



National Association of State Mental Health Program Directors

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 (703) 739-9333 Fax (703) 548-9517

Board of Directors

October 12, 2007

Carlos Brandenburg, Ph.D.
President
Nevada

Virginia Trotter Betts, M.S.N., J.D.
Vice President
Tennessee

James S. Reinhard, M.D.
Treasurer
Virginia

Brian Hepburn, M.D.
Secretary
Maryland

Renata Henry, M.Ed.
At-Large Member
Delaware

Kevin Martone
North-Eastern Regional
Representative
New Jersey

Eddy Broadway
Western Regional
Representative
Arizona

Cathy Boggs
Mid-Western Regional
Representative
Indiana

Michael Moseley
Southern Regional
Representative
North Carolina

Robert W. Glover, Ph.D.
Executive Director
NASMHPD

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

To Whom It May Concern:

Reference: File Code CMS-2261-P

The National Association of State Mental Health Program Directors (NASMHPD) is submitting comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. The regulation changes the definition of rehabilitative services and limits federal financial participation (FFP) for services that are intrinsic to other federal, state or local programs.

NASMHPD represents the \$27.3 billion public mental health service delivery systems serving 6.1 million people annually in all 50 states, four territories, and the District of Columbia. It is the only national association to represent state mental health commissioners/directors and their agencies. In addition, NASMHPD has an affiliation with the approximately 220 state psychiatric hospitals. Our members administer and manage community-based systems of care for the millions of individuals with serious mental illness who at times require immediate access to a variety of inpatient facilities and psychiatric units in general hospitals but are often cared for successfully in the community.

The federal savings from the changes recommended in the proposed regulation are estimated to be \$2.2 billion over 5 years, with a total reduction of over \$4 billion when combined with state matching funds. Since the majority of the spending under the rehab option is for services for individuals with mental illness, the impact on this vulnerable population will be devastating. NASMHPD is deeply concerned that services for individuals with mental illness will be significantly curtailed at a time when only a small fraction of individuals in need of services receive them. There is a substantial body of evidence that the mental health care system lacks the capacity to meet the growing need for services for disabling conditions that exact a heavy toll on both children and adults.

The proposed rule recognizes the seminal findings by the President’s New Freedom Commission with the preamble’s references to person-centered planning, recovery and community-based services. While these principles are reflected in proposed rule’s provisions requiring client involvement in the development of the rehab plan and active treatment, NASMHPD is concerned that some vital services for individuals with mental illness are threatened in an attempt to realize savings. NASMHPD also strongly encourages CMS build a meaningful partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement policies that promote the use of evidence-based practices such as assertive community treatment (ACT), supportive employment and integrated dual disorders treatment. Recent actions by CMS to require states to unbundle services under ACT have the potential to undermine the delivery of coordinated, integrated services that have proven to effective and evidence-based. We are also concerned that the introduction of the “intrinsic element” standard in the proposed rule will prohibit federal support for life skills services that enable an individual to secure and retain employment which is a vital part of recovery from mental illness for many individuals.

The states wholeheartedly support the important role CMS must play to ensure the fiscal integrity of the Medicaid program but find the approach outlined in the proposed regulation to be deeply problematic. We urge CMS to strengthen its efforts to reduce fraud and abuse and increase accountability and cost effectiveness through the audit process and improved utilization review. However, the reduction in services of this magnitude that would result from this regulation would significantly harm a population that is already underserved and vulnerable.

PROVISIONS OF PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

440.130(d)(1)(ii): Other Licensed Practitioner of the Healing Arts

This section defines “other licensed practitioner of the healing arts” as a practitioner “who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.” NASMHPD recommends that the definition be broadened to include practitioners who are credentialed and accredited to practice. Requiring licensure limits the states’ ability to include practitioners who can provide cost-effective and evidence-based treatment.

440.130(d)(1)(iii): Qualified providers of rehabilitative services

NASMHPD strongly recommends that CMS continue to recognize qualified therapeutic foster parents as valid providers of rehabilitative services.

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

“Rehabilitation plan” is defined in this section as “a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals.” The proposed regulation states that the plan will be developed by a qualified provider(s) with input from the individual and others and also ensures the active participation of the individual and others in the “development, review, and modification of the goals and services.” We strongly recommend that the individual and the others described in the regulation are active participants in the plan development as well as in the development, review, and modification of goals and services. It also would be a useful clarification to make a specific reference to person-centered planning processes to ensure a team-oriented process where the individual is an active participant along with the

family. The regulation should establish an exception to the requirement for an individual's participation if the individual has a medical condition that prevents such participation, and for the family's participation if there are compelling therapeutic reasons for excluding family members. These recommendations also apply to Section 440.130(d)(3)(ii) and (xiii).

