Submitter : Ms. Gregory Morris **Date:** 10/11/2007

Organization : LEAnet

Category : Attorney/Law Firm

Issue Areas/Comments

Background

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We believe the proposed rule 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 changes would undermine the very purpose of the Title XIX program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Collections of Information Requirements

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The proposed rule is typical of a long-standing campaign undertaken by CMS to restrict federal Medicaid payment policies. In the case of 2261-P, these restrictions were considered and expressly rejected by Congress during debate on the 2005 DRA. This regulation suffers from a fundamental legal flaw under Title XIX. This proposed rehabilitation rule attempts to introduce into the statute precisely the type of educational and social exclusions barred by Medicaid as a result of mandatory early and periodic screening diagnostic and treatment (EPSDT) benefit.

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called rehab option, which has been given broad and expansive administrative interpretation. This section says, inter alia, that medical assistance to be provided at state option includes other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level.

The current rule emanating from this statute is the target of the current CMS proposal. For more than forty years, the rehabilitation benefit has been the authority for a range of medically necessary services, including mental illness, developmental disabilities, children with behavioral and emotional afflictions, and those who fail to reach developmental milestones. Without disputing the need for these services or the efficiency of providing them in any appropriate environment, CMS has proposed a rule that severely limits the flexibility of the current rule, which would make it far more burdensome and expensive to provide these services within the Medicaid framework and, in some cases, would restrict coverage altogether.

In proposing this rule, CMS has excluded services that are furnished through programs other than Medicaid from the definition of rehabilitation. This is direct conflict with Title XIX, which has long recognized that Medicaid-reimbursable services may be provided through other state programs.

The rehabilitation benefit is required for categorically needy individuals under age 21 as a result of their entitlement to services under EPSDT. All benefits and services that fall within the definition of medical assistance under EPSDT are required when medically necessary as a result of an EPSDT screen. Rehabilitative services fall within this benefit and are codified within the definition of medical assistance and are therefore required under federal law for individuals under twenty-one.

In 1988, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized education plan . The prohibition specifies as follows:

Nothing in this chapter shall be construed as prohibiting or restricting or authorizing the Secretary to prohibit or restrict payment under subsection (a)[relating to federal payments generally] for medical assistance for covered services furnished to a child with a disability because such services are included in the children s IEP established pursuant to part B of the [IDEA] or furnished to child with a disability because such services are included in the child s individualized family service plan adopted pursuant to part C of the IDEA. This proposal would replace the current definition of rehabilitative services, which is one sentence long, with an 8 paragraph definition of the scope of services and a mandated 17 rehabilitation plan for each service recipient. In sum, even when benefits are furnished by qualified providers and the treatment is covered, the rehabilitation service NPRM would add a payment exclusion that simply has no basis in the statute.

GENERAL

GENERAL

See attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

All provisions of the proposed rule are addressed in our attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

All provisions are addressed in our attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

N/A

Response to Comments

Response to Comments

Executive Order 13132 imposes certain requirements when an agency promulgating a proposed rule that will impose substantial direct compliance costs on States. Among other requirements, before an agency promulgates a rule that will impose such costs on states, it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the process of developing the rule prior to promulgation . If exercising the consultation option, an agency must provide a federalism impact summary to the Office of Management and Budget that describes the agency s consultation with the states, summarizes their concerns and explains how those concerns were addressed . CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states .

To the contrary, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, most states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them, they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the requirements of Executive Order 13132.

In addition, CMS asserts that this rule will not have a direct impact on providers of rehabilitation services . This is also incorrect. These regulations narrow the scope of the service and, directly and indirectly, impose requirements that will have significant, direct impact on providers. The requirement of the detailed written rehabilitation plan will also require additional work by providers. The discussion of how providers need to separate incidental personal care functions from rehabilitation services for billing, record keeping and administration shows how many additional duties will be necessary for providers.

CMS-2261-P-812-Attach-1.DOC

CMS-2261-P-812-Attach-2.DOC

In the Matter of

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

This document is submitted on behalf of LEAnet, a California unincorporated association representing a national coalition of local education agencies in response to the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201

Summary:

We believe the proposed rule 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.[1]" 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 changes would undermine the very purpose of the Title XIX program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Preliminary Comments:

We believe these proposed regulations would result in the denial of coverage for medically necessary services. This is especially a problem with regard to coverage of services for beneficiaries under 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those services are covered for adults[2].

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[1] Social Security Act, Section 1905(a)(13)]
[2] 42 U.S.C. § 1396d(r)(5)

We further believe that the proposed definitions impermissibly narrow the scope of services that can be covered under the rehabilitation option. Moreover, the proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals attain or retain capability for independence or self-care . . .[3]"

Regulatory Impact Analysis: Overall Impact

Executive Order 13132 imposes certain requirements when an agency promulgating a proposed rule that will impose "substantial direct compliance costs on States." Among other requirements, before an agency promulgates a rule that will impose such costs on states, it must either (1) provide the funds necessary for the states to comply with the rule; or (2) consult with state officials during the process of developing the rule prior to promulgation[4]. If exercising the consultation option, an agency must provide a federalism impact summary to the Office of Management and Budget that describes the agency's consultation with the states, summarizes their concerns and explains how those concerns were addressed[5]. CMS asserts that these requirements do not apply, because no substantial, direct compliance costs will be imposed on the states[6].

To the contrary, it is apparent that implementing these proposed regulations will result in significant costs to the state. For example, most states will likely be forced to change their billing procedures and, possibly, prior authorization procedures. Also, a number of states are currently providing services that would be categorized as day habilitation services under the proposed regulations. If they choose to continue them, they will be forced to pay for them with state funds, or make drastic changes to the way they provide services. Moreover, the primary purpose of E.O. 13132 is to promote state autonomy and authority. This rule runs counter to that concept because it will significantly limit state flexibility. Accordingly, CMS should comply with the

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[3] 42 U.S.C. § 1396 (emphasis added)
[4] Exec. Order 13132, § 6(b)
[5] Id., at (b)(2).
[6] 72 Fed. Reg. at 45209 (Preamble, V.A)

requirements of Executive Order 13132.

In addition, CMS asserts that this rule will not have a direct impact on providers of rehabilitation services[7]. This is also incorrect. These regulations narrow the scope of the service and, directly and indirectly, impose requirements that will have significant, direct impact on providers. The requirement of the detailed written rehabilitation plan will also require additional work by providers. The discussion of how providers need to separate "incidental" personal care functions from rehabilitation services for billing, record keeping and administration shows how many additional duties will be necessary for providers[8].

Overview:

The proposed rule is typical of a long-standing campaign undertaken by CMS to restrict federal Medicaid payment policies. In the case of 2261-P, these restrictions were considered and expressly rejected by Congress during debate on the Deficit Reduction Act of 2005.9

This regulation suffers from a fundamental legal flaw under Title XIX. This proposed rehabilitation rule attempts to introduce into the statute precisely the type of "educational" and "social" exclusions barred by Medicaid as a result of mandatory early and periodic screening diagnostic and treatment (EPSDT) benefit.

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called "rehab option," which has been given broad and expansive administrative interpretation. This section says, inter alia, that medical assistance to be provided at state option includes "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level."

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[7] 72 Fed. Reg. at 45208 (Preamble, V.A.)
[8] 72 Fed. Reg. at 45206 (Preamble, II.F.2)
[9] See discussion of the DRA in Jeff Crowley and Molly O'Malley, Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues (Kaiser Commission on Medicaid and the Uninsured, August, 2007).

The current rule[10] emanating from this statute is the target of the current CMS proposal. For more than forty years, the rehabilitation benefit has been the authority for a range of medically necessary services, including mental illness, developmental disabilities, children with behavioral and emotional afflictions, and those who fail to reach developmental milestones. Without disputing the need for these services or the efficiency of providing them in any appropriate environment, CMS has proposed a rule that severely limits the flexibility of the current rule, which would make it far more burdensome and expensive to provide these services within the Medicaid framework and, in some cases, would restrict coverage altogether.

In proposing this rule, CMS has excluded services that are furnished through programs other than Medicaid from the definition of "rehabilitation." This is direct conflict with Title XIX, which has long recognized that Medicaid-reimbursable services may be provided through other state programs.

The rehabilitation benefit is optional for adults but required for categorically needy individuals under age 21 as a result of their entitlement to services under the Early and Periodic Screening, Diagnostic, and Treatment services. All benefits and services that fall within the definition of "medical assistance" under EPSDT are required when medically necessary as a result of an EPSDT screen. Rehabilitative services fall within this benefit and are codified within the definition of "medical assistance" and are therefore required under federal law for individuals under twenty-one.

There have been previous attempts to curtail federal Medicaid contributions for covered benefits furnished to Medicaid-enrolled children who also are receiving services through public educational or social programs. The first such attempt occurred in 1988, when the Reagan Administration attempted to halt federal payments for medical assistance furnished as a related service under a child's special education plan. In response, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized

[10] (42 C.F.R. 440 130(d))

education plan[11]. The prohibition specifies as follows:

> Nothing in this chapter shall be construed as prohibiting or restricting or authorizing the Secretary to prohibit or restrict payment under subsection (a)[relating to federal payments generally] for medical assistance for covered services furnished to a child with a disability because such services are included in the children's individualized education program established pursuant to part B of the [IDEA] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of [the IDEA][12]

The CMS proposal would replace the current definition of rehabilitative services, which is one sentence long, with an eight-part definition of the scope of services and a mandated seventeen-part "rehabilitation plan" for each service recipient.

In sum, even when the benefits are furnished by qualified providers and the treatment is covered, the rehabilitation service NPRM would add a payment exclusion that simply has no basis in the statute. Indeed, the proposed rule contravenes the statute's EPSDT benefit and its federal financing provisions. As such, the proposed rule goes far beyond Secretarial powers under Medicaid. Most astoundingly perhaps, CMS specifically characterizes the rule as a third party liability rule[13], even though doing so would appear to be a direct admission that the agency is attempting to achieve in regulation what was rejected in statute.

Overarching Issue - Conflict with EPSDT

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a States' plan[14]. There are numerous ways in which the proposed regulations

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[11] 42 U.S.C. §1396b(c). Interestingly CMS concedes the existence of this statute in the school administration regulations but ironically, as justification for denying federal payments for administrative services. 72 Fed. Reg. 51398.
[12] Id.
[13] 72 Fed. Reg. 45209
[14] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5)

conflict or potentially conflict with the EPSDT requirements.

Recommendations:

We recommend the following:

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

Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct a physical or mental illness or condition.

Amend § 441.45(b)(4) to refer to the EPSDT requirement and instruct states to comply with it.

Proposed § 440.130(d)(1)(v)-(vii) - Maintenance v. Restorative Services

The discussion of services that maintain, rather than restore, function may lead to inappropriate denials of services that should be covered as rehabilitative, particularly the discussion of the requirements of the written rehabilitation plan. Throughout the preamble and proposed regulations, CMS emphasizes that rehabilitation services must reduce disability and restore function in order to be reimbursable under Medicaid[15]. The discussion of a written rehabilitation plan in the preamble emphasizes the "ultimate goal" of reduction of medical care[16]. Moreover, the preamble states that "[i]t is important to note that this benefit is not a custodial care benefit but should result in a change in status.[17]" Id. At the same time, the proposed regulations acknowledge that maintaining a functional level may be necessary to achieve a rehabilitation goal[18]. But, the discussion of the written plan in the preamble states that "[i]f 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 . . .[19]"

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[15] 72 Fed. Reg. at 45211 (Proposed 42 C.F.R. §§ 440.130(d)(1)(i)(A))
[16] Id. at 45203 (Preamble, II.C)
[17] Op. Cit.
[18] Id. at 45211 (Proposed 42 C.F.R. § 440.130(d)(1)(vi))
[19] Id. at 45204 (Preamble, II.C)

This discussion creates confusion. This emphasis on change in status and on achievement of specific goals may lead states to deny coverage for medically necessary rehabilitation services because such services may not lead to immediate results. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse. Again, the Medicaid statute, which CMS is apparently attempting to bypass, emphasizes the importance of rehabilitation services to attain independence and health[20]. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations.

This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is an even greater likelihood that the actual service needed will be covered. Moreover, this agency has a long-standing policy of recognizing that maintenance therapy may be covered[21]. The overly restrictive definition and interpretation in this area may conflict with longstanding agency policy.

Recommendations:

Add the following language to proposed regulation § 440.130(d)(1)(vi): "Failure to make measurable progress toward a particular goal within a certain time period does not necessarily indicate that a service is not necessary to help achieve a rehabilitation goal."

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[20] 42 U.S.C. § 1396

[21] See, e.g., Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, Medicaid State Bulletin, 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991).

Add a new subsection (c) to § 441.45, with the following language: "If a service cannot be covered as a rehabilitative service, states shall determine whether the service can be covered under another category of Medicaid services." Also, add discussion to Section II.C. of the preamble that maintenance services could qualify for coverage under another category of services and give examples of other categories.

Delete the language at 72 Fed. Reg. at 45204, Section II.C of the preamble stating that "[i]f 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 . . ."

Proposed § 440.130(d)(5) - Settings for Service Provision

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be provided.[22]" This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation 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." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

Clarify that rehabilitation services should be covered in any setting permitted by state law, including schools.

Add the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to § 440.130(d).

[22] 72 Fed. Reg. at 45205 (Preamble, II.E)

Proposed § 440.130(d)(1)(vi) – Restorative Services

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option[23]. As CMS acknowledges in the letter, this is an important service for individuals with mental illness and substance abuse services. Given its obvious importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in the regulations.

Recommendations:

Section 440.130(d)(1)(vi), which describes "restorative services" should be amended and language added stating that peer guidance is a covered rehabilitation service.

Proposed § 441.45(b)(1) – Non-Covered Services

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid[24]. The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services. Moreover, it is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. Thus, these children will all be eligible for EPSDT, under which a service should be covered if it is necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity and ambiguity in promulgation of regulation never works in favor of the regulated community.

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included

[23] Dear State Medicaid Director, Peer Support Services – SMDL #07-011 (August 15, 2007)
[24] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))

under the IDEA[25]. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services[26]. Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . .[27]" Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party[28]. Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

The proposed rule excludes Medicaid reimbursement for rehabilitative services that are "intrinsic element of other programs" even if they meet all of the other requirements in the proposed rule at 441.45(b). This exclusion is has no legal foundation. Title XIX does not exempt Medicaid reimbursement for services merely because they are part of another program. In fact, Title XIX was designed by Congress to work in concert with child welfare, special education, and other complementary health care and social services. Medicaid is a financial services program and as such is the payer of items and services known as medical assistance. In addition, it is the enabler of medical assistance and program administrative activities. The other programs the proposed rule would eliminate are the means by which this medical assistance financing actually delivers health care services and support to children. The Medicaid law was designed to augment and enhance education, social support, and child welfare programs, not duplicate them.

It is difficult to understand what CMS means by the term "intrinsic." When the administration attempted to advance its "intrinsic" argument in 2005[29], it became evident that the concept reflected a fundamental misunderstanding of Medicaid's interaction with other programs serving children and the recommendation was rejected. Now the Administration seeks to do by regulation what Congress already has

[25] 72 Fed. Reg. at 45202
[26] 42 U.S.C. § 1396b(c)
[27] 42 U.S.C. § 1396a(a)(25)(A)
[28] 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007).
[29] Medicaid's Rehabilitation Service Option, op. cit. p. 13

rejected by statute. The rehabilitation NPRM resuscitates the "intrinsic" exclusion once again, this time broadening it still further. As before, the Administration excludes payments for "intrinsic" elements while offering no definition of "intrinsic elements." But the NPRM also goes beyond the vagaries of the "intrinsic element" test to exclude payment for covered rehabilitation benefits in the case of children who are receiving services in the case of other specific programs. As a result, the rule adds a coverage condition not contemplated by the statute, which functions as the type of coverage exclusion common to commercial insurance[30]. In the proposed regulations, CMS states:

> 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. . . . We propose . . . 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 proposed that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid[31].

This specific exclusion of payment in the case of children whose medical assistance covered treatments are being arranged for by other programs represents a blatant attempt to add conditions of coverage not permitted under the statute. It grafts onto Medicaid a payment exclusion that simply does not exist. The exclusion is a reflection of a desire on the part of the Administration to push Medicaid, in terms of coverage design, in the direction of commercial insurance, a direction that Congress has rejected in the case of children[32].

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[30] Crossing the Medicaid and Private Health Insurance Divide, op. cit.
[31] 72 Fed. Reg. 45201, 45202 and 42505
[32] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

Recommendations:

We believe this section should be omitted in its entirely, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Section 441.45(b)(1)(iv) should be amended to restate that Medicaid coverage should not be denied merely because a service is provided in an individual education plan.

The responsibilities for states regarding third party payers, and the third party payers' own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

Proposed § 441.45(b)(2) - Habilitation Services

The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function[33]. The discussion and regulation regarding habilitation is problematic for several reasons.

First, it seems to be based on the premise that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate.

Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy[34]. These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services.

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental

[33] 42 C.F.R. § 441.45(b)(2), see also 72 Fed. Reg. at 45205 (Preamble,II.F.2)
[34] 42 C.F.R. § 435.1010 (2007)

health and/or substance related disorders can be appropriately treated with rehabilitation services[35]. However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

Recommendations:

Add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health services.

Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy) and medical or other remedial care provided by licensed practitioners, defined at 42 C.F.R. § 440.60."

Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.

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

If proposed rule 2261 is interpreted by CMS to allow continued Medicaid reimbursement for school-based rehabilitative services, LEA staff would be required by the proposed rule to develop and implement individualized rehabilitation plans which may be duplicative of the individualized education programs (IEP) required under IDEA.

We believe that an IEP developed in accordance with IDEA should satisfy CMS's stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student's physical or mental disability and restoration of the student to the best functional level. The IEP process

[35] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2))

includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Proposed Elimination of Transportation Services

Proposed rule 2261 would eliminate Medicaid reimbursement for transportation services that are provided for under the rehabilitative services option under a state's plan for Medicaid.

Many state include school-based transportation services under the rehab option in the State plan for Medicaid. Under proposed rule 2261, CMS seems to imply that transportation services are not appropriate "rehabilitative" services under the rehab option and that elimination of reimbursement for the services is the appropriate remedy to correct the state plan amendments that CMS previously approved. This approach is extreme, unreasonable and fundamentally unfair to school districts unless CMS is only requiring that the State Medicaid agency to amend the State plan to provide for school-based transportation services under an alternative section. This can be done without any disruption in current school-based transportation services or Medicaid revenue.

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, 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)[36]. 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.

Recommendations:

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

Summary:

As we have discussed above, 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.[37]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources

[36] 42 U.S.C. §§ 1396a(a)(10), 1396d(r)
[37] [Social Security Act, Section 1905(a)(13)]

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.

- END -

Submitter : **Ms. Deanna Berry** **Date: 10/11/2007**

Organization : **Russell Child Development Center**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

As the Director and Part C Coordinator of a rural nonprofit agency providing Part C of IDEA early intervention services to infants and toddlers with developmental delays and disabilities I have serious concerns about the proposed elimination of rehabilitative services for Medicaid-eligible children under CMS-2261-P. The ability to access Medicaid funds for these services is extremely important to our agency. We must patch together a variety of funding resources in order to maintain quality services through the employment of required service providers. We are already facing significant staff shortages and higher costs for everything from travel costs to supplies.

Our agency prides itself on being accountable and makes every effort to submit claims in a conservative fashion. We believe we provide an extremely cost-efficient service delivery model that ultimately saves money for the health care system. Southwest Kansas is home to a large number of families living in poverty where lack of access to health care is a constant. The eligible children receiving our services are, and should continue to be eligible for rehabilitative services coverage through Medicaid.

The proposed rule would hinder access to prevention services. It illegally imposes an intrinsic element test and does not fully comply with the EPSDT mandate for children. Implementation of the proposed rule would severely harm several Medicaid populations including those with mental illness, intellectual and other disabilities.

In particular, I am concerned that new provider qualification standards will restrict our ability to serve children in early childhood settings. Congress has been clear in its intent for Medicaid to support the goals of IDEA and these narrow interpretations of the law are inconsistent with that intent. I urge the Secretary to withdraw the proposed rule. Thank you.

Sincerely, Deanna Berry

Submitter : Dr. Monalisa McGee **Date:** 10/11/2007

Organization : Mosaic

Category : Long-term Care

Issue Areas/Comments

Background

Background

The third option sited for continued coverage for individuals with mental retardation and related conditions is Medicaid s Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) which is by statue defined as an institution. Certainly, persons now able to live in the community with the assistance of habilitation services provided under state plan rehab and clinical services should not be asked to live in more restrictive settings in order to continue to receive habilitation services. Taking this into account however, we must be cognizant of ensuring that persons who do transition into community based supports have adequate supports, i.e. medical and behavioral health as examples, in place to meet their needs and that providers are compensated fairly for those services.

Collections of Information Requirements

Collections of Information Requirements

Community based services both in urban and rural Nebraska (as well as many other States) are not adequate to transition individuals who reside in ICF MR settings into the community. In Nebraska, as an example, the community based funding methodology is not adequate to meet the developmental disability, increasing behavioral health and medical needs of persons.

The must be an expectation within each State that: There is a partnership with all human service providers- developmental disability services, behavioral health, medical providers as well as housing and others to ensure that people's needs are met as they transition out of ICF MR settings.

The people impacted must feel SAFE, SECURE, and have their NEEDS as the primary focus of any program change or plan developed.

Submitter : Mr. Don Barney **Date:** 10/11/2007

Organization : Keystone Community Resources, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-815-Attach-1.DOC

#815

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by : Donald L. Barney, Jr, MA, Director of Clinical Services, Keystone Community Resources Inc.,100 Abington Executive Park, Clarks Summit, PA 18411

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 part be separately billed.

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 such as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs.

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. 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.

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 the 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 now 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.

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

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 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 is 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. There is concern that states and providers will interpret the current proposed regulation as prohibiting coverage of services necessary for retention of improved functioning and for 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 was 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.

Second, 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 who can be expected to otherwise deteriorate.

Related Medicaid Rehabilitation Issues:

1) 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 denying payment through daily rates, case rates and similar arrangements is supported by language in the regulation, at least by inference.

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

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

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

Recommendation:

It is strongly urged that CMS work with other federal agencies, 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.

2) 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.

Submitter : **Benilda Asuncion** **Date: 10/11/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-816-Attach-1.DOC

#816

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

October 17, 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,

Benilda Asuncion
472 Aleo Place
Kahului, HI 96732

Submitter : Mrs. Mindy Cheyne **Date:** 10/11/2007

Organization : NAMI

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-817-Attach-1.DOC

#817

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.

To whom it may concern:

Thank you for providing opportunities for individuals living with mental illness and their family members to comment 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 a member of NAMI, I have lived through experiences with mental illness that gives me a personal and unique to my comments on these rules.

Through my personal experience I know that access to rehabilitative services can make all the difference in a person's life. I have watched as these services help individuals recover from severe and persistent mental illness. With services and support, individuals with this type of 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. Personally I've fought to keep our loved out of jail and off the street. Without services this would not be possible. NAMI members know that treatment works, if you can get it.

This may save money now, but experiences tell us 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.

NAMI appreciates 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.

There are 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,

Mindy Cheyne

Submitter : Mrs. Laureen Tanner **Date:** 10/11/2007

Organization : Ranken Jordan A Pediatric Specialty Hosptial

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-818-Attach-1.RTF

#818

October 11, 2007

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

Attn: CMS—2261--P
Medicaid Program; Coverage for Rehabilitation Services

Dear Sir/Madam:

On behalf of Ranken Jordan A Pediatric Specialty Hospital, I would like to submit comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid proposed rule on rehabilitation services published in the August 13th *Federal Register.* The changes proposed in this regulation would have a negative impact on our hospital and the children we serve. We ask that you make necessary changes to the proposed rule to ensure that children with special health care needs continue to receive critical rehabilitation services.

Medicaid is the single largest payer for children's hospitals and the single largest insurer for children. Children's hospitals devote more than half of their care to children insured by Medicaid and more than three-fourths of their care to children with chronic or congenital conditions. At our hospital, 87% of our patients are insured by Medicaid and all of them have serious and complex health care conditions. More than one-fourth of all children and one-third of all children with disabilities are insured by Medicaid. The rehabilitation service category has ensured that children in our state with chronic conditions have access to an array of physical and mental health services required for their conditions.

Comments on Proposed Rule on Medicaid GME

Although Medicaid is the major insurer for children and in particular children with disabilities, the proposed regulation fails to consider how the changes would affect the children our hospital cares for every day. The proposed regulation does not acknowledge the unique needs of these very vulnerable children, but attempts to make broad policy for all groups without considering how it could specifically affect children.

Ranken Jordan's largest concern with the proposed rule is that it threatens the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children. EPSDT guarantees that children insured by Medicaid receive all medically necessary services as determined by their health care provider. Absent a clarification that children would not be

affected because of EPSDT, the proposed rule would limit the definition of rehabilitation services and therefore threaten the health care of children. N.A.C.H. recommends that CMS add language into the regulation to clarify that children will continue to receive all medically necessary care, including all necessary rehabilitation services, as required by EPSDT.

Our hospital also has the following specific objections to the rule:

- **The proposed regulation asserts that rehabilitation services would not include services that are "intrinsic elements" of programs other than Medicaid, such as foster care, child welfare, education, and child care.** Since many of the programs highlighted in the regulation focus on children, this would have a disproportionate impact on children, specifically children in foster care or receiving other social or educational services. The regulation does not provide the criteria for what constitutes an "intrinsic element" of another program. Traditionally, Medicaid has worked closely with a multitude of programs to ensure that children get the services that they need. This new requirement would not allow federal match for services that are determined to be part of another program. Due to a lack of resources, the other programs will not be able to pay for these services without Medicaid as a partner.

  We recommend that this requirement be removed from the regulation. In order to implement such a change, the U.S. Department of Health and Human Services would need to identify other funding sources that would be able to sustain services without federal Medicaid funding. Most of the programs specified in the regulation would not have adequate resources to provide the needed services without additional funding. The result would be children not receiving medically necessary physical and mental health services.

- **The regulation does not clearly state that rehabilitation services could be provided to retain or maintain function.** In many cases, children with neuromuscular conditions, such as spinal bifida or muscular dystrophy, and those with serious hearing problems or development delays require rehabilitation services that help them retain or maintain a certain function level. Many of these children would experience deterioration of their conditions without rehabilitation services.

  The preamble to the regulation does state that services could be provided to retain or maintain function if necessary to help an individual achieve a certain rehabilitation goal as outlined in their rehabilitation plan. The regulation does not include any details on what constitutes a rehabilitation goal.

  Ranken Jordan recommends adding regulatory language to clarify that

rehabilitation services would include services needed to retain or maintain function. In addition, we would suggest that CMS add a definition of a rehabilitation goal for children that would include retaining or maintaining function.

- In the preamble to the regulation, CMS says that rehabilitation focuses on restoring individuals to their best functional levels. This requirement would be particularly troublesome for children because some functions may not have been possible (or age appropriate) at an earlier date. Once again, the proposed regulation fails to recognize that children have unique needs that need to be addressed.

  We recommend adding language to specify that children need not demonstrate that they were once capable of performing a specific task in the past if it was not age appropriate for the children to have done so.

- The regulation states that federal matching funds for rehabilitation services are not available for room and board. Several children's hospitals, particularly specialty children's hospitals, provide inpatient rehabilitation services to children with serious health care conditions.

  We recommend that the regulation be revised to allow room and board as an appropriate rehabilitation service for children who require that level of care.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact either Laureen Tanner at 314-872-6401 or email lauri.tanner@rankenjordan.org or Jean Bardwell at 314-872-6406 or email jean.bardwell@rankenjordan.org. Thank you for your consideration.

Sincerely,

Laureen K. Tanner, RN, MSN
Chief Executive Officer

Jean Bardwell
Chief Financial Officer

Submitter : **Ms. Kimberley Erickson** **Date: 10/11/2007**

Organization : **Colorado School Medicaid Consortium**

Category : **Local Government**

Issue Areas/Comments

Background

Background

October 11, 2007

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

RE: CMS 2261-P
Notice of Proposed Rule
Medicaid Coverage: Coverage for Rehabilitation Services

Submitted Electronically

Dear Secretary Leavitt:

We believe that these proposed rules could result in the denial of coverage for medically necessary services to children and adults with disabilities. This is extremely concerning in regard to coverage of services for children under the age of 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those services are covered for adults. 42 U.S.C. ? 1396 d(r) (5)-EPSDT

These proposed regulations indicate that habilitation services are not coverable as rehabilitation services, because they are to help individuals acquire new functional abilities rather than to restore function. Medicaid has had a long history of recognizing that maintenance therapy may be covered and this restrictive definition is in direct conflict with current Medicaid policies. These proposed rules will cause confusion for State Medicaid agencies, practitioners, community agencies and parents, whieh will result in wrongful denials of necessary therapy services to children. These proposed regulations seem to be inconsistent with the purpose of Medicaid, which is to enable each State, as far as practicable&to furnish (1) medical assistance& and (2) rehabilitation and other services to help&families and individuals attain or retain capability for independence or self-care& 42 U.S.C. ?1396.

