June 3, 2008

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2249-P
P.O Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

Reference: File code CMS-2249-P

The Coalition of Behavioral Health Agencies, Inc. is submitting the following comments on 42 CFR Parts 431, 440, and 441 **Medicaid Program: Home and Community-Based State Plan Services**; Proposed Rule published in the Federal Register on April 4, 2008.

The Coalition of Behavioral Health Agencies, Inc. is the umbrella trade association and public policy advocacy organization of New York's behavioral health community, representing over 100 non-profit behavioral health agencies. Taken together, these agencies serve more than 350,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of a diverse New York City and its environs.

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

While we applaud CMS for introducing a whole new concept and option for providing Medicaid services to vulnerable populations, we are deeply concerned that the proposed regulations will pose additional barriers and prove to be more burdensome for providers, including non-profit community based organizations. The Coalition believes the proposed regulations should maximize flexibility and the use of community-based services.

Below, please note the Coalition's specific recommendations and comments as they pertain to the proposed regulations.

Comments re: PROVISIONS OF THE PROPOSED REGULATIONS

**State Plan Home and Community-Based Services Benefit §440.182(b) and§440.182(c)**
**The final rule should not omit "other services" listed in 1915(c)(4)(b). Such services should remain intact under 1915(i) of the Act.**

In §440.182(b) and§440.182(c), the proposed rule states "that the optional State plan HCBS benefit may consist of any or all of the HCBS listed in section 1915(c)(4) for waiver programs, as specified in regulation §440.180, except for the "other" services which the Secretary has the authority to approve for an HCBS waiver." The proposed rule's failure to incorporate "other services" may significantly inhibit providers from delivering the necessary levels of community-based services required to fully meet the needs of diverse individuals across all disability groups. Further, through the omission of an "other services" category, the proposed rule stands in contradiction to the intent of the Act to promote inclusivity across disability groups, and avoid any preferential or detrimental treatment toward particular classes of disabled persons; omission of such services is tantamount to the type of "targeting" strictly prohibited under the Act. We believe the omission of an "other services" category from 1915(i) will also unwisely limit a State's ability to develop a service array most consistent with the provision of comprehensive community-based support. Without proper remedy, 1915(i) enrollment will be affected adversely, and both government and provider efforts to promote community integration for people with disabilities toward avoiding institutional care whenever possible will be impeded.

Recommendation
We strongly urge CMS to include the provision for an "other services" category under 1915(i) of the Act.

**Eligibility for home and community-based services under section 1915(i) of the act §441.556(a)(3)**
**In determining eligibility, the final rule should more accurately account for the nature and current array of community-based housing models for people with mental illness and other disabled persons.**

In the background information section (pg.18685), attention is given to perceived relationship between numbers of residents and the character of a residence (institutional vs. community). While the proposed rule acknowledges the lack of "objective criteria" including numbers of residents in differentiating between institutional and community residences, CMS maintains that

this criterion constitutes "reasonable" cause to "trigger an assessment of the nature of the residence for a specific individual." Given the wide array of housing models in the community designed to meet the needs of individuals with mental illness and other disability groups likely to be classified as "larger," individuals living in these types of community residences face the prospect of unwarranted assessment and bureaucratic delay in service receipt pending a determination of eligibility.

The proposed rule's requirement for "documentation" that the individual is in fact living in a community setting, and not an institution in cases where the individual resides in a setting with four or more persons unrelated to the proprietor, places an undue administrative burden on providers given the high frequency with which this situation will likely occur. Additionally, the rationale for using the number "four" is unclear, as is the type of documentation that would be required by States.

Recommendation
We urge CMS to provide guidance to States on defining a community residence toward promoting the inclusion of all housing types vital to people living with mental illness and other disabilities. We further urge CMS to reconsider using number of residents in determining the nature of a residence, and ultimately, the need for further assessment in determining eligibility for services under 1915(i). In cases where a State may call into question whether or not a particular individual's residence is in fact in the community per an accepted definition, we recommend CMS provide clear direction to States on what types of documentation would be required of providers to prove that a particular residence, or type of residence, is in fact considered a community living facility.

