#1001

Reference: File Code CMS-2261-P

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

Santo Booth
P.O. Box 2117
Chapel Hill, 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 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 been a place for me to come and spend time with people. I enjoy working in the Thrift Shop because I enjoy working with people and socializing with people. Club Nova means a lot to me because it keeps me off the streets and out of trouble.

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.

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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,

Santo Booth

Submitter : Anne Quashen **Date:** 10/12/2007

Organization : Anne Quashen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that you withdraw the proposed habilitative services regulations for people with developmental disabilities. Elimination of critical services that enable these people to improve or maintain basic life skills would be disasterous.The regs.impose discriminatory & arbitrary criteria to exclude people with developmental disabilities from receiving essential services.

Submitter : **Mrs. Judy Sabater James** **Date: 10/12/2007**

Organization : **Saint Dominic's Home**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

We oppose the provisions outlined related to excluding federal financial participation for habilitation services for individuals with developmental disabilities. This is a valuable service that enables individuals to work on goals, make choices, fosters independence and lead more productive lives. We urge you to withdraw this proposed rule

Submitter : Mr. Phillip Lubitz **Date:** 10/12/2007

Organization : NAMI NEW JERSEY

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attached

#1004

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

CMS-2261-P-1005

Submitter : Ms. Marilyn Ciocci **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1005-Attach-1.RTF

#1005

Reference: File Code CMS-2261-P

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

Marilyn Ciocci
103 D West Main Street
Apt 2E
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 guaranteed friendship, emotional interdependency, empathy, and mutual understanding. Other clients have told me that I do an excellent job of maintaining the clubhouse an hour a day. It's good to know that I'm pleasing other people even if I'm not in the mood to work. It's about being somebody's strength when the chips are down.

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?

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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,

This discussion creates confusion. This emphasis on change in status and on achievement of specific goals may lead states to deny coverage for medically necessary rehabilitation services because such services may not lead to immediate results. Recovery is not necessarily a linear process. It may appear that progress toward a goal is not being made when, in fact, a plateau or relapse may be part of the natural progression of recovery. This is true with physical or mental illnesses and with substance abuse. Again, the Medicaid statute, which CMS is apparently attempting to bypass, emphasizes the importance of rehabilitation services to attain independence and health[20]. The overall emphasis of the rules and commentary, however, creates a strong possibility that states will actually apply a more narrow definition than is appropriate.

Moreover, services aimed at maintaining function could fit under a category of service other then rehabilitation For example, assistance with dressing or eating could be covered as a personal care service, as could supervision to prevent injury. This should be recognized both in the preamble and in the regulations.

This is particularly true under EPSDT. Because any of the categories of Medicaid services that are necessary to "correct or ameliorate" must be covered to address an individual child's physical or mental condition, there is an even greater likelihood that the actual service needed will be covered. Moreover, this agency has a long-standing policy of recognizing that maintenance therapy may be covered[21]. The overly restrictive definition and interpretation in this area may conflict with longstanding agency policy.

Recommendations:

Add the following language to proposed regulation § 440.130(d)(1)(vi): "Failure to make measurable progress toward a particular goal within a certain time period does not necessarily indicate that a service is not necessary to help achieve a rehabilitation goal."

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[20] 42 U.S.C. § 1396

[21] See, e.g., Letter from Andrew A. Frederickson, Chief, Medicaid Operations (Region VIII) to Garth L. Splinter, CEO, Oklahoma Health Care Authority (April 9, 1999); HCFA, Medicaid State Bulletin, 231 (Sept. 10, 1992); Letter from HCFA to Regional Administrator, Region VIII (Oct. 2, 1991).

Add a new subsection (c) to § 441.45, with the following language: "If a service cannot be covered as a rehabilitative service, states shall determine whether the service can be covered under another category of Medicaid services." Also, add discussion to Section II.C. of the preamble that maintenance services could qualify for coverage under another category of services and give examples of other categories.

Delete the language at 72 Fed. Reg. at 45204, Section II.C of the preamble stating that "[i]f it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy . . ."

Proposed § 440.130(d)(5) - Settings for Service Provision

Proposed § 440.130(d)(5) includes the statutory requirement that services be provided in a facility, home or other setting. In the preamble, however, it is stated that states "have the authority to determine in which settings a particular service may be provided.[22]" This conflicts with the statutory definition of 42 U.S.C. § 1396d(a)(13). The statutory definition defines the service as "rehabilitation services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts." The way this definition is written does not give states the authority to pick and choose among appropriate settings for services. Rather, the point of the definition is that the services constitute rehabilitation services if they meet the definition, regardless of the setting in which they are provided.