Under the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child s individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [20 U.S.C. 1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child s individualized family service plan adopted pursuant to part C of such Act [20 U.S.C. 1431 et seq.]. Therefore any efforts to eliminate payment to schools under proposed regulations at ? 441.45 (b) (1) would seem to violate the above law and EPSDT services for children under the age of 21.We urge you not to take action that would be harmful to the most vulnerable of Colorado s children those with disabilities and with very limited access to health care.

To support the President s efforts under No Child Left Behind Medicaid should be working in partnership with state educational agencies and local educational agencies to make sure children with Medicaid receive all medically necessary services to enhance learning, independence and self-care. We encourage CMS to expand it s participation with local educational agencies to help deliver health and health related services to children. Please reconsider these proposed rules that will limit children s access to needed health services in schools and the community.

The Colorado School Medicaid Consortium and our school district members strongly urge you to reconsider implementing these proposed rules and to work with schools and school districts to ensure that all children receive the health services that they deserve. Without access to appropriate health care, children with disabilities will face even more challenges to becoming educated, healthy, independent and productive adults.

Thank you for the opportunity to respond to these proposed rules.

Kimberley M. Erickson
Director
Colorado School Medicaid Consortium
1330 Fox St., 2nd Floor
Denver, CO 80204-2602

720-423-8250

Collections of Information Requirements

Collections of Information Requirements

On behalf of the Colorado School Medicaid Consortium, a non profit organization that represents over 60 school districts serving over 417,000 students in Colorado, we are writing to express strong opposition to CMS 2261-P amending the definition of Medicaid rehabilitation services.

CMS-2261-P-819-Attach-1.DOC

#819

October 11, 2007

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

RE: CMS 2261-P
Notice of Proposed Rule
Medicaid Coverage: Coverage for Rehabilitation Services

Submitted Electronically

Dear Secretary Leavitt:

On behalf of the Colorado School Medicaid Consortium, a non profit organization that represents over 60 school districts serving over 417,000 students in Colorado, we are writing to express strong opposition to CMS 2261-P amending the definition of Medicaid rehabilitation services.

We believe that these proposed rules could result in the denial of coverage for medically necessary services to children and adults with disabilities. This is extremely concerning in regard to coverage of services for children under the age of 21 who are entitled to all Medicaid services necessary to correct or ameliorate a physical or mental condition, regardless of whether those services are covered for adults. 42 U.S.C. § 1396 d(r) (5)-EPSDT

These proposed regulations indicate that habilitation services are not coverable as rehabilitation services, because they are to help individuals acquire new functional abilities rather than to restore function. Medicaid has had a long history of recognizing that maintenance therapy may be covered and this restrictive definition is in direct conflict with current Medicaid policies. These proposed rules will cause confusion for State Medicaid agencies, practitioners, community agencies and parents, which will result in wrongful denials of necessary therapy services to children. These proposed regulations seem to be inconsistent with the purpose of Medicaid, which is "to enable each State, as far as practicable...to furnish (1) medical assistance... and (2) rehabilitation and other services to help...families and individuals attain or retain capability for independence or self-care..." 42 U.S.C. §1396.

Under the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) "Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [20 U.S.C. 1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act [20 U.S.C. 1431 et seq.]. " Therefore any efforts to eliminate payment to schools under proposed regulations at § 441.45 (b) (1) would seem to violate the above law and EPSDT services for children under the age of 21.We urge you **not** to take action that would be harmful to the most vulnerable of Colorado's children – those with disabilities and with very limited access to health care.

To support the President's efforts under "No Child Left Behind" Medicaid should be working in partnership with state educational agencies and local educational agencies to make sure children with Medicaid receive all medically necessary services to enhance learning, independence and self-care. We encourage CMS to expand it's participation with local educational agencies to help deliver health and health related services to children. Please reconsider these proposed rules that will limit children's access to needed health services in schools and the community.

The Colorado School Medicaid Consortium and our school district members strongly urge you to reconsider implementing these proposed rules and to work with schools and school districts to ensure that all children receive the health services that they deserve. Without access to appropriate health care, children with disabilities will face even more challenges to becoming educated, healthy, independent and productive adults.

Thank you for the opportunity to respond to these proposed rules.

Kimberley M. Erickson
Director
Colorado School Medicaid Consortium
1330 Fox St., 2nd Floor
Denver, CO 80204-2602

720-423-8250

Submitter : **Dr. Richard Weber** **Date: 10/11/2007**

Organization : **Dr. Richard Weber**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please see my comments in the attached Word document

CMS-2261-P-820-Attach-1.DOC

#820

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

Public Comments

I am Dr. Richard Weber from Upper Arlington, Ohio. I am retired school administrator who still serves as a consultant to schools and educational organizations. I am very concerned about the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201 as it violates federal law and could prevent Schools from receiving reimbursement for providing federally mandated medical services to students.

Issue - Conflict with EPSDT

Medicaid's Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT) requirements provide that all Medicaid beneficiaries under age 21 must receive all necessary services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a States' plan. There are numerous ways in which the proposed regulations conflict or potentially conflict with the EPSDT requirements. First, this regulation suffers from a fundamental legal flaw under Title XIX. This proposed rehabilitation rule attempts to introduce into the statute precisely the type of "educational" and "social" exclusions barred by Medicaid as a result of mandatory early and periodic screening diagnostic and treatment (EPSDT) benefit.

The proposed rule would reduce the scope of services provided under Section 1905(a)(13), the so-called "rehab option," which has been given broad and expansive administrative interpretation. This section says that medical assistance to be provided at state option includes "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) . . . for the maximum reduction of physical or mental disability and the restoration of an

individual to the best possible functional level."

The current rule emanating from this statute is the target of the current CMS proposal. For more than forty years, the rehabilitation benefit has been the authority for a range of medically necessary services, including mental illness, developmental disabilities, children with behavioral and emotional afflictions, and those who fail to reach developmental milestones. Without disputing the need for these services or the efficiency of providing them in any appropriate environment, CMS has proposed a rule that severely limits the flexibility of the current rule, which would make it far more burdensome and expensive to provide these services within the Medicaid framework and, in some cases, would restrict coverage altogether.

In proposing this rule, CMS has excluded services that are furnished through programs other than Medicaid from the definition of "rehabilitation." This is direct conflict with Title XIX, which has long recognized that Medicaid-reimbursable services may be provided through other state programs.

The rehabilitation benefit is optional for adults but required for categorically needy individuals under age 21 as a result of their entitlement to services under the Early and Periodic Screening, Diagnostic, and Treatment services. All benefits and services that fall within the definition of "medical assistance" under EPSDT are required when medically necessary as a result of an EPSDT screen. Rehabilitative services fall within this benefit and are codified within the definition of "medical assistance" and are therefore required under federal law for individuals under twenty-one.

There have been previous attempts to curtail federal Medicaid contributions for covered benefits furnished to Medicaid-enrolled children who also are receiving services through public educational or social programs. The first such attempt occurred in 1988, when the Reagan Administration attempted to halt federal payments for medical assistance furnished as a related service under a child's special education plan. In response, Congress amended the statute to prohibit the Secretary from excluding federal Medicaid medical

assistance payments for covered benefits furnished to Medicaid-enrolled children whose treatment was specified in an IDEA individualized education plan. The prohibition specifies as follows:

> Nothing in this chapter shall be construed as prohibiting or restricting or authorizing the Secretary to prohibit or restrict payment under subsection (a)[relating to federal payments generally] for medical assistance for covered services furnished to5 a child with a disability because such services are included in the children's individualized education program established pursuant to part B of the [IDEA] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of [the IDEA].

The CMS proposal would replace the current definition of rehabilitative services, which is one sentence long, with an eight-part definition of the scope of services and a mandated seventeen-part "rehabilitation plan" for each service recipient.

In sum, even when the benefits are furnished by qualified providers and the treatment is covered, the rehabilitation service NPRM would add a payment exclusion that has no basis in statute. The proposed rule contravenes the statute's EPSDT benefit and its federal financing provisions. As such, the proposed rule goes far beyond Secretarial powers under Medicaid.

Recommendations:

I recommend the following:

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

Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct a physical or mental illness or condition.

Amend § 441.45(b)(4) to refer to the EPSDT requirement and instruct states to comply with it.

Sincerely,

Dr. Richard Weber

Submitter : **Mr. Daniel Brzovic** **Date: 10/11/2007**

Organization : **Protection & Advocacy, Inc.**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

See attached letter dated October 11, 2007.

CMS-2261-P-821-Attach-1.DOC

#821

PAI Protection & Advocacy Inc.

Advancing the rights of Californians with disabilities

OAKLAND REGIONAL OFFICE
1330 Broadway, Suite 500
Oakland, CA 94612
Tel: (510) 267-1200
TTY: (800) 649-0154
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Fax: (510) 267-1201
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October 11, 2007

Via Fed-Ex and e-mail: http://www.cms.hhs.gov/eRulemaking/
(One original and two copies)

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

Reference: File Code CMS 2261-P
Medicaid Program; Coverage for Rehabilitative Services; proposed regulations

To Whom It May Concern:

Protection & Advocacy, Inc. (PAI) is the federally-mandated protection and advocacy agency for the State of California. As such, PAI represents individuals with disabilities in a wide range of matters, including assistance in obtaining rehabilitative health care and services under the Medicaid program.

PAI concurs with the comments and recommendations made by the Bazelon Center for Mental Health Law, and the National Health Law Program. PAI submits the following additional comments directed to specific provisions of the proposed regulations.

Section 440.130(d)(1)(i)(A) – Definition of "Recommended by a physician or other practitioner of the healing arts"

Section 440.130(d)(1)(i)(A) adds a definition of "Recommended by a physician or other practitioner of the healing arts" that provides that the physician or other practitioner has determined that receipt of services "would result" in reduction of the individual's disability and restoration to the individual's best possible functional level.

It is unlikely that any practitioner could state that any provision of medical care or services "would result" in anything. That degree of certainty is impossible.

The proposed regulation should be amended to read: "is expected to result."

Section 440.130(d)(1)(iii) – Definition of "Qualified providers of rehabilitative services

The regulations should specify that peer providers can be qualified providers of rehabilitative services.

Section 440.130(d)(1)(v) – Definition of "Rehabilitation plan"

The first sentence of this section defines "rehabilitation plan." The following sentences set forth requirements for the plan. The additional sentences following the definition in the first sentence appear to be unnecessary because the standards for rehabilitation plans contained in those additional sentences are also set out in Section 440.130(d)(3). In addition, the sentences following the definition contain slightly different terminology than the plan requirements in Section 440.130(d)(3). Although the requirements overlap, they are not the same in all respects. Therefore, the portion of section 440.130(d)(1)(v) following the definition in the first sentence is redundant and potentially confusing and should be eliminated.

The second sentence refers to providers working within the "State scope of practice act." This is different from the terminology generally used in the

Medicaid statute and regulations. In order to avoid confusion, this provision should be changed to: "acting within the scope of the provider's practice under state law." The same change should also be made wherever "State scope of practice act" terminology appears in the proposed regulations.

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

The definition of "restorative services" correctly points out that the emphasis in covering rehabilitation services is on ability to perform a function rather than actually having performed the function in the past. The definition also points out that rehabilitation goals are often contingent on an individual's maintenance of a current level of functioning. However, while the regulations state that assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan, the regulations do not make it clear that, at times, the rehabilitation goal may not be immediately obtainable.

The mental health recovery model, referenced in the regulations, Section 440.130(d)(3)(iv), recognizes that recovery may be a long-term, even lifelong process that may involve periods of time when there is a plateau in recovery or even deterioration in functioning. The regulations should be amended to acknowledge this so that they are not interpreted as requiring unrealistic goals, or goals at variance with the recovery model. The regulations should be amended to require states to provide the specific rehabilitation services described in Section 1905(a)(13) of the Social Security Act, 42 U.S.C. § 1396d(a)(13)[1] for the purposes of carrying out the broad and overarching rehabilitation goals of the Medicaid

[1] "...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...."

program contained in Section 1901 of the Social Security Act, 42 U.S.C. 1396.[2] This is necessary in order to carry out the purposes of the entire Medicaid statute as expressed in both of the above-referenced sections.

The regulation should specify that rehabilitation services are available to an individual who can be expected to benefit from the services because the services are directed at maximum reduction of disability and restoration of best possible functional level, that the rehabilitation goals must be directed toward helping the individual "attain or retain capability for independence or self-care," that attainment or retention of independence and self-care may be a long-term, or even a lifelong process, and that rehabilitation goals should not impose unreasonable time limits on the attainment or retention of independence and self-care, or unreasonable expectations as to what represents independence and self-care.

The regulations should also be amended to provide that for individuals eligible for EPSDT services, Medicaid rehabilitative services must be provided that are necessary to "correct or ameliorate" a physical or mental condition, and that the scope of Medicaid rehabilitative services that a State offers to individuals under age 21 (or 22 in some cases) must be as broad as is allowed under the federal Medicaid program.

Section 440.130(d)(2) – Scope of Medicaid rehabilitation services

"Within the scope of his practice under State law" should be changed to "within the scope of the provider's practice under State law."

The regulations should also be amended to provide that for individuals eligible for EPSDT services, Medicaid rehabilitative services must be provided that are necessary to "correct or ameliorate" a physical or mental condition, and that the scope of Medicaid rehabilitative services that a State offers to individuals under

---

[2] "...rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care...."

age 21 (or 22 in some cases) must be as broad as is allowed under the federal Medicaid program.

The regulations should also specify that peer services are included in the scope of services.

Section 440.130(d)(3)(ii) – Development of rehabilitation plan

Subsection (ii) provides standards for development of the plan while Subsection (iii) provides standards for development, review and modification of plan goals and services.

It is difficult to see a distinction between development of a plan and development of plan goals and services. These things seem to be inseparable. The functional difference between the two provisions in the proposed regulations seems to be that the individual receiving services provides "input" into the development of the plan, but "actively participates" in development, review, and modification of plan goals and services. Again, there seems to be no distinction between these two activities that would lead to this functional difference.

An individual should be able to actively participate in every aspect of the development of the plan. This does not mean that all decisions regarding the plan are made by the individual or that the individual is present during all discussions about the plan. For example, the individual would not necessarily decide how much the services cost and would not necessarily be present when a provider is asked if the provider would be available or willing to provide services. However, the individual should actively participate in development of all aspects of the plan if the individual's participation can make a difference in the outcome to the individual. This participation goes well beyond development, modification or review of the plan goals and services.

Also, if the individual has provided written instructions in an advance directive, these instructions should be considered in the development of the plan and in the development, review, and modification of plan goals and services.

In addition, the section provides that the plan should be developed with input from various individuals. Input from individuals such as family members can be helpful in developing a plan. However, the requirement as written can easily be interpreted as requiring that the provider seek out and obtain input from various individuals in preparing the plan. In order to avoid this interpretation, the regulation should be changed to provide that input "received" by the provider is considered.

Finally, some individuals may not be authorized to provide input, such as an attorney who has not been authorized to disclose confidential information. The section should be amended to provide that only authorized persons may provide input.

Subsection (iii) should be deleted and Subsection (ii) should be amended to read:

> Be developed by a qualified provider(s), within the scope of the provider(s) practice under State law, with the active participation of the individual, in accordance with instructions in the individual's advance health care directive, and/or with the active participation of persons of the individual's choosing, which may include members of the individual's family and the individual's authorized health care decision maker. In developing the plan the provider(s) shall consider input received from persons of the individual's choosing and/or other individuals authorized to provide input. This may include members of the individual's family.

"Working within the State scope of practice act" in Subsection (ii) should be changed to "acting within the scope of the provider's practice under State law."

Section 440.130(d)(3)(xiv) – Reevaluation of rehabilitation plan

Subsection (xiv) provides that if there is no measurable reduction in disability and restoration of functional level there would have to be a different rehabilitation strategy. This appears to be inconsistent with the mental health recovery model under which there may not be measurable reduction in disability or restoration of

functional level for periods of time. It also appears to be inconsistent with the regulation that provides that services directed at maintaining functioning may be appropriate. *See* discussion of Section 440.130(d)(1)(vi), above.

The purpose of this subsection could be carried out by referring to the goals of the plan being met rather than requiring "measurable" reduction and restoration. If the goals are directed at reduction and restoration over time but this cannot be achieved during the course of the plan, services should not be denied. Therefore, the clause: "If it is determined that there has been no measurable reduction of disability and restoration of functional level..." should be replaced with:

> If it is determined that the goals set forth in the plan are not being met, or that there is no progress in meeting the goals....

Section 441.45(b)(1) – Services furnished through a non-medical program

This section provides that FFP is not available for covered Medicaid rehabilitation services that would otherwise be reimbursed if the individual is receiving the services under a non-medical care program such as foster care, and the services are an "intrinsic element" of the program.

This provision violates comparability provisions of the Medicaid Act because it denies Medicaid-covered services to a class of individuals who are otherwise eligible to receive the covered services. This is because the denial is based on the individual being enrolled in a particular non-medical program rather than on receipt of the otherwise-covered services from that program. The requirement places Medicaid beneficiaries in the position of not receiving the covered Medicaid rehabilitation services at all if the State chooses not to provide the same service under the non-medical care program. This is because the proposed regulation prohibits otherwise-covered Medicaid rehabilitation services from being provided to individuals enrolled in certain categories of non-medical programs regardless of the services that are actually provided under those programs.

States have considerable leeway in structuring their programs and should receive FFP for Medicaid-covered services if the State chooses to cover the services under the State Medicaid program rather than under another program. The other portions of the regulations requiring that services be provided by qualified providers in accordance with a comprehensive written rehabilitation plan, as well as other Medicaid quality assurance requirements contained in the proposed regulations and other Medicaid regulations, should be sufficient to insure that Medicaid programs do not pay for services that are not covered by Medicaid. Moreover, the "intrinsic elements" requirement is not defined in the regulations, is found nowhere in the Medicaid Act and has been rejected by Congress. This should counsel restraint in adopting the standard.

Section 441.45(b)(1)(i) and (ii) –Therapeutic foster care services and "packaged" services

These sections allow Medicaid rehabilitation services to be provided to eligible individuals who are receiving foster care services if the Medicaid rehabilitation services are "clearly distinct" from "packaged" foster care services. It is unclear from the regulations what "clearly distinct" and "packaged" mean. How distinct must the service be in order to be "clearly" distinct? What is clear to one auditor auditing payments to a particular provider (or Federal payments to a State) may not be clear to another auditor. Providers need clear standards in order to comply with regulatory requirements. The "clearly distinct" standard is not a clear standard. It allows auditors too much discretion to deny claims and will therefore make it difficult for beneficiaries to receive the services because providers will be reluctant to provide them.

In addition, the regulation does not make it clear that "packaged" services refers only to combining Medicaid and foster care services in such a way that it cannot be determined which services should be billed to Medicaid and which services should be billed to the foster care program. "Packaging" does not refer to the provision of services under the Medicaid rehabilitation service category alone.

States have considerable leeway in developing or not developing service sub-categories within the Medicaid rehabilitation service category. The regulations should make it clear that states can develop or not develop service subcategories that reduce administrative complexity so long as there is an appropriate audit trail that enables an auditor to determine that the services billed for are medically necessary rehabilitation services that have actually been provided.

The regulation is unnecessary for the same reason that the "intrinsic elements" regulation is unnecessary. The other portions of the regulations requiring that services be provided by qualified providers in accordance with a comprehensive written rehabilitation plan, as well as other Medicaid quality assurance requirements contained in the proposed regulations and other Medicaid regulations, should be sufficient to insure that Medicaid programs do not pay for services that are not covered by Medicaid.

Section 441.45(b)(2) - Habilitation services exclusion

This section proposes to eliminate habilitation services from coverage as a Medicaid rehabilitation service. CMS should not eliminate this service in the absence of Congressional authorization particularly since habilitation services have been provided under the rehabilitation option and Congress imposed a moratorium on denial of federal financial participation (FFP) for the service.

The moratorium on denial of FFP for habilitation services did not authorize CMS to eliminate the service. Section 6411(g)(2) of the Omnibus Budget Reconciliation Act of 1989 provides the following requirement for habilitation regulations:

> (A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and
> (B) any requirements respecting such coverage.

This statutory language does not permit CMS to eliminate habilitation services from the definition of rehabilitation services. Instead, it requires CMS to define the types of day habilitation and related services that are covered rehabilitation services.

While CMS refers to other sections of the Social Security Act that allow FFP for habilitation services, those sections provide for limits on the number of people eligible for services, caps on services and other exceptions to comparability requirements. Attempting to shift all habilitation services from the Medicaid rehabilitation service category to other service categories would violate comparability requirements because habilitation services fit within the broad definition of rehabilitation services.

Rehabilitation services, within the statutory definition, are not limited to services directed at "regaining" previous functioning that has been lost. As the regulations point out at 440.130(d)(i)(vi) (definition of "Restorative functioning"): "The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function." Habilitation services, like other rehabilitation services, are directed at the ability to perform a function rather than actually having performed the function. There is no principled distinction between habilitation services and rehabilitation services.

Despite the proposed elimination of reimbursement for habilitation services under the rehabilitation category, the regulations seem to provide that individuals with mental retardation or related conditions are eligible to receive rehabilitation option services if they otherwise meet the criteria for receiving them. This result is required under the comparability requirements of the Medicaid Act. Unfortunately, the proposed regulations are not clear and as currently worded could be interpreted to deny all rehabilitation services to individuals with mental retardation or related conditions. The regulations should clarify that individuals with mental retardation or related conditions are eligible for rehabilitation

services on the same basis as other Medicaid-eligible individuals by adding the following:

> An individual with a diagnosis of mental retardation or a related condition is eligible to receive rehabilitation services under the state plan on the same basis as other Medicaid-eligible individuals when the rehabilitation services address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs.

Sections 441.45(b)(4) and (5) – Public institution and IMD exclusions

These subsections relating to the public institution and IMD (institutions for mental diseases) exclusions are unnecessary and have the potential for causing confusion. The subsections are unnecessary because these exclusions, which apply to the entire Medicaid program, are covered by other regulations that are general in scope. See, 42 C.C.R. §§ 435.1009, 435.1010, and 441.13. The subsections have the potential for creating confusion because their existence suggests that there are different or additional public institution or IMD exclusions that apply to the rehabilitation option apart from the public institution or IMD exclusions generally applicable to the Medicaid program.

If CMS chooses to emphasize that these exclusions apply to the rehabilitation option, as they do to the rest of the Medicaid program, CMS should cross reference the general regulations governing these exclusions here.[3]

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[3] However, CMS should not amend the general regulations related to public institutions or IMDs as part of this rule-making process because any amendment of those regulations would go beyond the scope of making changes to the rehabilitation option regulations.

Thank you for this opportunity to comment.

Sincerely,

Daniel Brzovic
Associate Managing Attorney

F:\DOCS\DAN\Legislation and Regulations\Regulation comments\Medicaid Rehabilitation Regs\Medicaid.Rehabilitation.Prop.Regs.2007.10.08.doc

Submitter : **Mr. Tim Patrick** **Date: 10/11/2007**

Organization : **Lighthouse Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

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,

Tim Patrick
1401 State Street
Springfield, MA 01109

Submitter : **Ms. Joannie Aguayo** **Date: 10/11/2007**

Organization : **Child Dev. Inst./ CSU, Northridge- PT Faculty**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

As a professional working with infants and toddlers with disabilities and a parent of an adult son with autism, I support the statement submitted by the Council for Exceptional Children. Passage of the rule would be devasting to the children and families I serve. It would severely alter the quality of life that my son currently has. He would not be able to continue his training in computers, that will eventually help him get a job and decrease his reliance on social security as his only source of income.

As your consituent, please do not support this change as it is currently written. Please consider carefully how this will impact the most vulnerable members of our society.

I am attaching further comments with specific concerns and recommendations.

Thank you for your careful consideration.

Sincerely,

Joannie Aguayo, MS
Parent of an Adult with Autism
Community Program Manager- Early Intervention Program
Part Time Faculty- Child and Adolescent Development, CSU,Northridge
25707 Holiday Circle #C
Stevenson Ranch, CA 91381
661-799-7204

CMS-2261-P-823-Attach-1.DOC

#823

From: fchasen.ci@juno.com
Sent: Wednesday, October 10, 2007 8:28 PM
To: ladams@stancoe.org; keakana@sbcglobal.net; obyanago@hotmail.com; carranders@aol.com; talkfortots@msn.com; cces@arellano.sdcoxmail.com; tarora1@earthlink.net; emiliano.ayala@sonoma.edu; dazzolini@wecarebmcc.org; cinefille@yahoo.com; gypsysb@hotmail.com; meem143@mac.com; nbell@lblp.com; ambcsfcec60@aol.com; cindyb@ucla.edu; pilotpony949@aol.com; CABlacKaller@csudh.edu; llindabrault@cox.net; LINDA.BREKKEN@sonoma.edu; jbrennan@tustin.k12.ca.us; STIRLINGWV@aol.com; carbob1@cox.net; ebrzykcy@slocoe.org; ekb1977@hotmail.com; heller_jessica@hotmail.com; jb108424@student.fullerton.edu; Joannie.busillo@csun.edu; soupfam5@yahoo.com; denisecarbon@yahoo.com; chrisesba@yahoo.com; mleif@aol.com; anikamc@aol.com; DEBORAH.CHEN@csun.edu; dchen0701@yahoo.com; MACINPV@cs.com; dmattingly4@earthlink.net; danielle.colin@sbcglobal.net; rcook@scu.edu; JCOOTS@CSULB.EDU; allchildrenfirst@sbcglobal.net; scoston@mcoe.org; shelcox@aol.com; annie.cox@csun.edu; curtiscdm@adelphia.net; cathdaily@earthlink.net
Subject: Fw: [Dec-leader] Fwd: Urgent! Respond by Friday- Medicaid Regulations!

Please review and respond to this alert by October 12th. Thanks

Fran Chasen

Please note: forwarded message attached

Please take a moment and send a message to CMS as described in this CEC's Alert. This is very important to ensuring adequate funding for services under IDEA. Comments are due October 12th!
Thank you!
Sharon Walsh, DEC Consultant

-----Original Message-----
From: Jill Berthiaume <jillb@cec.sped.org>
To: Jill Berthiaume <jillb@cec.sped.org>
Sent: Wed, 10 Oct 2007 2:41 pm
Subject: Urgent! Respond by Friday- Medicaid Regulations!

Please disregard the earlier e-mail sent out with the same subject line; this e-mail serves as a replacement. We regret any inconveniences that this may cause.

Dear CAN Coordinators:

CEC will be submitting its comments on proposed regulation CMS-2261(rehabilitation services). The comments are attached to this e-mail. The proposed elimination of rehabilitative services for Medicaid-eligible children with disabilities is a critical issue because it will shift the financial responsibility to the school districts and early childhood providers.

If you have not submitted comments, the deadline is 5:00PM on Friday, October 12. Please feel free to use any or all of the material in our comments. If you choose to use our comments, be sure to download the document, sign your name, and save it in order to attach the document on CMSb□s website.

Here are the instructions for filing, as set out by CMS:

> b□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.) 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.b□

Please activate your networks and urge everyone to respond. We need every member to take action on this significant issue. Thanks for your help!

CEC Policy and Advocacy Services

Submitter : **Date: 10/11/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Background

Background

'It will increase the costs from hospitalization, incarceration and other bad outcomes that result from a failure to get needed treatment'...
cited Nami Comments.
This Medicaid Bill will ONLY cut 2.2 billion dollars from this massive spending program for which the Congress has oversight while continuing to meet the much needed services elsewhere.

Thank you for bi-partisan participation.

GENERAL

GENERAL

I totally agree with this Medicaid proposal which cuts 2.2 billion dollars out of wasteful spending for which the Congress has oversight while continuing to meet the much needed services elsewhere.

Thank you for bi-partisan participation.

Submitter : **Date: 10/11/2007**

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Please do not limit behavior health "wraparound" services at this time until more information is available about the impact this proposal will make on individuals. This is an important service to many and more time is needed to discuss and review. Thank you.

Submitter : Mrs. Elizabeth Rauscher **Date:** 10/11/2007

Organization : Mrs. Elizabeth Rauscher

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that CMS withdraw, revise and re-issue the regulations proposed under Section 441-45(b), with greater clarity as to the implications for children and adolescents with special needs who are currently receiving necessary medial services (BHRS) here in Pennsylvania.

