Submitter : Mr. Wm. Michael Johnson **Date:** 10/12/2007

Organization : South Shore Mental Health Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-983-Attach-1.PDF

#983

Dedicated to building a healthier community

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CHARLESTOWN, RI 02813
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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

Reference: File code CMS-2261-P

To Whom It May Concern:

South Shore Mental Health Center is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

South Shore is a 501(c) 3, Not for Profit organization that has been providing mental health services in Washington County since 1964. Washington County has an estimated population of 120,000 people and South Shore is the only community mental health center in the county. The agency serves over three thousand individuals each year. Over 50% of those individuals and their families strive to effectively overcome serious and persistent mental illness. South Shore has been a leader in delivering outpatient and emergency mental and psychiatric care as well as collaborating and coordinating the delivery of primary health care, access to appropriate housing, as well as vocational habilitation and rehabilitation. Medicaid is the primary revenue source generated from fee-for-service programs provided to adults with severe and persistent mental illness, acute mental disturbances, and services to children and adolescents with serious emotional disturbances. Medicaid reimbursed services generates approximately 70% of the agency revenues, 20% comes from State contracts and grants, and the remaining 10% from private pay.

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

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

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

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

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

Section 1901 of the statute specifically authorizes funds for 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(viii)(3) Written Rehabilitation Plan

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

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and bill services in 15-minute increments, a progress note for every encounter will become a major burden, especially when services are delivered to a group.) We would recommend that progress notes be required at least monthly, leaving it to states to require, or

providers to make, more frequent notes in cases where that may be appropriate. The guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

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

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

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

<u>Recommendations</u>:

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

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 waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at both the state and provider agency level. The development of new forms as well as staff training, administrative processes all pose significant challenges at the Agency level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of the State Plan Amendment by the Agency.

OTHER ISSUES

Payment and Accounting for Services

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

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

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

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

Sincerely,

Wm. Michael Johnson, Ph.D.(c)
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 : Mr. Douglas Day **Date:** 10/12/2007

Organization : Ohio Dept. of Alcohol and Drug Addiction Svcs.

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachemnt

CMS-2261-P-984-Attach-1.DOC

#984

October 11, 2007

Kerry Weems
Acting Administrator
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. Weems:

The Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services, in conjunction with the Ohio Council of Behavioral Healthcare Providers, the Ohio Association of County Behavioral Health Authorities, the Ohio Association of Child Caring Agencies, the Family Service Council of Ohio, NAMI Ohio, Ohio Advocates for Mental Health and Ohio Citizen Advocates respectfully submit this comment letter related to the proposed rules on Medicaid coverage for rehabilitative services as published in the August 13, 2007, Federal Register (72 FR 45201) for the Centers for Medicare and Medicaid Services.

In the past state fiscal year, Ohio's community behavioral healthcare system provided approximately 30,000 Medicaid consumers with needed substance abuse services and approximately 196,000 Medicaid consumers with needed mental health services through the federal rehabilitation option. We appreciate the opportunity to provide feedback on the rules as proposed and support the ongoing efforts of CMS to provide clarity around federal expectations and to assure that there is programmatic and fiscal integrity in the programs serving those in need.

The major areas of concern requiring additional clarification or reconsideration identified by the behavioral healthcare system in Ohio are as follows:

• Section 441.45(b)(1) – Coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid. We would like to request 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 would like to request clarification on the distinction between the concepts of restorative services and maintenance as they relate specifically to behavioral health services. In addition, clarification of this issue as it relates to children and older adults would be helpful.

• Provisions of the Proposed Regulations A. Definitions - We would like to request that the requirements related to the definition of "qualified providers of rehabilitation services" be reconsidered. By applying additional, more burdensome qualifications there will be 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 rules will also affect workforce development and staff retention strategies in many community behavioral health centers given the increased costs associated with adding additional training, educational, licensing, work experience and supervision requirements.

While Ohio believes that its community behavioral health programs are fundamentally in alignment with the requirements outlined in the proposed rules, any additional clarification on the above issues would be appreciated in order to assure that we continue to operate programs that meet federal expectations.

Sincerely,

Sandra Stephenson, Director
Ohio Department of Mental Health

Angela Cornelius, Director
Ohio Department of Alcohol and Drug Addiction Services

Hubert Wirtz, CEO
Ohio Council of Behavioral Healthcare Providers

Cheri Walter, CEO
Ohio Association of County Behavioral Health Authorities

Penny Wyman, Executive Director
Ohio Association of Child Caring Agencies

Margaret F. Burns, Executive Director
Family Service Council of Ohio

James Mauro, Executive Director
NAMI Ohio

Doug DeVoe, CEO
Ohio Advocates for Mental Health

Donna Conley, Executive Director
Ohio Citizen Advocates for Chemical Dependency Prevention & Treatment.

Submitter : Harvey Rosenthal **Date:** 10/12/2007

Organization : NY Ass'n of Psychiatric Rehabilitation Services

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-985-Attach-1.PDF

#985

New York Association of Psychiatric Rehabilitation Services
1 Columbia Place • Albany, NY 12207 • PHONE: (518) 436-0008 FAX: (518) 436-0044

October 9, 2007

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

To Whom It May Concern:

As the NYS Chapter of the United States Psychiatric Rehabilitation Association (USPRA), the New York Association of Psychiatric Rehabilitation Services (NYAPRS) is pleased to comment on behalf of its 145 psychiatric rehabilitation agencies, practitioners, and interested organizations and individuals who are dedicated to promoting and strengthening community-oriented rehabilitation services that support recovery from psychiatric disabilities. Based upon the collective experience of our members and state and national colleagues in the field of psychiatric rehabilitation over the past 26 years, we offer the following comments on the provisions of the proposed regulations related to Medicaid's Rehabilitation Services Option.