It is crucial that the rehabilitation plan recognize that individuals may experience relapses or crisis situations. While the potential for recovery exists for all individuals with mental illness, the path will vary by individual and may not be a steady, predictable road to recovery. There may be unavoidable factors that result in relapse or crisis situations. The plan must allow for adjustments that are needed because of changed circumstances and recognize that goals may need to be revisited when unanticipated changes occur.

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

The proposed rule defines "restorative services" as services that are provided to an individual who has had a functional loss and have a specific rehabilitative goal toward regaining that function. The definition is clear that the ability to perform a function may be present even though it has not been demonstrated. Further clarification may be needed for children with serious emotional disturbance. Restorative services should include services to allow a child to achieve age-appropriate growth and development and should not require that a child demonstrate that he or she was once capable of performing the specific task in the past.

The regulation acknowledges that rehabilitation goals are often contingent on maintaining a certain level of functioning but considers services to be rehabilitative only when they are necessary to help the individual achieve a rehabilitation goal. While the regulation should encourage active, goal-oriented treatment, it is vital to recognize there will be instances when retaining functional level is an appropriate rehabilitation goal. Continuous flexible treatment is needed for mental illnesses that can be cyclical or episodic in nature. It is crucial to allow a rehabilitation goal to include maintenance of function for individuals who could deteriorate if services were withdrawn.

440.130(viii)(3) Written Rehabilitation Plan

NASMHPD supports the requirement for a written rehabilitation plan as part of a single, comprehensive treatment plan. Requiring one plan facilitates coordination and accountability and reduces administrative complexity. It would be useful for CMS to be explicit that there should be a single plan, developed by a qualified provider(s) who uses a team-based approach and ensures the active participation of the individual and others. We are concerned that the administrative requirements are excessively burdensome and could result in some providers withdrawing from or limiting their participation in the Medicaid program. The administrative requirements could be especially burdensome if CMS continues to require documentation in 15-minute intervals of service, especially if case notes are required for each unit of service.

441.45: Rehabilitative services

441.45(a)(2)

We recommend that this section be explicit that rehabilitative services under certain circumstances can be furnished to retain or maintain function.

441.45(b) Non-covered services

NASMHPD members have expressed grave concern about the introduction of the intrinsic element standard described in this section. The proposed regulation prohibits Medicaid payment for services that are furnished through a non medical program “as either a benefit or administrative activity” that are intrinsic elements of other programs. Many states and localities pay for services for low-income individuals who are not Medicaid eligible. These services are similar to or identical in nature to those paid for by the state under the Medicaid Rehabilitation Option. These state and county programs generally are not entitlements and are strictly capped by state or county appropriations. Without clarification, this proposed rule might be interpreted to prohibit federal financial participation (FFP) for state plan services that are also funded by states and counties for non-eligible individuals. The "intrinsic element" provision should be stricken in its entirety.

Current regulations prohibit FFP for people residing in public institutions (including jails and prisons) and Institutions for Mental Diseases (IMDs). Beyond current prohibitions, it is unclear what the inclusion of the phrase "in secure custody of law enforcement" intends to accomplish in the context of IMDs and public institutions. The criminalization of persons with mental illness is a critical issue confronting state and federal governments. To address this problem, it is essential to intercept, divert and treat persons with serious mental illness who are in custody of law enforcement officers prior to booking. We urge that the phrase "in secure custody of law enforcement" be deleted as it could result in unnecessary confusion.

Congress has rejected the intrinsic element standard in the past and instead clarified the third-party liability standard which makes Medicaid the payor of last resort. Because this standard is well-established and adhered to by the states, it is clear that this new intrinsic element standard is significantly more restrictive and would result in substantial service reductions under the rehabilitation option.

NASMHPD appreciates the opportunity to comment on the proposed regulation but fundamentally disagrees that it would not have a significant impact on the provision of rehabilitative services as stated in the preamble. In light of the major concerns raised by state mental health commissioners, other mental health advocates and by Congress with its call for a moratorium on the regulation in the recently passed SCHIP bill, NASMHPD recommends strongly that the regulation be withdrawn and that Congress and CMS involve the mental health community and other stakeholders in a thorough evaluation of the rehabilitation option and its effectiveness in providing recovery-oriented services to those with mental illness.

Sincerely yours,



Robert W. Glover, PhD
Executive Director