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

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

Submitter : Mr. Michael Gelineau **Date:** 10/11/2007

Organization : Lighthouse Clubhouse

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

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 Gelineau
Education Unit Coordinator
1401 State Street
Springfield, MA 01109

Submitter : Mr. Eugene Bianco **Date:** 10/11/2007

Organization : PA Association of Rehabilitation Facilities

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-828-Attach-1.DOC

#828

PARF

Pennsylvania Association of Rehabilitation Facilities
2400 Park Drive, Harrisburg, PA 17110 Phone 657-7608 Fax: (717) 657-8265

October 11, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–2261–P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: File Code CMS–2261–P
http://www.cms.hhs.gov/eRulemaking

To Whom It May Concern:

The Pennsylvania Association of Rehabilitation Facilities (PARF) wishes 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 association represents 100 organizations offering community services to people with disabilities in need of medical or vocational rehabilitation services and/or community supports. PARF has been active in seeking reforms in Medicaid-funded systems of care so that necessary home and community based services may be provided to people with disabilities. PARF believes that community services must be made more available and can be provided more effectively.

In the interests of assuring that effective services are available and accessible, PARF asks that proposed rules be withdrawn. PARF shares with major national coalitions, associations, and organizations identified below a common concern that the proposed regulations would result in the denial of necessary services to people with disabilities and would have an adverse impact on the system of care and supports.

PARF endorses the comments and recommendations of the national associations and groups that have asked that Centers for Medicare and Medicaid Services (CMS) withdraw the current proposed regulations. PARF supports the specific observations and comments presented by the Consortium for Citizens with Disabilities (CCD), the National Alliance for the Mentally Ill (NAMI), Judge David M. Bazelon Center for Mental Health Law, and the National Health Law Program. The specific concerns are identified and discussed in the information provided by those groups to CMS. Specific comments from PARF are attached.

Members of PARF providing rehabilitation services are concerned with the impact of the rules on the access and availability of many types of rehabilitation services to people with disabilities. For example, the proposed rules would shift the burden of paying for many services needed to achieve and maintain employment to state programs such as the vocational rehabilitation program. These programs are currently under-funded. PARF is also concerned that that rules will not only cause peril to existing services but will frustrate efforts to implement programs of evidence-based psychiatric rehabilitation for people with chronic mental illness.

We ask that CMS withdraw the proposed rule.

Sincerely,

Eugene Bianco

Gene Bianco, President/CEO
Pennsylvania Association of Rehabilitation Facilities
2400 Park Drive
Harrisburg, PA 17110
Phone 717-657-7608
Fax 717-657-8265
E mail: gbianco@parf.org

Comments Submitted by Pennsylvania Association of Rehabilitation Facilities
October 11, 2007

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by:

Gene Bianco, President/CEO
Pennsylvania Association of Rehabilitation Facilities
2400 Park Drive
Harrisburg, PA 17110
Phone 717-657-7608
Fax 717-657-8265
E mail: gbianco@parf.org

Non-covered services: 441.45(b)

This section 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. PARF is concerned that services such as pre-vocational and support services during employment may be denied to people with disabilities if this rule were applied. The proposed rule offers no means of deciding if the services offered by the state programs, including the support services offered through state vocational rehabilitation programs, are "resources otherwise available." The regulations are not clear how this provision would be applied. The regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program. The proposed rule may result in a Medicaid-eligible person receiving a denial of service by the Medicaid program because of the Medicaid program applied the new rule and a denial by a state or local program because they lack resources in their program. The rule would in effect deny a person medically necessary Medicaid services. That would be in direct contradiction of the statute.

Recommendation: We strongly recommend that this entire section be dropped. 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.

Rehabilitative Services: 441.45(a) (2)

This section offers a partial definition of rehabilitation services. This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level, as defined in the law. It is necessary here to indicate when services may be furnished to retain or maintain functioning. PARF urges CMS to include language on how to determine whether a particular service is a rehabilitation service based on its purpose.

Recommendation: PARF recommends that CMS describe when services may be furnished with the goal of retaining or maintaining functioning. CMS should add language from the preamble (page 45204) into this section. It should 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.

Definition of Restorative Services: 440.130(d) (1) (VI)

This definition establishes restorative services as those that enable an individual to perform a function and indicates that the individual does not have to have actually performed the function in the past. 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 is at times essential to retain a functional level. Failure to provide a supportive level of rehabilitation would result in deterioration that would require intensive services to be provided. PARF is concerned the current proposed regulation may be interpreted to prohibit coverage of services necessary for retaining improved functioning and for maintaining the highest possible functional level. The law specifically authorizes funds for "rehabilitation and other services" to help individuals "retain" capability for independence and self-care. CMS should allow states to furnish services that will maintain an individual's functional level. The regulation needs to be modified to make the meaning of this section clearer.

Recommendation: The rule should be revised to establish when services may be furnished to maintain functioning and should include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

Related Issue: Payment/Documenting Services

PARF is concerned with CMS approaches to rate-setting methodologies that are not efficient and detrimental to the provision of effective services. There are alternative ways to hold states accountable for ensuring that non-covered activities are not reimbursed

Recommendation: It is strongly urged that CMS work with other federal agencies, states and the field to devise payment methodologies that support the best practice and the most successful outcomes for people with disabilities.

Submitter : Mr. Daniel Sylvester **Date:** 10/11/2007

Organization : Pennsylvania Association of Psychosocial Rehabilit

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-829-Attach-1.DOC

#829

October 11, 2007

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

Re: CMS-2261-P

To Whom It May Concern:

I am pleased to submit the following comments regarding the proposed regulations related to Medicaid's Rehabilitative Services Option on behalf of The Pennsylvania Association of Psychosocial Rehabilitation Services (PAPSRS). The PAPSRS organization has 184 organizations and practitioners, who are actively engaged in Psychiatric Rehabilitation services every day and share years of experience in the tradition of strength-based, person-centered and Recovery-oriented programming. PAPSRS is also a Chapter of the United States Psychiatric Rehabilitation Association (USPRA).

In our initial review of the proposed regulations, we were impressed with the progressive thinking and clear vision of Rehabilitation and Recovery that seems to be evident with CMS. We support and encourage the apparent intent of the regulations to focus, enhance and better define Rehabilitation within the mental health field. In moving forward with this mission, the collective membership of PAPSRS ask that CMS seriously consider the following points. We believe they mirror some of the positions of our national affiliate (USPRA) and fellow Chapters as well as those served by the related services.

Individualized Rehabilitation Plans:

Person Centered, strength-based, recipient-accepted and signature-endorsed planning as reflected in [§440.130(d)(3)] is strongly supported by PAPSRS.

Recognition of Psychiatric Rehabilitation Services:

PAPSRS salutes the language and concepts within the proposed regulations, which more clearly define Psychiatric Rehabilitation and recognizes its important and essential role in the individual Recovery process and necessary component of any effective mental health service system.

Engagement/ Orientation/ Informed Choice:

PAPSRS strongly recommends that CMS review and broaden the provisions in the proposed regulations involving the reimbursement of services, for at least a short period of time prior to a formal, documented, fully accepted and recipient-signed Rehabilitation Plan. While the concept of a Rehabilitation Plan has been strongly endorsed, some of the ambivalence and uncertainty, inherent in individuals with mental illness, because of prior negative experiences and stigma, may make them reluctant to "commit" to a service without the benefit of some direct knowledge and experience with the service. This is a reasonable expectation of "informed-choice" and necessary before a recipient might free properly oriented and willingly engaged in a commitment to a formal goal-oriented plan and process. PAPSRS joins USPRA and several fellow state chapters in suggesting some variation of the following revised language that supports early engagement: *"In the event that an individual is initially unwilling or refuses to participate in the development of a rehabilitation plan, early engagement services may be used as a short-term reimbursable expense that encourages a sense of trust, hope and empowerment to improve an individual's participation in rehabilitation goal setting, assessment. Planning and/or development activities. ...."* The fact that time and participant resolve in the "pre-contemplative" phase of decision making is well documented and many well-recognized Psychiatric Rehabilitation approaches acknowledged this need for a supported readiness process.

State Reimbursement Flexibility:

PAPSRS supports the position of the regulations [§441.45(a)(5)] allowing states to specify the manner in which payment is made to rehabilitation providers to reflect the particular structure, methodology, needs and approach of effective rehabilitation services.

Intrinsic Services:

PAPSRS recommends further clarification of the term "intrinsic" in sections of the proposed regulations [441.45(b)(1)]. This is particular needed regarded services related to housing and employment. These services are essential considerations in rehabilitation planning and therefore appropriately dealt with within a *Rehabilitation Option.* Neither the individual's need nor provider's ability to address these essentials should be unduly compromised by excessively narrowed definition or reimbursement structure.

Staff Qualifications:

PAPSRS supports that services under the proposed regulations and Rehabilitation Option need to be provided by qualified staff capable of demonstrating core competencies. Giving flexibility to the states to set forth those qualifications is also endorsed. PAPSRS strongly encourages that CMS amend the proposed regulations to more firmly assert to the states a need to employ professionals who are competent in Psychiatric Rehabilitation practice, as well as persons in recovery trained as peer providers. Pennsylvania, as well as several other states, has required the Certified Psychiatric Rehabilitation Practitioner (CPRP) as an industry developed, nationally recognized credential.

PAPSRS appreciates the opportunity to comment on the proposed regulations. We salute and applaud the informed, if not enlightened, position of CMS reflected in the regulations. I hope you find the suggestions within this letter relevant and will consider them as you move forward with the important task of putting forth the very important **Rehabilitation Services Option.**

Sincerely,

Daniel L. Sylvester, ACSW, LSW, CPRP
Executive Director
Pennsylvania Association of Psychosocial Rehabilitation Services
P.O. Box 8071
Philadelphia, PA 19101

Submitter : **Mrs. Stacie Runion** **Date: 10/11/2007**

Organization : **Mrs. Stacie Runion**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-830-Attach-1.DOC

#830

October 11, 2007

Greetings,

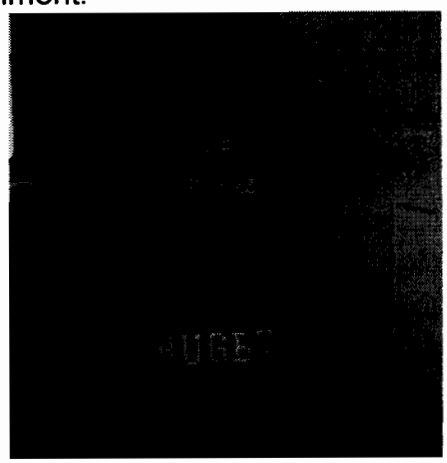
As the mother of a precious 2 ½ year old boy with autistic spectrum disorder, I am dismayed that medicaid-funded wraparound services are being considered for regulations changes which could drastically affect my family's ability to access them.

1 in 150 children are being diagnosed with this disabling disorder which not only affects the child's medical, educational and quality of life for their lifetime, but it also can cripple their family emotionally, spiritually, relationally and financially. As autism is not covered by insurance, and children with autism often require 24/7 care, services like wrap-around are necessary to help children like mine access medically necessary treatments and keep families like mine keep from ending up in divorce and bankruptcy.

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

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

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



Sincerely,

Stacie Runion, mother of William Runion, 2 ½ with
Autistic Spectrum Disorder
610 Beechwood Road
Willow Grove, PA 19090
215-346-2542

Submitter : Mrs. Renee Estremera **Date:** 10/11/2007

Organization : Mrs. Renee Estremera

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attached word document, R. Estremera

CMS-2261-P-831-Attach-1.DOC

#831

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

Public Comments

My name is Rene Estremera from Parma Hts, Ohio. I am a very concerned taxpayer and I am writing about the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201. My concern arises when our federal government imposes ridiculous paperwork requirements on local governmental agencies. This proposed regulation will put our local school district in the unhappy position of imposing unnecessary paperwork on its overburdened medical rehab staff or passing up federal reimbursement for federal mandated medical services to students.

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

If proposed rule 2261 is interpreted by CMS to allow continued Medicaid reimbursement for school-based rehabilitative services, LEA staff would be required by the proposed rule to develop and implement individualized rehabilitation plans which is duplicative of the individualized education programs (IEP)) required under IDEA.

RECOMMENDATION:

I believe that an IEP developed in accordance with IDEA should more than satisfy CMS's stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student's physical or mental disability and restoration of the student to the best functional level. The IEP process includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Sincerely,

Mrs. Renee Estremera

Submitter : Mrs. Lynne Dentz **Date:** 10/11/2007

Organization : Mrs. Lynne Dentz

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-2261-P-832-Attach-1.DOC

#832

Proposed Medicaid Program Rule CMS 2261-P

(Rehabilitative Services)

Public Comments

My name is Lynne Dentz from Parma, Ohio. I am a very concerned taxpayer and I am writing about the proposed rule on rehabilitative services published on August 13, 2007, at 72 Fed. Reg. 45201. I am very concerned about federal mandates imposed by the federal government where the local taxpayer is forced to pay for them without federal assistance. This proposed regulation will, through a regulatory slight of hand, cause my local school district to lose the ability to bill Medicaid for legitimate, eligible medical rehab services that the District is forced to provide by federal statute.

Proposed § 440.130(d)(5) - Settings for Service Provision

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be provided." This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation 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." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

Clarify that rehabilitation services must be covered in any setting permitted by state law, including public school districts.

Add the other settings listed in the preamble (schools, community mental

health centers, and substance abuse treatment centers) to § 440.130(d).

Sincerely,

Mrs. Lynne Dentz

Submitter : Mr. Andrew Runion **Date:** 10/11/2007

Organization : Mr. Andrew Runion

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-833-Attach-1.DOC

#833

October 11, 2007

Greetings,

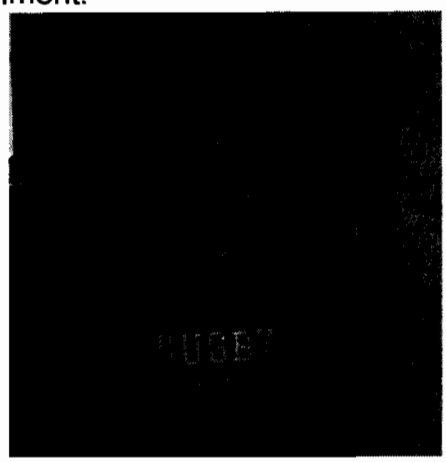
As the father of a precious 2 ½ year old boy with autistic spectrum disorder, I am dismayed that medicaid-funded wraparound services are being considered for regulations changes which could drastically affect my family's ability to access them.

1 in 150 children are being diagnosed with this disabling disorder which not only affects the child's medical, educational and quality of life for their lifetime, but it also can cripple their family emotionally, spiritually, relationally and financially. As autism is not covered by insurance, and children with autism often require 24/7 care, services like wrap-around are necessary to help children like mine access medically necessary treatments and keep families like mine keep from ending up in divorce and bankruptcy.

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

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

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



Sincerely,

Andrew Runion, father of William Runion, 2 ½ with
Autistic Spectrum Disorder
610 Beechwood Road
Willow Grove, PA 19090
215-346-2542

Submitter : **Mr. Francis Paranzino** **Date: 10/11/2007**

Organization : **Newport County Community Mental Health Center**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-834-Attach-1.DOC

#834

Newport County Community
Mental Health Center

127 Johnny Cake Hill Road Middletown, RI 02842-5674
Voice/TDD 401.846.1213 · Fax 401.848.9151

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

Newport County Community Mental Health Center (NCCMHC) 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.

NCCMHC, Inc. is a comprehensive behavioral health organization serving approximately 1200 residents of Newport County or other regions of RI since 1964. We provide a broad spectrum of services to both children and adults including psychiatric assessment and medication prescription services, emergency services and crisis intervention, medication supervision, therapeutic counseling, substance abuse treatment and vocational services, case management, day treatment, Representative-Payee, and residential services. We maintain the highest standards of quality for our clinical services and we maintain accreditation status with the Joint Commission of Accreditation of Healthcare Organizations.

Many of our clients have low incomes and meet federal poverty guidelines for eligibility for subsidized services. Many of our clients experience disability due to serious behavioral health concerns and are recipients of Medicaid benefits. Our organization receives a significant amount of its revenue as a result of the services we provide to these individuals and bill through Rhode Island Medicaid Options. The services we provide are effective in helping our clients with their recovery. We do not want to see fundamental changes to the Medicaid funded system of care for people with behavioral health concerns that could undermine the effectiveness of these services.

We have concerns with the proposed regulations that we believe significantly impact the recovery process of the children and adults served by our Center. We would like to comment on the following areas of the proposed rule:

Submitter : Marsha Wilson **Date:** 10/11/2007

Organization : Seven Counties Services

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-835-Attach-1.DOC

#835

October 9, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

As Division Director with Seven Counties Services in Louisville, Ky, our Centers for Supported Living provide services to individuals with a severe mental illness. We are submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

The Centers for Supported Living provide services to over 2,000 adults in the Louisville area who are diagnosed with a severe mental illness. We provide individual and group therapy, skills training, therapeutic rehab, vocational training and placement, case management and peer support services.

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

<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 individuals diagnosed with a mental illness at an early age, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a

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

This definition stipulates that restorative services are those "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." A clarifying example is provided for the adult population, but not for children. It would be important to clarify how this definition applies to children's services as some functions may not have been possible (or age-appropriate) at the onset of disability, but may be vital to recovery or attainment of one's highest level of functioning during the treatment process.

This definition also includes as appropriate rehabilitation services those designed to maintain current level of functioning, but only when necessary to help an individual achieve rehabilitation goals. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of services is at times essential to maintain their functional level and prevent deterioration. 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 maintenance services could result in clinical deterioration necessitating more intensive services. Page 45203 (under Written Rehabilitation Plan) states, "the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health." We are concerned that our state leaders may 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, risking individuals' deterioration to the point of necessitating more intensive or restrictive services undermining our clients' civil rights.

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is

a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."

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

Additionally, the preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss and have a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

Paragraph II. C. (Written Rehabilitation Plan) states, "We propose to add a new requirement, at Sec 440.130(d) (3), that covered rehabilitative services for each individual must be identified under a written rehabilitation plan." It is unclear whether the "new requirement" is "that covered rehabilitative services for each individual must be identified" or "a written rehabilitation plan." If the new requirement is a written rehabilitation plan, is this plan separate and distinct from the current requirement for a master treatment plan?

It is unclear whether it is 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.

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 may be episodic. 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. It would likely be true, that at this point in the individual's life, retention of services are vital to prevent hospitalization, incarceration, or other public or personal safety consequences. The individual may not have appointed a representative, or in time of crisis, the consumer may not be able to identify this person. Therefore, CMS should allow for documentation by the provider who meets state requirements of reasons that the client or their representative is not able to sign the treatment plan.

The requirement that each plan include information on alternate providers of the same service unnecessarily lengthens the plan and creates a paperwork burden. Similar to a client's rights and responsibilities brochure, alternate providers information could be provided to each client at the beginning of treatment or with each plan and assurance that it has been received could be included in the plan.

Recommendations:

Clearly define the "new" requirement of Sec 440.130(d) (3).

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Specify that a single plan for services is both preferable and intended.

Allow for documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan should that be the case.

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.

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) Limitations for Rehabilitative Services

This section appears to deny Medicaid coverage for covered services to covered individuals if such services are furnished through another program in which they are considered intrinsic elements of the 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.

It appears CMS is concerned that Medicaid is paying for services when other resources are available to provide them. However, 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). 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:

Clearly define "intrinsic element of another program" and provide examples. Examples specific to vocational and prevocational training, housing and parole and probation would be most helpful. Identification of other providers or payers for these services would be essential to continuity of care.

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 his/her 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.

Impact of the Proposal on Consumers

Under the category of "Anticipated Effects", the proposal states, "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." In Rhode Island, the State budget is already in a crisis state and deep cuts are being made across the board. State Medicaid funding is expected to be cut. This reduction in available funds coupled with transferring the cost of current programming from the Federal budget to the State budget may well have a catastrophic impact on services for our consumers, especially the severely, chronically mentally ill.

The greatest impact will likely be in the following areas.

Transportation: Many of the severely, chronically mentally ill are unable or unwilling to self-transport to appointments or to provide for their own basic needs, such as grocery shopping. Often their symptoms include denial of their illness and they will not come to see the doctor or therapist or substance abuse group unless they are transported by staff. Even if they had a personal willingness to attend appointments, most of this population is on a very limited Social Security income and cannot afford cab fare. Consumers are assisted with acquisition of a bus pass, but many do not live on a bus line. A loss in this benefit will result in a loss of services for many of our clients, some of whom have the greatest need.

Vocational and Prevocational Services: Employment or lack thereof is an integral part of the self-image of Americans. A job may be the incentive a depressed person needs to get out of bed in the morning. An addict with a job may be motivated to stay sober. The ability to contribute to society through work may inspire someone with a mental illness to stay on medication. Success in a job, even a small job of a few hours a week, often builds confidence and creates opportunities for success in other areas of the consumer's life. The ability to work, to contribute, to support oneself is often a key loss for those suffering from mental illness. Recovery includes regaining that ability and prevocational and vocational services are a vital part of that recovery. The Office of Rehabilitation Services (ORS) provides funding for some aspects of vocational rehabilitation, but does not provide the services or funding for the majority of the vocational and prevocational services provided through the mental health centers. The loss of this service would greatly impact our consumers and our programming. It would also negatively impact the welfare rolls. Consumers who are now receiving prevocational or vocational supports in order to work or prepare for work would likely be unable to work without supports and would become more dependent on welfare and Social Security for sustenance income.

Personal Care: The ability or motivation to care for oneself or one's home is a significant negative symptom of those suffering from mood disorders or psychosis. Assistance with personal hygiene and Adaptive Daily Living Skills is essential to reintegration into the community. The inability to maintain their homes independently puts our consumers at great risk of homelessness. Consumers without the ability to maintain their personal hygiene are often turned away from the busses, eating establishments, stores, employment and other public places. Whether it is called rehabilitation, recovery or reintegration, these skills and thus these services, are essential to consumers.

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, administrative processes, as well as staff training, 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,

F. L. Paranzino,
Vice President, Chief Operating Officer/NCCMHC

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

Submitter : Mrs. Barbara Kindon **Date:** 10/11/2007

Organization : Mrs. Barbara Kindon

Category : Individual

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

As a parent of a young man who recieves Wrap around services, and as an advocate who serves many young people recieving wrap around I can tell you that decreasing funding for wrap around will force MANY young people into residential living settings. While wrap around is not used to replace family, the shared responsibility of having behavioral staff in the home allows many children and young adults to live outside of a far more restrictive environment. The thought of decreasing funding to a service which is already vastly under funded is ludicrous. Many people are waiting for wrap around services which can not be provided because the funding isn't there to do so. By decreasing that funding young people who might reasonably become functioning members of our society are shoved away into a setting where they can not learn the nuances essential to ever break that cycle. I STRONGLY urge you NOT to decrease the funding, quite conversely it needs to be increased to meet the growing number of young people with potential to have the quality of their lives improved and allow more success stories to surface - we already have too many nightmares of lack of service provision!

Submitter : **Ms. Carla Donina** **Date: 10/11/2007**

Organization : **consumer**

Category : **Individual**

Issue Areas/Comments

Background

Background

It is critical that Medicaid funding continues for vocational, housing ,and other community mental health services. The long term effects of your proposed rule would most likley increase overall dollars to hospitals and in patient treatment centers.
It is imperative we, as tax payers continue to fund rehabilitative services for our youth through foster care, juvenile justice, and adults through housing and vocational training. Let's not go backwards in the foward steps community mental heath service programs have made in improving the recovery and functioning of children and adults with serious mental illness.

Submitter : Mr. Jerry Fuller **Date:** 10/11/2007

Organization : Alaska Dept. of Health and Social Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2261-P-838-Attach-1.DOC

#838

October 9, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

As Division Director with Seven Counties Services in Louisville, Ky, our Centers for Supported Living provide services to individuals with a severe mental illness. We are submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

The Centers for Supported Living provide services to over 2,000 adults in the Louisville area who are diagnosed with a severe mental illness. We provide individual and group therapy, skills training, therapeutic rehab, vocational training and placement, case management and peer support services.

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

<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 individuals diagnosed with a mental illness at an early age, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a

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

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

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

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

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

Additionally, the preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss as a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

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

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

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

clarify that this is indeed preferable.

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

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

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

Recommendations:

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

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

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered 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 waiver 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,

Marsha Wilson, MSW
Division Director
Seven Counties Services

CC: Members of the ____ State Congressional Caucus
The Honorable _____, Governor of the state of _____

Submitted on behalf of the Alaska Department of Health and Social Services, Medicaid and Health Care Policy
Jerry Fuller, Medicaid Director

General Comments

The summary of the proposed rule indicates two purposes. One "in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records", and two "ensure fiscal integrity.....must be coordinated with but do not include services furnished by other programs....." The proposed regulation fails to meet either purpose. In fact the proposed regulation uses many undefined terms and vague descriptions such that it will be the standard that subsequent CMS guidance through letters, state plan discussions and denials, disallowances etc. will actually determine the meaning of this regulation. Given the $2.3 billion estimated federal fund savings it is easy to deduce the direction of future guidance.

Beneficiary protection fails as the impact of this regulation package will be fewer available services under rehabilitation; residential services pushed toward PRTF or inpatient level of care since community based residential services will be significantly reduced, in potential violation of the Supreme Court Olmstead decision; and the added administrative burden will drive up costs and remove funds from service provision. The current broad definition of rehabilitation services make it possible for Medicaid beneficiaries to live in the community while averting institutional placements in nursing facilities and state psychiatric hospitals. The current rehabilitation definitions do permit a cost effective service array and does avoid beneficiaries being placed in higher cost, more restrictive service settings.

The second purpose "ensure fiscal integrity" through limitations between Medicaid and all other federal, state or locally funded programs (intrinsic to) fails because there is no statutory basis for such a limitation and Congress has expressly rejected such a policy. This policy would save significant Medicaid federal funds by cost shifting to state and local funds, funds that are as limited as any other source. There would not be a cost shift to other federal funding sources as those programs are capped programs.

Section V Regulatory Impact Analysis states this is a major rule because it will save the federal government more than $100 million annually, $2.3 billion over 5 years, yet later in the same section it is quite clearly stated "we do not routinely collect data on spending for rehabilitation services" and at the time of this fiscal estimate "a comprehensive review of these rehabilitation services has not been conducted". In spite of this lack of review and knowledge the proposed rule is expected to save the federal government over $2 billion over 5 years. In one section it is stated "The rule would not directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to provisions of this rule". Elsewhere it states "Since this rule would not impose any costs on state or local governments" and under a section labeled "FROM WHOM TO WHOM" it states "In this case costs previously paid for by the

Federal Government would be transferred to State Governments." Given these conflicting and contradictory statements it must be questioned "Has CMS complied with the multiple reporting requirement that are necessary when regulations are promulgated?" There certainly isn't any straight forward data and the narrative is contradictory and confusing. Based solely on statements within this NPRM, it seems quite clear that the Unfunded Mandates Reform Act and Executive Order 13132 do apply and must be addressed. It must also be mentioned that because the proposed regulations are so vague and lack in clarity the true rule making will occur later in CMS guidance letters, the state plan approval or disapproval process and disallowance proceeding, all outside Administrative Procedures Act requirements. The only thing clear is this regulation represents a major cost shift to states without any federal statutory basis.

Specific Comments

Citation	Agree	Disagree	Comments
441.45(a)(2)		X	Partially agree that Medicaid payments are made for only those rehab services that would likely attain the maximum reduction of the mental disability and restoration of the individual to the best possible functional level. However, this statement is too restrictive and ignores Sec. 1901. "SEC. 1901. [42 U.S.C. 1396] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance." The proposed regulation ignores (2) above, thus would not provide FFP for rehabilitation services that permit a beneficiary to "retain" capabilities. "For maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level" is new to Medicaid – but it is a well worn Medicare phrase. Medicare services will be provided until the patient stops making progress – then they stop. Of

			course Medicare has no responsibility for long term care services. Medicaid does and must determine and balance the service array to best meet the clients needs, both restorative and long term care needs. We are concerned about no FFP for a person with the Developmentally Delayed diagnosis to receive mental health rehabilitation services. The diagnostic realities do not afford this exact a line to be drawn. A majority of clients in behavioral health systems have co-occurring disorders – as many of 87%. The regulation appears to negate the option for rehabilitation for children who have not learned the skills in the first place. This could potentially make services for SED children severely limited – basically holding them to the clinical service package only, or higher cost, more restrictive settings. The current focus on "restoration" of previously learned skills does not take into account the developmental stages that children/youth may present and later grow into further skill sets. 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. The regulation 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)). 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.