Individualized Rehabilitation Plan Signed by the Person Served
NYAPRS enthusiastically supports the inclusion of a required rehabilitation plan and recovery-oriented goals that is developed with the individual and requires a signature to demonstrate involvement, approval and receipt of the plan [§440.130(d)(3)]. The creation of a rehabilitation plan is good practice and is necessary for shared decision making and accountability. It is our belief that quality rehabilitation services are strength-based and person-centered, and are built upon the values of choice and self-determination within the cultural context of the individual receiving services.

Person Centered Planning
We are pleased that these values have been applied in the proposed regulations, and hope CMS will consider making person-centered planning a formal requirement of the written rehabilitation plan [§440.130(d)(3)(iii)] beyond the proposed recommendation. In fact, we believe these values should apply to all Medicaid funded services, not just rehabilitation.

The Value of Psychiatric Rehabilitation
We also appreciate the recognition of psychiatric (or psychosocial) rehabilitation services as an integral component of mental health services and its role in an

individual's recovery. The presence (or absence) of psychiatric rehabilitation services directly impacts the achievement of recovery-oriented outcomes. In this context, recovery refers to the process the individual goes through as they rebuild their lives, not just the treatment of symptoms. Certainly, treatment or medical activities should be incorporated within the rehabilitation plan, but are not necessarily the primary driver under the rehab option.

Engagement

Unfortunately, because of prior negative experiences or stigma, some individuals may not be initially ready or willing to become engaged in an intensive and formally documented rehabilitation plan. Therefore, NYAPRS recommends that CMS consider including the following language to §440.130(d)(3) to recognize the need for and use of early engagement services: "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."

In the absence of a signed rehabilitation plan, early engagement services must document efforts to revise approaches and engage the person to build a mutually satisfying course of action, including documentation of engagement goals and related services. Examples of early engagement services include opportunities to sit in on group activities and meet other people in recovery using the program; educating the individual about the recovery process, recovery outcomes, and the individual's rights and responsibilities; and motivational interviewing techniques or other explorations of personal interests and values.

Based upon the collective experience of our members, NYAPRS believes this process could realistically be accomplished within six months. If the individual has not engaged within this six-month period, he or she may not be ready for rehabilitation services or should seek another service provider better suited to supporting the individual's recovery.

Reimbursement Flexibility

NYAPRS is pleased that the proposed regulations allow for flexibility in how rehabilitation services are paid. Allowing States to specify the methodology under which rehabilitation providers are paid [§441.45(a)(5)] will ensure the continuation of many highly effective programs, such as Assertive Community Treatment, Clubhouses, and Crisis and Transitional Residential Treatment Programs, that tend to bill through a single daily rate or case rate. If executed correctly, these services would focus on the improvement of the disability and achievement of specific rehabilitative goals, as specified in the rehabilitation plan, and not duplicate services that are intrinsic to programs outside of Medicaid.

Intrinsic Services

Because of this, NYAPRS recommends that the term "intrinsic" be further clarified within §441.45(b)(1) as services that are the major focus of another agency based on statutory requirements, and is not meant to preclude funding of services which may

mirror service provided by another agency. Examples of services that mirror services provided by another agency include the following:
Supported employment is an intrinsic element of Assertive Community Treatment (ACT). Vocational Rehab services within a state may also fund supported employment services; however, these services are typically time limited and based on eligibility for vocational rehabilitation services, not mental health services. Support through Medicaid funding should be based on an identified medical need, and would involve symptom management and skills building in areas such as dealing with stress on the job, interacting with coworkers, and dealing with discrimination and stigma rather than job skills training.
Supported housing services may appear similar to traditional housing services at first glance. However, services funded through the Medicaid Rehab Option would not involve housekeeping or chore services, but rather skills in handling independent finances away from payeeship, interacting with neighbors appropriately, problem solving and managing stress as recommended by a practitioner of the healing arts for the purpose of reducing the psychiatric disability and restoring functional level.
The proposed regulations state that patient education provided in an academic setting is not covered under the Medicaid Rehab Option. However, supported education does not deal with academic prep but rather symptom management and skills in areas such as interacting appropriately with other students and faculty, stress management and advocating for oneself when illness interferes with academic progression. Medicaid funding would be appropriate based on an identified medical need and as outlined in the rehabilitation plan.

Value of Certification Programs like the CPRP
NYAPRS supports allowing States the flexibility to set forth the qualifications for providers of rehabilitation services [§440.130(d)(1)(iii)]. However, while the proposed regulations imply a set of core competencies are required, USPRA recommends that CMS emphasize within the regulations the need to employ professionals who are competent in mental health rehabilitation practice (e.g., those with national certification as psychiatric rehabilitation practitioners like the Certification Program for Psychiatric Rehabilitation Practitioners originally developed by USPRA), as well as persons in recovery trained as peer providers as indicated in the CMS guidance letter valuing Medicaid Peer Support services.

Thank you for your consideration of our comments.

Harvey Rosenthal
Executive Director
New York Association of Psychiatric Rehabilitation Services
harveyr@nyaprs.org

Submitter : Elena Fowler **Date:** 10/12/2007

Organization : Elena Fowler

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-986-Attach-1.RTF

#986

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program
Submitted By:

Elena Fowler
112 NC Hwy 54, Apt N4
Carrboro, NC 27514

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

I appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am a staff member of Club Nova, a Clubhouse Model Program. The clubhouse model is one of the most comprehensive, cost effective, and successful programs in the nation working with individuals living with severe and persistent mental illness. I have personally experienced the effectiveness of rehabilitation services offered through the Club Nova.

I am very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars by the year 2012 from an already under-resourced service system. I have had countless members tell me how important having a place such as Club Nova to come, work, and feel appreciated at is to them. They individually tell me that they don't know where they would be without it. If the proposed changes go into effect, our ability to maintain a place to come will be compromised. Members will lose a place to go and meaningful work, increasing their chance of isolation and hospitalization.