Recommendations

Clarify that rehabilitation services should be covered in any setting permitted by state law, including schools.

Add the other settings listed in the preamble (schools, community mental health centers, and substance abuse treatment centers) to § 440.130(d).

[22] 72 Fed. Reg. at 45205 (Preamble, II.E)

Proposed § 440.130(d)(1)(vi) – Restorative Services

Three days after CMS issued these proposed regulations, it also issued a letter describing peer guidance and explaining how it could be covered under the rehabilitation option[23]. As CMS acknowledges in the letter, this is an important service for individuals with mental illness and substance abuse services. Given its obvious importance to CMS, States, providers and patients, the specifics of this guidance should be referenced in the regulations.

Recommendations:

Section 440.130(d)(1)(vi), which describes "restorative services" should be amended and language added stating that peer guidance is a covered rehabilitation service.

Proposed § 441.45(b)(1) – Non-Covered Services

The proposed rule announces that services will not be provided if they are an "intrinsic element" of a program other than Medicaid[24]. The term "intrinsic element" is not defined. This will cause confusion for state Medicaid officials and providers and could cause erroneous denials of coverage for services. Moreover, it is based on a faulty premise. These service exclusions will predominantly, if not exclusively, apply to services for children under age 21, given the nature of the programs implicated. Thus, these children will all be eligible for EPSDT, under which a service should be covered if it is necessary to correct or ameliorate a physical or mental condition, even if it could be covered under another program. The proposed regulation appears to acknowledge this in § 441.45(b)(1)(i) and (ii), but not with sufficient clarity and ambiguity in promulgation of regulation never works in favor of the regulated community.

Moreover, this requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services under the Individuals with Disabilities Education Act (IDEA) and third party payment. In Section I.A. of the preamble, it is noted that Medicaid has been used to fund services that are included

[23] Dear State Medicaid Director, Peer Support Services – SMDL #07-011 (August 15, 2007)
[24] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(1))

under the IDEA[25]. Such coverage is permissible and appropriate as the Medicaid statute specifically provides that the Secretary cannot prohibit or restrict coverage of Medicaid services simply because the services are included in an individualized education plan for IDEA services[26]. Also, the Medicaid statute requires that State and local agencies administering the state Medicaid plan "will take all reasonable measures to ascertain the legal liability of third parties . . .[27]" Even if a third party is liable, when EPSDT services are at issue, the Medicaid agency is supposed to pay a claim for services, then pursue reimbursement from the liable third party[28]. Thus, when a service is the responsibility of a third party, the other program is still a third party payer.

The proposed rule excludes Medicaid reimbursement for rehabilitative services that are "intrinsic element of other programs" even if they meet all of the other requirements in the proposed rule at 441.45(b). This exclusion is has no legal foundation. Title XIX does not exempt Medicaid reimbursement for services merely because they are part of another program. In fact, Title XIX was designed by Congress to work in concert with child welfare, special education, and other complementary health care and social services. Medicaid is a financial services program and as such is the payer of items and services known as medical assistance. In addition, it is the enabler of medical assistance and program administrative activities. The other programs the proposed rule would eliminate are the means by which this medical assistance financing actually delivers health care services and support to children. The Medicaid law was designed to augment and enhance education, social support, and child welfare programs, not duplicate them.

It is difficult to understand what CMS means by the term "intrinsic." When the administration attempted to advance its "intrinsic" argument in 2005[29], it became evident that the concept reflected a fundamental misunderstanding of Medicaid's interaction with other programs serving children and the recommendation was rejected. Now the Administration seeks to do by regulation what Congress already has

[25] 72 Fed. Reg. at 45202
[26] 42 U.S.C. § 1396b(c)
[27] 42 U.S.C. § 1396a(a)(25)(A)
[28] 42 U.S.C. § 1396a(a)(25)(E); 42 C.F.R. § 433.139(b)(3)(i) (2007).
[29] Medicaid's Rehabilitation Service Option, op. cit. p. 13

rejected by statute. The rehabilitation NPRM resuscitates the "intrinsic" exclusion once again, this time broadening it still further. As before, the Administration excludes payments for "intrinsic" elements while offering no definition of "intrinsic elements." But the NPRM also goes beyond the vagaries of the "intrinsic element" test to exclude payment for covered rehabilitation benefits in the case of children who are receiving services in the case of other specific programs. As a result, the rule adds a coverage condition not contemplated by the statute, which functions as the type of coverage exclusion common to commercial insurance[30]. In the proposed regulations, CMS states:

> This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused on social or educational development goals in programs other than Medicaid. . . . We propose . . . that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole, and probation, juvenile justice or public guardianship. We also proposed that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid[31].