441.45(a)(3) & 441.45(a)(4)		X	(3) is another example of words without specific meaning. Which providers need to have a copy of this rehabilitation plan in their case records? Just those enrolled with Medicaid as rehabilitation providers or even the physician or clinic that may provide associated health care services? Alaska has been involved with a COSIG grant, resulting in the development of different and a more minimalist documentation requirement. The new emphasis of the Alaska effort has been to reduce the administrative burden, with a focus on outcomes based practice. The CMS emphasis on the specific details for a case record has not shown to be relevant to good practice, service delivery and outcomes. This level of proscription is counter productive and does not enhance beneficiary participation or protections, one of the major goals proclaimed in the introduction to this NPRM. It appears these proscriptive case planning requirements are being proposed without benefit of consultation and/or comprehension of best practices developed and promoted by SAMHSA and other leaders in the field of behavioral health treatments and outcomes. This requirement does not comport with "efficiency and economy" requirements in Title XIX. There will be significant added cost to comply with these extraordinary documentation requirement, cost that Medicaid providers will expect and rightly deserve to be compensated for doing, not to mention increased single state agency cost administrative costs to monitor. As an aside, if such a detailed and proscriptive approach is believed necessary for rehabilitation services then why is such an approach not being proposed for physician, therapies, hospitals etc. If this is being proposed for program integrity purposes it would seem it should be an equally effective tool across most all Medicaid services.
441.45(b)(1)		X	It is agreed there should not be duplicate payment for Medicaid services. And it is agreed that foster

			care, adoption assistance, family reunification etc. are not Medicaid reimbursable services. However, this rule introduces a much broader and very vague concept not found in statute and never before promulgated by CMS, other than a similar statutory concept proposed by CMS for the DRA, and rejected by Congress. The fact that statutory authority was sought earlier indicates that is necessary, and the fact that statutory authority was not granted indicates this section of regulation must be withdrawn; it is not valid or legal. The language in this section is very vague, which means CMS will provide meaning through guidance letters, state plan discussion and denials and disallowances. Intrinsic elements of another program, based on current CMS verbiage, could mean a state funded program for mental health could mean no FFP for Medicaid funded mental health programs. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has insurance with a legal obligation to pay. CMS appears to be stretching Medicaid Third Party Liability statute and meaning to be inclusive of "intrinsic elements of programs other than Medicaid," even if those other programs are dollar capped or intended for those citizens without access to care. 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. The language of this regulation is broad enough to easily reach the above conclusions. This language could also be used to deny FFP for children in the care of juvenile justice, even though not in inmate status, and fully eligible for Medicaid and EPSDT.

			The tenor of this proposed regulation could indicate the same for children in foster care, whether eligible for IV-E or not. CMS can take this much farther and interpret it more stringently, and use this rule to more dramatically to cut FFP. The language of this regulation indicates CMS does not understand that therapy of various types can be delivered in many different settings. Foster care is one such setting. Medicaid can not and does not pay for the maintenance of the child in foster care. That is other federal funding sources and state GF. However it is appropriate, and before this regulation, legal, to define and enroll into Medicaid foster parents that had special education or training in therapy techniques and to reimburse them for the therapy they provided to Medicaid eligible children in their care. This is a well established and cost effective model to provide therapy services to these most vulnerable children. This model is in sync with CMS stated community-based services preference. While we agree that foster care in and of itself should not be Medicaid reimbursable, we assert that foster parents who provide rehabilitative services and are employed and supervised through a mental health centers or clinics should be able to provide Medicaid reimbursable services. These services should be limited to children who have been assessed and determined to be in need of specific rehabilitation services provided by these specialized foster parents. To reiterate, we believe services are best delivered in the environment where the client lives. Alaska disagrees that providers of therapy in foster care should meet the same provider qualifications as those individuals who provide the same service outside of foster care because we believe this will severely limit the availability of Alaskan Native providers who are a valuable resource in keeping children in their communities. Research shows that

			children are more effectively treated by providers whom they see as being similar to them. Also, properly trained and certified personnel can be as or more effective than higher level professional staff. Rehabilitation is defined separately in Title XIX of the Social Security act. There is no statutory basis for requiring different services to have the same provider qualifications. Determining the appropriate level of education, training, licensing and certification for providers has historically been the purview of states and there has not been any statutory change to require or permit this to change. Rehabilitation therapy can and should be delivered in many setting other than a clinical office. States have apparently erred by the labels used to describe their Medicaid services. In order to promote understanding perhaps this should be called therapy in a foster care setting, therapy while at a camp, therapy at or during recreation, etc. The important point is therapy can occur in most any setting and likely will be much more effective on a 24/7 basis compared to one hour session in an office. Of course the state plan must describe who is qualified to provide this therapy, what the therapy entails and the documentation to show it occurred and meet all other requirements. Rehabilitation services are most effective when they are delivered in the setting in which the problem behavior occurs. For example, we believe that a mental health associate out stationed in a school is more effective in resolving a child's inability to get along with his fellow students, than working with that student in a 'free standing" mental health clinic The current regulation adds to the silo programs and funding from HSS. HSS must find a way (perhaps through statutory changes) to coordinate across these programs to get global efficiency and the best outcomes, not each program only looking at their realm and ignoring all else.

			Alaska supports the concept of including vocational and prevocational activities as permitted services, but clarity is needed about when support for successful community living gets too close to prohibited vocational, pre-vocational, housing, and educational support services. We should be encouraging outcomes like successful community living (especially including employment, housing and education) with all state and federal programs.
441.45(b)(2)		X	Without doing research into OBRA 89, it appears from the language in the I) Background B. Habilitation Services that the proposed regulation ignores the Congressional direction in OBRA 89 to promulgate regulations that "specifies types of day habilitation services that a state may cover under paragraphs (9) (clinic services)or (13) (rehabilitation services) of Section 1905 (a) of the act....". to maintain the CMS position of no FFP for habilitation services covered under the state plan option. Since this doesn't comport with OBRA 89 and Congressional direction this should be withdrawn.
441.45(b)(3)	X	X	Agree with Medicaid not reimbursing social or recreational activities, but also believe that an activity that may be social or recreational can also be "rehabilitative" (in which case it would be identified in an assessment and treatment/rehab plan with an associated goal.) However it must be recognized, and thus far is not, that rehabilitation services can be delivered during or in a social or recreational setting that are appropriate and directly related to the rehab plan and treatment goals. Think outside the box for a moment. Rehabilitation and therapies of various types can be delivered an office, home, moving vehicle, classroom, camping etc. As long as the service is documented and the reimbursement rate does not include costs associated with the setting or room and board that service should be a valid and reimbursable Medicaid rehabilitation service. A

			fundamental principle of non-institutional services is that to help people recover or maintain you treat them in real world settings. Medicaid statute does not proscribe where psychiatrist may deliver services, nor does it proscribe where rehabilitation services may be provided. The Preamble includes examples of when recreational or social activities may be covered services due to a focus on skill building or other rehabilitative needs. However, the regulation does not include any examples or any specific language explaining when these activities are covered services. This is a serious omission, as the regulation alone may be interpreted in the field as denying any recreational or social activities no matter how therapeutic and how focused they are on restoring functioning.
441.45(b)(4)	X	X	Agree with excluding payment for rehab services provided to inmates in a secure setting, etc., but this is an exclusion that applies to all Medicaid services, thus should not be lumped into just the regulation about rehabilitation. It is appreciated that CMS has finally given some clarity to what is meant by 'inmate in a public institution.' It is recommended that the terms be used consistently throughout. In the first paragraph it says "in the secure custody of law enforcement and residing in a public institution". Later on this is shortened to public institution system. It must be explicit that all references in this section to public institutions only mean "in the secure custody of law enforcement residing in a public institution". Otherwise at some future date different, more expansive meaning will be given to public institution and the intent will be unnecessarily confused.
441.45(b)(5)		X	This appears to be a new and novel approach to limiting a state's ability to provide community services for children. Applying the IMD 16 bed limit to all other community residential treatment

			facilities, except those meeting the PRTF requirements, has the potential to limit, if not eliminate critical services needed to either keep children out of inpatient care or PRTF level of care, or negatively impact the ability to transition children from inpatient care to community setting. This regulation does not assist in beneficiary protections or enhance program integrity. Again, the guidance CMS provides will determine the magnitude of the negative impacts this section will have upon state programs. Again, there does not appear to be any program need for this regulation nor statutory basis to support its inclusion.
441.45(b)(6)	X		Agree with excluding payment for room and board as a rehab service, but again this restriction is much broader than just rehabilitation and should be elsewhere in the regulatory scheme.
441.45(b)(7)	X		Agree to exclude payment for rehab services provided to a non-eligible and strongly agree to the exception to this rule that allows providing family therapy (ineligibles) as long as it is in relation to the eligible family member's treatment goals. The language in the preamble explaining when services may be furnished through contacts with relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services should be included in the regulation.
441.45(b)(8)	X		Agree all services must be documented in the recipient's case record. Again this restriction is much broader than just rehabilitation and should be elsewhere in the regulatory scheme.
440.130(d)		X	It is common to refer to the benefit in Section 1905(a)(13) as the "rehab option," but the statutory language is broader, covering "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services . . . recommended by a physician or other licensed practitioner of the healing arts." The inclusion of "diagnostic, screening and preventive" services, the

			use of the expansive terms "other" and "any," the description of "rehabilitative" as including both "medical" and "remedial" services, and the reference to "other licenses practitioner[s] of the healing arts" as well as physicians -- indicate the statute was intended to give States significant flexibility to define the benefit broadly to meet the service needs of the clients. The proposed regulation, through the use of vague terms and a lack of definition will result in stricture of flexibility, since the meaning of the terms will be defined through CMS guidance, the state plan process and disallowances.

440.130(d)(3)	X	X	Agree in general with this section's requirement that speaks to a treatment & rehabilitation plan that comes from a comprehensive assessment, a plan (related to the assessment) that's overseen by a qualified provider, that the client is involved in the planning process, that there are clear treatment goals and recommended services. Disagree with the fact that CMS micro manages the whole section about rehabilitation plans and the addition of "recovery goals". This includes too much detail that should be left to state-level regulations. Example: CMS proposed rules includes the client signature as a requirement for the rehab plan. There are two problems with this: First, this is micro managing on the part of CMS. In most all other areas CMS policy is written in fairly "broad" language rather than this level of detail. This level of detail should be contained in state regulation not federal. Second, the recipient signature on a plan, especially for SMI adults, doesn't really indicate any involvement in the planning process. The real desire from consumers and consumer advocacy groups is client "involvement" not client "signature." The challenge of getting client "involvement" should be a responsibility of each state. If a patients signature has so much added value then why not require it of physicians, hospitals, etc? Why single out rehabilitation services for special treatment? We are often involved in cases in which a parent has harmed a child and the non offending parent is in denial. Demanding their input, when these parents may not be cooperative, and denying payment for services under these cases would not be in the child's best interest. The emphasis on such detail in the clinical record and plan requiring client signature also confronts the reality of states developing a "electronic medical record". This also has implications for telemedicine development, and face to face requirements. Disagree with the increased liability placed on the

			supervising providers – who could potentially be held responsible for the actions of others providing the treatment that is in the treatment plan. This looks to make the individual who signs the treatment plan responsible for the actions of individuals providing the care. That is inappropriate. Regulations should allow for "professional responsibility" to be shared by agency and licensed professional overseeing patient care. The proposed language seems appropriate only in instances where the clinician is the enrolled provider. 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? 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 audit purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided. Make it permissible 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.). Do not require two separate planning processes and two separate planning documents. This is burdensome not only on providers but also on the individual consumer. Clearly, multiple service plans do not facilitate coordination or accountability. Please clarify that a single planning process and document is preferable. Including information on alternate providers of the same service in the plan is uncalled for and does not

			serve any useful purpose. In almost all communities, the number of providers willing to accept Medicaid reimbursement is small. This reality is even more problematic in rural and frontier areas of the country. In a metropolitan area how could providers be expected to even have this information. It is difficult enough for the single state agencies to keep this information current and accessible. Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative in a significant number of cases may be problematic. It is not uncommon for those with severe mental illness to believe they are not sick and not 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 no guarantee 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. Also, when children are removed from parental homes it is not uncommon for parents to be in a denial state and not cooperate with the care needed by the children. Signature does not translate to plan involvement.
440.130(d) (v)			Clarify that a rehab plan may be part of a treatment plan. A separate/additional planning effort or

			document would not be required for rehab services. Regulation should clearly require patient/family participation in plan development. However, there should be a provision to allow for service delivery w/o signatures as long as the rationale for no signature is documented. Note that in Alaska a child may be hundreds of miles from the parents home in order to receive services, thus no parent is available for signing. Documents may be mailed back and forth, but still no guarantee of obtaining a signature. The proposed must provide flexibility in obtaining signatures. The requirement to document that the services are "determined to be rehabilitative services consistent with the regulatory definition" appears to be administratively burdensome and requires clinical staff to perform compliance activities.
440.130(d)(vi)		X	The intent and meaning of this section is unclear. 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 proposed rule raises more questions than it answers regarding services provided to children. While the preamble addresses the provision of services to persons with developmental disabilities, it is not clear how this narrow definition of rehabilitation would apply with respect to services provided to children, who may not have lost a functional ability but instead need services to assist them in achieving the developmental milestones appropriate for their age.

			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. Please refer to Sec 1901. This definition appears much more restrictive than permitted in statute. Rehabilitation services may be appropriate for people with chronic serious mental or emotional disabilities to permit retention of their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. The proposed regulation could be interpreted 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. 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 and has a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.
440.130(d)(1)(vii)		X	The definition of medical services should be explicit and make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service.

Conclusion

Many sections of the proposed regulation lack statutory basis. Congress explicitly rejected the 'intrinsic to' approach during the DRA process. Most sections use vague and/or undefined terms that will result in endless quibbling and legal challenges. As was stated by a CMS official in a recent conference discussing this proposed regulation, mention was made of an "evolving policy". The vagueness of the language does suggest that CMS doesn't quite know what it wants the policy to be for rehabilitation services, other than the current broad language that provides flexibility to states to devise services that work appears to no longer be acceptable and that saving over $2 billion federal funds with a significant cost shift to the state is acceptable. It is extremely difficult, if not impossible, for states to reconfigure programs to an 'evolving policy'. It is suggested this regulation be withdrawn until such time as CMS has a clear understanding of the policy intent and it has statutory authority for the regulation.

Submitter : Mrs. Marie Gaul **Date:** 10/11/2007

Organization : MARC

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

To CMS

- Withdraw, Revise and Republish proposals with clarification of impact to children with ASD and MR
- Allow sufficient a sufficient comment period so that individuals and families impacted may respond

Submitter : **Ms. Michelle Sanborn** **Date: 10/11/2007**

Organization : **Children's Alliance**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-840-Attach-1.DOC

#840

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

Re: CMS 2261-P; Comments on Proposed Rule Medicaid Program – Coverage for Rehabilitative Services

To Whom It May Concern:

Thank you for the opportunity to offer comment on the proposed CMS-2261-P - Rehabilitation Services: State Plan Option rule. We recognize the need to reduce Medicaid costs and encourage accountability for its use, however we believe the proposed ruling will have detrimental and long-term negative impacts on children, therefore, only increasing costs for Medicaid long-term.

441.45(b), Non-Covered Services and Intrinsic Element

The Federal Regulations at 1356.60 Fiscal Requirements (Title IV-E) prohibits States from claiming Title IV-E funds for medical or rehabilitative services, however the facts indicate that children entering the foster care system experience more physical and mental health conditions than other children. States are utilizing Medicaid Rehabilitative services as encouraged by the 2003 New Freedom Commission on Mental Health to fund the medical and rehabilitative services that Title IV-E does not allow. These services offer a practical opportunity to reduce the physical and mental disabilities that many children in foster care have, thereby restoring the child's functioning level, and ultimately reducing any cost on society. Evidence indicates that therapeutic foster care improves the lives of the children they serve, therefore, reducing the use of Medicaid permanently. We request that Therapeutic Foster Care not be eliminated as a covered Rehabilitative service.

We are further concerned that 440.45(b) provides no guidance on how to determine whether a service is an "intrinsic element" of a program other than Medicaid, nevertheless, foster care is listed as non-covered service. We believe Medicaid rehabilitative services are not "intrinsic to" foster care and would request the language about foster care and other child welfare programs be removed.

441.45 (b)(1)(i) and (ii), Therapeutic Foster Care and Packaged Services Furnished by Foster Care and Child Care Institutions

The President's New Freedom Commission on Mental Health encouraged services within the community; yet, the proposed rule is eliminating the use of Medicaid funds for therapeutic foster care services. Therapeutic foster care services are designed to treat the child holistically, in the least restrictive setting. This service was created as a

comprehensive service array to allow the child to remain in a community setting, being protected and receiving therapeutic services simultaneously to attain the goal of reducing the cost and use of significantly higher institutional settings. Again, reducing the use of Medicaid and saving money long-term. We request that States maintain the flexibility to define therapeutic foster care services as a single service and pay through a case or daily rate.

441.45(b)(5), Institution of Mental Disease

Excluding services provided to residents of an institution for mental disease, including residents of community residential treatment facilities more than 16 beds would, once again, increase costs and force children in more restrictive settings. Again, this goes against the New Freedom Commission and the best interest of the child. We request this language be deleted.

According to the EPSDT mandate, all children under age 21 appropriately screened are eligible for all federal Medicaid-covered services, regardless of the State plan. We applaud this mandate and agree that children, especially those who have been abused and neglected, obtain vital Medicaid services. However, with this ruling, we believe treatment services will no longer be available to these vulnerable children who are eligible under federal statutes. We respectfully submit our comments for consideration.

Sincerely,

Michelle M. Sanborn, MSW
Director of Public Policy
Children's Alliance
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Submitter : Mr. Christian Stephens **Date:** 10/11/2007

Organization : NRI Community Services, Inc.

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-841-Attach-1.PDF

#841

NRI Community Services, Inc
A Community Mental Health and Substance Abuse Treatment Provider

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October 11, 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**

NRI Community Services, Inc. is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

We are a licensed and accredited Medicaid and Medicare provider for children, adults, and seniors with serious behavioral health problems. We have been in operation for over 40 years and prioritize diversion from more costly and restrictive levels of care.

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:

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

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

This definition also includes, as appropriate rehabilitation services, those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and longer

term rehabilitation services are key to reducing the intensity, duration, and disabling impact of these acute episodes.

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. If individuals must deteriorate to a point where they will be eligible for services it will just increase the public cost of care unnecessarily.

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

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

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

Additionally, The preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss and have a specific rehabilitation goal of regaining that functioning. Behavioral health assist clients to work att an appropriate pace, stay on task, increase attention span, increase memory, as well as other communication and social skills that are necessary for daily living and work, such as taking instructions and/or guidance, and asking for help.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to

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

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

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

2. 440.130(viii)(3) Written Rehabilitation Plan

We do urge some amendments; 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.

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.

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.

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

reasons that the client, or their representative is not able to sign the treatment plan.

Recommendations:

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

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

b. 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;

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

d. that the plan include intermediate rehabilitation goals;

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

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

g. 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;

h. that a single treatment and rehabilitation plan is acceptable and encourage a single planning team and service planning meetings.

3. 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.

4. 441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. Many programs operate on capped appropriations distributed through grants to providers. This is a very different situation than when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

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

We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service - in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). 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 by Medicaid or by the other cited program. Thus, the rule effectively denies individuals 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.

A child with a serious mental disorder being reunified with his/her family may have specific issues directly stemming from a 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. 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 this entitlement.

Recommendation:

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

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

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

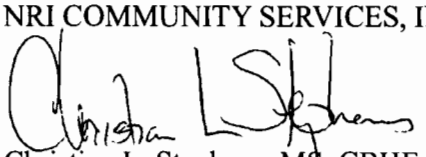
To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at both the state and provider

agency level. The development of new forms as well as staff training, administrative processes all pose significant challenges at the Agency level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of the State Plan Amendment by the Agency.

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

Sincerely,

NRI COMMUNITY SERVICES, INC.



Christian L. Stephens, MS, CBHE
President/CEO

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

Submitter : **Date: 10/11/2007**

Organization : **UCAN**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments. thank you!

CMS-2261-P-842-Attach-1.DOC

#842

11 October, 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: Proposed rule 2261-P/72 Federal Register 45201

To Whom It May Concern:

Uhlich Children's Advantage Network (UCAN) appreciates the opportunity to comment on the Proposed Rule for coverage for Rehabilitative Services under the Medicaid Program, as published in the Federal Register 13 August, 2007.

Impact on poor children:
The proposed amendments by CMS to protect Medicaid beneficiaries will limit access to Medicaid for currently eligible poor children. Because level of funding available to assist a state with the care of its children is based on the number of Medicaid-eligible children, limiting access is seen as an effort to cut federal funds to states by reducing funding for children. Children of the child welfare system fit squarely in the Medicaid Eligibility group defined as "recipients of adoption assistance and foster care under Title IV-E of the Social Security Act" and should not be a factor in determining the amount of federal assistance a state receives.

Recommendation:
Work with the child welfare and advocate communities, the states, other federal agencies to create a system that ensures best practices for children with mental health needs and allows for the provision of the most appropriate Medicaid rehabilitative services in the least restrictive setting.

Provisions of the Proposed Rule:
I. Written Rehabilitation Plan
Section 440.130(d)(3) adds a requirement that covered rehabilitative services for each individual must be identified in a written rehabilitation plan.

Section 440.130(d)(xvii) notes that the rehab plan must include a complete relevant history and current medical findings as needed to achieve the rehabilitation goals.

Concerns:
Seventeen included requirements pose a significant administrative burden on the Medicaid providers who must complete the plans. The requirement that all necessary services are noted in the plan and include the anticipated service provider as well as any alternate provider of the exact services is an undue administrative burden and takes time away from direct rehabilitative services with the individual.

There is no mention of giving consideration to other plans that a child may have, and the importance of coordinating all plans to ensure the most thorough, responsive care is provided.

Some youth come into a new placement without complete, up-to-date medical records or information about previous health care providers. Some may nave never had a primary care physician.

Recommendation:
Rather than listing all potential alternate providers for a service, include in the plan a note that the individual received sufficient referrals to the extent known by the service planning team. Ensure that all plans are considered and coordinated efficiently for the child's best care. Allow for information to be included as it is available, without penalty to the current provider for any past inconsistencies in care or service.

II. Intrinsic Elements:
The proposed rule sees mental health services as 'intrinsic to' rehabilitative service provision and therefore duplicative of other federal programs which provide financial assistance to the provider, and are there ineligible for Medicaid reimbursement.

Concern:
Congress explicitly rejected the "intrinsic to" test regarding Medicaid rehabilitative services when finalizing the Deficit Reduction Act. Their final decision should not be overturned as their course of action maintains the integrity of rehabilitative mental health services to eligible children and youth, especially those who have suffered great trauma prior to being removed from their natural family home. If Medicaid is not there to assist in the payment for mental health services, what will be done to infuse greater dollars into the mental health system so that needed services are available and are provided?

Recommendation:
Remove the "intrinsic to" reference in the rule and use the basic definitions from other federal programs as the guideline for determining the coverage of services. This must apply for foster family homes and child care institutions. Mental health services are not covered under Title IV-E and should be covered under Medicaid if they meet Medicaid regulations.

III. Rehabilitative Services:
Section 441.45 (a)(2) speaks to the distinction between "rehabilitative" and 'habilitative' services. Rehabilitation is used to **restore** individuals to their best functional levels.

Concern:
When identifying the extent of emotional and/or physical trauma that many children come into the child welfare system with, it follows easily that "rehabilitative" services are beneficial when they can help a child **reach** a healthy, functional level of interactions, of educational conversation, and of personal mental health, by healing from their traumatic histories.

Recommendation:
Allowing rehabilitative services to be provided towards this goal is more beneficial to the individual and reflects his/her actual level of need.

IV. Exclusion of Services Provided to residents of an Institution for Mental Disease
In section 441.45 (b) (4) it is proposed 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 to person with mental illness, that does not meet the requirements at Section 440.160.

Concern:
It appears that language here is more readily applicable to the adult population in determining what an IMD is. In the child welfare system, funding is provided through Title IV-E to child care institutions as referenced in 45 CFR Chapter 13 Part 1355 and 1356 and, although the interchange of wording used when speaking about them may at times include "residential treatment facility," this is not a licensing category within the child welfare system. Child welfare programs are licensed as child care institutions per the language of the IV-E federally funded program and not as "Psychiatric Under 21 Residential Treatment Facilities." Title IV-E pays for room and board costs for the placement of children in foster family homes or child care institutions.

Recommendation:
According to the definitions for Title IV-E under the Social Security Act (45 CFR Chapter 13 Part 1356) for foster care and child care institutions, these settings would be allowable for Medicaid services if the state licensing provisions (Title 89: Social Services, Chapter III, Dept. of Children and Family Services, Subchapter e: Requirements for Licensure, Part 404) are so established within a state and the services provided meet the definitions for Medicaid rehabilitative services. Because the intent of the child care institution is to improve a child's level of functioning so that s/he can be moved to a less restrictive setting, this would meet the definition for rehabilitative services.

Any child welfare program licensed as a "child care institution" should not be included in the language of a "community residential treatment facility" referenced in section 441.45 (b) (4). The reference to an IMD should not apply to child care institutions as defined by state licensing rule.

Settings
Section 440.130(d)(5) proposes that rehabilitative services may be provided in a facility, home or other setting.

Recommendation:
Child care institutions should be included as an "other setting." "Inpatient care" is associated with a psychiatric facility. "Child care institutions" do not meet the definition of "inpatient care" according to state licensing regulations (Title 89: Social Services, Chapter III, Dept. of Children and Family Services, Subchapter e: Requirements for Licensure, Part 404) and should not meet

that definition in order to provide a level of care needed in a community based setting, but not in the inpatient setting of a hospital. It is agreed that rehabilitative services do not include room and board in an institutional setting as that is paid through other federal funding in the child welfare system such as Title IV-E. Rehabilitative services provided within the child care institution setting should be eligible for Medicaid if they meet the definitions.

Thank you for the opportunity to comment on the Proposed Rule.

Jodi Doane
Vice President, Government and Community Affairs
UCAN

Submitter : **Bryan Pullen** **Date: 10/11/2007**

Organization : **Peoria Medicaid Consortium**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-843-Attach-1.PDF

#843

Peoria Medicaid Consortium
Comments on CMS-2261-P
October 11, 2007

On behalf of the Peoria Medicaid Consortium representing over 280 school districts and special education cooperatives across Illinois, we strongly oppose Rule CMS-2261-P.

We believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law. 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.[1]" In 1988 the United States Supreme Court made it perfectly clear, in **Bowen v. Massachusetts** (47 U.S. 879), that Medicaid is responsible for paying for medically necessary services provided by education programs to Medicaid-eligible children with disabilities.

In **Bowen**, the Supreme Court upheld a determination by the United States Court of Appeals, First Circuit, that ***it is the nature of the services, not what the services are called or who provides them*** that determines whether the services qualify for Medicaid reimbursement. Based on this decision, CMS cannot determine that a service is not eligible for Medicaid reimbursement by calling a medical service "education" or by pointing out that the services are provided by education personnel. Likewise, if the nature of a school-based service is medical or therapeutic, CMS cannot determine that the service is not eligible for Medicaid reimbursement by labeling it as an "intrinsic element" of an education program.

Subsequent to the **Bowen** decision, the United States Congress amended federal Medicaid law, at Section 1903(c) of the Social Security Act, to further clarify Medicaid's responsibility to pay for school-based health services provided in accordance with IDEA. Proposed rule 2261 that would exclude Medicaid reimbursement for school-based health services because they are identified as intrinsic elements of an education program appears to be an effort by CMS to blatantly defy current Medicaid law as established by the United States Supreme Court and the United States Congress.

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid[2]. The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services.

If proposed rule 2261 is interpreted by CMS to allow continued Medicaid reimbursement

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[1] Social Security Act, Section 1905(a)(13)
[2] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))

for school-based rehabilitative services, LEA staff would be required by the proposed rule to develop and implement individualized rehabilitation plans which may be duplicative of the individualized education programs (IEP) required under IDEA. We believe that an IEP developed in accordance with IDEA should satisfy CMS's stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student's physical or mental disability and restoration of the student to the best functional level. The IEP process includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Title XIX of the Social Security Act provides for annual appropriation of funds to enable state Medicaid programs to furnish "rehabilitation and other services to help... families and individuals attain or retain capability for independence or self-care." Rule 2261 proposes to make reimbursement available only for rehabilitation services necessary "to achieve specific, measurable outcomes". This would impose a definition more restrictive than in federal law and ignores the reality that rehabilitation services can also be needed to maintain gains or prevent deterioration in an individual's condition and functioning. Does CMS mean that only students who get better should receive services?