Experience tells us that creating barriers and excluding vital services will not save money in the long run. Rather, it will increase the costs for hospitalization, incarceration and other negative outcomes that result from a failure to obtain needed treatment. We disagree with rules that lead to a solely crisis-oriented system which is not cost effective. Most importantly, we consider such rules inhumane.

The focus on time limited services versus longer term support services does not take

into account the nature of mental illness. Time limited rehabilitation services will not work for the majority of persons with a severe mental illness. How can you address a long term, chronic illness with a short term solution?

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

If the proposed rules go into effect, this will have a devastating effect on the lives of our citizens who live with mental illness. We must provide the necessary support networks that have allowed Americans with serious mental illness to begin and continue the long and difficult process of rebuilding their lives.

I encourage you to consider true reform of the mental health system in the United States. True reform would guarantee individuals living with mental illness the basic human rights to the rehabilitation necessary to begin and remain on the path to recovery.

Sincerely,

Submitter : **Mr. scott feldman** **Date: 10/12/2007**

Organization : **Mr. scott feldman**

Category : **Individual**

Issue Areas/Comments

Background

Background

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 : Mrs. Ruth G. Gray **Date:** 10/12/2007

Organization : family member

Category : Individual

Issue Areas/Comments

Background

Background

CMS-2261-P - Rehabilitation Services: State Plan Option

Collections of Information Requirements

Collections of Information Requirements

Research shows that people with serious mental illnesses who receive rehabilitation services have better livves in the community, such as stable housing and employment. They also have fewer hospitalizations and spend less time in jails ands prisons. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses and their families. They need Medicaid to provide these services.

GENERAL

GENERAL

I have a son who is 35 and was diagnosed with schizoaffective disorder 10 years ago. It took 5 years to find the correct medicine that would help him. It relieves part of his symptoms, but not all of them. The support he has recieved helps him to live more independently than he could without support. If he did not have support to live in the community he would need to be in a hospital where he could be monitored and therapy would be provided on a regular basis. Outside the hospitl he can receive those supports and live in his own apartment which is much cheaper for the government and much healthier for him. Why would anyone want to not continue this? Would you take away a wheelchair from someone who can not walk or and just give hima pain killer? Would you deny a paraplegiac someone to help him get in and out of the bed or bath tub? Serious mental illnes has theraputic requirements the same as physical illness does.
Do not change this regulation. Rehabilitive services are necessary for our family members with serious mental illness. Because they are able to work very little, Medicaid is essential to their well being. Without it, many more will be unable to work at all.

Response to Comments

Response to Comments

Rehabilitative services that support mental health consumers so they are able to live in the community rather than in hospitals is essential to the promise that was made when the hospitals were closed 30 years ago. We currently have too many people with mental illness in jails and prisons because we do not have enough services to reach everyone who needs them. To take away services for those who are receiving them and living in the community rather than a hospital or prison seems counter-productive. Are we going to build more hospitals for these people or more prisons because they will lack the supports to live in the community (which was the promise when the hospitals were closed) Currently people revert to hospitals for short stays when their illness cycles. It is often during these times of extraordinary stress of their illnes that their behavior causes them to end up in the hospital or the jail. Rehabilitative services helps to prevent going to jail and shortens their stay in the hospital.

Submitter : Patricia Tursi **Date:** 10/12/2007

Organization : Elizabeth Seton Pediatric Center

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-989-Attach-1.RTF

#989

Elizabeth Seton
PEDIATRIC CENTER

Changing lives, one child at a time

COMMENT LETTER TO CMS ON THE AUGUST 13, 2007 PROPOSED RULE ON MEDICAID REHABILITATION SERVICES

October 12, 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 Elizabeth Seton Pediatric Center, a long term care facility for 136 medically fragile children, we 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 an extremely negative impact on the children we serve. We ask that you consider changes to the proposed rule to ensure that children with complex care needs continue to receive critical rehabilitation services.

Medicaid is the single largest payer for pediatric long term care and the single largest insurer for children. Almost 100% of the children served by Elizabeth Seton Pediatric Center are insured by Medicaid and the majority live here for over a year. They require rehabilitation services to achieve their highest level of independence in activities of daily living, self-care, education, and function. The skills acquired through rehabilitation therapies enable children to return home to their families and communities, an opportunity that would not be possible without physical, occupational, and speech therapy services.

Comments on Proposed Rule on Medicaid GME:

1. Although Medicaid is the major insurer for children, in particular children with disabilities, the proposed regulation fails to consider how the changes would affect the children in our care. For example, rehabilitation is defined as ``any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." This requirement would be particularly troublesome for children because some functions may not have been possible medically or developmentally at an earlier

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date, or may not have been age appropriate. Many of the children in our therapeutic feeding program have never acquired the oral feeding skills that are developmentally appropriate for children of their age due to a variety of medical diagnoses and/or dependence on feeding tubes and/or the fact that they are premature newborns. Through intensive daily feeding therapy provided by Speech Language Pathologists, these children learn to accept food orally, chew and swallow various textures, and in many cases, feed themselves. Under the proposed regulations, this therapy would not be covered by Medicaid as they would be considered "habilitation". The proposed regulation does not acknowledge the unique needs of developmentally delayed children who require extensive rehabilitation therapies to learn the skills that come naturally to other children of their age.

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 or developmentally-appropriate, or if their medical condition prevented them from acquiring the skill previously.

2. The regulation does not clearly state that rehabilitation services could be provided to retain or maintain function. Children with developmental delays often require rehabilitation services to retain or maintain a certain function level. The National Institute of Child Health and Human Development recommends speech therapy, occupational therapy and physical therapy for children with nervous system disabilities, sensory-related disabilities, metabolic disorders, and degenerative disorders. For example, rehabilitation services are required to maintain range of motion and function in children with cerebral palsy, a condition that is characterized by muscle spasticity. The National Institute of Neurological Disorders and Stroke advocates that cerebral palsy symptoms be managed by a comprehensive plan that includes: "physical therapy to improve walking and gait, stretch spastic muscles, and prevent deformities; occupational therapy to develop compensating tactics for everyday activities such as dressing, going to school, and participating in day-to-day activities, speech therapy to address swallowing disorders, speech impediments, and other obstacles to communication. Children with neuromuscular conditions also require bracing and adaptive equipment, carefully customized by an occupational therapist or physical therapist, to enhance function and promote independence. Without consistent and ongoing rehabilitation services, these children would experience a decline in function, health, and quality of life. This deterioration would lead to increased intensity and intrusiveness of medical care, such as institutionalization of a child who was previously cared for at home, which is directly contrary to the intent of the proposed rule.