This specific exclusion of payment in the case of children whose medical assistance covered treatments are being arranged for by other programs represents a blatant attempt to add conditions of coverage not permitted under the statute. It grafts onto Medicaid a payment exclusion that simply does not exist. The exclusion is a reflection of a desire on the part of the Administration to push Medicaid, in terms of coverage design, in the direction of commercial insurance, a direction that Congress has rejected in the case of children[32].

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[30] Crossing the Medicaid and Private Health Insurance Divide, op. cit.
[31] 72 Fed. Reg. 45201, 45202 and 42505
[32] Crossing the Medicaid and Private Health Insurance Divide, op. cit.

Recommendations:

We believe this section should be omitted in its entirely, because it conflicts with the EPSDT requirements and other parts of the Medicaid statute.

In the alternative:

Section 441.45(b)(1)(iv) should be amended to restate that Medicaid coverage should not be denied merely because a service is provided in an individual education plan.

The responsibilities for states regarding third party payers, and the third party payers' own responsibilities, should be recognized and clarified in § 441.45(b)(1), and reference made to 42 C.F.R. § 433.139 (2007).

Proposed § 441.45(b)(2) - Habilitation Services

The proposed regulations make it explicit that habilitation services are not coverable as rehabilitation services, because they are designed to help individuals acquire new functional abilities rather than to restore function[33]. The discussion and regulation regarding habilitation is problematic for several reasons.

First, it seems to be based on the premise that individuals with mental retardation or similar conditions would never have a need for rehabilitation services. This is overly broad and will lead to automatic exclusion of services for this population when they may be appropriate.

Second, neither the regulations nor preamble acknowledge the different nature of some "related conditions," which include epilepsy, autism, and cerebral palsy[34]. These diagnoses can cause loss of function that needs to be restored, thus, those individuals would need and could benefit from rehabilitation services.

Third, the proposed rules do not provide guidance for coverage of services for individuals with dual diagnoses of mental retardation/related conditions and mental illness. The proposed regulations acknowledge that physical impairments and mental

[33] 42 C.F.R. § 441.45(b)(2), see also 72 Fed. Reg. at 45205 (Preamble,II.F.2)
[34] 42 C.F.R. § 435.1010 (2007)

health and/or substance related disorders can be appropriately treated with rehabilitation services[35]. However, there is no explanation of how states may cover services for those with dual diagnoses and how they may justify doing so when claiming FFP. This is likely to lead to denial of medically necessary covered services for a population that already faces significant barriers to care.

Recommendations:

Add language to § 441.45(b)(2) stating that a diagnosis of mental retardation or related conditions does not automatically exclude a person from coverage of mental health services.

Add the following language to § 441.45(b)(2): "Habilitation services may also be provided under other Medicaid services categories, including but not limited to therapy services, defined at 42 C.F.R. § 440.110 (including physical, occupational, and speech/language or audiology therapy) and medical or other remedial care provided by licensed practitioners, defined at 42 C.F.R. § 440.60."

Clarify that services for individuals with a dual diagnosis of mental retardation/related condition and mental illness may be covered, and provide further explanation of how that coverage can be achieved.

Proposed § 440.130(d)(3) - Written Rehabilitation Plan

If proposed rule 2261 is interpreted by CMS to allow continued Medicaid reimbursement for school-based rehabilitative services, LEA staff would be required by the proposed rule to develop and implement individualized rehabilitation plans which may be duplicative of the individualized education programs (IEP) required under IDEA.

We believe that an IEP developed in accordance with IDEA should satisfy CMS's stated intent to ensure that rehabilitative services are medically necessary and designed and coordinated to lead to maximum reduction of the student's physical or mental disability and restoration of the student to the best functional level. The IEP process

[35] 72 Fed. Reg. at 45212 (Proposed § 441.45(b)(2))

includes student progress evaluation and monitoring standards as well as extensive due process protections for students and their families. Therefore CMS should clarify that the IEP will satisfy Medicaid requirements for rehabilitation service.

Proposed Elimination of Transportation Services

Proposed rule 2261 would eliminate Medicaid reimbursement for transportation services that are provided for under the rehabilitative services option under a state's plan for Medicaid.

Many state include school-based transportation services under the rehab option in the State plan for Medicaid. Under proposed rule 2261, CMS seems to imply that transportation services are not appropriate "rehabilitative" services under the rehab option and that elimination of reimbursement for the services is the appropriate remedy to correct the state plan amendments that CMS previously approved. This approach is extreme, unreasonable and fundamentally unfair to school districts unless CMS is only requiring that the State Medicaid agency to amend the State plan to provide for school-based transportation services under an alternative section. This can be done without any disruption in current school-based transportation services or Medicaid revenue.