School districts are already overburdened under IDEA and NCLB education mandates. If rule 2261 is implemented, millions of dollars will be lost annually that is used to provide services to 19,000 Medicaid eligible children by 1,900 clinical professionals including social workers, psychologists, nurses, speech pathologists, physical and occupational therapists and hearing/vision technicians to these students at over 926 school sites within the Consortium. School districts and special education cooperatives will still be obligated to provide those services under EPSDT and IDEA to those 19,000 students, but the financial burden will be great. Special education will continue, but at the cost of regular education and taxpayers. As districts lose this important funding (as proposed in this rule), property taxes could increase, staff terminations could occur, students could receive less "non-mandated" services, the quality of the staff could decrease to meet the budgetary restrictions within school districts, extra-curricular activities could be cut, etc. Not only will the students suffer (Medicaid and non-Medicaid), but entire communities will see the affects.

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.

Respectfully,

Bryan Pullen, Director
Peoria Medicaid Consortium

Submitter : **Ms. Joyce Williams** **Date: 10/11/2007**

Organization : **Unity House of Cayuga County Inc.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

1)Unity House takes great exception to the statement by CMS that it's "ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health," which boils down to spending as little as possible to keep a person alive. It is our understanding that according to Section 1901 of the Social Security Act, the goal of these rehabilitation services should be to provide "rehabilitation and other services to help such families and individuals attain and retain capability for independence or self-care.

2) Section 6411 of the OBRA '89 clearly states that the HHS Secretary shall not promulgate or propose any rule that does not specify "the types of day habilitation and related services that a state may cover under paragraph 9 or 13 of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions." This NPRM does not specify which day habilitation services a state may cover. Instead the proposed regulation would prohibit provision of any habilitation services under paragraphs 9 & 13 of section 1905(a) of the Social Security Act. We believe that this NPRM exceeds the regulatory authority granted by the Congress and must be withdrawn. At a minimum, since the regulation does not comply with the OBRA '89 language, the Secretary would not have authority to deny Federal Financial Participation for habiliation services provided in those states with approved state plan coverage prior to June 30, 1989.

3) We strongly oppose the proposed rule's exclusion of habilitation services, see Section 441.45(b)(2) including "services provided to individuals with mental retardation and related conditions," from covered rehabilitative services. Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary, under Section 1902(a)(10(B) of the Social Security Act. This section further puts forth a false premise that people with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option.

4) Section (V) (Regulatory Impact Analysis) of the Proposed Regulation- pg 45208 claims "this major rule would not have a direct impact on providers of rehabilitative services." Such a statement is a misrepresentation.

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 that amount and quality of essential services; reducing eligibility, benefits or payments to providers; cutting back on other state programs to use those funds to replace Medicaid dollars lost; or a combination of all of the above. This clearly impacts providers.

5) This section (V) also claims that "since this rule would not mandate spending in any 1 year of $120 Million or more, the requirements of the Unfunded Mandates Reform Act are not applicable." For the same reasons stated this claim is false. States and local governmental units would most certainly be severely financially impacted by the implementation of this rule, and by CMS' own admissin a few paragraphs below this claim in the accompanying chart, it shouw that the rule would impact $180 million in FY 2008 alone.

FOR THESE AND OTHER REASONS, WE URGE THE SECRETARY TO WITHDRAW THE ENTIRE PROPOSED RULE.

Sincerely,
Joyce Williams
Executive Director
Unity House of Cayuga County Inc.

Submitter : Mr. Dinnen Cleary **Date:** 10/11/2007

Organization : Columbia Legal Services

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-845-Attach-1.DOC

#845

Columbia Legal Services

Seattle Office

101 Yesler Way, Suite 300
Seattle, WA 98104
(206) 464-5933
(800) 542-0794
(206) 464-1518 TDD
(206) 382-3386 (fax)

John Midgley, Director

October 11, 2007

VIA ELECTRONIC MAIL

Center for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: **File Code CMS-2261-P**
Notice of Proposed Rule
Medicaid Coverage: Coverage for Rehabilitative Services

Dear CMS:

Columbia Legal Services is a non-profit, public interest law firm that represents low income, elderly and disabled persons in the State of Washington. Many of our clients are Medicaid recipients and, as such, utilize many of the rehabilitative services covered by the proposed rule referenced above.

The primary purpose of this letter is to endorse the comments to these proposed rules already sent to you by the National Health Law Program (NHeLP), the Bazelon Center for Mental Health, the National Alliance on Mental Illness (NAMI), and the Consortium for Citizens with Disabilities (CCD). We share the concerns expressed in the NHeLP letter that the proposed definitions will "impermissibly narrow the scope of services that can be covered under the rehabilitation option" and "leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all."

In particular, we endorse the following recommendations made in the comments referenced above:

- In order to avoid a conflict with EPSDT, insert a new paragraph at §441.45(a) clearly stating that states must ensure that children receive all federally Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition, and clarify at §441.45(a)(5) that even when a state plan does not cover certain rehabilitative services, they must nevertheless be made available to children when medically necessary.

- Therapeutic foster care should be listed as a covered rehabilitative service for children with serious mental disorders at imminent risk of placement in a residential treatment facility.

- In order to prevent states from denying coverage for medically necessary rehabilitation services merely because such services may not lead to immediate results or may only prevent a condition from worsening, amend § 440.130(d)(1)(vi) to indicate that failure to make measurable progress toward a particular goal within a certain time period does not necessarily indicate that a service is not necessary to help achieve a rehabilitation goal.

- Delete §441.45(b)(1) because of the danger that it could cause statutorily covered Medicaid services to be denied under the mistaken belief that such services are covered by another program (the "intrinsic elements" provision).

- Delete §441.45(b)(2) because denying medically necessary habilitation services to persons with mental retardation and related conditions would violate the federal Medicaid statute.

There is another aspect of these proposed rules that we would like to raise, that being the ability of the states, as part of the collaborative relationship between the state and federal governments that characterizes the Medicaid program, to define what is a medically necessary service, item of equipment, or prescription drug. Washington defines "medically necessary" as follows:

> **"Medically necessary"** is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

WAC 388-500-0005. This definition has been place for thirty years and has served well the interests both of the state and of recipients of medical assistance to have clearly defined, comprehensive standards to apply when establishing what services, equipment and drugs will be provided. The definition reflects a sound medical approach in determining how requests for services should be evaluated, including consideration of the latest evidence-based practices. You will note that medical services (or equipment or drugs) are deemed to be medically necessary if they "alleviate or *prevent worsening* of conditions that...cause suffering or pain...or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction." (Emphasis added).

If the federal rehabilitation rules are worded so that it appears that certain services won't be covered because they don't meet a clearly defined rehabilitation goal, or are determined to be habilitation, this would negatively impact the ability of Washington and other states to define what is medically necessary. We urge that the cooperative balance that has existed in the Medicaid program since its inception over forty years ago has been well served by placing the power to define medical necessity with the states. Consequently, your consideration of the many

thoughtful comments you will be receiving in response to these proposed rules, including the ones we have endorsed, should be done with the principle in mind to fashion your rules in a way that doesn't unsettle this cooperative balance.

Thank you for your consideration of these comments.

Sincerely,

Dinnen Cleary
Attorney

Submitter : **Ms. Lynn Hallowell-Gottsleben** **Date: 10/11/2007**

Organization : **Madonna TherapyPlus**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See attached comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached comments

CMS-2261-P-846-Attach-1.DOC

#846

Comments Regarding Medicaid Program Coverage for Rehabilitation Services

http://www.cms.hhs.gov/eRulemaking
File code CMS 2261-P

Please find my comments below regarding the proposed Medicaid Program Coverage for Rehabilitation Services

PROVISIONS OF THE PROPOSED REGULATIONS

(3) Written Rehabilitation Plan – Pages 61-63

The proposed rule describes the rehabilitation plan as a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized goals and the medical and remedial services to achieve these goals. The plan is to be developed by a qualified provider(s) working within their scope of practice as prescribed by the state they are practicing in. The plan should include input from the patient, patient's family, and/or patient's decision maker of individual choosing in the development, review, and modification of the goals and services. The plan must document that the services are rehabilitative services consistent with the regulatory definition. There must be a timeline and must be based on the patient's assessed needs and anticipated progress. Reevaluation of the plan cannot be longer than 1 year. The plan should be reasonable and based on the patient's condition, as well as general standards of practice for provision of rehabilitative services to a patient with the patient's condition.

Comment:
The patient history, findings, contraindications and care coordination are all vital parts of patient care and should be maintained as part of the medical record. However, typically in outpatient physical and occupational therapy settings, this information is obtained during the patient evaluation and is recorded on the evaluation or daily note sheet. Requiring this information on an additional rehabilitation plan sheet will cause duplication and increased paperwork by the clinician and will take away time from direct patient care. Requiring this information as part of the medical record is indicated, however, duplication on an additional form is redundant.

If containment of these areas on the written plan and not just in the medical record is not the intent of this element, then additional clarifying language is required.

(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

Comment:
It is inappropriate and unrealistic to expect providers to research and document alternate providers as part of a patient's written care plan. In outpatient physical and occupational therapy settings, the clinicians that are providing treatment typically also complete the plan of care. Requiring clinicians to research other providers to include the patient's written plan of care will take away actual treatment time, which would have a significantly negative impact on the care provided to patients.

If researching other providers including other physical and occupational therapy providers and exploring their options and costs to provide care is not the intent of this element, then additional clarifying language is required.

Submitter : **Susana Burns** **Date: 10/11/2007**

Organization : **NAMI Orange County**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-847-Attach-1.DOC

#847

October 11, 2007

To Whom It May Concern:

Please read my comments and recommendations concerning the proposed rule to amend the definition of Medicaid Rehabilitative Services

Pertaining to Section 440.130(d)

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 we have seen so far.

It is also part of your job to design a system where abuses are not tolerated and are fully prosecuted.

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. 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.

As a member of the Orange County Community, I see that offering rehabilitative services to those afflicted with a mental illness is the least we can do as a society. Let's treat them as we would like to be treated.

Sincerely

Susana Burns
103 Westbury Ct.
Chapel Hill, NC 27516

Submitter : Macario Pinieda **Date:** 10/11/2007

Organization : Hale o Lanakila

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-848-Attach-1.DOC

#848

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

October 17, 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,

Macario Pinieda
456 S. Lanai St.
Kahului, HI 96732

Submitter : **Mrs. Lynne Longo** **Date: 10/11/2007**

Organization : **NAMI-Coachella Valley**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

October 11, 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.
Thank you

Submitter : Ms. Diane Wagner **Date:** 10/11/2007

Organization : Ms. Diane Wagner

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2261-P-850-Attach-1.PDF

#850

Dear Sir or Madam:

As a volunteer coordinator who works regularly with individuals who have serious mental illness, I strongly endorse the comments which were already sent in regarding the new proposed rule for the Medicaid Program, Coverage for Rehabilitation Services by: St. Luke's House, the Community Behavioral Health Association of Maryland and the National Council on Community Behavioral Health.

Diane M. Wagner
Silver Spring, MD

Submitter : Ms. Cheri Walter **Date:** 10/11/2007

Organization : Ohio Assn. of County Behavioral Hlt. Authorities

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-851-Attach-1.DOC

CMS-2261-P-851-Attach-2.DOC

#857

Ohio Association of
COUNTY BEHAVIORAL HEALTH AUTHORITIES

October 11, 2007

Kerry Weams
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: CMS-2261-P: Comments on Proposed Rule Medicaid Program; Coverage for Rehabilitative Services

Dear Mr. Weams:

On behalf of the Ohio Association of County Behavioral Health Authorities, I am providing written comments on the proposed rule for Medicaid Program; Coverage for Rehabilitative Services.

The Ohio Association of County Behavioral Health Authorities represents the interest of all 54 Behavioral Health Boards in the state of Ohio. Our ultimate concern is to ensure that access to quality mental health, alcohol and other drug prevention, treatment and support services is available to every Ohioan. We are concerned that the proposed rules, as written, may restrict our ability to provide essential services in the community to our most vulnerable populations.

We are requesting that the Centers for Medicare and Medicaid Services provide additional clarification within the rule, and reconsideration concerning the following issues:

- Section 441.45(b) (1) - Coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid. We are requesting that CMS provide additional clarification on the intent of this language, specifically as it relates to behavioral health services and to children in foster care.

- Provisions of the Proposed Regulations C. Written Rehabilitation Plan- We are requesting that clarification on the difference between the concepts of restorative services and maintenance as they relate specifically to behavioral health services. Clarification is also being requested as this issue relates to children and older adults.

33 North High Street – Suite 500 – Columbus, Ohio 43215 – Telephone (614) 224-1111 – Fax: (614) 224-2642
Cheri L. Walter

- Provisions of the Proposed Regulations A. Definitions- "Qualified Providers of Rehabilitative Services"- We are requesting that these qualifications related to the definition of "Qualified Provider of Rehabilitative Services" be reconsidered. Applying additional qualifications will have an impact on consumer access to services provided by lower level clinical staff and provider capacity to serve consumers at all levels of clinical need will decrease. This provision of the proposed rule will also affect workforce development and staff retention strategies in many community behavioral health centers given the increased costs associated with adding additional training, education, licensing, work experience and supervision requirements.

Thank you for the opportunity to provide written comments regarding the proposed rule. If you have any questions, please feel free to contact me at (614) 224-1111 or cwalter@oacbha.org.

Sincerely,
Cheri L. Walter
Chief Executive Director

33 North High Street – Suite 500 – Columbus, Ohio 43215 – Telephone (614) 224-1111 – Fax: (614) 224-2642
Cheri L. Walter

Submitter : Mr. Rick Gawenda **Date:** 10/11/2007

Organization : Mr. Rick Gawenda

Category : Physical Therapist

Issue Areas/Comments

Background

Background

Under Section C, Written Rehabilitation Plan, I feel the proposed requirement of having the patient or their representative sign the plan of care is not necessary and may not always be able to be signed by the patient or their representative. Under Medicare Part B therapy benefits, The CMS does not require that the patient or their representative sign the plan of care that was developed by the therapist in collaboration with the patient based on the patient's initial evaluaiton and functional deficits. In addition, a scenario may occur where the therapist performs an initial evaluation and establishes a program for the patient to work on independently and does not require further follow-up treatments and will not return for therapy. In this case, the therapist would not document the evaluation and plan of care until after the patient left the facility and the patient will not be returning for future therapy appointments to then sign the plan of care. I feel it should be assumed the plan of care was developed by the therapist in collaboration with the patient and/or their representative and addresses the patients functional and/or mental deficits.

Submitter : Mr. Michael Fitzpatrick **Date:** 10/11/2007

Organization : National Alliance on Mental Illness

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2261-P-853-Attach-1.DOC

#853

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 440.130(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,

Michael J Fitzpatrick

Michael Fitzpatrick
Executive Director

Submitter : Ms. Sandy Loerch Morris **Date:** 10/11/2007

Organization : DSHS, DDD, Infant Toddler Early Intervention Prog.

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. The Washington Infant Toddler Early Intervention Program has attaehed document with questions, comments and concerns about these proposed regulations.

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attached.

#854

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 : **Mr. John and Marla Jo Green** **Date: 10/11/2007**

Organization : **Mr. John and Marla Jo Green**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

We have a child with autism.

We feel it is imperative that CMS withdraw, revise and re-issue the regulations proposed under section 441.45(b)(2), with greter clarity as to the implications necessary medical service (BHRS) here in PA. As written, these proposed regulations raise questions as to whether the federal government will use them to force PA to restrict these vital services for our children.

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

Wraparound services have saved our son from the worst of autism and is giving our family skills and hope that we all can conduct and live a 'normal' life.

Please feel free to contact us for more information.

John and Marla Green

Submitter : **Dr. Kathleen McGinley** **Date: 10/11/2007**

Organization : **National Disability Rights Network**

Category : **Consumer Group**

Issue Areas/Comments

Background

Background

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-2261-P-856-Attach-1.DOC

CMS-2261-P-856-Attach-2.DOC

#856

October 11, 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

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. These comments are being submitted on behalf of the National Disability Rights Network (NDRN). NDRN is the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) systems and the Client Assistance Programs (CAP). The P&A/CAP network operates in every state and territory and provides free legally-based advocacy to ensure the rights of children and adults with disabilities. NDRN strongly urges you to reconsider numerous provisions of the proposed rules which appear to violate EPSDT requirements and overstep CMS's rulemaking authority.

Medicaid has long been recognized -- on a bipartisan basis -- as the driving force behind the availability of individualized, community-based supports and services that enable people with disabilities of all ages to lead fuller, healthier, and more productive lives. Medicaid's structure is critical to future progress toward community integration. For years, CMS has recognized the great opportunity and role it has to identify new avenues for Medicaid coverage of community supports and services. These efforts have been consistent with the Presidents New Freedom Initiative and Executive Order 13217 issued on June 18, 2001 announcing an effort among all federal entities to remove barriers to community living for people of all ages with disabilities. For example, CMS has issued numerous "state Medicaid Director letters" that demonstrate to Medicaid Directors how long-standing or recently issued Medicaid policies can be used to assist individuals with disabilities to move from institutions to the community with appropriate Medicaid supports.

NDRN is concerned that the proposed rehabilitation rules will scale back the rehabilitative services available to children and adults with disabilities and create new barriers to full participation in the community. In many such cases, loss of these vital rehabilitation services will

likely lead to deterioration in abilities (resulting in a need for higher cost medical treatment) and loss of independence, community and family involvement. In addition, NDRN is concerned that unwanted institutionalization will end up being the only option available to receive critical services. Numerous studies have shown institutional costs to be higher than the cost of providing comparative services in the community (See: Stancliffe and Lakin, 1998; and Moss, D., & Foss, A. 2000). Yet, additional costs from treating more involved medical needs, and increased institutionalization were not taken into account in the CBO score of savings from the proposed rule.

The comments submitted to CMS by the Coalition of Citizens with Disabilities (CCD) go into detail regarding our concerns. NDRN is in full support of CCD's comments and the accompanying recommendations. As a legal services organization we feel it important to highlight those portions of the comments reflecting our belief that the proposed rule contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.

I. The Intrinsic Element Test Oversteps CMS Rulemaking Authority

The proposed rule would deny Federal financial participation (FFP) for services 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." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

In addition, the reference to services "that are intrinsic elements of programs other than Medicaid is not properly defined and this lack of definition is likely to lead to 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. This uncertainty is sure to mean fewer states seeking to implement the multi-program coordination that has been identified by CMS as a promising practice leading to improved coordination between programs and intensive community supports. There are already mechanisms states use to ensure that Medicaid does not pay for services that are the responsibility of other programs, such as pursuing a fraud and abuse action. Also, the Medicaid statute requires that State and local agencies administering the state

Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . ." 42 U.S.C. § 1396a(a)(25)(A).

Another unintended consequence of the proposed rule may be denial of necessary EPSDT services for children. When EPSDT is at issue, even if a third party is liable, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party. 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007). Thus, when a service is the responsibility of a third party, the other program is still a third party payer. The proposed rule adds yet another layer of administrative cost and likely confusion and may have a chilling effect on a states willingness to attempt multi-program coordination.

II. The proposed rule does not fully comply with the EPSDT mandate for children.

We are very troubled by the potential impact of the proposed rule on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that the proposed rule complies with Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a state's Medicaid plan. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement.

We believe that the proposed definitions impermissibly narrow the scope of services that can be covered under the rehabilitation option. Moreover, the proposed regulations, when combined with the commentary in the preamble, leave the distinct and incorrect impression that certain services cannot be covered under Medicaid at all. The regulations are inconsistent with the statutory purpose of Medicaid coverage of rehabilitation services, which is "to enable each State, as far as practicable . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services to help . . . families and individuals *attain* or retain capability for independence or self-care . . ." 42 U.S.C. § 1396 (emphasis added).

We suggest an overall restatement of the EPSDT requirement in the regulations, consistent with the recommendation in the comments of the Judge David L. Bazelon Center for Mental Health Law:

> Insert a new paragraph in § 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when necessary to correct or ameliorate a physical or mental illness or condition.
>
> Amend § 441.45(a)(5) to state that even when a state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when necessary to correct a physical or mental illness or condition.
>
> Amend § 441.45(b)(4), to refer to the EPSDT requirement and instruct states to comply with it.

III. The proposed rule will lead to unnecessary institutionalization of individuals with disabilities.

To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. The Rehabilitation Services option is the most important funding source of services for people with mental illness such as assertive community treatment (ACT), multi-systemic therapy for children and adolescents (MST), and other important evidence-based services. NDRN is concerned that the proposed rules will have a negative impact on the ability of states to pay for these services.

By limiting access to effective community-based rehabilitative services, the proposed rule would place Medicaid beneficiaries with mental illness at risk for poorer health outcomes and this could lead to relapse or new episodes of illness. Such incidents typically result in increased utilization of high cost services such as emergency room care and unnecessary institutionalization. As we explained earlier in our comments, unnecessary institutionalization usually costs more than equivalent community services and these costs were not reflected in the CBO score for the proposed rule. Much more important, is knowing that the proposed rule will deny the civil right of and individual to receive services in the most integrated setting appropriate as required by the Americans with Disabilities Act (28 C.F.R. § 35.130(d)).

IV. The proposed rule would harm people with intellectual and other developmental disabilities

In contradiction to the plain language of Section 6411(g) of OBRA '89, the proposed rule **does not** specify which day habilitation services that a state may cover. Instead, the proposed regulation would prohibit the provisioning of *any* habilitation services under paragraphs (9) and (13) of section 1905(a) of the Social Security Act. We believe that this NPRM exceeds the regulatory authority granted by the Congress and must be withdrawn. At a minimum, since the regulation does not comply with the OBRA '89 language, the Secretary would not have authority to deny FFP for habilitation services provided in those states with approved state plan coverage prior to June 30, 1989.

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

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not

restricting their efforts to do so." It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

We also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that individuals receive the highest quality habilitative and rehabilitative services according to current standards of treatment. The preamble of the proposed rule states that the rehab option is not a "custodial" benefit. We agree with the Secretary that state programs operated under the rehab and clinic options should set high standards for delivering active treatment and for innovating to develop programs for people with intellectual and other developmental disabilities that maximizes their ability to attain, maintain, and retain their maximum ability to function, consistent with the original conception of rehabilitation, as found in section 1901 of the Social Security Act.

V. Transitioning Rehab Option Services into Waiver Services Does Not Provide an Equal Service

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under 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)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

Further, section 1915(c) waivers and the section 1915(i) option are not equivalent to the rehab or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something that is not required for rehab or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities.

NDRN is already concerned that 1915(c) and 1915(i) waiver programs often have long waiting lists, on which individuals needing community services can languish for years. When a state provides these services under the rehabilitation option waiting lists are not permitted. It seems in

direct conflict with the ADA integration mandate (28 C.F.R. § 35.130(d).) and the new Freedom Initiative to restrict access to rehabilitation services, knowing that there is no ready alternative source of these services – except for unwanted, inappropriate and often more costly institutionalization. NDRN strongly recommends that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

VI. Discriminatory Definition of Rehabilitation Services

NDRN strongly opposes the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehab option services for people with mental retardation and related conditions. CMS policy appears to be that these individuals should receive services only through waiver programs (or the related 1915(i) option), and this is nonsensical in circumstances such as where a person with an intellectual disability has a knee replacement and needs services to regain physical functioning of the knee or where a person with epilepsy develops a substance abuse disorder. Further, this policy is likely to increase federal and state costs, as benefits for home- and community-based services (HCBS) waiver programs tend to be far more extensive than is generally provider under the rehab option.

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. CMS must comply with all civil rights laws and this policy appears to violate the ADA's prohibition of discrimination on the basis of disability (see: 28 C.F.R. § 35.130(d). We urge the Secretary to rescind this constraint on rehab option services.

II. Challenges efforts by states and school districts to effectively deliver health care services to children with disabilities in school settings.

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to a free, appropriate public education in conformity with an individualized education program (IEP). An IEP is developed for eligible individuals with disabilities and describes the range of services and supports needed to assist individuals in benefiting from and maximizing their educational opportunities. The types of services provided under an IEP include services such as speech pathology and audiology services, and physical, psychological and occupational therapies. While IDEA confers rights to individuals and obligations on the part of school systems, it is not directly tied to a specific program or an automatic funding source. For years, the Federal government has failed to provide anywhere near the level of funding promised in the IDEA statute. States' ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP helps defray some of the state and local costs of implementing IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IEPs have been a contentious issue in the past. Some time ago, the Health Care Financing Administration (HCFA, the predecessor to CMS) attempted to limit the availability of Medicaid funding for services under IEPs. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP. Under current law, the Social Security Act at section 1903 (c) reads,

> "Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act."

Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitation services in school settings, new requirements of this rule could be disruptive to schools and could make it more difficult to use the school environment to assure that children with disabilities receive the rehabilitation services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools. While we share the goal of ensuring that all rehabilitation services are of the highest quality and are only provided by providers who meet state credentialing standards, we are concerned that this rule would limit state flexibility to establish provider qualification requirements in school settings. Further, we are concerned that the any willing provider requirement could be disruptive to school efforts to serve children. We believe that the existing free choice of provider which guarantees parents the right to access medically necessary therapy and other services by other providers—outside of the school environment—is an appropriate way to protect parents' right to access the Medicaid qualified provider of their choice. Again, the Secretary has not provided a policy justification for this new requirement, and we believe the net impact will be to make it less desirable for Medicaid

programs to use school settings to provide essential rehabilitation services to children. The Congress could not have been clearer in its intent that it wants Medicaid to support the goals of IDEA; we believe that these narrow interpretations of the law are inconsistent with that intent.

For these and other reasons, we urge the Secretary to withdraw the proposed rule.

We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitation services, consistent with Title XIX of the Social Security Act. Thank you for the opportunity to comment on the proposed rule. If you have any questions, please let me know (Kathy.mcginley@ndrn.org)

Sincerely,

Kathleen H. McGinley, Ph.D.
Deputy Executive Director for Public Policy

Submitter : Mr. Allen Blough **Date:** 10/11/2007

Organization : NAMI PA

Category : Individual

Issue Areas/Comments

Background

Background

Section 440.130(d)(1) Rehabilitation and Restorative Services:
for individuals with mental health challenges, often there are periods of months, or even years, when the goal of treatment can only be to prevent regression or deterioration. I have a relative who, in fact, benefitted from services that, for a period of time, did not evoke progress but instead combatted regression.

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, 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.

I hope the agency will adjust its regulations to take into account the nature of mental illnesses 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)(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. I do not support the exclusion of groups on the basis of their disability.

Recommendation:

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

Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan:
I would like to see some flexibility in the rules to allow providers to conduct outreach to individuals who may not be ready to be part of a formal treatment planning process. Sometimes, it takes repeated visits before a person is ready and understands how treatment will be a benefit to him or her.
In addition, there are times when a person is in crisis and needs help. At that point, they might not be able to be part of a planning process. If they are new to a community or have recently been in the hospital, 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.

GENERAL

GENERAL

Rehabilitation services can change a person s life. 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 around us. 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 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.

Submitter : Marty Ford **Date:** 10/11/2007

Organization : Consortium for Citizens with Disabilities

Category : Consumer Group

Issue Areas/Comments

Background

Background

See attached

GENERAL

GENERAL

See Attached

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attached

CMS-2261-P-858-Attach-1.DOC

#858

CONSORTIUM FOR CITIZENS WITH DISABILITIES

October 10, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. These comments are being submitted on behalf of the Consortium for Citizens with Disabilities (CCD). The CCD is the leading coalition of national organizations working together to advocate for national public policy that ensures the self determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. CCD's membership consists of disability advocacy organizations, services providers, and other interested parties and covers the full spectrum of disabilities, including people with mental illness, people with developmental disabilities, children receiving foster care, people with physical disabilities, and other populations directly impacted by this proposed rule.

We are organizing our comments into major issues and concerns. Individual organizations, under separate cover, will also submit more detailed technical recommendations and section-by-section comments.