Elizabeth Seton Pediatric Center recommends adding regulatory language to clarify that rehabilitation services would include services needed to retain or maintain function. In addition, we request that CMS add a definition of a rehabilitation goal for children that would include retaining or maintaining function and preventing decline in range of motion.

3. 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 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.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact our administrator, Lisa Poskanzer at 646-459-3902 or lisa.poskanzer@setonpediatric.org. Thank you for your consideration.

Sincerely,

Patricia Tursi
CEO

Submitter : Ms. Stacey Sanders **Date:** 10/12/2007

Organization : Ms. Stacey Sanders

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-990-Attach-1.DOC

#990

October 12, 2007

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

Dear Sir(s) or Madam(s):

As special education director of Laurens County Schools in Dublin, Georgia, I am writing in response to the August 13, 2007 *Federal Register* announcement requesting public comment on the Notice for Proposed Rule Making for Coverage for Rehabilitative Services under the Medicaid program.

I am deeply concerned about the devastating impact that the proposed CMS regulations for the rehabilitation services option will have on the welfare of children with disabilities. The elimination of these reimbursements would inevitably shift the financial responsibility for rehabilitation claims to individual school districts and early childhood providers across the nation. The Administration estimates that the elimination of the reimbursement for the Medicaid rehabilitation services option will provide a savings of $2.29 billion over the next five years. However, there is no corresponding increase in funding for the federal special education law, the Individuals with Disabilities Education Act (IDEA), that will enable schools and early childhood providers to make up for the reduction in Medicaid reimbursements for rehabilitation services option provided to children with disabilities.

I am asking that you carefully reconsider this proposed rule.

Sincerely,

Stacey Sanders
Special Education Director
Laurens County Schools
Dublin, GA 31021

Submitter : Dr. Manuel Martinez **Date:** 10/12/2007

Organization : Northwest Rehab Center

Category : Physician

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

Response to Comments

Response to Comments

Physical therapists should not be authorized to diagnose medical conditions. Diagnosis should be done by a properly trained physician.

CMS-2261-P-992

Submitter : Kara Baldwin **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-992-Attach-1.RTF

992

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program
Submitted By:

Kara Baldwin
c/o Ed Hudginson
103 D West Main Street
Carrboro, NC 27510

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

I appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am a member of Club Nova, a Clubhouse Model Program. The clubhouse model is one of the most comprehensive, cost effective, and successful programs in the nation working with individuals living with severe and persistent mental illness. I have personally experienced the effectiveness of rehabilitation services offered through the Club Nova and have been able to participate in my community as a direct result of these services.

Club Nova means a lot to me because it gives me a place to come and a place to belong. If it wasn't for Club Nova I would be at home looking at the four walls with nobody to talk to. Club Nova is a place of healing. Club Nova to me is a support group—support from friends, staff, volunteers, or anyone associated with Club Nova and the mental health system. Any time I have a problem—such as a recent period of homelessness—staff have been there to see me through it. I have met a lot of friends since I came to Club Nova. I have been with Club Nova since 1987—an original member and founder. My favorite job in the clubhouse is helping out with the transitional employment program. Club Nova has been there for me; has cried when I cry; when one person hurts, we all hurt; when one is happy, we all are happy.

I am very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars by the year 2012 from an already under-resourced service system.

#993

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program
Submitted By:

Robert Longmire
404 Jonesferry Rd.
Carrboro, NC 27510

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

I appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am a member of Club Nova, a Clubhouse Model Program. The clubhouse model is one of the most comprehensive, cost effective, and successful programs in the nation working with individuals living with severe and persistent mental illness. I have personally experienced the effectiveness of rehabilitation services offered through the Club Nova and have been able to participate in my community as a direct result of these services.

Club Nova has enriched the quality of my life and helped me to stay off drugs and alcohol. It gives me an opportunity to contribute to the community alongside people dealing with similar illnesses. It also keeps me out of the hospital.

I am very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars by the year 2012 from an already under-resourced service system.

Experience tells us that creating barriers and excluding vital services will not save money in the long run. Rather, it will increase the costs for hospitalization, incarceration and other negative outcomes that result from a failure to obtain needed treatment. We disagree with rules that lead to a solely crisis-oriented system which is not cost effective. Most importantly, we consider such rules inhumane.

The focus on time limited services versus longer term support services does not take into account the nature of mental illness. Time limited rehabilitation services will not

work for the majority of persons with a severe mental illness. How can you address a long term, chronic illness with a short term solution?

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

If the proposed rules go into effect, this will have a devastating effect on the lives of our citizens who live with mental illness. We must provide the necessary support networks that have allowed Americans with serious mental illness to begin and continue the long and difficult process of rebuilding their lives.

I encourage you to consider true reform of the mental health system in the United States. True reform would guarantee individuals living with mental illness the basic human rights to the rehabilitation necessary to begin and remain on the path to recovery.

Sincerely,

CMS-2261-P-994

Submitter : Jessica Jerald **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-994-Attach-1.RTF

#994

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program
Submitted By:
Karen Kincaid Dunn, Executive Director
Club Nova
103 D West Main Street
Carrboro, NC 27510

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

I appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am a staff member of Club Nova, a Clubhouse Model Program. The clubhouse model is one of the most comprehensive, cost effective, and successful programs in the nation working with individuals living with severe and persistent mental illness. I have personally experienced the effectiveness of rehabilitation services offered through the Club Nova and have been able to participate in my community as a direct result of these services.

