



October 2, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Coalition of Behavioral Health Agencies, Inc. is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

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. Take 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.

We are deeply concerned that the proposed regulations will pose additional barriers and prove to be more burdensome for providers of rehabilitative

services, including non-profit community based organizations. We fear the new regulations will result in a decrease in both the quality and quantity of services individuals receive. With the implementation of the proposed regulations, consumers are at greater risk of depending on emergency services – including hospitalization – at a tremendous cost to individuals, communities and ultimately to federal and state governments. Below, please note the Coalition’s recommendations and comments as they pertain to the proposed rule.

Comments re: PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130: Diagnostic, screening, preventive and rehabilitative services

440.130(d)(1)(i)

The final rule should clarify the requirements of an acceptable “individualized recovery goal.”

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

Recommendation:

We urge CMS to clarify the requirements of a Medicaid reimbursable “individualized recovery goal”.

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

The final rule should clarify the definition of an individual providing “input” and “active participation”.

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

Recommendation:

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

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

The final rule should clarify the meaning of restorative services.

The proposed definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before

restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

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

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

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

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

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

Recommendation:

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

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

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

440.130(d)(1)(vii) Definition of medical services

The final rule should include diagnosis as a covered rehabilitation service.

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

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

Recommendation:

We urge CMS to revise the final rule to cover functional assessments as a rehabilitation service. Specifically, we ask CMS to add to section (vii) the word “assessment” before the word “diagnosis” and replace the word “care” with the word “rehabilitation.”

440.130(d)(1)(viii)(2) Scope of Services

The final rule should clarify the definition of scope of services.

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

Recommendation:

We urge CMS to insert the word “restorative” after “medical” in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

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

440.130(viii)(3) Written Rehabilitation Plan

The final rule should clarify the requirements of the written rehabilitation plan.

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, some of the language in this provision is unclear and needs clarification. The proposed requirements will be burdensome, both administratively and financially, for agencies serving individuals in need of rehabilitative services. They will also create another level of complexity for documentation compliance and audits.

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

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

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

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

Recommendation:

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

- that the plan be written plainly in multiple languages so that it is understandable to all individuals;

- that the plan indicate the individual’s level of participation, as well as his or her concurrence with the plan;
- that the plan allow for a qualified provider to sign the treatment plan when the client or their representative is unable to do so or has no family or designated representative;
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that the plan include, if necessary, provisions for crisis intervention;
- that the plan include individualized anticipated review dates that correspond with the anticipated achievement of long-range and intermediate rehabilitation goals;
- provide certification that the individual has been informed about their rights regarding advance directives;
- that the plan allow providers to provide information on potential alternate providers of the same service instead of listing all of the alternative providers in the treatment plan.

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

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

440.130(4) Impairments to be addressed

The final rule should state that all individuals are eligible for coverage of rehabilitation services.

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

Limiting services to only one group, based on diagnosis or disability violates Medicaid’s requirement that services be furnished in sufficient amount, duration and scope to reasonably

achieve their purpose. Not providing coverage of rehabilitative services to individuals with a mental illness would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:

We urge CMS to delete the word “or” after the word “and” in Section 440.130(4).

440.130(5) Settings

The final rule should include a more extensive list of settings where rehabilitative services can be provided.

Recommendation:

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

The final rule should clarify the definition of a rehabilitative service.

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

Recommendation:

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

441.45(b) Non-covered services

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

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

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

foster care or child care institutions for a foster child). What is the legal basis for denying federal financial participation (FFP) for the Medicaid-covered individual? Thus, the rule effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

Recommendation:

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

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

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

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

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

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). This mental health intervention is designed for children both in and outside of the foster care system; it is not a service exclusively for children in the foster care system. The alternative for most children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, a significantly more costly setting.

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

Recommendation:

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

In discussing therapeutic foster care, the preamble states that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, states should

be given the discretion to define therapeutic foster care as a single service and pay through a case rate, daily rate or other appropriate mechanism.

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

441.45(b)(2)

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

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

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

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

Recommendation:

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

441.45(b)(3)

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

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

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are a covered rehabilitative service. The proposed regulations are unclear regarding when personal care services are covered rehabilitation services.

Recommendations:

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

Individuals in Secure Custody and Residing in Public Institutions

The final rule should not include the phrase “in secure custody” and “system”.

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

Recommendation:

We urge CMS to delete the phrase “in secure custody” and “system”.

441.45(b)(7) Services for individuals who are not Medicaid eligible

The final rule should clarify when services for individuals who are not Medicaid eligible are a covered rehabilitation service.

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

Recommendation

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

OTHER ISSUES

Payment and Accounting for Services

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

This new shift in rate setting methodology is inconsistent with evidence-based mental health practices that are based on delivering services together in a flexible and coordinated way. The

shift in documentation and billing procedures significantly increases the amount of time that clinicians must spend completing paperwork, thus reducing the amount of time available to spend with clients. Furthermore, if providers are asked to bill services individually, they will be moving away from the evidence-based model (i.e. therapeutic foster care). Current evidence-based practices include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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

Recommendation:

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

EPSDT Mandate

The proposed regulations ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults.

Recommendation:

We strongly urge CMS to do the following:

- Insert a new paragraph to Section 441.45(a) that will make clear that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.
- Clarify Section 441.45(a)(5) to state that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically-necessary.
- To reference the federal EPSDT mandate in Section 441.45(b)(4), which refers to services having to be targeted under the State’s plan.

CONCLUSION

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

A reduction in federal support for rehabilitation services would force States to make a choice between continuing service provision at the same level at a greater cost in state/local dollars; decreasing the amount and quality of essential services individuals receive; reducing eligibility, benefits, or payments to providers; cutting back on other state programs and using those funds to replace federal Medicaid dollars lost; or a combination of all of the above.

If funding for rehabilitation services is eliminated, overall expenditures for both the Federal Government, States and localities may actually increase because consumers will be re-directed into more costly Medicaid-funded settings, including in-patient psychiatric beds. Other individuals may end up in homeless shelters or in jail, settings which are exorbitantly expensive for taxpayers and personally debilitating for consumers. We are deeply concerned that the proposed rule will harm vulnerable beneficiaries with severe mental illnesses.

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

If you have any questions, please contact Heather R. Mermel, Policy Associate, at (212) 742-1600 ext. 109.

Sincerely,

A handwritten signature in black ink that reads "Phillip A. Saperia". The signature is written in a cursive style with a long horizontal line extending from the end.

Phillip A. Saperia
Executive Director

cc: Members of the New York State Congressional Caucus
The Honorable Spitzer, Governor of the State of New York