Major Issues and Concerns

The CCD has major issues with the proposed rule. We believe it is fatally flawed and should be withdrawn. We recognize that the proposed rule, in some cases, seeks to address legitimate policy issues. We welcome the opportunity to work in partnership with the Congress and the Administration to achieve consensus on appropriate policies and procedures to ensure that Medicaid beneficiaries receive the highest quality rehabilitative services, consistent with Title XIX of the Social Security Act, and to ensure that states operate their Medicaid programs to achieve the best clinical outcomes and in the most publicly accountable manner. We believe that this proposed rule prevents a necessary dialogue between federal officials, state Medicaid officials, other state officials (including individuals responsible for programs for people with mental illness, developmental disabilities, and child welfare), rehabilitative

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services providers, and representatives of affected Medicaid populations. We are not aware of any meaningful effort by the Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services (CMS) to work with affected stakeholders to address current policy concerns. Indeed, we have been troubled by dubious enforcement actions and audits by the HHS Office of the Inspector General (OIG) that have appeared more focused on limiting federal expenditures than improving the appropriateness or effective administration of services under the rehabilitative services (rehab) option. To the extent that policy changes are needed, we believe that the legislative process is the appropriate arena for addressing these issues. The following are major concerns:

1) **Unjustified and unnecessary, the proposed rule would not further the purposes of Title XIX of the Social Security Act.**

A central purpose of the Medicaid law is to provide rehabilitative services. Section 1901 of the Social Security Act reads,

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish... (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

Not only does the proposed rule not further this core goal of Medicaid, it erects new obstacles for Medicaid beneficiaries to receive medically necessary rehabilitative services. It does not justify the need for new rules and it does not provide a reasonable description of the impact of the proposed rule on Medicaid beneficiaries or rehabilitative services providers. The Regulatory Impact Analysis makes numerous assertions that are contradictory and appear intended to mask the impact of the proposed rule. For example, it states that, "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." In reality, the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on providers. The proposed rule also states that, "...because FFP [Federal financial participation] 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 would impose substantial increased costs on states that must change many of their administrative practices and that must either limit access to medically necessary services or increase state spending to provide services that were previously eligible for Medicaid FFP.

2) **Contradicts Title XIX of the Social Security Act and exceeds the regulatory authority vested in the Executive Branch.**

In several instances, we believe that the proposed rule exceeds the Executive's regulatory authority and is inconsistent with Medicaid law.

a. The proposed rule would hinder access to prevention services.

We are troubled that the proposed rule could interfere with states' ability to deliver preventive services, authorized by section 1905(a)(13) of the Social Security Act, as defined by 42 C.F.R. § 440.130(c). Although the proposed rule ostensibly amends only 42 C.F.R. § 440.130(d), it creates the clear impression that numerous preventive services would be prohibited under section 1905(a)(13), even if they could be covered as preventive services.

Any revised rule should make clear that states can continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. § 440.130(c).

b. The proposed rule illegally imposes an intrinsic element test.

The proposed rule would deny FFP for services 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." This so-called "intrinsic element test" presents a barrier that could prevent Medicaid beneficiaries from receiving medically necessary Medicaid covered services that is not authorized by Title XIX of the Social Security Act. Indeed, we understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

c. The proposed rule does not fully comply with the EPSDT mandate for children.

We are very troubled by the potential impact of the proposed rule on children who are Medicaid beneficiaries. In particular, as drafted, we do not believe that the proposed rule complies with Medicaid's Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions, regardless of whether those services are covered under a state's Medicaid plan. We believe that the proposed rule must be re-drafted to include a restatement of the EPSDT requirement.

3) Implementation of the proposed rule would severely harm several Medicaid populations.

We believe that the proposed rule could severely restrict access to services and cause significant harm to several Medicaid populations:

a. The proposed rule would harm people with mental illness.

People with mental illness are primary recipients of Medicaid rehab option services. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that in 2004, 73% of Medicaid beneficiaries receiving rehab option services had a mental health diagnosis, and they were responsible for 79% of rehab option spending. To the extent that the proposed rule significantly reduces federal spending on rehab option services, this results in a direct cut in services for beneficiaries with mental illness. By limiting access to effective community-based rehabilitative services, the proposed rule would place Medicaid beneficiaries with mental illness at risk for poorer health outcomes and this could lead to relapse or new episodes of illness. Such incidents typically result in increased utilization of high cost services such as emergency room care and inpatient care. The proposed rule does not alter Medicaid eligibility, it would simply restrict access to certain services—often those that are the most effective and the least costly. Therefore, we also worry that this proposal could lead to increased Medicaid spending if individuals are forced to get more costly, but less effective or appropriate services. In particular, we are concerned that the proposed rule could lead to increased hospitalizations that would be otherwise preventable, through the provisioning of community-based rehabilitative services.

It should be noted that given the high proportion of Medicaid beneficiaries receiving rehab option services who have mental illness, all of the harms and concerns raised in these comments should be considered to apply to people with mental illness.

b. The proposed rule would harm people with intellectual and other developmental disabilities

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

Elimination of FFP for habilitation services provided under the rehab and clinic options: In 2006, roughly $808 million was spent on Medicaid clinic and rehab option services for persons with intellectual and other developmental disabilities. In the same year, it has been estimated that approximately 52,000 people with intellectual and other developmental disabilities received day habilitation services through the clinic and rehab options (Unpublished estimates, David Braddock, Coleman Institute for Cognitive Disabilities, University of Colorado). We believe that this proposed restriction contravenes the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239). This section reads:

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with mental retardation and related conditions. In fact, a House of Representatives Committee Report accompanying this legislation stated, "In the view of the Committee, HCFA [Health Care Financing Administration, predecessor to CMS] should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so." (Report of the House Budget Committee, "Explanation of the Commerce and Ways and Means Committees Affecting Medicare-Medicaid Programs," Sept. 20, 1989). It establishes that the Secretary may not deny FFP for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover...on behalf of persons with mental retardation or with related conditions."*

In contradiction to the plain language of Section 6411(g) of OBRA '89, the proposed rule **does not** specify which day habilitation services that a state may cover. Instead, the proposed regulation would prohibit the provisioning of *any* habilitation services under paragraphs (9) and (13) of section 1905(a) of the Social Security Act. We believe that this NPRM exceeds the regulatory authority granted by the Congress and must be withdrawn. At a minimum, since the regulation does not comply with the OBRA '89 language, the Secretary would not have authority to deny FFP for habilitation services provided in those states with approved state plan coverage prior to June 30, 1989.

We also oppose the prohibition of coverage for habilitation services as a component of the clinic and rehab options on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that individuals receive the highest quality habilitative and rehabilitative services according to current standards of

treatment. The preamble of the proposed rule states that the rehab option is not a "custodial" benefit. We agree with the Secretary that state programs operated under the rehab and clinic options should set high standards for delivering active treatment and for innovating to develop programs for people with intellectual and other developmental disabilities that maximize their ability to attain, maintain, and retain their maximum ability to function, consistent with the original conception of rehabilitation, as found in section 1901 of the Social Security Act.

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under 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)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under their state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding options as part of their state plans.

Further, section 1915(c) waivers and the section 1915(i) option are not equivalent to the rehab or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something that is not required for rehab or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed aspects of section 1915(i) in the Deficit Reduction Act that permit enrollment caps and that do not extend an entitlement to services. Also, the Secretary has not issued regulations on this coverage authority, so it is not clear to us that additional constraints on the use of the option will not arise in the future. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehab and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists, something that is not permitted for clinic or rehab option services. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006). Shifting habilitation services to 1915(c) and 1915(i) coverage authorities will make access to habilitation services less secure and reliable.

We strongly recommend that the proposed exclusion of FFP for habilitation services under the clinic and rehab options not be implemented.

Discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with mental retardation and related conditions: We strongly oppose the proposed rule's definition of habilitation services [see section 441.45(b)(2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehab option services for people with mental retardation and related conditions. CMS policy appears to be that these individuals should receive services only through waiver programs (or the related 1915(i) option), and this is nonsensical in circumstances such as where a person with an intellectual disability has a knee replacement and needs services to regain physical functioning of the knee or where a person with epilepsy develops a substance abuse disorder. Further, this policy is likely to increase federal and state costs, as benefits for home- and community-based services (HCBS) waiver programs tend to be far more extensive than is generally provided under the rehab option.

Additionally, this population exclusion exposes a false premise that persons with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehab option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. This policy was not the result of Congressional action and preceded a period of significant progress in advancing the civil rights of people with disabilities. While the Americans with Disabilities Act (ADA) does not apply to federal administration of Medicaid, we believe that this policy violates, at a minimum, the spirit of the ADA, wherein the Congress was intending to impose a comprehensive national prohibition against discrimination on the basis of disability.

We urge the Secretary to rescind this constraint on rehab option services that is so blatantly stigmatizing and discriminatory to people with intellectual and other developmental disabilities.

c. The proposed rule would harm children receiving foster care

According to an Urban Institute analysis, 869,087 children were enrolled in Medicaid on the basis of receiving foster care in 2001, and 509,914 of these children were enrolled for Medicaid for the full year (Geen, Sommers, and Cohen, Urban Institute, August 2005). An analysis of Medicaid spending on these children found that 13.1% of Medicaid spending was for rehabilitative services. Prior research has shown that children receiving foster care have more health problems, especially mental health problems, than the general population or the population of poor children (Geen and others). As many as 80% of young people involved with child welfare have emotional or behavioral disorders, developmental delays, or other issues requiring mental health intervention (Farmer and others, *Social Service Review* 75(2):605-24). A Department of Health and Human Services (HHS) review found that only one state met federal standards for the provisioning of health and mental health services to children involved in the child welfare system (DHHS, 2005, "General Findings from the Federal Child and Family Services Review"). We are deeply concerned that the proposed rule will significantly harm Medicaid beneficiaries receiving foster care in two major ways: It could restrict access to Medicaid rehabilitative

services for children receiving foster care by determining that such services are intrinsic to other foster care programs, and it would eliminate coverage for therapeutic foster care services.

Restriction on access to Medicaid rehabilitative services for children receiving foster care by determining that such services are intrinsic to other foster care programs: Medicaid is the major provider of health and long-term services to children receiving foster care. The other federal programs that fund or support the child welfare system do not have primary responsibility for providing medical assistance services—this is Medicaid's role. Ten percent of federal child welfare spending comes from Medicaid (*Profiles of Medicaid's High Cost Populations*, Kaiser Commission on Medicaid and the Uninsured, December 2006). We are deeply concerned by the proposed intrinsic element test—and the rule's specific invocation of services for children receiving foster care that would be un-coverable by Medicaid as a result of the proposed rule. There seems to be a perception that other funding components of the child welfare system should assume responsibility for medical assistance services currently provided by Medicaid. This is inconsistent with past Congressional action. In particular, the Title IV-E foster care program exists to help states provide safe and stable out-of-home care for children until the children are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements for permanency (HHS Administration for Children and Families). The purpose of the IV-E program does not include medical assistance, and children in the IV-E program are entitled to Medicaid coverage.

As children eligible for Medicaid, these children are entitled to EPSDT services. However, under the proposed rule, FFP 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 of rehabilitative services is clearly in conflict with the EPSDT mandate. 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 "also is meaningless when considering whether a service should be covered for a Medicaid-eligible child. The proposed rule does not define "intrinsic element," and this lack of definition is likely to lead to 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.

The implementation of an intrinsic element test could make children receiving foster care unable to receive medically necessary mental and physical health services even when another component of the child welfare system is not available to shoulder Medicaid's current responsibility for providing medical assistance services.

It would eliminate coverage for therapeutic foster care services: The proposed rule also prohibits the use of federal Medicaid funds for therapeutic foster care, designed for children with serious mental illness. For most children, 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 — is an alternative to more costly care in a residential treatment program or psychiatric hospital (*Mental Health—A Report of the Surgeon General*, 1999).

d. The proposed rule would have an unclear impact on other populations

Due to data limitations, and the lack of a meaningful impact analysis by the Secretary, we are unclear how the proposed rule will impact other populations. Nonetheless, we remain concerned that the proposed rule could have serious negative impacts on other populations of Medicaid beneficiaries.

4) Implementation of the proposed rule would create an unreasonable barrier for states seeking to effectively deliver evidence-based practices and efficiently administer rehabilitation programs under Medicaid.

A major goal of Medicaid mental health treatment programs in recent years has been to re-orient the delivery of services to support recovery. Recovery is defined as a process of restoring or developing a positive and meaningful sense of identity apart from one's condition, and then rebuilding one's life despite, or within the limitations imposed by that condition. In a report issued in 2003, the President's New Freedom Commission on Mental Health recognized the importance of Medicaid services and urged that they be focused on recovery because this could have, "a powerful impact on fostering consumer's independence and their ability to live, work, learn and participate fully in their communities." This challenges many common conceptions of rehabilitation, as it suggests that the goal of treatment is not to cure or eliminate a condition, but it focuses the delivery of services on long-term management of a condition. Unlike individuals recovering from a physical injury in which intensive rehabilitation may be needed for a short, time-limited period, rehabilitative services needed by people with mental illness may be medically necessary over a lifetime.

Psychiatric rehabilitation services are designed to assist the recovery of adults with serious mental illness and children and youth with emotional, behavioral, and mental disorders. Such disorders cause significant deficits in functioning, including deficits in daily living skills, impaired social interactions and behavior, ineffective problem solving, a diminished ability to maintain relationships and a marked impairment in role function, including age-appropriate behavior and functioning in children.

We are deeply concerned that the implementation of the proposed rule would hinder state efforts to operate evidence-based treatment programs.

Starting in the late 1990s, the Robert Wood Johnson Foundation and other public and private funders, including the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Johnson & Johnson, the West Family Foundation, and the John D. and Catherine T. MacArthur Foundation have funded the Dartmouth Psychiatric Research Center to operate an Evidence-Based Practice Project. The project has convened a consensus panel of a broad range of mental health practitioners and other stakeholders to review the evidence for various mental health practices. The panel identified the following practices for which there is a consensus that the practices were evidence-based and represented the best practices for the treatment of schizophrenia and severe mental illness:

- Assertive community treatment (ACT);
- Family psycho education;
- Illness management and recovery;
- Integrated dual disorders treatment;
- Medication management; and,
- Supported employment.

In June 1999, federal officials acknowledged through a State Medicaid Directors letter that Medicaid funds could be used to pay for ACT programs (See June 7, 1999 State Medicaid Director letter from Sally K. Richardson). The letter references an evaluation of the Schizophrenia Patient Outcomes Research Team (PORT) that was funded by the Agency for Health Care Policy and Research and the National Institute for Mental Health that found that,

> "randomized trials have demonstrated consistently the effectiveness of these programs [ACT and a related program, Assertive Case Management or ACM] in reducing inpatient use among such high-risk patients. Several studies also support improvements in clinical and social outcomes. These studies suggest that both ACT and ACM are superior to conventional case management for high-risk cases."

CMS has recognized all of these practices as promising practices and has confirmed (with certain restrictions) that these practices (or aspects of these practices) can be covered under the rehab option (*Medicaid Support of Evidence-Based Practices in Mental Health Programs*, Centers for Medicare and Medicaid Services, October 2005).

The proposed rule appears to continue disturbing CMS administrative practices to restrict flexibility in states use of various payment methodologies to pay for rehabilitative services. Several of our member organizations represent rehabilitative services providers in numerous states that have reported that CMS has tied approval of state plan amendments to the adoption of fee-for-service payment methodologies in which specific services are billed in discrete time increments, such as fifteen minute units of service. States and service providers need greater flexibility to use case rate payment methodologies, to pay daily rates, or use other payment methodologies. Current CMS restrictions are inconsistent with the efficient administration of the Medicaid program because such rigidity will lead to increased administrative costs. Further, numerous services providers report that many of the proven, effective, evidence-based practices cannot be efficiently administered without greater flexibility in using alternative payment methodologies. The Administration position also appears inconsistent with HHS policy to promote capitated managed care, and it does not recognize that per diem and other payment methodologies are used in other parts of the Medicaid program. For example, per diem nursing home payments are a much larger drain on the federal treasury, and we are not aware of any HHS policy to eliminate and transition away from per diem nursing home payments.

We do not ignore the federal responsibility to ensure accountability for significant federal resources that are being used to fund rehabilitative services. This is just one specific instance, however, where the Secretary should engage in a collaborative dialogue with states and rehabilitative services providers to maximize payment flexibility that leads to improved services, yet which also responds to federal obligations to ensure transparency and accountability.

5) Challenges efforts by states and school districts to effectively deliver health care services to children with disabilities in school settings.

The civil rights law, the Individuals with Disabilities Education Act (IDEA), entitles children with disabilities to a free, appropriate public education in conformity with an individualized education program (IEP). An IEP is developed for eligible individuals with disabilities and describes the range of services and supports needed to assist individuals in benefiting from and maximizing their educational

opportunities. The types of services provided under an IEP include services such as speech pathology and audiology services, and physical, psychological and occupational therapies. While IDEA confers rights to individuals and obligations on the part of school systems, it is not directly tied to a specific program or an automatic funding source. For years, the Federal government has failed to provide anywhere near the level of funding promised in the IDEA statute. States' ability to appropriately rely on Medicaid funds for Medicaid services provided to Medicaid-eligible children pursuant to an IEP helps defray some of the state and local costs of implementing IDEA. This, in turn, helps assure that children receive all of the services they have been found to need in order to meet their full potential.

The sources of funding available to fund services under IEPs have been a contentious issue in the past. Some time ago, HCFA attempted to limit the availability of Medicaid funding for services under IEPs. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP. Under current law, the Social Security Act at section 1903 (c) reads,

> "Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act."

Under separate cover, the CCD will comment on the NPRM issued on September 7, 2007 to restrict Medicaid coverage for school-based administration and transportation services. Our concern here is that, while the proposed rule does not explicitly restrict access to rehabilitative services in school settings, new requirements of this rule could be disruptive to schools and could make it more difficult to use the school environment to assure that children with disabilities receive the rehabilitative services that they need. In particular, we are concerned with new provider qualification standards that could restrict the ability of certain providers of services to serve children in schools. While we share the goal of ensuring that all rehabilitative services are of the highest quality and are only provided by providers who meet state credentialing standards, we are concerned that this rule would limit state flexibility to establish provider qualification requirements in school settings. Further, we are concerned that the any willing provider requirement could be disruptive to school efforts to serve children. We believe that the existing free choice of provider which guarantees parents the right to access medically necessary therapy and other services by other providers—outside of the school environment—is an appropriate way to protect parents' right to access the Medicaid qualified provider of their choice. Again, the Secretary has not provided a policy justification for this new requirement, and we believe the net impact will be to make it less desirable for Medicaid programs to use school settings to provide essential rehabilitative services to children. The Congress could not have been clearer in its intent that it wants Medicaid to support the goals of IDEA; we believe that these narrow interpretations of the law are inconsistent with that intent.

For these and other reasons, we urge the Secretary to withdraw the proposed rule.

Thank you for the opportunity to comment on the proposed rule. For further information, please contact Marty Ford, Co-Chair of the CCD Long Terms Services and Supports Task Force (202-783-2229, ford@thepdc.org) or Kathy McGinley, Co-Chair of the CCD Health Task Force (202-408-9514, Kathy.McGinley@ndrn.org).

Sincerely,

1. ACCSES
2. American Academy of Pediatrics
3. American Association of People with Disabilities
4. American Association on Intellectual and Developmental Disabilities
5. American Music Therapy Association
6. American Counseling Association
7. American Network of Community Options and Resources
8. American Occupational Therapy Association
9. American Therapeutic Recreation Association
10. APSE – The Network on Employment
11. Association of University Centers on Disabilities
12. Autism Society of America
13. Autism Speaks
14. Bazelon Center for Mental Health Law
15. Council for Exceptional Children
16. Council for Learning Disabilities
17. Disability Rights Education and Defense Fund
18. Division for Early Children of the Council for Exceptional Children
19. Easter Seals
20. Epilepsy Foundation
21. IDEA Infant Toddler Coordinators Association
22. Inter-National Association of Business, Industry and Rehabilitation
23. Learning Disabilities Association of America
24. Mental Health America
25. National Alliance on Mental Illness
26. National Association for the Advancement of Orthotics and Prosthetics
27. National Association of Councils on Developmental Disabilities
28. National Association of County Behavioral Health and Developmental Disability Directors
29. National Association of Social Workers
30. National Association of State Head Injury Administrators
31. National Association of State Mental Health Program Directors
32. National Council for Community Behavioral Healthcare
33. National Disability Rights Network
34. National Down Syndrome Congress
35. National Down Syndrome Society
36. National Spinal Cord Injury Association
37. NISH

38. Paralyzed Veterans of America
39. TASH
40. The Arc of the United States
41. United Cerebral Palsy
42. United Spinal Association
43. World Institute on Disability

Submitter : **Mr. Jim FitzGerald** **Date: 10/11/2007**

Organization : **Intermountain**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

October 11, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244-1850

Attn: CMS-2261-P
Proposed rule making on the Coverage for Rehabilitative
Services 42 CFR parts 440 and 441
Federal Register (72 FR 45201)

To Whom It May Concern:

Intermountain has been in existence for nearly 100 years, providing services to seriously emotionally disturbed (SED) children and their families. Our main programs include adoption, foster, and family support; therapeutic youth group homes; an outpatient psychiatry clinic for children; a day treatment program for children not able to attend public schools, and an in-school treatment program for a local middle school.

We are very concerned about the proposed rehabilitation rule changes by the Centers for Medicare & Medicaid Services (CMS). One area of concern is it appears that these changes would alter the Community Based Psychiatric Rehabilitation Services (CBPRS) approach to reimbursing treatment costs. We have worked with the Montana Department of Public Health and Human Services and the Children s Mental Health Bureau regarding unbundled services based on the ability of providers to use the CBPRS to reimburse treatment costs. This rule change would pull the rug out from under months of work that has been accomplished by both the State of Montana and the providers of therapeutic services. These parties have worked hard to try to find ways to treat children under the CMS-directed unbundled approach.

There are other concerns with the proposed rule such as the definition of rehabilitative services , requirement of all treatment foster parents to meet definition of qualified providers of rehabilitation services yet no reimbursement for recruitment and training, and the Intrinsic-To test.

We urge CMS not to implement the proposed rules as scheduled in June 2008. If enacted as proposed, we believe that America and our children could very well see the least restrictive, cost effective community based services completely dismantled. In addition, more children will, out of necessity, be served at the highest restrictive and most expensive levels of care.

Thank you for your cooperation and consideration of these critically important issues. If I can be of further assistance please contact me at 406-439-3050 or jfitzgerald@intermountain.org

Sincerely,

Jim FitzGerald
Executive Director

Submitter : **Date: 10/11/2007**

Organization : **Coalition on Children with Special Needs**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-860-Attach-1.DOC

CMS-2261-P-860-Attach-2.DOC

#860

Coalition on Children with Special Needs
C/o The Community Children's Council Office
1177 Alakea St. #B100
Honolulu, HI 96814

RE: Proposed Rule 2261 affecting 42 CFR Parts 440 and 441
As published in the Federal Register, August 13, 2007

On behalf of the Coalition on Children with Special Needs we thank you for the opportunity to make comments regarding the above proposed rule.

We concur with LEAnet, a coalition of Local Education Agencies dedicated to the protection and enhancement of school health programs, that proposed rule 2261 is contrary to current federal Medicaid statutes and without legal basis. Further, this proposed rule would result in the denial of coverage for medically necessary services for children with special needs.

Therefore, the Coalition on Children with Special Needs supports the following recommendations proposed by LEAnet and has attached a copy of their comments for further clarification:

1) Sec. 440.130(d)(5) – Clarify that rehabilitation service should be covered in any setting permitted by state law, including schools.
2) Sec. 441.45(a)(2) - Add language to describe when services may be furnished with the goal of retaining or maintaining functioning.
3) Sec. 441.45(a) – Add a new paragraph requiring states to ensure that children receive all federally covered Medicaid rehabilitation services when medically necessary to correct or lessen the adverse affect of a physical or mental illness or condition.
4) Sec. 441.45(b) – Omit this section on Non covered services in its entirety due to its conflicts with the existing Medicaid statute.
5) Sec. 441.45(b)(1)(i) – If Sec 441.45(b) is not omitted as recommended above, list therapeutic foster care as a covered rehabilitation service.
6) Sec. 441.45(b)(2) – Add language stating that a diagnosis of mental retardation does not automatically exclude a person from coverage of mental health services.

Submitter : Mrs. Shoshanna Bacquie-Walden **Date:** 10/11/2007

Organization : Creative Community Services

Category : Social Worker

Issue Areas/Comments

Background

Background

Please reconsider making drastic changes to rehabilitative services. This will have a direct impact (negatively) to the necessary services for our consumers, clients with developmental disabilities and therautic foster care youngsters. For many of our clients, the rehabilitative services are the only way we can meet their needs that are not provided for through other means.

Submitter : Virginia Trotter Betts **Date:** 10/11/2007

Organization : TN Dept.of Mental Health&DevelopmentalDisabilities

Category : State Government

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We would like to commend CMS for the new emphasis on recovery that the proposed regulations contain. Including recovery goals in the rehabilitation plan and the emphasis on improved functioning and outcomes is very much in keeping with the recommendations of the President s New Freedom Commission on Mental Health. So too is the use of a person-centered planning process, with the individual at the center of that process and the inclusion of the individual/family in the development, review, and modification of goals and services. We are encouraged that the rules permit coverage for contacts with family members for the purpose of providing rehabilitation services to Medicaid-eligible individuals. We suggest that the definition of recovery found in the New Freedom Commission on Mental Health Report to the President, 2003, be included in the regulations: The process in which people are able to live, work, learn, and participate fully in their communities. Recovery is the ability to live a fulfilling life despite a disability.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The new regulations would require that a person-centered rehabilitation plan be written, specifying an individual s rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance-related disorders. We feel that this is positive as it will lead to a focus on recovery goals apart from treatment goals. However, while we are supportive of this in concept, we do recognize that it will require a reorientation of providers who may not be well-versed in writing rehabilitation plans with specific recovery goals. We believe that education at the provider level will be necessary in order to equip staff with the proper tools to incorporate the concept of recovery and set achievable recovery-oriented goals in the context of rehabilitation. There will be added complexity and administrative burden for both the Tennessee Department of Mental Health and Developmental Disabilities and agencies licensed by the department specifically to the extent existing licensing rules and regulations will need to be reviewed and revised to assure consistency with the proposed CMS Rehabilitation Option rules should they be promulgated. In addition, all agencies may experience the compliance challenge of distinct treatment/service plans but small agencies that typically do not have benefit of a more efficient electronic medical record may experience a greater administrative burden.

Submitter : **Date: 10/11/2007**

Organization : **Special Education Advisory Council**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-863-Attach-1.DOC

#863

Coalition on Children with Special Needs
C/o The Community Children's Council Office
1177 Alakea St. #B100
Honolulu, HI 96814

RE: Proposed Rule 2261 affecting 42 CFR Parts 440 and 441
As published in the Federal Register, August 13, 2007

On behalf of the Coalition on Children with Special Needs we thank you for the opportunity to make comments regarding the above proposed rule.

We concur with LEAnet, a coalition of Local Education Agencies dedicated to the protection and enhancement of school health programs, that proposed rule 2261 is contrary to current federal Medicaid statutes and without legal basis. Further, this proposed rule would result in the denial of coverage for medically necessary services for children with special needs.

Therefore, the Coalition on Children with Special Needs supports the following recommendations proposed by LEAnet and has attached a copy of their comments for further clarification:

1) Sec. 440.130(d)(5) – Clarify that rehabilitation service should be covered in any setting permitted by state law, including schools.
2) Sec. 441.45(a)(2) - Add language to describe when services may be furnished with the goal of retaining or maintaining functioning.
3) Sec. 441.45(a) – Add a new paragraph requiring states to ensure that children receive all federally covered Medicaid rehabilitation services when medically necessary to correct or lessen the adverse affect of a physical or mental illness or condition.
4) Sec. 441.45(b) – Omit this section on Non covered services in its entirety due to its conflicts with the existing Medicaid statute.
5) Sec. 441.45(b)(1)(i) – If Sec 441.45(b) is not omitted as recommended above, list therapeutic foster care as a covered rehabilitation service.
6) Sec. 441.45(b)(2) – Add language stating that a diagnosis of mental retardation does not automatically exclude a person from coverage of mental health services.

Submitter : **Mr. James Jones** **Date: 10/11/2007**

Organization : **Indiana Council of Community Mental Health Centers**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

no attachment

Response to Comments

Response to Comments

See Attachment

#864

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 : Ms. Virginie Mitchem **Date:** 10/11/2007

Organization : National Alliance on Mental Illness

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2261-P-865-Attach-1.DOC

CMS-2261-P-865-Attach-2.DOC

#865

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,

Submitter : Ms. Sandy Loerch Morris **Date:** 10/11/2007

Organization : DSHS, DDD, Infant Toddler Early Intervention Prog.

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. The Washington Infant Toddler Early Intervention Porgram has attached document with questions, comments and concerns about these proposed regulations.

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attached.