I am deeply concerned about the recent proposed changes and can not help but feel disappointed, confused, and un-cared for by CMS. As a staff person at Club Nova, I have personally witnessed the devastating effects of severe Mental Illness with our members. I often wonder where our members would be if Club Nova was not here to serve as a support system, as a place of vital resources for stability, and as a social network to reduce the isolation and loneliness that accompanies the illness.

I am also bothered by the excessive documentation required by CMS that is deeply burdening my ability to work with our members throughout the day. I am often pulled away from member engagement, sometimes for hours, just to write a daily note that I am finding is not reflective of a person's overall comprehensive progress. I strongly urge that something is done to de-emphasize paper work and re-emphasize the importance of client support and person centered care. I fear that I, as well as my co-

workers, can not continue to avoid "burn-out" and stress if daily notes continues to be the rule. I have witnessed that unnecessary stress contributes to staff turnover which is detrimental to any non-profit organization.

Please consider the impact that Medicaid has on the lives of people around the United States that have major disabilities. Specifically, take into consideration of the gravity of your decisions on each individual personal life. I can not imagine that CMS would purposefully want to jeopardize the health care nor well-being of anyone, especially not an already under-represented mentally ill population.

Sincerely,

Jessica Jerald
Associate Director
Club Nova Community, Inc.

Submitter : Ms. Christine James-Brown **Date:** 10/12/2007

Organization : Child Welfare League of America

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-995-Attach-1.DOC

995

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

October 12, 2007

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

The Child Welfare League of America (CWLA), representing hundreds of public and private child- and family-serving member agencies across the country, respectfully submits these comments on the Proposed Rule for the Medicaid Program's Coverage of Rehabilitative Services (CMS-2261-P) that was published in the Federal Register on August 13, 2007 (72 Fed. Reg. 45201).

CWLA recognizes and appreciates that this proposed rule attempts to move towards a more transparent system that will promote administrative and managerial integrity, while also making rehabilitative services more person-centered and focused on positive, effective outcomes. In attempting to do so, however, significant ambiguity remains and CWLA is highly concerned that various provisions of the proposed regulation—albeit well-intentioned—will greatly restrict access to vital community-based services for many vulnerable populations, including children involved with the child welfare system and in our nation's foster care system.

In addition, CWLA is troubled by the Regulatory Impact Analysis's certification that CMS-2261-P "would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act." As the proposed regulation significantly changes the scope of rehabilitative services that have been made available to children and other individuals with mental and physical disabilities for quite some time and imposes new administrative requirements, it is hard to imagine that providers would not be impacted.

Similarly, while it is sometimes necessary to change the contours of a service or program, the evolution here seems to be one-sided, reducing Federal Medicaid spending on rehabilitative services by $2.2 billion between FY 2008 and FY 2012 and although acknowledging that States

will be affected, merely stating that "we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule." As a federal-state partnership, Medicaid has a responsibility to provide health care for those deemed eligible, including children in foster care, and we fear the result if such a substantial amount of Federal funding is withdrawn.

At a point in time in FFY 2004, there were 509,662 children in out-of-home care and during that same year, approximately 800,000 children spent at least some time in a foster care setting. Many children that enter the foster care system are at an extremely high risk for both physical and mental health issues as a result of biological factors and/or the maltreatment they were exposed to at home. Some children are in out-of-home care for other reasons, such as their parent(s) voluntarily placing them or feeling compelled to do so. For example, the Government Accounting Office estimates that in 2001, due to limits on public and private health insurance, inadequate supply of services, and difficulty meeting eligibility requirements, parents placed over 12,700 children into the child welfare or juvenile justice systems solely so that these children would be more likely to receive necessary mental health services.

Regardless of why the child has come into the child welfare or foster care systems, removing the child from his/her home, breaking familial ties and the continued instability that often ensues greatly exacerbate any original vulnerability. Numerous studies have documented that children in foster care have medical, developmental and mental health needs that far surpass those of other children, even those living in poverty.

When children are removed from their home base and placed in state custody due to no fault of their own, Medicaid steps in to provide many of these children with health care that helps them get on the road to recovery. Medicaid Rehabilitative Services are especially vital, as they offer a realistic opportunity to—in the least restrictive setting possible—reduce the physical and/or mental disabilities that many children in foster care have, thereby restoring the child's functioning level, decreasing lingering and long-term negative impacts, and ultimately reducing costs. Rehabilitative services are also community-based and consumer- and family-driven services, in line with both the President's New Freedom Commission on Mental Health and the U.S. Surgeon General's recommendations. As the status quo stands, despite concerted efforts, when evaluating the Federal Child and Family Services Reviews (CFSRs), the U.S. Department of Health and Human Services in 2005 found that only one state achieved substantial conformity in ensuring that children involved with the child welfare system's physical and mental health needs were met.

Many children involved with the child welfare and foster care systems are already slipping through the cracks and it is essential to bridge rather than widen the gaps. CWLA sincerely appreciates our opportunity to comment on this proposed regulation. We look forward to working with you to ensure that the best policies are put in place for our nation's children.

Child Welfare League of America
2345 Crystal Drive, Suite 250, Arlington, VA 22202
Phone: 703/412.2400; Fax: 703/412.2401; www.cwla.org

PROVISIONS OF PROPOSED RULE:

Section 440.130: Diagnostic, screening, preventative, and rehabilitative services

440.130(d)(1)(iii), Qualified providers of rehabilitative services: We appreciate that CMS holds with us the joint desire for providers of rehabilitative services to be aptly prepared, but we urge that States be granted the latitude necessary to ensure that services would not be restricted as a result. For instance, States' recognition of and threshold for therapeutic foster parents as qualified providers should remain untouched.