Non-covered services: 441.45(b)

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 "intrinsic elements" of that program. 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 "intrinsic element" of another program.

There appear to be 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, 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)[36]. 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.

Recommendations:

We strongly recommend that this entire section be eliminated because it conflicts with the Medicaid statute.

Summary:

As we have discussed above, we believe that proposed rule 2261, as published in the Federal Register on August 13, 2007, is contrary to established federal Medicaid law and totally without any legal basis. The Social Security Act includes the following language when addressing rehabilitative services: "Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[37]" The fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources

[36] 42 U.S.C. §§ 1396a(a)(10), 1396d(r)
[37] [Social Security Act, Section 1905(a)(13)]

has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service. We believe the proposed change would undermine the very purpose of the program, eroding coverage for and therefore access to services needed by many of our most vulnerable citizens.

Therefore, we respectfully request that CMS retract this proposed rule to the extent that it applies to school-based rehabilitative services provided to or on behalf of children with disabilities.

- END -

Submitter : **Dr. David Birney** **Date: 10/12/2007**

Organization : **Peak Wellness Center, inc.**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-1007-Attach-1.DOC

#1007

Peak Wellness Center, Inc.
P.O. Box 1005
Cheyenne, WY 82003-1005
October 12, 2007

Centers for Medicare & Medicaid Services
Dept. 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

I am writing as Executive Director of Peak Wellness Center, Inc. in Cheyenne, Wyoming to express my concern regarding the Proposed Rule for Coverage for Rehabilitation Services under the Medicaid program, as published in the Federal Register on August 13, 2007. Peak Wellness Center the state-designated community mental health and substance abuse center for the southeast portion of Wyoming. We serve well over five thousand of our citizens each year. A large number of our clients are adults with serious and persistent mental illness and children with serious emotional disturbance.

I am concerned that there are several provisions within the Proposed Rule that will serve as a barrier to care for our clients, and result in less effective care, deterioration in their quality of life, and a surge in expensive hospitalizations.

Within the Rule 440.130(d)(vi) there is a definition of restorative services that may suggest that services are designed only to restore previous functioning. Why this is usually our goal, activities to maintain functioning are also a crucial component of the treatment we provide. Lacking this supportive function, many clients would lose the gains they have made and relapse into more severe illness. In addition, for many clients, including children, their illness has interrupted normal development and prevented them from acquiring age appropriate skills. Limiting services to "restorative" for individuals

who have been unable to gain needed skills is unrealistic, since there are often no skills to "restore." We strongly recommend that the definition include provisions for services for both those who have never had necessary skills and for services to maintain functioning.

Within Rule 440.130(viii)(3) Written Rehabilitation Plan there are various provisions for what may be a rehabilitation plan separate from the integrated treatment plans we already develop with our clients. There are also numerous provisions that make this document unnecessarily complex for all involved, including the client and the client's family. While there appears to be intent to increase client involvement, these complexities will in fact make the plan unintelligible to the average client. Our recent goal in planning has been to work cooperatively with clients to develop treatment plans that are clear, concise, comprehensive, and relevant to our client's lives. Anything that makes this process more complicated is a serious detriment to client care. We are recommending that the planning provision in the rule be re-examine to ensure that plans are integrated and client-friendly.

In 441.45(b) Non-Covered Services, Medicaid coverage is denied for covered services to covered individuals if such services are furnished through another program. While this provision makes sense on the face of it, its implications remain extremely unclear. I need not tell you that health care is extremely complex and what is covered and not is a swiftly moving target. Since Medicaid is always the payer of last resort, I simply do not know what this provision means. We recommend that it be dropped, or minimally clarified and narrowed.

Finally, should these proposals become final, we encourage that states be provided a substantial planning and implementation period of a minimum of one year and preferably longer. We fear that these proposals may throw our systems of care into chaos, endangering the lives of our clients. Provisions need to be made to protect the well-being of our citizens.

Yours truly,

David Birney, Ph.D.
Executive Director
Peak Wellness Center, Inc.

Cc: Senator Mike Enzi
Senator John Barrasso
Representative Barbara Cubin
Governor Dave Freudenthal
Dr. Brent Sherard, Wyoming Department of Health
Rodger McDaniel, Wyoming Department of Health

Submitter : Mr. Timothy Pettrey **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1008-Attach-1.RTF

#
1008

Reference: File Code CMS-2261-P

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

Timothy Pettrey
PO Box 57
Cedar Grover, NC 27231

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 Club Nova and have been able to participate in my community as a direct result of these services.

