National Alliance to
END HOMELESSNESS

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IMPROVING POLICY | BUILDING CAPACITY | EDUCATING OPINION LEADERS

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October 12, 2007

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

RE: Medicaid Coverage for Rehabilitative Services
Proposed Rule, File Code CMS-2261-P

I am writing on behalf of the National Alliance to End Homelessness (the Alliance) to comment on the proposed rule, which was published in the Federal Register on August 13 regarding Medicaid coverage for rehabilitation services.

The Alliance represents a united effort that calls for communities to consciously plan to end, not merely manage, homelessness; government institutions and programs to prevent homelessness; the homeless service system to more quickly move homeless families, individuals and youth back into housing; and the country as a whole to make progress on increasing available affordable housing and strengthening social services for low-income Americans.

The ability to access rehabilitation services is vital to our ability to end homelessness. Primarily for the chronically homeless and unaccompanied homeless youth populations, access to physical rehabilitation services, mental health or substance use treatment and other services is the key to maintaining a stable housing situation. A need for these services is apparent when you consider the causes of chronic or youth homelessness.

Research has shown that 45% of homeless people report having a mental health issue in the last year and 57% report having a mental health problem in their lifetime. These is often the people who will become members of the 200,000 chronically homeless people in the United States. In addition, substance abuse and cognitive disorders either cause homelessness or are developed while homeless. In the case of substance use, it can be a way to self-medicate and deal with the trauma associated with homelessness or substance use can contribute to an inability to work or gain income which can cause homelessness.

Cognitive disorders arise as people experiencing homelessness are abused, get in fights or have other accidents that can cause brain injury or for people, like veterans, who acquire a brain injury or cognitive delay and, receive inadequate care and homelessness is one of the adverse results.

Several of the same factors for adults manifest themselves for homeless youth. Substance use disorders and mental health issues are often found among the homeless youth population. Another strong predictor of homelessness is contact with the foster care system. Every year, between 20,000 and 25,000 youth, ages 18 and older, age out of the foster care system. Twenty-five percent of former foster youth nationwide reported that they had been homeless at least one night within 2.5 to 4 years after exiting foster care. One way to prevent youth homelessness is adequately treating mental health or substance use issues. In addition, any developmental or cognitive disorders must be addressed early. Rehabilitation services can accomplish this if they are accessible.

For either population, homelessness can either be prevented or resolved with housing and access to appropriate services, many of which are available under the rehabilitation option for Medicaid eligible populations. It is our aim to strength Medicaid's rehabilitation services coverage to keep the United States moving toward end homelessness.

Alliance Specific Comments

<u>Provisions of the Proposed Regulations</u>

<u>Section E – Settings [440.130(5)]</u>

This section of the regulation can be very helpful in reinforcing that rehabilitative services may be provided in natural settings and build upon natural supports. However, the Alliance urges CMS to revise the preamble language which gives states the authority to determine the setting for service delivery. Rehabilitation services should be available in whatever setting will yield the best results and the appropriate setting should be determined as part of the rehabilitation planning process with input from the individual with mental illness and his or her family.

We also recommend adding to the settings listed in the proposed regulations to clarify that rehabilitative services can be provided in setting such as schools, workplaces and in the community. Assertive community treatment and mobile crisis, for example, often take place in the community and outside of a home or facility. The preamble includes some of these settings and it would be helpful to expand the list or state simply 'other settings as deemed appropriate by the provider'.

Recommendation:
Delete section of the preamble granting states the authority to determine the setting.

Add to the list of settings: … **school, workplace, foster home, group home, mobile crisis vehicle, homeless shelter, outdoor setting, community mental health center, substance abuse treatment setting, community setting** and other settings.

Or

Delete the list and state 'Other settings **are flexible and are determined by the provider and individual with mental illness and his or her family.**' (make sure this includes outside for ACT teams or homeless shelters)

Comments on General Provisions

Section 440.130(d)(1)(v) Definition of Rehabilitation Plan
We agree that the treatment process should be person-centered and include the individual, the individual's family and others of the individual's choosing. This kind of participation is essential to the recovery process. In addition we commend CMS for the requirement that the plan establish goals for rehabilitation services, outlines the services to be provided, and establishes a timeline for re-evaluation and assessment.