440.130(d)(1)(v), Rehabilitation plan: The requirement for a written rehabilitation plan will help ensure accountability, but we suggest that children's developmental stages and the often difficult-to-predict phases of restoration be taken into account. With children consistently progressing through developmental stages, even upon the most informed initial assessment of needs, it is complicated to pinpoint anticipated progress. Similarly, children—as all individuals suffering from physical or mental impairment—can quickly deteriorate, necessitating an adjustment to the rehabilitation plan's enumerated goals. Providers therefore should be granted ample flexibility to adjust children's rehabilitation plans in the form of crisis planning so that prior steps forward are not negated.

In regards to the plan needing to be developed with input from "the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing," we applaud the person- and family-centered approach taken. However, we remind CMS that children involved with the child welfare and foster care systems—though the beneficiary of services—are not always competent to be heavily involved in the process, or in the case of strained familial relations, to be the ones determining who is involved. Similarly, much of this population has limited contact with certain members of their family, so we urge language be added to ensure that "family" is broadly interpreted to include guardians and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, custodial public agency staff, and group or residential care staff).

440.130(d)(1)(vi), Restorative services: Restorative services and thus covered rehabilitative services, under the proposed definition, are contingent upon the individual having experienced a functional loss and having had the *ability* to perform the function in the past (and not necessarily having actually performed it). This definition affords fair latitude in the adult context, but does not properly consider children and their special circumstances. A child may not have experienced a "functional loss" per se and/or have had the ability to perform the function in the past because simply, it was not age appropriate for him/her to have had the ability. In addition, children who are exposed to trauma, such as the abuse or neglect that lands many children in our nation's child welfare and foster care systems, may never had had an opportunity to develop "normally" because factors beyond their control compromised that potential. In those situations, it is the very point of rehabilitative services to fill deficiencies and seek to bring the child to an age- or developmentally-appropriate level. This definition should be more child-aware such that even if a child did not have the ability to perform the function in the past, restorative services and thus rehabilitative services include services to enable a child to achieve age-appropriate growth and development.

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CWLA agrees that rehabilitative services' goal is not just to maintain functioning, but to move the individual toward recovery. It is difficult, however, to continue the individual—in our case a vulnerable child or youth—on the path towards *meaningful* recovery if at the moment s/he reaches the originally stated goal, services and accompanying funds are withdrawn. Were that to happen, the child's progress would be nullified, his/her health would likely rapidly deteriorate—only requiring more intensive and more costly intervention at a later date that could possibly force the child into a more institutional setting. Maintaining functioning should be a permissible goal under the rehabilitation plan if the child/youth's health and progress would otherwise deteriorate.

440.130(d)(2), Scope of services: This provision maintains the definition of rehabilitative services as "medical or remedial services," but to more accurately reflect the entire proposed regulation that encompasses certain "restorative services" as covered rehabilitative services (440.130(d)(1)(vi)), the phrase "restorative services" should be added.

440.130(d)(3), Written rehabilitation plan: CWLA supports the written rehabilitation plan's goals of transparency and ensuring that "services are designed and coordinated to lead the goals set forth in the statute and regulation" and the general avenues taken to achieve those goals. We submit only the following clarification questions and recommendations.

The written rehabilitation plan should be able to be integrated with any concurrent health plans that the child has, as well as with any child welfare service plan for the child and family. This will lessen the administrative burden and by crossing system lines, work towards a more integrated, effective structure for the child.

CWLA appreciates the desire to have surrounding parties involved in the development, review, and modification of the plan goals and services, but hopes to have language added that acknowledges the very different situation held by children involved with the child welfare and foster care systems. These children, especially those who have had parental rights terminated and are in the custody of the state, may not have familial support or input to turn to. We therefore recommend adding to 430.130(d)(3)(ii) and (iii) (or alternatively, to a new subsection) the following language: "For a recipient involved with the child welfare or foster care systems, input or guidance in the development, review, and modification of plan goals and services may be obtained from the child's parents when appropriate, guardians, and/or caregivers responsible for the child's wellbeing (including, but not limited to, foster parents, kinship caregivers, custodial public agency staff, and group or residential care staff)."

Along similar lines, while CMS is properly hoping for a person-centered process by requiring the involvement of the individual in the development, review, and modification of the plan, a child may not always be competent to participate. Language or a new subsection should be inserted stating that "A child under 18 should be actively involved in the development, review, and modification of the plan if deemed developmentally ready and appropriate."

If the child is deemed competent to participate in the process, any materials provided to the child to inform him/her should be age- and developmentally appropriate and the plan should be

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thoroughly explained to the child. The plan, on a more general note, should be culturally appropriate and plainly understandable by those who are involved.

In regards to 440.130(d)(3)(xi), which requires the written plan indicate the extent to which services may be available from alternate providers, a standardized list of alternate providers should be acceptable (to lessen administrative burden of repeating this process).

Section 440.130(d)(3)(xii) requires the written plan to include the individual's "relevant history, current medical findings, contraindications, and identify the individual's care coordination needs." This is important, but is not always possible. Because the children who CWLA and its members serve are often moved frequently through the system and between placements and because of other uncontrollable factors such as lapses in health care, relevant history and current medical findings may not be accessible. The child may not have even had a primary care doctor. This subsection should emphasize that the written plan should reference these documents *when possible.*

Section 441.45: Rehabilitative services

441.45(b), Newly Deemed Non-Covered Services, Intrinsic Element Standard: CWLA wholeheartedly desires for providers to properly and accurately bill various, distinct programs, including Medicaid, and appreciates CMS's attempts to draw more recognizable lines. However, we feel that 441.45(b), which would put in place an "intrinsic element" standard, is a disproportionately large reaction to the situation and any existing concerns. Gradual changes are occasionally needed to better programs and services, but we do not view 441.45(b) as an improvement and instead see it as an enormous step backwards with a devastating real world impact.

