility to allow Medicaid financing for crisis stabilization services.

Of course, it is preferable to have a planning process and a crisis plan included in the rehabilitation plan. However, the regulations should have sufficient flexibility to recognize that this will not always be possible.

In addition, a mental health provider does not always have knowledge of alternate providers of the same service and it may be confusing to the individual being served if the provider attempts to give this information. However, the rehabilitation plan should indicate that the person has been given information about any available resource listing alternative providers. We suggest adding language that clarifies this obligation and recognizes that in some circumstances, such as an emergency intervention, it may not be feasible to do so.

Recommendation:

Amend the proposed rule to add bolded language:

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

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

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

Section 440.130(d)(4) Impairments to be Addressed

The regulation states that services "may address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs." NAMI appreciates the express inclusion of mental health and substance-related treatment needs. However, NAMI is concerned about the explicit omission of developmental disabilities from the list of impairments to be addressed in this section and in other parts of the rule and preamble. NAMI believes that a categorical exclusion of a particular disability is disability-based discrimination and should not be included in the proposed regulations. We urge CMS to allow all individuals regardless of disability to be eligible to receive rehabilitative services if the requirements for provision of the service are met.

Recommendation:

Amend to add bolded language: may address the individual's physical or mental impairments, mental health impairments, and/or substance-related disorder treatment needs."

Section 440.130(d)(5) Settings

This section of the regulation can be very helpful in reinforcing that rehabilitative services may be provided in natural settings and build upon natural supports. However, NAMI urges CMS to revise the preamble language which gives states the authority to determine the setting for the service. Rehabilitation services should be available in whatever setting will yield the best results and the appropriate setting should be determined as part of the rehabilitation planning process with input from the individual with mental illness and his or her family.

We also recommend adding to the settings listed in the proposed regulations to clarify that rehabilitative services can be provided in setting such as schools, workplaces and in the community. Assertive community treatment and mobile crisis, for example, often take place in the community and outside of a home or facility. The preamble includes some of these settings, but it would be helpful to also have them in the regulation itself.

Recommendation:

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

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

Section 441.45 Rehabilitative Services

Section 441.45(a)(1) – Assurance of compliance with other federal regulations

NAMI appreciates the specific inclusion of these regulatory requirements. However, it would be helpful to also include the regulatory and statutory requirements of Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), which mandate that Medicaid beneficiaries under the age of 21 must receive all medically necessary services to ameliorate or correct a physical or mental condition regardless of whether the services are included in a state's Medicaid plan. 42 U.S.C. Section 1396d(r)(5) and 42 C.F.R. Section 440.40(b).

EPSDT is a critical requirement for children with mental illness who require rehabilitative services to facilitate their recovery and full participation in their schools and communities. States should be required to ensure that nothing in their implementation of these regulations will compromise the mandate in the EPSDT provisions.

Recommendation:

Add bolded language: and 440.40(b) of this chapter and 42 U.S.C. Sections 1396d(r)(5) and 1396a(a)(43).

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

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

Many states find it administratively efficient to combine services provided in these evidence based treatment programs, a practice commonly known as "bundling." Services can be bundled into a case rate, daily rate or similar arrangement. This allows a provider to predict revenue and facilitates its ability to hire the extensive teams of individuals required to provide these services with fidelity to the model. ACT services, for example,

will often be provided by a 10 member team, including nurses, a psychiatrist, a peer specialist, a substance abuse specialist and others. Numerous research studies have confirmed that good outcomes are dependent on fidelity to the model, including the active participation of a full team. States should be given the flexibility to choose the method that they believe will best allow them to ensure fidelity to the evidence based practice and replication throughout the state.

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

Recommendation:

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

Section 441.45(b)(1) Services that are excluded from rehabilitation, including those that are intrinsic elements of other programs

NAMI strongly urges CMS to strike this section of the regulation because these provisions create an ambiguous standard that states and beneficiaries will be unable to apply. The preamble and the regulation give no guidance on how to determine if a service is an intrinsic element of programs other than Medicaid. Individuals with mental illnesses, their families, and state policymakers will not be able to determine what is intrinsic to other programs and this lack of clarity undermines the integrity of the Medicaid program.