CMS-2261-P-866-Attach-1.DOC

#866

CENTER FOR MEDICAID AND MEDICARE (CMS) PROPOSED RULE
42 CRF PARTS 440 AND 441: Coverage for Rehabilitative Services
October 11, 2007

SUMMARY	ITEIP QUESTIONS/COMMENTS/IMPACTS
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. 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.** 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. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures.	Possible 2.2 billion dollar federal reduction between 2008 – 2012, 180 million for 2008 This is of high concern. It could heavily impact IDEA, Part C early intervention services which are funded by health, public and private insurance, social and education funding. Federal Part C regulation clearly defines Medicaid as a funding source that must be used before IDEA, Part C funding. The State of Washington only bills Medicaid for services defined as medically necessary and within our State Medicaid Plan The proposed Medicaid rule is not clear. Does this include children who are dually eligible through Medicaid and Part C? Or is this aimed at older children and/or adults? Does it only include rehabilitation service or does it also include habilitation services? How does EPSDT fit into this rule – where treatment needs to be provided to children found with concerns through a well-child exam, even if the service is not in the state plan?
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. 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).**	Mentions using the Medicaid rehabilitation benefit as a "catch all" to cover services included in other Federal, State, and local programs. We are required to use Medicaid as a funding source per IDEA, Part C. These proposed rules do not address conflicting federal rules or acknowledge the need to coordinate rules and funding of therapies. To the extent early intervention services, schools and other programs that serve individuals with mental retardation and related conditions rely on funding via the

	rehab option, these regulations will eliminate or reduce that funding and the availability of those services. • Based on current practice, it is likely the greatest impact will be a reduction in services for children (i.e., birth to 18). • This will result in greater pressure on the DDD waiver program and DDD waivers do not currently assist in the early intervention funding or coverage o Increased number of enrollment requests o Increased provision of occupational therapy, physical therapy, and speech and language services under a waiver for current waiver enrollees.
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.	How will Medicaid school based services program be impacted? • A concern that funding for needed services for children will be significantly reduced. Washington only bills services that meet medical definition. We do not bill for special education as it does not meet the medical definition. 1. This proposed rule would amend the definition of rehabilitative services to provide important protections. 2. The proposed regulations would also impact school-based programs and perhaps foster care.
This proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are, in fact, **rehabilitative outpatient services**, are furnished by qualified providers, are provided to Medicaid eligible individuals according to goal-oriented rehabilitation plan, and **are not for services that are included in programs with a focus other than that of Medicaid.**	Reference to Outpatient services, in conflict with IDEA, Natural Environments Early Intervention Services, including medically defined services, must occur in home or community settings. Medicaid rules and practices must be made consistent with this practice. The apparent automatic exclusion of services for individuals with "mental retardation and other conditions" ignores the fact that individuals with developmental disabilities can achieve functioning in many areas and that such functioning may deteriorate over time for a variety of reasons. In those instances, provision of services under the rehab option would be appropriate. Please consider removing the automatic exclusion of services to individuals with mental retardation and related conditions from the rehab option. Again, this is an area of concern that funding that is currently available for services for children will be significantly reduced.
Definitions. In 440.130(d)(1), we propose to define the terms used in this	For infants and toddlers, services are to enhance development, across health, social

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.**	services, and education. For children, we can't break out what is "medical/rehabilitative" and what is "developmental" and "habilitative." This rule needs clarity and to assure funding is maintained for children's services. Part C enhances child development and doesn't seem to fit into the definition that it be restorative – to bring back to the original state OR remedial – meant to correct – provide a remedy. Need careful wording for children's services.
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."	Where do services that are developmental enhancements fit in?
Written Rehabilitation Plan. We propose to add a new requirement, at § 440.13(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).	Requires a written rehabilitation plan – could the individual family service plan (IFSP) be this plan for the state for Medicaid/Part C eligible children? Need clarification and comprehensive plans for children and their families. Part C states the IFSP must be the global plan for all early intervention services regardless of funding, including Medicaid.
In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the lease 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.	States these are not benefits for custodial care for persons with chronic conditions, but should result in a "change of status". This plays out when kids get early intervention services paid by Medicaid and they reach a "plateau" and don't progress any further, they get "discharged" by therapists, while still are in the Part C system.
Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services.	There is no wording in this rule to "improve" or "enhance." Talks about "restored functional abilities", "recovery oriented goals" "restoration of the individual to the best functional level." Children served in Part C are not being "restored", but "enhanced" by Medicaid funds and other early intervention services.
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.**	

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.**	Need to define "intrinsic elements of programs other than Medicaid and avoid eliminating Medicaid defined services that are also defined as early intervention or Special Education therapies that also meet the medical definitions, such as PT, OT, speech and language pathology services, psychology services, etc.
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. 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.	
In §441.45(b)(2), we **propose to exclude Federal Financial Participation (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.	We would want to have assurances and clarity added that this means habilitation services will continue to be covered. This proposed statement could be taken more than one way and need clarification.
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 1915I, (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 under the 1915(i) State Plan Home and Community Based Services pursuant to the Deficit Reduction Act of 2005.	Align with IDEA, Part C Rules & Regulations. Recommend adding "including Part C services that meet Medicaid Definitions and included in state plans. Where do Part C infants and toddlers fit in here, under habilitation services? How is CMS working within IDEA requirements regarding non-supplanting and maintenance of effort? States may not use IDEA, Part C funds to make up for losses (state and federal) created by Medicaid, with other federal, state or local funding. Thus, these reductions may be so severe that states will no longer be able to participate in the federal early intervention program (IDEA, Part C).
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, 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.	See above comments.
Rehabilitation does not include, and Federal Financial Participation (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. 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: (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.)	See above comments.

This document was submitted electronically to: http://www.cms.hhs.gov/Rulemaking on Thursday, October 11, 2007 by Sandy Loerch Morris, Washington Part C Coordinator/ks

Submitter : Mr. John Dobrosky **Date:** 10/11/2007

Organization : Mr. John Dobrosky

Category : Individual

Issue Areas/Comments

Background

Background

I am opposed to the provisions related to excluding federal financial participation fpr habilitation services/ Please withdraw this proposal. This would devistate families with a member who has a developmental disability and depends upon these services. Ultimately, this will be a more costly proposition in the long run if institutions will nmeed to be the solution--an inhumane solution. Haven't we learned from the past?
John Dobrosky

Submitter : Mr. Roland Lamy **Date:** 10/11/2007

Organization : NH Community Behavioral Health Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-868-Attach-1.DOC

CMS-2261-P-868-Attach-2.PDF

#868

NH Community
Behavioral Health
ASSOCIATION

1 Pillsbury Street, Suite 200 Concord, NH 03301-3570 603-225-6633 FAX 603-225-4739

October 11, 1007

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

Reference: File code CMS-2261-P

To Whom It May Concern:

The New Hampshire Community Behavioral Health Association is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

The NH Community Behavioral Health Association is an organization comprised of the ten community mental health centers throughout New Hampshire. These centers serve individuals in our state who are living with – and recovering from – mental illness and emotional disorders. In fiscal year 2006, this network of mental health centers provided ongoing and emergency behavioral health services to over 41,000 New Hampshire residents, a number that includes over 11,000 children.

The goal of the Association is to raise awareness about the crucial role played by community-based mental health centers to ensure public safety and overall public health for all New Hampshire residents. In addition, the Association serves as an advocate for a strong mental health system across New Hampshire.

While specific programs vary in different communities, the following list encompasses the core services available through the community mental health system in New Hampshire:

Supporting Adults living with severe mental illness. Over forty years of successful community-based support and recovery-oriented, evidence-based treatment protocols has proven that many adults living with severe and persistent mental illness (SPMI) can be best served – and more cost effectively served – through a local community mental health center. The medical, behavioral, and social supports available through community mental health centers provide these individuals

with the tools to manage their symptoms and live successfully in our community. Without this kind of support, the only option for many individuals is incarceration and/or hospitalization, at great fiscal and social cost to the State of New Hampshire.

Helping Children and families recover, heal, and develop new skills for living. The children served through the mental health center system are dealing with a range of mental health issues of significant severity, and their families often experience multiple problems as well. We work with local schools and other agencies to intervene and treat children. Community mental health centers are on the front lines of helping children negotiate the difficulties they face in childhood, which we believe is the best way to ensure a better future for us all.

Assisting Elders and Their Families facing mental health challenges – such as depression and age-related dementias – is critical to their overall healthcare needs. As the "baby boom" generation ages the demand for mental health services for elders will continue to grow. The community mental health centers have received national recognition for pioneering a "wrap-around" service model that brings together and coordinates all of the services available to elders, who often present multiple medical, social, and mental health needs.

Emergency-Response Professionals are available for psychiatric emergencies. Your local police department, fire department, and the medical professionals working in the emergency room at your local hospital depend upon the emergency interventions provided by your community mental health center every day. Available 24 hours a day, seven days a week, emergency psychiatric services are part of the safety-net of essential services that your community depends upon.

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

440.130(D)(1)(VI) DEFINITION OF RESTORATIVE SERVICES

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

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

remain severely ill over long periods of time. (Jablensky et al., 1992: Gerbaldo et al., 1995.) While these individuals can significantly improve, "most do not return to their prior state of mental function." (Mental Health: Report of the Surgeon General, 1999, pg. 274.)

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

Section 1901 of the statute specifically authorizes funds for rehabilitation and other services to help individuals retain the 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 and have a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past. [Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR

438.210(a)(4)(ii)(B)]. An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

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

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

440.130(VIII)(3) WRITTEN REHABILITATION PLAN

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

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

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

We are puzzled by the requirement that the plan include information on alternate providers of the same service. In the state of New Hampshire, there are ten state-designated community mental health centers who provide services to the most severely and persistently mentally ill adults and severely emotionally disturbed children. In almost all communities, the number of providers willing to accept Medicaid reimbursement is small. Beyond the issue of reimbursement, these clients often require a scope of services beyond that which is available in the private practice community. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation.

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

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

Recommendations:

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

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

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

SECTION 441.45: REHABILITATIVE SERVICES

441.45(A)(2)

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

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

Recommendation:

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

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

441.45(B) NON-COVERED SERVICES

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

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

Sincerely,

Roland P. Lamy

Roland P. Lamy
Executive Director

cc: Members of the New Hampshire State Congressional Caucus
The Honorable Judd Gregg
The Honorable John E. Sununu
The Honorable Carol Shea-Porter
The Honorable Paul Hodes
The Honorable John Lynch, Governor of the State of New Hampshire

Submitter : Debra Falvo **Date:** 10/11/2007

Organization : Valley Mental Health

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-869-Attach-1.DOC

CMS-2261-P-869-Attach-2.DOC

#869.

October 11, 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

Valley Mental Health 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.

Valley Mental Health in celebrating its 20th year is the sole source provider of community behavioral health services for the counties of Salt Lake, Summit, and Tooele counties in the state of Utah. We serve approximately 45% of the Medicaid population in the state. Our organization serves 20,000 individuals a year and employees over 1200 employees. We also maintain a wide range of subcontracting agencies to allow clients the ability of choice when possible. The service delivery system is such that our clients treatment needs for all levels of care, from outpatient to hospitalization, help with supported housing, employment, education, access to physical health care is considered in the overall recovery plan.

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.

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

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

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

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

Section 1901 of the statute specifically authorizes funds for Arehabilitation and other services@ to help individuals 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 necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

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

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

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

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

The definition of medical services should explicitly make clear that functional assessment, as

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

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

Recommendation:

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

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

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

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

Recommendation:

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

We do urge some amendments (see below). In addition, there are some issues where the

regulation is unclear and issues are unaddressed. Without attention to our suggestions, this new requirement will add significantly to the administrative time and expense of agencies serving individuals in need of rehabilitative services.

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

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

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

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

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

<u>Recommendations</u>:

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

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

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

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

X that the plan include intermediate rehabilitation goals;

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

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

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

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

440.130(4) Impairments to be addressed

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

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

Recommendation:

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

440.130(5) Settings

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

Recommendation:

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered Aintrinsic elements@ of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a

very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 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.

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

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

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

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

Recommendation:

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

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

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

441.45(b)(2)

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

It should be noted that the exclusion of habilitation services does and should not equal exclusion from FFP for any rehabilitative services provided to persons with mental retardation or related conditions. Related conditions include such illnesses as cerebral palsy, and epilepsy and it is clear that individuals with these illnesses can gain and lose functionality and would benefit from rehabilitative services. Some individuals with serious mental illnesses may also experience periods of extreme cognitive impairment as a result of their illneses.

Recommendation:

Clarification should be provided 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.

441.45(b)(3)

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

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

Recommendations:

Language that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation services should be included in the regulation

at section 441.45(b)(3).

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

Individuals in Secure Custody and Residing in Public Institutions

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

Recommendation:

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

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

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

Recommendation

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

OTHER ISSUES

Payment and Accounting for Services

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

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

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

Section 441.45(b)(4), which refers to services having to be target 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 Amendments by the Agency.

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

Sincerely,

Debra Lynn S. Falvo, MHSA RN C.
CEO/President
Valley Mental Health

CC: Members of the Utah State Congressional Caucus
The Honorable Jon Huntsman, Jr., Governor of the state of Utah

Submitter : Mr. Robert Labbe **Date:** 10/11/2007

Organization : Mr. Robert Labbe

Category : Individual

Issue Areas/Comments

Background

Background

Provisions of the Proposed Rule

Provisions of the Proposed Rule

F.2.Limitations for Rehabilitative Services
I will limit my comments to parts of this section as others will no doubt comment in detail on the remainder of the proposed regulations.

441,(b)(1): CMS needs to clarify what is meant by 'intinsic elements of programs other than Medicaid'. In order to be an 'intrinsic element' is it necessary that the other program have a legally enforceable requirement to provide the service such as would be the case for an insurance policy if such policy included such coverage? If the other program has limited funds such as a block grant, and cannot pay for a program service, would Medicaid be permitted to pay for the service assuming all other Medicaid requirements for coverage and eligibility are met?

441.45(b)(4): '...living in the secure custody of law enforcement and residing in a public institution'. CMS needs to clarify whether both conditions 'living in secure custody' and 'residing in a public institution' need to exist for excluding FFP. For example, if a Medicaid eligible individual is residing in a public institution (not an IMD) but is there voluntarily, is FFP excluded for otherwise covered services such as medical or dental care or rehabilitative services that would meet the conditions as proposed in this rule?

The proposed exclusion of FFP for 'inmates' and the definitions included in 441.45(b)(4) ought to be part of 435.1009 and/or 435.1010, as they appear to apply to all services not merely 'rehabilitative services'.

The statement 'Rehabiltative services could be reimbursed on behalf of Medicaid-eligible individuals paroled,on probation,on home release,in foster care, in a group home...' is confusing. Does the phrase 'that are not part of the public institution system' modify 'Medicaid eligible individuals' or the places they reside (foster care, group home etc...)? The statement suggests that Medicaid eligible individuals on parole or probation may receive services as long as they are not reeeiving them as part of the 'public institution system'. 'Public institution system' is not defined. It suggests something broader than 'institution' and 'public institution' as defined in 435.1010. Does CMS intend to exclude FFP for services provided in 'public institutions' that are not penal facilities. Such non penal facilities may be shelters, child care institutions and other residential settings that may provide services that would seem to be covered by Medicaid if operated by a private provider rather than by a governmental entity. If a unit of government elects to provide such programs and services but is not legally responsible to do so, they should be entitled to reimbursement for Medicaid services as long all other program requirements are met.

CMS proposes to exclude payment for services provided to residents of an IMD including residents of a community residential treatment facility of over 16 beds that is 'primarily' engaged in providing diagnosis, treatment etc.. of persons with mental illness...not meet...440.160. This is current law and regulation and its inclusion in this package suggests that CMS intends to restrict coverage of rehabilitative services in community residential programs that have more than 16 beds. There are child care institutions that are larger and provide a broad array of services including some rehabilitative services for children with mental disorders. They are not however primarily organized to provide such care and treatment. CMS should clarify the criteria to determine when a child care institution as defined in 435.1010 would become an IMD since many children today in such placements have mental, emotional and behavioral issues.

Thank you for the opportunity to comment.

Submitter : Ms. Reina Reyes **Date:** 10/11/2007

Organization : Arrowhead Ranch

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Please see attachement letter dated October 9, 2007

Submitter : **Ms. Margaret Puddington** **Date: 10/11/2007**

Organization : **Ms. Margaret Puddington**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

My 27-year-old son has developmental disabilities and I am distressed at the proposed regulations regarding habilitative services for people like my son. The regulations would cause great harm to people with intellectual disabilities and related conditions by:
(1) denying them essential services that they require in order to improve or maintain their basic life skills and (2) imposing discriminatory and arbitrary criteria to exclude them from receiving these critical services. I urge you to withdraw these proposals.

Submitter : **Ms. Elizabeth W. Pfromm** **Date: 10/11/2007**

Organization : **Los Angeles Child Guidance Clinic**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-873-Attach-1.PDF

#873

Los Angeles Child Guidance Clinic

A nonprofit community-based agency which has served the needs of children and families in Central and South Los Angeles since 1924. For more information, visit our website at www.lacgc.org

UNIVERSITY PARK OFFICE
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Fax (323) 373-2425
STEPPING UP TO SCHOOL READINESS
Fax (323) 373-2402
EARLY INTERVENTION and COMMUNITY WELLNESS
Fax (323) 373-2442
HUMAN RESOURCES
Fax (323) 373-1946
LIFE LEARNING
Fax (323) 373-2446
FIRST STEPS and DAY TREATMENT
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LATENCY / INTENSIVE OUTPATIENT
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MIS DEPARTMENT
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OUTPATIENT
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♥♥♥♥♥♥♥♥

Elizabeth W. Pfromm, M.S., MPA
Executive Director

♥♥♥♥♥♥♥♥

A Charter Agency of the United Way of Greater Los Angeles

A Short Doyle Contractor of the County of Los Angeles

Affiliate of USC Keck School of Medicine, Division of Child and Adolescent Psychiatry

Accredited by The Rehabilitation Accreditation Commission for Job Development and Placement Services

October 11, 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 Los Angeles Child Guidance Clinic is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

The Los Angeles Child Guidance Clinic has provided mental health and allied services to those in the Central and South Los Angeles communities since 1924. Included are a full continuum of outpatient services, on-site services at 16 Los Angeles Unified School District schools and 11 Head Starts, and in-home services for difficult-to-reach consumers. The Clinic's model early intervention services for children, ages 0-5, and their families have been recognized nationally. In 2006 the Clinic's First Steps Home Visitation Program was honored by the American Psychiatric Association with its Award for Advancing Minority Mental Health.

We have significant concerns with the proposed Rule, as it will create barriers to providing mental health care to the children and young adults that our agency serves. Overall, the proposed changes will result in a lack of clarity as to what is a covered service versus non-covered service. Also, to comply with the changed Rule agencies like the Clinic will need to add administrative costs to their operating structures, largely to set up mechanisms to research and determine what is an intrinsic element of another program so that this aspect is not claimed as a Medicaid service. Because of the increased risks faced by mental health providers and the related need to adopt a conservative billing stance, anticipated should be massive appeals by beneficiaries who believe they are denied needed mental health services.

<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.

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 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.

440.130(viii)(3) Written Rehabilitation Plan

How does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter?

Is it allowable for a service planning team to create a single plan of services that address both treatment issues and rehabilitation issues? Typically 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 in 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.

441.45(b) Non-covered services

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

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

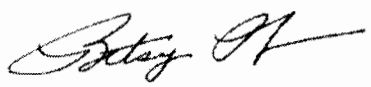
We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and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

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

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).

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

Sincerely,



Elizabeth E. Pfromm, M.S., MPA
Executive Director

CC: Governor Arnold Schwarzenegger sent via mail and fax 916-445-4633
Senator Barbara Boxer sent via e-mail senator@boxer.senate.gov
Senator Dianne Feinstein sent via e-mail senator@feinstein.senate.gov
Congresswoman Diane Watson sent via e-mail diane_watson@watson.senate.gov
Congresswoman Maxine Waters sent via e-mail maxine_waters@waters.senate.gov

Submitter : Ms. Janet Varon **Date:** 10/11/2007

Organization : Northwest Health Law Advocates

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#874

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 : **Ms. John Chappuis** **Date: 10/11/2007**

Organization : **Montana DPHHS**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-875-Attach-1.PDF

#875

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO Box 4210
HELENA, MT 59604-4210

October 11, 2007

To Whom It May Concern:

The Montana Department of Public Health and Human Services is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

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

42 CFR Parts 440 and 441 (File Code CMS-2261-P)
RIN 0938-A081
Medicaid Program; Coverage for Rehabilitative Services

PROVISIONS OF THE PROPOSED REGULATIONS
C. Written Rehabilitation Plan - 45204 Top of Second Column
"Ensure 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;"

What is the definition of "active participation"? Is the requirement for active participation met if the individual signs the written rehabilitation plan or is other documentation required?

Are providers required to have all persons of the individual's choosing actively participate in the development, review and modification of the written rehabilitation plan or can providers limit it to a reasonable number?

PROVISIONS OF THE PROPOSED REGULATIONS
E. Settings – 45205 First Column
"Other settings may include the office of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings."

What is the definition of an appropriate community setting? Does the state determine the definition of appropriate community settings?

Eliminating the current provision allowing rehabilitation services to be provided in any setting will ruin the flexibility to go where the client is, a critical component of rehabilitation services.

PROVISIONS OF THE PROPOSED REGULATIONS
F. Requirements and Limitations for Rehabilitation Services.1. Requirements for Rehabilitative Services – 45205 Bottom of first column
"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."

Only after services have been provided will it be possible to establish whether or not the services have achieved the maximum reduction of physical or mental disability. Under this proposed rule, providers would be forced to provide services to clients knowing that if their outcomes after several months were not beneficial they may be required to return payment for services. Also, since a client's progress is not a static line, a client usually makes progress, then regresses slightly and then makes progress again. The timing of the determination of maximum reduction of the disability would be key. Would the state need to wait until discharge of the client before determining if the maximum reduction of disability was achieved?

PROVISIONS OF THE PROPOSED REGULATIONS
F. Requirements and Limitations for Rehabilitation Services 2. Limitations for Rehabilitative Services – 45205 Third column
"For instance, therapeutic foster care is a model of care, not a medically necessary service defined under Title XIX of the Act. State have used it as an umbrella to package an array of services, some of which may be medically necessary services, some 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."

If states have packaged (bundled) medically necessary services together as part of a daily service (not a model of care), does this rule require the unpacking or unbundling of the medically necessary services?

PROVISIONS OF THE PROPOSED REGULATIONS
F. Requirements and Limitations for Rehabilitation Services 2. Limitations for Rehabilitative Services - Page 45206, column 1.
"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."

This definition of habilitation versus rehabilitation services will hurt those consumers that have both developmental disabilities and mental health issues. Often mental health providers offer both habilitation and rehabilitation services to these dual diagnosed individuals under one integrated treatment plan. The divided funding streams will make this more difficult for providers to do and the DD/MH population will suffer from inconsistent treatment among multiple providers. Another challenging population that will be hurt by this division of services will be individuals with mental health issues and FASD.

PROVISIONS OF THE PROPOSED REGULATIONS
F. Requirements and Limitations for Rehabilitation Services 2. Limitations for Rehabilitative Services - Page 45206 Second Column.

"Likewise, for 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 ..."

Since it must be in the individual's plan, it would also need to be documented in the individual's assessment. However, a key component of person centered planning is that the whole team (the individual, the parents, teachers, other persons included by the individual being served, teachers, case managers, clinicians and direct care workers) are required to develop the individual's plan. Would decisions regarding recreation versus rehabilitation be made by the individual's person centered treatment team or would the supervising mental health professional make those decisions? What is the authority of the person centered treatment team?

PROVISIONS OF THE PROPOSED REGULATIONS
F. Requirements and Limitations for Rehabilitation Services 2. Limitations for Rehabilitative Services – 45206 Bottom of third column
"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."

Many states have day treatment services that are provided in an academic setting and billed as rehabilitation services. Does this rule end day treatment rehabilitation services since they are provided in an academic setting?

Thank for your consideration of these comments. Please feel free to contact me if you have any further questions.

Sincerely,

John Chappuis
Montana Department of
Public Health and Human Services
Deputy Director
jchappuis@mt.gov

Submitter : **Ms. Reina Reyes** **Date: 10/11/2007**

Organization : **Arrowhead Ranch**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter dated October 9, 2007

CMS-2261-P-876-Attach-1.DOC

#876

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:

Reference: File code CMS-2261-P

Arrowhead Ranch 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.

General Comments about the impact on children and families

The proposed amendments by CMS to the Medicaid Program coverage for rehabilitative services are of concern to Arrowhead Ranch. We encourage and support CMS's efforts to ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services 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 are however concerned that these amendments will result in cutting vital funds to states at the expense of our nations poor children and families. We ask that states not be penalized for stepping up to meet this populations needs. According to the Medicaid regulations which identify **mandatory eligibility groups**, states have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, states are required to provide Medicaid coverage for most people who get federally assisted income maintenance payments, as well as for related groups not getting cash payments. Some examples of the mandatory Medicaid eligibility groups include the following:

- Limited income families with children, as described in Section 1931 of the Social Security Act, who meet certain criteria of the eligibility requirements in the state's Aid to Families with Dependent Children (AFDC) in effect on July 16, 1996;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act."

Arrowhead Ranch welcomes rule clarifications and CMS's efforts to protect the fiscal integrity of the Medicaid program, however many of these rule changes could eliminate rehabilitative services offered in child care institutions that served

children identified in the mandatory eligibility groups. We strongly recommend that CMS work with child welfare providers, the states, and other federal agencies to create a system of fiscal accountability, which supports best practice for children with mental health needs and allows for the provision of the most appropriate Medicaid rehabilitative services in the least restrictive setting.

Arrowhead Ranch has conferred with similar agencies through membership with the Child Care Association of Illinois and we ask that CMS take into consideration the importance of rehabilitative services for children in Foster Care and Child Care Institutions.

It is important to note that children that enter the foster care system or are placed in child care institutions under the federal requirements applicable to Title IV-E are at an extremely high risk for both physical and mental health issues as a result of biological factors and the maltreatment they were exposed to at home. 80% of children in out of home care meet the clinical criteria for behavioral problems or psychiatric diagnosis.

When children are removed from their home and placed in state custody, child welfare agencies funded through Title IV-E are responsible for meeting their health and mental health needs, and virtually all children in foster care and child care institutions are eligible for and obtain health care services through Medicaid.

Funding for applicable rehabilitative services have increasingly been accessed by states in response to the recommendations from the President's New Freedom Commission on Mental Health, issued in 2003, to improve the nation's mental health system. Additionally the Children's Federal Services Review (CFSR) has identified mental health services as the major area of deficiency that is not being met within the child welfare system funded through Title IV-E.

I. BACKGROUND

A. Overview

In Section 440.130(d) the definition of rehabilitative services is addressed. The proposed regulation would amend language to "... provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are in fact rehabilitative out-patient services..."

Concern: Arrowhead Ranch finds the reference to rehabilitative out-patient services contradictory to later language that states services can be provided in foster care, in a group home or other community placement. Section 441.45 (b)(4) states that "Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individual 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."

Recommendation: The definition for Title IV-E specifically provides for payment for a child placed in a foster family home or child care institution and that these children are Medicaid eligible and therefore eligible for Medicaid defined services. We would recommend the reference to out-patient services be eliminated because rehabilitative services provided to children in foster homes and child care institutions are not outpatient. Language clarification regarding the beneficiary, providers and goals of rehabilitative services can be made without eliminating providers and settings that are clearly Medicaid eligible.

II. PROVISIONS OF THE PROPOSED RULE

C. Written Rehabilitation Plan

In Section 440.130(d)(3), a requirement that covered rehabilitative services for each individual must be identified in a written rehabilitation plan is added.

Concerns: Arrowhead Ranch and other Child Care Institutions in Illinois are concerned about the extent of the requirements that must be included in the written rehabilitation plan. The administrative burden placed on our agency in order to address the overall extent of all requirements in the proposed section would be difficult to address with current funding. In addition the plan requirement to indicate the anticipated providers of the services and the extent to which the services may be available from alternate providers of the same service would be administratively burdensome.

Recommendation: We suggest that instead of the requirement that the plan list the potential providers of the same service requirement, that the plan include an assurance that the individual received this information to the extent the service planning team is aware of all existing providers.

F. Requirements and Limitations for Rehabilitative Services

1. Requirements for Rehabilitative Services – Habilitation vs. Rehabilitation

Section 441.45(a) (2) states 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.

Section 441.45(b) (2) speaks to a distinction between the terms "habilitation" and "rehabilitation". Rehabilitation refers to measures used to restore individuals to their best functional levels. It states that individuals receiving rehabilitation

services must have had the capability to perform an activity in the past rather than to actually have performed the activity.