Rather than making such sweeping changes through rulemaking, CWLA believes that these important decisions that impact vital community-based services should be debated thoroughly and done through the legislative process. Some of this debate occurred when Congress deliberated over the Deficit Reduction Act of 2005 (DRA, P.L 109-171). During that process, Congress specifically rejected adopting the "intrinsic elements" test for Medicaid rehabilitative services that CMS-2261-P would put in place. This indicates that Congress foresaw the dangers of such language and instead, desires for Medicaid rehabilitative services to remain a strong and viable stream of care. The language proposed in 440.145(b) seems to do the exact opposite, as it will ultimately burden already struggling systems and restrict access to services for some of the most vulnerable segments of the Medicaid beneficiary population, including children in foster care. We also believe it will intensify disparities in service provision between localities—and therefore among children. If federal dollars are removed, wealthier communities may be able to sustain the availability of rehabilitative services, while children living poorer and/or rural areas with be left unattended to.

Denying services to eligible and needy individuals hugely conflicts with the entire backbone of the Medicaid program and in particular, with Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under EPSDT, children eligible for and enrolled in Medicaid must receive regular check-ups, including vision, dental, and hearing exams, as well

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as necessary immunizations and laboratory tests and all medically necessary follow-up testing and treatment. By excluding federal dollars from certain rehabilitative services furnished through non medical programs, access to medically necessary services will be restricted, leaving the promise of EPSDT unfulfilled. This is especially egregious considering the extreme nature of the health needs of children involved with the child welfare and foster care systems and the fact that the Department of Health and Human Services in analyzing the Federal Child and Family Services Reviews (CFSRs), found that only one state achieved substantial conformity in ensuring that children involved with the child welfare system's physical and mental health needs were met. In other words, the situation for these children—many of whom have experienced life-altering trauma and have little or no familial support—is already dire and should Medicaid step out of the picture, will only worsen.

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 and rather, seems to charge ahead, listing certain public programs such as child welfare and foster care as likely targets. The child welfare system's role is to respond to reports of abuse and neglect, help at risk families, and help secure permanent, safe, and secure homes for children. Part of this equation is to assist children who have suffered trauma in the recovery process and to help locate adequate services when the child has been removed from his/her family. Child welfare, however, is not qualified to provide certain services and because the system instead merely acts as a go-between, Medicaid rehabilitative services are *not* "intrinsic to" child welfare.

Similarly, Medicaid rehabilitative services are not "intrinsic to" foster care. Title IV-E, Section 475(4) of the Social Security Act and the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20 states that foster care maintenance payments are "to cover the cost of (and the cost of providing) 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." Clarifying further that rehabilitative services are not intrinsic to foster care, the Code of Federal Regulations prohibits States from claiming Title IV-E federal financial participation (FFP) for "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*" (45 CFR, Chapter XIII, Part 1356.60(c)(3)) (emphasis added). States have more discretion under Title IV-B, but because its primary purpose is not to provide medical assistance, rehabilitative services are not "intrinsic to" it either. Moreover, IV-B is a capped program that does not envision providing and is not able to provide all necessary services.

CWLA envisions and has long advocated for (as detailed in CWLA's Standards of Excellence for Health Care Services for Children in Out-of-Home Care) the child welfare system and Medicaid to work collaboratively towards the wellbeing and healthy development of each child in its care. It is essential that the systems work together, rather than one stepping completely out of the picture, as 441.45 would permit Medicaid to do in certain, vital circumstances. The section also completely defeats the Substance Abuse and Mental Health Services Administration's (SAMHSA) diligent work to promote a system of care that provides a coordinated network of community-based services and supports that are organized to meet the

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Phone: 703/412.2400; Fax: 703/412.2401; www.cwla.org

challenges of children and youth with serious mental health needs and their families. As such, CWLA strongly urges 441.45(b) to be wholly dropped.

441.45(b)(1)(i) and (ii), Therapeutic Foster Care and Packaged Services Furnished by Foster Care and Child Care Institutions: CWLA wishes to specifically address the exclusion of therapeutic foster care services except for "medically necessary rehabilitative services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers" (441.45(b)(1)(i)) and similar packaged services furnished by foster care or child care institutions (445.45(b)(1)(ii)) from the definition of Medicaid rehabilitative services. As the Surgeon General indicated in his 1999 report on mental health, with care provided in private homes with specially trained foster parents, therapeutic foster care is considered "the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders." It provides evidence-based care for children who otherwise would be placed in more institutional and costly settings—settings which can also reap emotional tolls on children and their families. The Surgeon General recommended therapeutic foster care as a community-based avenue forward for children's health and it also seems very much in line with the report issued by the President's New Freedom Commission on Mental Health.

Unfortunately, the proposed language, while not explicitly prohibiting therapeutic foster care, whittles away at its core so much that access will surely be restricted, if not completely shut off. As a result, because there is a continuum of care in foster care, children who cannot be maintained in regular foster care due to serious emotional or other health issues will be forced into more restrictive settings—a result that cannot be justified by any amount of federal savings. Also, while federal dollars may be saved up front, by not helping these children and youth early on, the long-term cost to both the children and society will be far greater. Again, CWLA urges that 441.45(b)(1)(i) and (ii) be dropped.

Only therapeutic foster care services that are "clearly distinct from packaged therapeutic foster care services" could be billed as rehabilitative services, but it is unclear what is meant by "clearly distinct." CWLA strongly advocates that states be afforded the discretion to define therapeutic foster care as a single service and pay through a case, daily, or appropriate mechanism. Packaged services allow the necessary amount of time and attention to be spent on children suffering from intense mental issues. The alternative imposes the significant administrative burden of relegating activities into somewhat arbitrary time blocks, which ultimately takes time away from the child and reduces services' effectiveness and the child's progress.

441.45(b)(5), Institution of Mental Disease: Summarily excluding services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of community residential treatment facilities more than 16 beds would likely drive costs up and force children into more restrictive environments. This goes against the best interests of the child and again, conflicts with the President's New Freedom Commission on Mental Health's reports urging more community-based care. This subsection should be stricken. Alternatively, before changes go into effect, an appropriate and reasonable transition period must be provided for impacted parties.