Moreover, the ambiguity of the proposed regulations places states in an untenable position. They can either forego federal funds that they may be entitled to or they can bill Medicaid and risk an audit and the eventual loss of state dollars. For Medicaid to operate successfully as a state-federal program, the terms and conditions of the relationship and what can be provided must be clear and readily applied by states.

Furthermore, the current language in the proposed rule can be read to disallow rehabilitative services that are furnished through a non-medical program as either a benefit or an administrative activity, including those that are intrinsic elements of other programs. However, under the Medicaid statute, a Medicaid eligible individual who resides in a state that has chosen the rehabilitation option is entitled to rehabilitative services paid for by Medicaid regardless of their participation in another program. The proposed language in Section (b) (1)(i) regarding therapeutic foster care acknowledges

this distinction and provides an exception for "medically necessary rehabilitation services for an eligible child." This language should be included in Section (b)(1) to clarify the agency's intent.

Clarifying language is particularly important for children, who are entitled to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). As previously noted, this mandate requires that children receive all necessary services to correct or ameliorate a physical or mental condition, regardless of whether the service is covered under the state Medicaid plan. See 42 U.S.C. Section 1396d(r)(5). Thus, Medicaid eligible children are entitled to all rehabilitative services necessary to ameliorate a physical or mental condition such as mental illness. This clear mandate also applies regardless of whether the rehabilitative service is intrinsic to another program or is furnished as a benefit or administrative activity of another program.

Finally, third party liability rules under Medicaid have recognized that states have an obligation to determine if another entity is legally liable for payment of the services. If CMS is unwilling to strike the language, the proposed regulations should be clarified such that services are only excluded if the other program has a specific legal obligation to pay for services to a specific Medicaid recipient. Programs that are financed by capped or discretionary appropriations from state or local entities should be specifically excluded from these provisions.

NAMI believes that if this language is unchanged, it will have a devastating effect on the ability and willingness of other programs to provide quality treatment to adults and children with serious mental illnesses. These other programs are often operating with little resources and growing need. If they are denied Medicaid resources to pay for the treatment for individuals with mental illnesses, some are likely to fail to provide needed services and others may refuse to serve individuals with mental illnesses.

Moreover, the ambiguity inherent in the language of the proposed rule will discourage the dissemination of evidence based practices in these other programs. NAMI is just beginning to see child welfare, juvenile justice and corrections programs that serve large numbers of adults and children with serious mental illnesses recognize the value of these mental health interventions and coordinate with the mental health system to adopt such practices. Research clearly shows that this coordination leads to better outcomes. The proposed rule should facilitate and not impede such progress.

Finally, the President's New Freedom Commission report decried a fragmented service system that denied hope and opportunity to adults and children with serious mental illnesses. They wrote:

The promise of the New Freedom Initiative-a life in the community for everyone-can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic-the result of disjointed reforms and policies. Instead of ready access to quality care, the

system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

NAMI strongly urges CMS to reconsider the current language in this section of the proposed rule which furthers fragmentation by discouraging other systems from offering treatment to individuals with serious mental illnesses. NAMI is deeply concerned that this provision will move us in the wrong direction at a time when states are showing progress in moving toward systems' coordination.

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

If CMS is unwilling to strike this section, add:

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

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

Sections 445(b)(i) and (ii) Exclusion of Therapeutic Foster Care Services

Therapeutic foster care, also known as treatment foster care (TFC), has a strong evidence base supporting its effectiveness for children with serious mental illness. Trained parent/providers work with youth in the treatment home to provide a structured and therapeutic environment while enabling the youth to live in a family setting. These services are effectively used to avoid out of home placement and more trauma to the child and family. Moreover, this intervention has been proven in multiple clinical trials to improve functional behavior, reduce contact with law enforcement, and decrease hospitalization and out of home placements.

As part of the President's Executive Order on Community Based Alternatives for People with Disabilities, the President ordered federal agencies to review their policies and regulations "to improve the availability of community-based services for qualified individuals with disabilities" and promote the integration of adults and children with disabilities in their local communities. The proposed language in these sections should be altered to facilitate the provision of treatment foster care so children with mental illnesses can continue to live in the community, rather than in more costly residential and hospital settings.