Concern: The language and definition of rehabilitative services seems geared toward adults rather than children and adolescents. Child Welfare Agencies and Child Care Institutions strive to move children to expected levels of development in physical and mental health. We do not focus solely on restoring a child to a previous level of functioning as is the case with adults.

Recommendation: Language should be included that references rehabilitative services are also used to achieve an "expected level" of development for children. In cases where a child is placed in a Child Care Institution due to a mental health diagnosis which impacts their ability to function in the home, school and/or community, discharge to a less restrictive environment and transition back to the home, community and school of origin should be recognized as a rehabilitative service and Medicaid funded.

2. Limitations for Rehabilitative Services – Intrinsic Elements

Under this section it explicitly states that rehabilitation does not include services "furnished through a non medical program as either a benefit or administrative activity including services that are intrinsic to elements of programs other than Medicaid, such as foster care, child welfare, education, child care ..... juvenile justice. (Proposed Section 441.45 (b) (1) through (b) (8).

Concern: The term "intrinsic to" is not defined, however the proposed rule seems to support the assumption that rehabilitation services are "intrinsic elements" within a series of other federally funded programs, and that states are duplicating their funding streams in seeking support from Medicaid for these services.

Recommendation: The Code of Federal Regulations at 1356.60 Fiscal Requirements (Title IV-E) specifically prohibit States from claiming Title IV-E federal financial participation (FFP) for medical or rehabilitative services as "Allowable administrative costs do not include the costs of social services provided to the child, the child's family or foster family which provide counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions." Mental health services are a critical portion of the services that are made available to children in foster care and child care institutions however they are not covered under Title IV-E. These services should be covered by Medicaid if they meet the Medicaid regulations.

Concern: The proposed "intrinsic to" language is undefined by CMS. While it is helpful to clarify what is covered by Medicaid and what is covered by other federal programs, the proposed regulation and its "intrinsic to" test does not

properly consider the child welfare system funded under Title IV-E and the application of Medicaid programs to children's services. Arrowhead Ranch and similar Child Welfare Agencies/ Child Care Institutions are required to ensure that the children in their care get the services they need, including medical and mental health. We ask if Medicaid is not there to assist, what will be done to infuse greater dollars into the Mental Health system so that the services that are needed are being provided and available?

Recommendation: We would propose the removal of the reference "intrinsic to" in the rule and use the basic definitions from the other federal programs as the guideline for determining the coverage of services. In the definition for Title IV-E it specifically provides for payment for a child placed in a foster family home or child care institution and that these children are Medicaid eligible and therefore eligible for Medicaid defined services. As stated by the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20, Title IV-E covers the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child and reasonable travel for a child's visitation with family or other caretakers. For child care institutions it must also "include the reasonable costs of administration and operation of such institutions as are necessarily required to provide the items described in the preceding sentence".

Concern: Congress has not adopted an "intrinsic to" test in regards to Medicaid rehabilitative services even after a debating and finalizing the Deficit Reduction Act.

Recommendation: We would recommend the removal of "intrinsic to" referenced in the rule because the authority to make this application to Medicaid rehabilitation services should be done through change in the law and not through this regulation.

2. Limitations of Rehabilitative Services – Provider Choice

Section 441.45 (b) (1) emphasizes language that requires that "the individual must have free choice of providers".

Concern: The clients in the child welfare system are children and adolescents who are wards of the state and do not choose these services amongst a list of available providers.

Recommendation: We would propose the regulation recognize that some of the "individuals" the regulation is referring to are minors and wards of the state. The regulation should include language that allows minors parent/legal guardian to "choose from a list of available providers".

2. Limitations of Rehabilitative Services – exclusion of services provided to residents of an Institution for Mental Disease (IMD)

In section 441.45 (b) (4) it is proposed 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 to person with mental illness, that does not meet the requirements at Section 440.160.

Concern: As a Child Care Institution licensed by the Department of Children and Family Services in the State of Illinois, Arrowhead Ranch operates a residential program. We are concerned that language in the regulation referencing "community residential treatment facilities of over 16 beds" intended to give guideline to IMD's can easily be applied to agencies such as Arrowhead Ranch. Although an interchange of wording may often occur where Arrowhead Ranch is discussed as a residential treatment facility, we are not licensed as a residential treatment facility within the child welfare system. We are licensed as a Child Care Institutions per the language of the IV-E federally funded program and not as a psychiatric under 21 residential treatment facility. Title IV-E pays for room and board costs for the placement of children in foster family homes or child care institutions.

Recommendation: We would suggest clarity in the definition of "community residential treatment" and assurance that any child welfare program licensed as a child care institution should not be included in the language of a community residential treatment facility referenced in section 441.45 (b) (4). The reference to an IMD should not apply to child care institutions as defined by state licensing rule because according to the definitions for Title IV-E under the Social Security Act (45 CFR Chapter 13 Part 1356) for foster care and child care institutions, these settings would be allowable for Medicaid services if the state licensing provisions (Title 89: Social Services, Chapter III, Dept. of Children and Family Services, Subchapter e: Requirements for Licensure, Part 404) are so established within a state and the services provided meet the definitions for Medicaid rehabilitative services. The inherent intent of the child care institution is to improve the level of functioning of the child so that they would be moved to a less restrictive setting so this would meet the definitions for rehabilitative services.

E. Settings

Also under section 440.130(d) (5), it is proposed that rehabilitative services may be provided in a facility, home or other setting.

Concern: Child Care Institutions are not listed in acceptable settings however there is language that indicates rehabilitative services benefit is not an inpatient benefit. As a setting in which the children live at the facility our concern is that Arrowhead Ranch and other similar Child Care Institutions could be classified with a psychiatric facility.

Recommendation: Child care institutions should be included as an example of one of these settings. Inpatient is associated with a psychiatric facility and child care institutions do not meet that definition according to licensing regulations of the state (Title 89: Social Services, Chapter III, Dept. of Children and Family Services, Subchapter e: Requirements for Licensure, Part 404).

It is agreed that rehabilitative services do not include room and board in an institutional setting as that is paid through other federal funding in the child welfare system such as Title IV-E. Rehabilitative services provided within the child care institution setting should be eligible for Medicaid if they meet the definition and are not funded by Title IV-E.

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

Sincerely,

Reina Reyes
Quality Assurance Coordinator
Arrowhead Ranch
12200 104th Street Coal Valley, IL 61240
(309)799-7044 ext. 272
rreyes@arrowheadranchinc.com

Submitter : Ms. Nell Hahn **Date:** 10/11/2007

Organization : The Advocacy Center

Category : Attorney/Law Firm

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 : Mr. Brent Ewig **Date:** 10/11/2007

Organization : Association of Maternal and Child Health Programs

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#878

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 : Mr. Frank Mecca **Date:** 10/11/2007

Organization : County Welfare Directors Association of California

Category : Local Government

Issue Areas/Comments

Background

Background

Please see attachment.

CMS-2261-P-879-Attach-1.PDF

#879.

CWDA

COUNTY WELFARE DIRECTORS ASSOCIATION OF CALIFORNIA
925 L Street, Suite 350, Sacramento, CA 95814
Frank J. Mecca, Executive Director

WASHINGTON, D.C. OFFICE
Tom Joseph, Director
Waterman & Associates
900 Second Street, NE
Washington, D.C. 20002
202.898.1444

October 12, 2007

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

Re: CMS 2261-P: Comments on Proposed Rule Medicaid Program; Coverage for Rehabilitative Services, 72 *FR* 45201

Dear Mr. Weems

The County Welfare Directors Association of California (CWDA) is submitting these comments in response to the August 13, 2007 *Federal Register* proposed rule for Coverage of Rehabilitative Services (72 FR 45201). CWDA represents the human services directors in each of California's 58 counties. Our mission is to promote a human services system that encourages self-sufficiency of families and communities, and protects vulnerable children and adults from abuse and neglect.

The proposed rule raises a number of concerns for us, especially given that Congress rejected the Administration's efforts to include a legislative package of these proposals during the creation of the Deficit Reduction Act of 2005. In fact, Section 1901 of the Medicaid statute specifically authorizes funds for "rehabilitation and other services" to help individuals retain their 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.

Our members are responsible for ensuring that the physical, mental and safety needs of children in the child welfare system are met. Medicaid serves as a foundation for meeting those needs. The Child Welfare League of America notes that children in the foster care system are at an extremely high risk for both physical and mental health problems as a result of biological factors and/or maltreatment in the home. Up to 80 percent of children in out-of-home care meet clinical criteria for behavioral problems.

The rehabilitative services provisions under Medicaid help our agencies design effective systems of care that meet the needs of the children we serve and helps children live in the least restrictive setting possible. For these reasons, the ability for states to provide these needed services must be preserved.

Below are CWDA's key concerns. In addition to these two primary issues, we also share concerns raised in the comments submitted jointly by the American Public Human Services Association the National Association of State Medicaid Directors and the National Association of State Child Welfare Directors, as well as the numerous technical issues raised by the California Alliance for Child and Family Services.

Section 441.45(b) Non-covered services ("Intrinsic Elements" Test): CWDA urges that this section be removed from the proposed rule in its entirety. As we understand the proposal, if any other program provides a similar service, that program must be used rather than Medicaid's rehabilitative services provision. While the "intrinsic to" test is not defined, the proposed rule includes, but does not limit these other programs to: foster care, child welfare, child care, public guardianship and any other federal-, state- or locally-funded program.

Such a sweeping proposal will likely deny Medicaid coverage for any and all rehabilitative services provided to individuals who are Medicaid-eligible and is inconsistent with how services are provided and paid for. Counties often combine and consolidate a number of funding streams and programs to serve vulnerable individuals. Funding for many of these programs is provided through capped grants; often, these programs are not statutorily limited to serving only Medicaid-eligible individuals. Determining how and when one program should be financially responsible before another one should be tapped, especially when one or more of the programs are not limited to Medicaid-eligible individuals, is fraught with administrative complexity and leaves the individual at significant risk of not receiving any rehabilitative service whatsoever.

Finally, it is illogical – as well as inconsistent with federal Medicaid statute – to deny counties and states federal Medicaid reimbursement for services that Medicaid-covered individuals are entitled to receive. This 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.

For all of these reasons, we urge that this section be eliminated from the rule.

441.45(b)(1)(i) Therapeutic Foster Care: The proposed rule threatens counties' ability to place abused and neglected children in the least restrictive setting and should be deleted. It is both a requirement and good practice to avoid institutional care for children with serious emotional disturbances to the greatest extent possible. Consistent with this principle, counties use therapeutic foster care to enable children to live in the least restrictive environment possible. Not only is therapeutic foster care much less expensive than institutionalized care, it also has demonstrated successful outcomes for children. Therapeutic foster care is an evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see, for example, the Report on Mental Health from the U.S. Surgeon General).

The proposal to require counties and states to define, document, and claim Medicaid reimbursement for each and every service provided to an individual in such care will severely restrict the use of this option as a means to maintain the safety, permanence

and well-being of those children. The alternative will be placement in congregate care or an institution, such as a residential treatment center or psychiatric hospital, at significantly higher expense. This alternative will cost the federal government more in the long run and result in worse outcomes for children.

For these reasons, we urge that this proposal be deleted from the rule.

Thank you for the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to contact Tom Joseph, Director of the CWDA Washington Office, at (202) 898-1444 or tj@wafed.com.

Sincerely,

Frank J. Mecca
Executive Director

Submitter : **Date: 10/11/2007**

Organization :

Category : **Psychiatric Hospital**

Issue Areas/Comments

Response to Comments

Response to Comments

why

Submitter : Patricia Ryan **Date:** 10/11/2007

Organization : California Mental Health Directors Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-881-Attach-1.DOC

881

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: Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid Program
CMS-2261-P

To Whom It May Concern:

The California Mental Health Directors Association (CMHDA) is pleased to offer our comments on the proposed regulations for the Medicaid Rehabilitation Services Option.

CMHDA is a statewide association that represents the directors of public mental health authorities in counties (and some cities) throughout California, providing mental health services to children, transition-aged youth, adults, and older adults with mental illness. CMHDA's mission is to provide leadership, advocacy, expertise and support to California's county and city mental health programs (and their system partners) that will assist them in serving persons with serious mental illness and serious emotional disturbance. Our goal is to assist in building a public mental health system that ensures the accessibility of quality, cost-effective mental health care that is consumer-and family-driven, recovery- and resiliency-based, and culturally competent.

In California, county mental health agencies are officially designated as the "mental health plans" for Medi-Cal's "specialty mental health" program, which means they are responsible for providing and managing the care for Medi-Cal beneficiaries who have a serious mental illness or serious emotional disturbance

We enthusiastically support the inclusion of recovery-oriented goals as a requirement of rehabilitation option services. In our experience, recovery refers to both a process that individuals go through as they rebuild their lives, and to the mental health treatment movement focused on promoting an individual's recovery. It includes an underlying belief that every individual can recover substantially, if not totally, and deserves access to services that support their recovery. Therefore, the goal is not just treatment of the symptoms of mental illness, but improving the lives of persons living with mental illness.

We particularly appreciate recognition of the importance of psychosocial rehabilitation (PSR) services. The last thirty years have seen the emergence of the philosophy and principles of PSR and its importance to inform systems and services. The presence (or absence) of psychosocial rehabilitation services directly impacts the achievement of recovery-oriented outcomes.

Below are our specific comments to the proposed regulations:

A. Definitions. Restorative Services: 440.130 (d) (1) (vi)

This section 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 definition also includes as appropriate rehabilitative services designed to maintain current level of functioning, but only when necessary to help an individual achieve a rehabilitation goal. While we do not believe that rehabilitative services should be custodial, for people with serious mental disabilities continuation of rehabilitative services is, at times, essential to retaining their functioning level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services.

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.

CMHDA Recommendation: Further clarify that a child or adult need not demonstrate that he or she was once capable of performing a specific task in the past if it was not possible (due to disability) or age-appropriate for the child to have done so.

Also, 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 an individual who can be expected to otherwise deteriorate.

C. Written Rehabilitation Plan: 440.130 (d) (3)

We support the new requirement that covered rehabilitative services for each individual be identified in a written rehabilitation plan with recovery goals. We also support the purposes outlined for this plan, including the service coordination and coverage, and service transparency for beneficiaries and their identified supports.

CMHDA Recommendation: Provide states with additional guidance and clarification related to the important acknowledgement that "...rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning" by changing the following language:

"In these instances, services that provide assistance in maintaining functioning ~~may be~~ **are** considered rehabilitative only when necessary to help an individual achieve a rehabilitative goal as defined in the rehabilitation plan."

D. Impairments to be Addressed:

A general comment related to this section is that the emphasis on impairment is inconsistent with the basic tenets of the previous section's emphasis on recovery goals.

CMHDA Recommendation: Add additional language to this section that acknowledges the President's New Freedom Commission on Mental Health's promotion of a recovery focus in the treatment of mental illness.

F(1). Requirements and Limitations for Rehabilitative Services: 441.45(a) (2), (a) (3) and (a) (4).

The requirements for documentation outlined in these requirements should acknowledge that services that provide assistance in maintaining functioning are considered rehabilitative when necessary to the achievement of a rehabilitative goal.

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 the best possible functional level, as defined in law. However, it would be helpful to reiterate here when services may be furnished to retain or maintain functioning.

It would also be useful 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.

***CMHDA Recommendation*:** Add language in 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 preamble) to state that it is helpful to scrutinize the purpose of the service as defined in the rehab plan in order to determine whether a specific service is a covered rehabilitative benefit.

In 441.45 (a) (3) and (a) (4) add the following language:

"We also propose to require that the provider document the following for all individuals receiving rehabilitative services:

The progress made toward functional improvement **or maintenance of functioning consistent with the** attainment of the individual's rehabilitation goals."

F(2). Limitations for Rehabilitation Services: "Intrinsic Elements": 441.45 (b).

This section introduces a whole new concept into Medicaid. 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. The regulation needs to clarify how this provision would be applied and how to determine whether a program is an "intrinsic element" of another program.

***CMHDA Recommendation*:** The section should be clarified and narrowed 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 individuals. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded. We suggest the following definition: "*Intrinsic services are those that are the major focus of another agency based on their statutory requirements. This definition is NOT meant to preclude funding of services under the rehabilitation option which may mirror those by another agency (e.g., housing, employment) and are provided pursuant to an approved rehabilitation plan as defined in these regulations.*"

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, please contact me at (916) 556-3477, ext. 108.

Sincerely,

Patricia Ryan
Executive Director

Cc: Members, California Congressional Delegation
The Honorable Arnold Schwarzenegger
Stephen W. Mayberg, Ph.D, Director, California Department of Mental Health
Kelly Brooks, CSAC
Ellen Whitman, NACBHDD

Submitter : Ms. Edna Kleiman **Date:** 10/11/2007

Organization : Queens Chapter, Autism Society of America

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

We are the parents of a 43-year old with autism. The proposed regulations cutting essential services to people with developmental disabilities are arbitrary and discriminatory and we urge you to withdraw them. You must know that these services are critical to helping the developmentally disabled improve or maintain basic life skills, so to propose cutting them is cruel. The developmentally disabled have gone through their lives under a sad disadvantage and the regulations you propose are a further blow to them and to the families who love them.

Submitter : Mr. Jeffrey Booker **Date:** 10/11/2007

Organization : Mr. Jeffrey Booker

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2261-P-883-Attach-1.DOC

programs are designed, people whose lives are made better every day through the various programs that they attend, and most of whom will have no voice in whether or not this bill passes A loss in services and staff at the Day Habilitation programs would almost certainly lead to a decline in quality, negatively affecting the lives of the almost 7,000 disabled people who currently attend the programs. We must ask ourselves if saving what is likely a small amount of money is worth preventing these people from gaining the skills that they need to integrate themselves into their communities and generally improve their lives.

Sincerely,
Jeffrey Booker

Submitter : Mrs. Patricia Herrmann **Date:** 10/11/2007

Organization : Familycapped, INC

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a parent of a person with developmental disabilities, I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential serviees.

Submitter : Mrs. Margaret Velard **Date:** 10/11/2007

Organization : Mrs. Margaret Velard

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a parent of a person with developmental disabilities, I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential services.

Submitter : Mary Adams **Date:** 10/11/2007

Organization : Mary Adams

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am concerned that services such as speech,and physical therapy will be non available to these day hab clients without which they will not be able to function to their abilities.
nurses on board are so important to keeping our sons and daughters
well and enjoying life as much as possible.
please vote no on the movement of day habilitations services
from under the medicaid state plan!!!

Submitter : **Date: 10/11/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a family member of a person with developmental disabilities, I urge you to withdraw the proposed regulations regarding habilitative services for people with developmental disabilities. The regulations would eliminate critical services that enable people with intellectual disabilities and related conditions to improve or maintain basic life skills. The regulations impose discriminatory and arbitrary criteria to exclude people with developmental disabilities from receiving these essential services.

Submitter : **Ms. Karen Sprague** **Date: 10/11/2007**

Organization : **Pacific Clinics**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

Submitter : susan cheever **Date:** 10/11/2007

Organization : susan cheever

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It is so important that these people recieve the most comprehensive care, support, motivation and medical attention! The therapists, nurses and caregivers are key to the quality of life. Please don't jepordize the almost 7000 individuals who now recieve services.

Submitter : Ms. Victoria Boehm **Date:** 10/11/2007

Organization : John Muir Behavioral Health Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

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 with the experience of 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 are very troubled by the estimate in the proposed regulation that these rules would save the federal government 2.2 billion dollars.

Me and many of my collegue's 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.

Section 440.130(d)(1)(v) and 440.130(d)(3) Rehabilitation Plan:
Recommendation: Clarify the provisions in the regulation to allow payment for outreach and emergency services.

Section 440.130(d)(1) Rehabilitation and Restorative Services:
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:
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:
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:
Recommendation: The proposed rules should not exclude people with mental retardation and related conditions and habilitation services.

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 illillnesses. 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.

Submitter : **Tara Cheever** **Date: 10/11/2007**

Organization : **Tara Cheever**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

These services are vital, as many of the people in day programs are totally dependent. The existing State Medicaid Program works please don't change it!~

Submitter : Dr. Marvin Southard **Date:** 10/11/2007

Organization : Los Angeles County Department of Mental Health

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#892

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 : Ms. Marilyn Kresky-Wolff **Date:** 10/11/2007

Organization : Ms. Marilyn Kresky-Wolff

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am against the Medicaid changes to rehabilitation services. They will have a very negative impact on people with mental illness. Thank you.

Submitter : **Ms. Diane Supak** **Date: 10/11/2007**

Organization : **Texas Children's Hospital**

Category : **Occupational Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-894-Attach-1.DOC

To whom it may concern,

While it may seem to make economic sense to adopt Docket: CMS-2261-P - Rehabilitation Services: State Plan Option, there are numerous negative consequences that will likely arise as a result of the change, all of which may add up to actually make day habilitation programs both worse off and more expensive to run.

An adoption of the State Plan Option would result in many likely changes to Day Habilitation programs designed to increase efficiency, including the loss of nurses and other personnel, the inability to accept all who wish to join the various programs, and changes in the rate that patients must pay to attend Day Habilitation. A loss of nurses and other personnel at the Day Habilitation programs, while saving money, would likely result in a lower quality of services for clients attending the programs. Experienced nurses can be instrumental, both in helping clients with injuries and illnesses that occur at the program, and at discovering problems that may require medical attention. The loss of these staff may result in a failure to adequately assess the medical needs of the patients, potentially resulting in greater medical costs in the future.

In addition to the loss of nurses, case managers and other staff responsible for the coordination of clients' programs could be eliminated due to loss of funding. These people serve as a liaison between many groups, including the Day Programs, assisted living houses, and the clients' families. Without these important people, it would be much more difficult to adequately address the needs of the patients. It is possible that more people will in fact need to be hired to deal with the various cases, leading to a greater economic cost. In addition, economic productivity could be lost, as family members and other people involved with the clients could find themselves forced to play a greater role in the day-to-day lives of the patients, as the case managers and liaisons are no longer around.

Finally, a limit as to the number of people who can attend Day Habilitation, which would inevitably arise as a result of the passing of this plan, poses several problems. First, many people who attend Day Habilitation programs have few or no other options. Ninety-nine percent of patients are below the poverty line, and in the absence of Day Habilitation, it is unclear where else they could go and what kind of care they would receive. Also, a forced limit would likely result in a stricter definition of those who are eligible to attend the programs. Patients could be denied based on their level of disability, and those with conditions such as autism or physical disabilities could be turned away in favor of those with more severe disabilities, despite the fact that these people may not have other alternatives. The current program, in which no one who wishes to attend a program is turned away because of numbers, has worked very well, and to begin to deny people would be tragic.

In conclusion, the many negative costs associated with the passing of Docket: CMS-2261-P greatly outweigh the potential money that could be saved as a result, even though it is unclear whether or not any money would be saved anyway. When debating a change such as this, it is extremely important to remember those for whom Day Habilitation

From: Ellison, Shelley T.
Sent: Thursday, October 11, 2007 7:38 PM
To: Norman-Supak, Diane M.
Subject: letter

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

Attn: CMS□2261--P
Medicaid Program; Coverage for Rehabilitation Services

Dear Sir/Madam:

On behalf of **Texas Children's Hospital,** I would like to submit comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid proposed rule on rehabilitation services published in the August 13th edition of the *Federal Register.* I urge you to make necessary changes to the proposed rule so that children who have special health care needs will continue to receive rehabilitation services that are critical to ensure their health and ability to develop into fully integrated and functioning members of the community. The changes proposed in this regulation would have a serious negative impact on our hospital and the children we serve.

Medicaid is the single largest payer for children□s hospitals and the single largest insurer for children. Children□s hospitals devote more than half of their care to children insured by Medicaid and more than three-fourths of their care to children with chronic or congenital conditions. This is especially true for the children that are served by Texas Children's Hospital, where 75% of the children we provide occupational, physical, and speech therapy services to are insured by Medicaid and 50% of them have chronic, serious, complex heath care conditions. . The rehabilitation service category has ensured that children in Texas with chronic conditions have access to an array of physical and mental health services required for their conditions.

It is alarming that although Medicaid is the major insurer for children, particularly children with disabilities, the proposed regulation fails to consider how the changes would affect the children that we care for every day at Texas Children□s. For example, a child who has had a brain tumor resection will usually have serious physical impairments afterwards, including problems with walking, balance, coordination, self-care activities, and communication. Intensive rehabilitation by a team of physical, occupational and speech therapists is essential for the child to recover lost abilities and function as well as to enable the child to continue to develop the higher level skills that would normally emerge as the child grows and matures. The proposed regulation does not acknowledge the unique needs of these very vulnerable children, but attempts to make broad policy for all groups without considering how it could specifically affect children.

Our largest concern at Texas Children's Hospital with the proposed rule is that it threatens the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children. EPSDT guarantees that children insured by Medicaid receive all medically necessary services as determined by their health care provider. In the absence of clarification that children would not be affected because of EPSDT, the proposed rule would limit the definition of rehabilitation services and therefore threaten the health care of children. We strongly recommend that CMS add language into the regulation to clarify that children will continue to receive all medically necessary care, including all necessary rehabilitation services, as required by EPSDT.

Our hospital also has the following specific objections to the rule:

- **The proposed regulation asserts that rehabilitation services would not include services that are □intrinsic elements□ of programs other than Medicaid, such as foster care, child welfare, education, and child care.** Since many of the programs highlighted in the regulation focus on children, this would have a disproportionate impact on children, specifically children in foster care or receiving other social or educational services. The regulation does not provide the criteria for what constitutes an □intrinsic element□ of another program. Traditionally, Medicaid has worked closely with a multitude of programs to ensure that children get the services that they need. This new requirement would not allow federal match for services that are determined to be part of another program. Due to a lack of resources, the other programs will not be able to pay for these services without Medicaid as a partner.

  We recommend that this requirement be removed from the regulation. In order to implement such a change, the U.S. Department of Health and Human Services would need to identify other funding sources that would be able to sustain services without federal Medicaid funding. Most of the programs specified in the regulation would not have adequate resources to provide the needed services without additional funding. The result would be children not receiving medically necessary physical and mental health services.

- **The regulation does not clearly state that rehabilitation services could be provided to retain or maintain function.** In many cases, children with neuromuscular conditions, such as spina bifida or muscular dystrophy, and those with serious hearing problems or development delays require rehabilitation services that help them retain or maintain a certain function level. A child with muscular dystrophy quickly loses strength, joint range of motion, and endurance during even brief episodes of illness and often cannot recover to the preexisting level of function following resolution of the illness without the provision of rehabilitative therapies. So although the child□s health returns to the previous level, his ability to sit or stand independently, dress, bathe, physically manage school books and papers, hold a pen, etc. does not return. Sadly, the resulting decrease in activity by the child can lead to poor respiration, which predisposes the child to become acutely ill with respiratory disease. As you can see, for many children with chronic illness, a deterioration of their chronic condition will occur without rehabilitation services.

The preamble to the regulation does state that services could be provided to retain or maintain function if necessary to help an individual achieve a certain rehabilitation goal as outlined in their rehabilitation plan. The regulation does not include any details on what constitutes a rehabilitation goal.

Texas Children's Hospital recommends adding regulatory language to clarify that rehabilitation services would include services needed to retain or maintain function. In addition, we would suggest that CMS add a definition of a rehabilitation goal for children that would include retaining or maintaining function.

- In the preamble to the regulation, CMS says that rehabilitation focuses on restoring individuals to their best functional levels. This requirement would be particularly troublesome for children because some functions may not have been possible (or age appropriate) at an earlier date. In the case of an eight-year-old child with cystic fibrosis, the child often lacks the respiratory support for physical activity and so is unable to develop gross motor skills such as dynamic balance, running, skipping, and hopping. The child will likely have secondary musculoskeletal disorders as well. If the child receives a lung transplant, he may gain the respiratory support for gross motor development but will be unable to □catch up□ on his own because of the muscoloskeletal disorders that interfere with normal skill acquisition. He will need skilled physical therapy to reduce the musculoskeletal problems and enable him to engage in carefully selected activities aimed towards improving muscle strength, range of motion, and coordination so that he can be successful in developing gross motor skills. Once again, the proposed regulation fails to recognize that children have unique needs that need to be addressed.

  We recommend adding language to specify that children need not demonstrate that they were once capable of performing a specific task in the past if it was not age appropriate for the children to have done so.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Diane Supak, Assistant Director of Physical Medicine and Rehabilitation, at 832-826-2117 or dmsupak@texaschildrenshospital.org.

Thank you for your consideration.

Sincerely,

Diane Supak
Assistant Director
Physical Medicine and Rehabilitation
Texas Children's Hospital