**Independent assessment §441.562**
**The final rule should clarify the relationship between the ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) for the purposes of determining eligibility. Further, all assessments required for the periodic or circumstantial renewal of or change in services should be performed by the individual's regular service provider.**

§441.562 requires as part of the independent assessment "an objective evaluation of the individual's inability to perform two or more activities of daily living (ADLs)…or need for significant assistance to perform ADLs." While an individual's performance of ADLs constitutes an appropriate component of a thorough assessment and helps to identify necessary services and supports, a measure of performance of any number of ADLs, two or otherwise, is neither the best nor a sufficient indicator of disability for the purpose of determining eligibility for services.

When examined within the context of individual assessment, irrespective of whether or not such an assessment is used to determine eligibility, an inability to perform two or more ADLs (e.g. bathing, dressing, toileting, transferring, eating, and continence) is unduly limiting and inconsistent with needs-based criteria for each service established by the States. To the degree that ADLs are emphasized in an assessment, performance of Instrumental Activities of Daily

Living (IADLs) including shopping, food preparation, laundry, financial management, and housekeeping should be taken into consideration. Assessment of individual performance of IADLs affirms a person-centered approach to care, and provides for a more accurate determination of an individual's need for community-based services.

In addition to an initial independent assessment, §441.562(b) requires that an independent assessment of need is to be conducted at least every 12 months and as needed should significant change in need and circumstances of the individual require a revision of the plan of care. We call into question the appropriateness of a repeated "independent" assessment to determine continued eligibility in either case. Under these circumstances, the individual's regular provider of services is most clinically informed and able to, in partnership with the individual, conduct the necessary assessment required to substantiate the need for required ongoing services. We believe this approach to be most consistent with CMS efforts to ensure a person-centered, individualized approach to evaluation and assessment.

Recommendation
We urge CMS to clarify the degree to which an individual's ability or inability, with or without assistance, bears on the determination of eligibility to receive services under 1915(i). We further urge CMS to more closely align eligibility criteria with individual needs vis-à-vis IADLS, and allow an individual's regular service provider to conduct ongoing assessment as needed per the passage of time and or significant change in need or circumstances.

**State Plan HCBS administration: State responsibilities and quality improvement §441.577**
**The final rule should urge States to adopt least burdensome means by which to collect recipient data from providers.**

Per §441.577(a)(1)(i) *Number served* of the proposed rule, States are required to provide annually to CMS the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in State plan HCBS in the previous year. In order to accurately collect and furnish these data to CMS, we anticipate that a high degree of State coordination with providers will be required. The proposed rule does not acknowledge this eventuality nor does it address the resultant burden to providers it will impose.

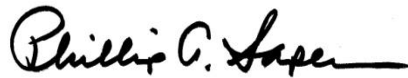
Recommendation
We strongly urge CMS to provide guidance to the States on how to collect required projected enrollment and previous year unduplicated individual numbers in a fashion least burdensome to providers.

## CONCLUSION

We would like to thank CMS for the opportunity to submit comments on 42 CFR Parts 431, 440, and 441 Medicaid Program: Home and Community-Based State Plan Services; Proposed Rule.

If you have any questions, please contact Marc Kutner at (212) 742-1600, ext. 204.

Sincerely,



Phillip A. Saperia
Executive Director

cc:David A. Paterson, Governor, New York State
New York State Congressional Delegation
Richard Daines, Commissioner, New York State Department of Health
Michael Hogan, Commissioner, New York State Office of Mental Health
Thomas Frieden, Commissioner, New York City Department of Health and Mental Hygiene
David Rosin, Executive Deputy Commissioner, New York City Department of Health and Mental Hygiene