Child Welfare League of America
2345 Crystal Drive, Suite 250, Arlington, VA 22202
Phone: 703/412.2400; Fax: 703/412.2401; www.cwla.org

CONCLUSION

On behalf of CWLA, its members, and the children and families we serve, we thank you for the opportunity to comment on this proposed rule. We hope that as we move forward with this process, we will work together to keep children's best interest at the forefront. Only then can we ensure that children and their physical and mental health needs are made a national priority.

Sincerely,

Christine James-Brown
President/CEO
Child Welfare League of America

Child Welfare League of America
2345 Crystal Drive, Suite 250, Arlington, VA 22202
Phone: 703/412.2400; Fax: 703/412.2401; www.cwla.org

Submitter : **Mrs. Nadine Moss** **Date: 10/12/2007**

Organization : **Mrs. Nadine Moss**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

Please do not cut administrative claims for school districts. These funds are essential to LEA finances.

Submitter : Ms. Lauren Sauerheber **Date:** 10/12/2007

Organization : Ms. Lauren Sauerheber

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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 : **Date: 10/12/2007**

Organization :

Category : **Social Worker**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I would like to urge the elimination of Provision 441.45(b), or request additional time to secure alternative funding sources due to the problematic assumptions in this provision. Disallowing MRO billing for children in child welfare placements will not only limit the much needed additional services that the children in therapeutic foster care (in addition to residential care) receive, it will increase the stress on foster parents throughout the state. The MRO billing allows Therapeutic Foster Care to focus more on a child's functioning and symptoms while also supporting foster parents who may be dealing with significant behavior problems and high stress situations. Without this funding, case management for therapeutic foster care will become less intensive and foster parents will have less support. This cannot be a positive situation for the children in care in the state of Indiana. There is already a shortage of foster parents in the state of Indiana and the regulations continue to become more stringent. While ensuring that the children who have been abused and neglected are in safe environments while in out-of-home care is very important, supporting those who are the caregivers to these children should be of utmost importance in order to ensure that the abused and neglected children of Indiana are receiving the best care possible. In addition, I ask for further clarification of 'restorative services' with children who are still developing.

Submitter : Mr. Jesse Nicholas **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-999-Attach-1.RTF

#999

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program
Submitted By:

Jesse Nicholas
130 Booth Rd.
Chapel Hill, NC 27516

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

I appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am a member of Club Nova, a Clubhouse Model Program. The clubhouse model is one of the most comprehensive, cost effective, and successful programs in the nation working with individuals living with severe and persistent mental illness. I have personally experienced the effectiveness of rehabilitation services offered through the Club Nova and have been able to participate in my community as a direct result of these services.

Club Nova has helped me to start working again. Also, it has given me confidence to do normal things like ride buses, and get out in the community to do socials. I would be at a loss without Club Nova

I am very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars by the year 2012 from an already under-resourced service system.

Experience tells us that creating barriers and excluding vital services will not save money in the long run. Rather, it will increase the costs for hospitalization, incarceration and other negative outcomes that result from a failure to obtain needed treatment. We disagree with rules that lead to a solely crisis-oriented system which is not cost effective. Most importantly, we consider such rules inhumane.

The focus on time limited services versus longer term support services does not take into account the nature of mental illness. Time limited rehabilitation services will not

work for the majority of persons with a severe mental illness. How can you address a long term, chronic illness with a short term solution?

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

If the proposed rules go into effect, this will have a devastating effect on the lives of our citizens who live with mental illness. We must provide the necessary support networks that have allowed Americans with serious mental illness to begin and continue the long and difficult process of rebuilding their lives.

I encourage you to consider true reform of the mental health system in the United States. True reform would guarantee individuals living with mental illness the basic human rights to the rehabilitation necessary to begin and remain on the path to recovery.

Sincerely,

Jesse Nicholas

CMS-2261-P-1000

Submitter : Ms. Shira Belovicz **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachments

CMS-2261-P-1000-Attach-1.RTF

#1006

Reference: File Code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services Under the Medicaid Program
Submitted By:

Shira Belovicz
103 West Main St.
Apt 2A
Carrboro, NC 27510

Centers for Medicare and Medicaid Services

Submitted To:
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam:

I appreciate the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid Program. I am a member of Club Nova, a Clubhouse Model Program. The clubhouse model is one of the most comprehensive, cost effective, and successful programs in the nation working with individuals living with severe and persistent mental illness. I have personally experienced the effectiveness of rehabilitation services offered through the Club Nova and have been able to participate in my community as a direct result of these services.

Club Nova means having a place to come to everyday. I have a place to have meals and things to do throughout the week. Without this opportunity I don't know where I would be, except locked up in my apartment all day long, which is not good for mental health. I appreciate having social events to do because it's nice to have positive things to do with my time rather than worrying about the negative. Please don't cut any services out for people with severe mental illnesses.

I am very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars by the year 2012 from an already under-resourced service system.

Experience tells us that creating barriers and excluding vital services will not save money in the long run. Rather, it will increase the costs for hospitalization, incarceration and other negative outcomes that result from a failure to obtain needed treatment. We disagree with rules that lead to a solely crisis-oriented system

which is not cost effective. Most importantly, we consider such rules inhumane.

The focus on time limited services versus longer term support services does not take into account the nature of mental illness. Time limited rehabilitation services will not work for the majority of persons with a severe mental illness. How can you address a long term, chronic illness with a short term solution?

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

If the proposed rules go into effect, this will have a devastating effect on the lives of our citizens who live with mental illness. We must provide the necessary support networks that have allowed Americans with serious mental illness to begin and continue the long and difficult process of rebuilding their lives.

I encourage you to consider true reform of the mental health system in the United States. True reform would guarantee individuals living with mental illness the basic human rights to the rehabilitation necessary to begin and remain on the path to recovery.

Sincerely,

Submitter : Mr. Santo Booth **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1001-Attach-1.RTF