However, many homeless families, individuals and youth have had several interactions with various service systems each requiring treatment plans. We recommend CMS encouraging coordination among these systems, increasing efficiency for both government and the individual, by allowing these plans, as long as they meet the requirements of Section 440.130(d)(3) can function as the rehabilitation plan.

Recommendation:
Add language: The requirement for a rehabilitation plan may be met by a treatment plan, individualized educational plan or other plan if the written document meets the requirements in Section 440(d)(3).

Section 440.130(d)(vi) Definition of Restorative Services
The Alliance is concerned about the definition of restorative services. Treatment is not a linear process and for many people is an up and down process. Sometimes over time an individual does not respond to medication that may have worked initially. Individuals in substance treatment have relapses that can cause them to regress in their rehabilitation treatment. In addition, it can be difficult to know what someone's previous abilities were prior to the need for rehabilitation services. People move, treatment systems are fragmented so people do not always interact with the same service providers, or clients are unable to articulate the help they need or the way their illness as progressed. Finally, for youth, rehab goals might be to make sure they can attain proper developmental milestones or skills. It is not logical to have to wait until after they are behind to be able to pay for treatment. Therefore, retention of improved function should be allowable for rehabilitation coverage.

Recommendation:

Amend the language to say: In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary **to prevent regression based on a documented history** and severity of illness or to help an individual achieve a rehabilitation goal defined in the rehabilitation plan.

Secondly, amend the language to: Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. **For children, this can include services to achieve age appropriate skills and development.**

Section 440.130(2) Scope of Services

As it relates to housing models for homeless families, individuals and youth, we agree that Medicaid services should focus on services and not room and board expenses. It is important that the housing community and Medicaid agencies work together toward ending homelessness. For example, permanent supportive housing programs serve the chronically homeless population and provide housing with intensive services. These services can be provided by the housing provider or clients are linked to community support services. Many of these services are rehabilitative and are Medicaid reimbursable. Homeless populations need housing plus the appropriate services to maintain their housing and improve outcomes so maintaining this partnership is essential.

Toward this end, we recommend clarifying language that explains that Medicaid will reimburse for services that are delivered with room and board programs provided that: the client is Medicaid eligible, the program/provider meets Medicaid requirements and the services are Medicaid reimbursable.

Recommendation

Add language: Rehabilitative services do not include room and board in an institution or community setting. However, rehabilitative services can be provided in conjunction with these services as long as Medicaid requirements are met.

Section 440.130(d)(3) Definition of Written Rehabilitation Plan

The Alliance comments CMS for requiring a written rehabilitation plan to guide treatment. We also support the inclusion of the individual and the individual's family in the development of the rehabilitation plan.

However, the Alliance strongly urges additional language to provide needed flexibility to address the nature of mental illness and the current practices in mental health service delivery.

Often services are provide prior to an individual signing off on a treatment plan. For example, assertive community treatment teams (ACT) are an evidence based practice based on an outreach model and a team approach to providing services to individuals with serious mental illness who also have a history of multiple hospitalizations and/or involvement with law enforcement. ACT teams report that they often will need to

provide services for a period of time before an individual is ready to sign a treatment plan. However, they can develop the plan and provide services with the goal of developing social and living skills such that the individual is able to more actively participate and sign a treatment plan.

Moreover, the mental health service delivery system is not always coordinated and individuals with serious mental illnesses can move into new communities. It is not uncommon for an individual with serious mental illness to lack sufficient linkages to the community provider system. An individual with serious mental illness who has been released from jail or the hospital without continuity of care or someone who has recently moved to a new community may experience a crisis and require rehabilitation services such as mobile crisis services. At the point of service, the provider of mobile crisis may not have a treatment plan signed by the individual on file, particularly if that individual was not a previous resident of that community. In addition, an individual in a psychiatric crises may not be able to actively participate in a treatment plan at that time. If the individual has Medicaid coverage, they should be able to get coverage for this intervention regardless of the fact that these requirements for a written treatment plan could not be met. The proposed regulations should have sufficient flexibility to allow Medicaid financing for crisis stabilization services.