The preamble to the regulation indicates that CMS is promulgating this regulation because some states have packaged services within therapeutic foster care which are not medically necessary rehabilitative services. CMS should clarify in the regulation that states may only provide medically necessary rehabilitative services as part of any

bundling of services, but should allow states to use a case rate, daily rate or other arrangement as long as the services included in that rate are medically necessary rehabilitation services.

Recommendation:

Revise these sections to read:

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

Section 445(b)(1)(iv): Exclusion for Teacher Aides

NAMI urges CMS to clarify that the language regarding school services does not apply to behavioral health aides and other mental health providers who address a child's functional impairments which interfere with his or her ability to learn. Mental health providers in the schools play an essential role in allowing children to develop into productive, independent adults and the proposed regulations should encourage the provision of these services. The New Freedom Commission called for schools to play a far greater role in effectively addressing the mental health needs of students and NAMI recommends amending this provision to ensure consistency with that call to action.

Recommendation:

Add: Routine supervision and non-medical support services provided by teacher aides in school setting (sometimes referred to as "classroom aides" and "recess aides"), however this exception shall not apply to behavior aides and other related service providers in the classroom that are designated to address a specific child's functional impairments and to provide rehabilitative services for that child.

Section 445(b)(2): Exclusion of habilitation services

As previously noted, NAMI is concerned about policies that exclude a particular disability or group of disabilities from eligibility for a Medicaid service. Individuals with mental retardation and related conditions, such as cerebral palsy, appear to be categorically excluded in this proposed regulation from rehabilitation services.

In addition, in Section 6411(g) of the Omnibus Reconciliation Act of 1989 (OBRA 89), Congress required that a final regulation specify the type of habilitation services to be covered. This Congressional directive does not contemplate complete exclusion of the services from coverage under the rehabilitation option.

Recommendation:

Delete the categorical exclusion for habilitation services. Additionally, delete the categorical exclusion of people with mental retardation and related conditions from eligibility for rehabilitation services.

Section 445(b)(3): Exclusion for recreation or social activities that are not focused on rehabilitation.

NAMI applauds CMS's statements in the preamble that specifically note that "for an individual with a mental illness, what may appear to be a social activity may in fact be addressing the rehabilitative goal of social skills development as identified in the rehabilitation plan." We also appreciate earlier clarification that an activity that may appear to be recreational may be rehabilitative if it is addressing a particular impairment and functional loss. NAMI urges CMS to include this clarifying language in the regulation itself in addition to the discussion in the preamble.

We also urge CMS to clarify that personal care services that are performed to teach the individual some independent living skills are coverable services. For individuals with mental illness, modeling and cuing are often used to teach these skills and personal care services may be provided as part of the process in furtherance of the rehabilitation goal. The purpose of the service is to achieve a rehabilitative goal, rather than to provide personal care to the individual. The preamble recognizes this distinction by specifying that teaching an individual to cook a meal to re-establish the use of her or his hands or to restore living skills may be a coverable rehabilitation service. It would be helpful to provide that clarification in the regulation as well.

NAMI further urges CMS to clarify that supportive services furnished to address rehabilitative goals may be provided in community settings, including employment and academic settings or in the context of preparing to enter employment or academic settings as long as the primary purpose of the services is to achieve a rehabilitative goal rather than to assist the person with gaining employment or education. Employment and education settings or contexts can be therapeutic because the individual must interact or prepare to interact with others and manage symptoms in an increasingly challenging environment. As long as the service is directed at achieving the rehabilitative goal rather than retaining a job or furthering an education, the services should be reimbursable as rehabilitation services.

Recommendation:

Add: Recreational and social activities that are addressing a particular impairment or functional need, such as social activities addressing a goal of social skills development, are reimbursable as rehabilitation services.

Add: Services, however, that are directed at achieving a rehabilitative goal may be provided in the context or setting for work or education if the purpose of the service is to address a functional impairment rather than to assist with employment or academic enhancement.

Add bolded language: Personal care services, except for those which are furnished to teach a skill in furtherance of a rehabilitative goal.

Section 441.45(b)(4): Exclusion of services provided by public institutions.

This section of the proposed rules restates current law with respect to public institutions. NAMI appreciates the language stating that "rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement..."