Of course, it is preferable to have a planning process and a crisis plan included in the rehabilitation plan. However, the regulations should have sufficient flexibility to recognize that this will not always be possible.

Recommendation
Amend the proposed rule to add:

(xi) …if it is determined that there has been no measurable reduction of disability, **prevention of regression**, or restoration of functional level, any new plan…

(xiv) document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan **or document the exigent circumstances which prevented such participation in the development of the plan, signing of the plan and/or receipt of a copy of the plan. Such circumstances my include, but are not limited to, the need to provide services to allow an individual to begin the planning process or to receive services in the event of an emergency or crisis.**

<u>Section 440.130(4) Impairments to be Addressed</u>

The regulation states that services "may address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs." The Alliance appreciates the express inclusion of mental health and substance-related treatment needs. However, we are concerned about the explicit omission of developmental disabilities and cognitive disorders from the list of impairments to be addressed in this section and in other parts of the rule and preamble. Rehabilitation

services also serve people with these ailments and for clarity, the Alliance believes these disorders should be explicitly stated. We urge CMS to be clear and include developmental and cognitive disorders in the list of impairments.

Recommendation:

Amend to add bolded language: may address the individual's physical impairments, **developmental or cognitive impairments**, mental health impairments, and/or substance-related disorder treatment needs."

Section 441.45 Rehabilitative Services

<u>Section 441.45(a)(1) – Assurance of compliance with other federal regulations</u>

The Alliance appreciates the specific inclusion of these regulatory requirements. However, it would be helpful to also include the regulatory and statutory requirements of Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), which mandate that Medicaid beneficiaries under the age of 21 must receive all medically necessary services to ameliorate or correct a physical or mental condition regardless of whether the services are included in a state's Medicaid plan. 42 U.S.C. Section 1396d(r)(5) and 42 C.F.R. Section 440.40(b).

EPSDT is a critical requirement for children with mental illness who require rehabilitative services to facilitate their recovery and full participation in their schools and communities. Early treatment for mental illness is a prevention measure for poor outcomes, including homelessness. States should be required to ensure that nothing in their implementation of these regulations will compromise the mandate in the EPSDT provisions.

Recommendation:

Add bolded language: **and 440.40(b)** of this chapter and **42 U.S.C. Sections 1396(d)(r)(5) and 1396a(a)(43).**

<u>Section 441.45(a)(5)(iii) Specifies the methodology under which rehabilitation providers are paid.</u>

Each state will be required to submit a state plan amendment on rehabilitation services. The Alliance strongly urges CMS to allow states maximum flexibility in payment methodology to support evidence based practices. As the preamble notes, the President's New Freedom Commission determined that more adults and children with serious mental illnesses would recover if they had access to evidence based treatment. CMS should ensure that its policies facilitate providing more access to effective services such as Assertive Community Treatment, Multi-Systemic Therapy and Therapeutic Foster Care.

Many states find it administratively efficient to combine services provided in these evidence based treatment programs, a practice commonly known as "bundling." Services

can be bundled into a case rate, daily rate or similar arrangement. This allows a provider to predict revenue and facilitates its ability to hire the extensive teams of individuals required to provide these services with fidelity to the model. ACT services, for example, will often be provided by a 10 member team, including nurses, a psychiatrist, a peer specialist, a substance abuse specialist and others. States should be given the flexibility to continue bundling services to treat the whole person as comprehensively as possible.

CMS's goal of ensuring that Medicaid is not paying for non-rehabilitative services can be achieved by examining the services that are combined in the bundled rates. States should be required to explain their rate setting methodology, but they should not be arbitrarily prohibited from using bundling methodologies that are efficient and essential to significant expansion of the availability of the evidence based services. CMS allows managed care arrangements that use similar methodologies and should be consistent in its review of state rehabilitation plan amendments.

Recommendation:

In reviewing state plan amendments, CMS should allow states flexibility in rate setting methodologies. If there are concerns about the services that are provided within a bundled rate methodology, CMS should review the state's documentation of the specific services they intend to provide within the combined rate.

Section 441.45(b)(1) Services that are excluded from rehabilitation, including those that are intrinsic elements of other programs

The Alliance urges CMS to strike this section because these provisions create an ambiguous standard that states and beneficiaries will be unable to apply. The regulation gives no guidance on how to determine if a service is an intrinsic element of programs other than Medicaid. Individuals with mental illnesses, their families, and state policymakers will not be able to determine what is intrinsic to other programs and this lack of clarity undermines the integrity of the Medicaid program.

Moreover, the ambiguity of the proposed regulation places states in an untenable position. They can either forego federal funds that they may be entitled to or they can bill Medicaid and risk an audit and the eventual loss of state dollars. For Medicaid to operate successfully as a state-federal program, the terms and conditions of the relationship and what can be provided must be clear and readily applied by states.

Furthermore, the current language in the proposed rule can be read to disallow rehabilitative services that are furnished through a non-medical program as either a benefit or an administrative activity, including those that are intrinsic elements of other programs. However, under the Medicaid statute, a Medicaid eligible individual who resides in a state that has chosen the rehabilitation option is entitled to rehabilitative services paid for by Medicaid regardless of their participation in another program. This is particularly important for permanent supportive housing (PSH) programs, an evidence based model for housing chronically homeless individuals. For formerly homeless clients

to succeed, services are essential and Medicaid is the appropriate way to pay for these services. Clients in PSH are often Medicaid eligible due to their disability status. It is essential that this regulation not prohibit PSH providers from receiving Medicaid reimbursement. Services in PSH are essential to the program but not an intrinsic element of any single other ongoing federal payment source. In addition, the proposed language in Section (b) (1)(i) regarding therapeutic foster care acknowledges this distinction and provides an exception for "medically necessary rehabilitation services for an eligible child." This language should be included in Section (b)(1) to clarify the agency's intent.

Clarifying language is also important for children, who are entitled to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). As previously noted, this mandate requires that children receive all necessary services to correct or ameliorate a physical or mental condition, regardless of whether the service is covered under the state Medicaid plan. *See* 42 U.S.C. Section 1396d(r)(5). Thus, Medicaid eligible children are entitled to all rehabilitative services necessary to ameliorate a physical or mental condition such as mental illness. This clear mandate also applies regardless of whether the rehabilitative service is intrinsic to another program or is furnished as a benefit or administrative activity of another program.

Finally, third party liability rules under Medicaid have recognized that states have an obligation to determine if another entity is legally liable for payment of the services. If CMS is unwilling to strike the language, the proposed regulations should be clarified such that services are only excluded if the other program has a specific legal obligation to pay for services to a specific Medicaid recipient. Programs that are financed by capped or discretionary appropriations from state or local entities should be specifically excluded from these provisions.

The Alliance believes that if this language is unchanged, it will have a devastating effect on the ability and willingness of other programs to provide quality treatment to adults and children with serious mental illnesses. These other programs are often operating with little resources and growing need. If they are denied Medicaid resources to pay for the treatment for individuals with mental illnesses, some are likely to fail to provide needed services and others may refuse to serve individuals with mental illnesses.

Moreover, the ambiguity inherent in the language of the proposed rule will discourage the dissemination of evidence based practices in these other programs. The Alliance is just beginning to see child welfare, juvenile justice and corrections programs that serve large numbers of homeless adults and youth with serious mental illnesses recognize the value of these mental health interventions and coordinate with the mental health system to adopt such practices. Research clearly shows that this coordination leads to better outcomes. The proposed rule should facilitate and not impede such progress.

The Alliance strongly urges CMS to reconsider the current language in this section of the proposed rule which furthers fragmentation by discouraging other systems from offering treatment to individuals with serious mental illnesses. We are deeply concerned that this

provision will move us in the wrong direction at a time when states are showing progress in moving toward systems' coordination.

Recommendation:
Strike Section 441.45(b)(1).