The language, however, also states that such community services cannot be "part of the public institution system." NAMI strongly urges CMS to strike the word "system" to be clear that community services which are rehabilitative are reimbursable regardless of whether a child or adult remains part of the juvenile justice or correctional system. This is particularly important for rehabilitation services that are provided in the community while the youth or adult with mental illness is still under the auspices of the correctional system, such as mental health services in a group home for children who are under juvenile court jurisdiction or forensic assertive community treatment for adults who are still in the corrections system. This clarification is very important given the large numbers of youth and adults with mental illnesses who come under the jurisdiction of these systems. It is consistent with other sections of the preamble and regulation which recognize that involvement in other programs does not affect Medicaid eligibility for services.

NAMI also strongly urges deletion of language indicating that community services can only be reimbursable if they are not used in the administration of other non-medical programs. This language is ambiguous and the preamble gives no guidance to determine whether services are used in the administration of a non-medical program. NAMI believes that a Medicaid eligible individual should receive rehabilitative services if medically necessary to address a functional impairment regardless of any involvement in another program. This point is included in the preamble language noting "enrollment in these non-Medicaid programs does not affect eligibility for Title XIX services." NAMI seeks similar language in the final regulation.

Recommendation:
Strike the following language: ... that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

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

NAMI applauds the discussion in the preamble recognizing that "effective rehabilitation of eligible individuals may require some contact with non-eligible individuals." The preamble further explains that counseling sessions for the treatment of the child may include the parents or other non-eligible family members and concludes that "contacts

with family members for the purpose of treating the Medicaid eligible individual may be covered under Medicaid."

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

Recommendation:

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

Thank you for the opportunity to comment on the proposed regulations. We appreciate your consideration of our recommendations.

Sincerely,

Submitter : Ms. Leona McElvene **Date:** 10/10/2007

Organization : Ms. Leona McElvene

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare and Medicaid Services (CMS):

I am writing to let you know that psychiatric rehabilitation services are very important and you should be working to make those services more readily available to people with mental illness.

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

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

I 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.

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

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

Thank you.

Leona F. McElvene

Submitter : **Ms. Shirley Healy** **Date: 10/10/2007**

Organization : **National Alliance of Mental Illness**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

I am a parent of an adult severally mentally ill son. I am concerned with two areas of your proposed changes to CMS-2261 rehabilitation plan.
The first area of concern is section 440.130 (d) which requires showing progress in the person's rehabilitation. The need to show progress may apply to a person who has had a stroke, head injury,or other physical illness. The mentally ill do not always progress on a upward plane. Recurring set-backs can occur in these illnesses. Persons with mental illness tend to have a rise and fall progression in their illness. The ability to MAINTAIN some stability is often a sign of success. Without provisions to have support for this maintance often leads to frequent hospitalizions and possible criminal activity. Maintaing a level of health is much less costly than the alternatives. I do appreciate your plan to involve families. Often families know some aspects of the client that can be helpful. Also if the family knows the plan, they can reinforce what is being done.

My second area of concern is section 441.45(b). I have a Masters degree and do not understand your term of "intrinsic" to another system. I feel you need to clarify this term in detail and in language that families can fully understanding. The word "intrinisic" leaves for too much interpertation of this factor.

We need to avoid cuts in care of the mentally ill. I feel MORE should be provided so clients do not have to wait forever for assistance in some areas. My son has been waiting for nine months for a vocational assistant. There needs to be someone to help get and maintain work. Often the mentally ill obtain jobs in fast food service. The constant stimulation is too much. This has occurred often with our son. The mentally ill have difficulty in blocking out peripheral noise and commotion. Our son has walked out on at least 2 jobs because of his inability to handle all this stimulation. Meanwhile, he is able to do phone volunteer work for political candidates where there is no outside stimulation. I have had staff on compaigns come up and tell how well our son is able to function in this role. The mentally ill also need to avoid empolyment where they are exposed to extreme heat. We had a mentally ill person in our area who died from becoming overheated at work. The mentally ill person is more susceptal to heat stroke because of medications and often their inability to gauge how hot it may be. I have seen my son and other mentally ill persons where a long sleeve shirt on a very warm day and then where shorts and short sleeve shirt on colder days.

I would greatly appreciate your reevaluation of these two areas of proposed change