If CMS is unwilling to strike this section, add:

"including services that are intrinsic elements of programs other than Medicaid [list of programs], **except for services which are medically necessary rehabilitation services for an eligible individual.**

And add: **This exclusion will only apply if the programs other than Medicaid are legally liable to provide the services to a specific Medicaid eligible individual. Discretionary appropriations do not constitute legal liability to a specific individual.**

<u>Sections 445(b)(i) and (ii) Exclusion of Therapeutic Foster Care Services</u>
Therapeutic foster care, also known as treatment foster care (TFC), has a strong evidence base supporting its effectiveness for children with serious mental illness. Trained parent/providers work with youth in the treatment home to provide a structured and therapeutic environment while enabling the youth to live in a family setting. These services are effectively used to avoid out of home placement and more trauma to the child and family. Moreover, this intervention has been proven in multiple clinical trials to improve functional behavior, reduce contact with law enforcement, and decrease hospitalization and out of home placements.

As part of the President's Executive Order on Community Based Alternatives for People with Disabilities, the President ordered federal agencies to review their policies and regulations "to improve the availability of community-based services for qualified individuals with disabilities" and promote the integration of adults and children with disabilities in their local communities. Coverage for rehabilitation services should facilitate the provision of treatment foster care so children with mental illnesses can continue to live in the community, rather than in more costly residential and hospital settings.

Recommendation:

The Alliance agrees with the American Public Human Services Association to amend the proposed rule by striking 441.45(1)(i) and (ii).

<u>Section 445(b)(1)(iv): Exclusion for Teacher Aides</u>

The Alliance urges CMS to clarify that the language regarding school services does not apply to behavioral health aides and other mental health providers who address a child's functional impairments which interfere with his or her ability to learn. Mental health providers in the schools play an essential role in allowing children to develop into

productive, independent adults and the proposed regulations should encourage the provision of these services. The New Freedom Commission called for schools to play a far greater role in effectively addressing the mental health needs of students and the Alliance recommends amending this provision to ensure consistency with that call to action.

Recommendation:

Add: Routine supervision and non-medical support services provided by teacher aides in school setting (sometimes referred to as "classroom aides" and "recess aides"), **however this exception shall not apply to behavior aides and other related service providers in the classroom that are designated to address a specific child's functional impairments and to provide rehabilitative services for that child**.

Section 441.45(b)(4): Exclusion of services provided by public institutions.

This section of the proposed rules restates current law with respect to public institutions. The Alliance appreciates the language stating that "rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement…"

The language, however, also states that such community services cannot be "part of the public institution system." The Alliance urges CMS to strike the word "system" to be clear that community services which are rehabilitative are reimbursable regardless of whether a child or adult remains part of the juvenile justice or correctional system. This is particularly important for rehabilitation services that are provided in the community while the youth or adult with mental illness is still under the auspices of the correctional system, such as mental health services in a group home for children who are under juvenile court jurisdiction or forensic assertive community treatment for adults who are still in the corrections system. This clarification is very important given the large numbers of youth and adults with mental illnesses who come under the jurisdiction of these systems. It is consistent with other sections of the preamble and regulation which recognize that involvement in other programs does not affect Medicaid eligibility for services.

The Alliance also strongly urges deletion of language indicating that community services can only be reimbursable if they are not used in the administration of other non-medical programs. This language is ambiguous and the preamble gives no guidance to determine whether services are used in the administration of a non-medical program. The Alliance believes that a Medicaid eligible individual should receive rehabilitative services if medically necessary to address a functional impairment regardless of any involvement in another program. Again, this is particularly important in permanent housing programs for individuals, families or youth that also provide services. These primarily housing programs could be considered non-medical and thus unable to receive Medicaid reimbursement for rehabilitation related services. This will create a barrier to achieving

President Bush's goal of ending chronic homelessness by 2012 and will create unnecessary obstacles for other homeless populations too.

Recommendation:
Strike the following language: … that are not part of the public institution ~~system~~, when the services are identified due to a medical condition targeted under the State's Plan, ~~are not used in the administration of other non-medical programs.~~

The Alliance appreciates the opportunity to provide comments and looks forward to working with CMS to increase Medicaid coverage for homeless people.

Sincerely,

Nan Roman
President