I think Club Nova is a wonderful place. I have never been to a place like Club Nova before. I like meeting and socializing with people. I really like the chance to go on socials with other members and staff, especially festivals. I think it's important to work and stay busy. That's why I work in the kitchen every day. Club Nova gives me a place to work *and* relax. If I didn't have Club Nova, I feel like I would be wasting all my time. I don't think I'd have the opportunity to work like I do.

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?

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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. Steven Vernikoff **Date:** 10/12/2007

Organization : The Center for Family Support, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

The exclusion of habilitative services for people with developmentally disabled will cause them great harm. These services facilitate their integration into the community settings they now live in and enhance their capacity for independence. Removing these services will result in lesser independence for these individuals.

Submitter : Mr. Adrian Empson **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1010-Attach-1.RTF

#1010

Reference: File Code CMS-2261-P

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

Adrian Empson
148 Lincoln Lane
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.

I come to Club Nova for the friendship. The staff is very helpful whenever I have problems. Club Nova gives me work experience, which helps me with finding job opportunities. Club Nova gives me a place to hang out and have friends, a place to come whenever I feel lonely or sad. The meals are good and I like to help out wherever I can. Club Nova has a very safe atmosphere and provides me with transportation to and from the clubhouse. Club Nova is very supportive and backs their members up whenever problems happen.

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. Vicente Estrada **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1011-Attach-1.RTF

#1011

Reference: File Code CMS-2261-P

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

Vicente Estrada
103 West Main St.
Apt. 1 A
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 is a place where I can spend time with friends. I am satisfied with the services Club Nova provides. The staff is very friendly and I enjoy participating in the social events. It means to me being part of a family.

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

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Re: 441.45(b) Intrinsic Element Standard

Please eliminate this part of the proposed rules. This -- more than anything else you've proposed -- will be harmful to the kids who most need these services.

Submitter : Mr. Roy Probeyahn **Date:** 10/12/2007

Organization : L.I.Task Force on Aging Out Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a family member of 3 sons with autism/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.
These folks have no other resource for the quality of their life. This change will eviscerate their life in the community.

Submitter : Ms. Trina Scannapieco-Laurent **Date:** 10/12/2007

Organization : Quality Services for the Autistic Community

Category : Other Health Care Provider

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. Please withdraw your proposal because it would be devastating to millions of individuals that need these services to survive.

Submitter : Mr. Segun Shelton-Green **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : Mr. Ed Hudgins **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-1016-Attach-1.RTF

#1016

Reference: File Code CMS-2261-P

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

Ed Hudgins
1310 – 6 Ephesus Church Rd.
Chapel Hill, NC 27517

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,

As both a consumer and provider of mental health services, I can certifiably say there is no better way to treat mental illness than through rigorous, thorough, and excellent services. To give up and not provide adequate services is a statement that could lead to consumers giving up on any hope of recovery. Medicaid is a very important ingredient for many, many consumers. For Medicaid to turn its back on the very people it was designed to assist would be a travesty. As a consumer of nearly 30 years, many of the services I have received have indirectly been funded by Medicaid. Without personal Medicaid coverage during those years, the funding received by these programs has allowed me to benefit and continue on a progression of recovery and stability. Somewhat of a two-for-one deal and there are others who fall into this category. Please be diligent when considering new policies and please do not forget the people who need Medicaid the most and could suffer the most from cuts in the program.

Sincerely,

Ed Hudgins

Submitter : **Miss. Esther Thompson** **Date: 10/12/2007**

Organization : **Pathways Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1017-Attach-1.DOC

#1017

PATHWAYS CLUBHOUSE
A Part of: ADULT&child

October 17, 2007

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

To Whom It May Concern:

I am submitting the following opinion in response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

Some of the proposed rule changes simply reduce this population's access to needed services - without any back up plan to fund services or programs. Many of these services have been working effectively with CMS approved Medicaid funding for more than ten years, However, with the recent changes in CMS practice, they now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need. The net result is that vast numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.

To create, or suddenly start enforcing, bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial cut in services for people who already have more than their fair share of burdens. A reduction or elimination of services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse in our prison system.

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of functioning.' Because recovery from mental illness is often a long term process, this definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent

Beech Grove / 3841 S. Emerson Avenue / Suite C
Indianapolis, IN 46203: 317-882-3699 / Fax: 317-784-3068
www.geocities.com/pathways_clubhouse / Email: pathways_clubhouse@yahoo.com

funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses and other clubhouses using this model more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

Therefore it is my opinion that none of the proposed rule changes should be implemented until each state (or the federal government) has a plan actively in place to provide the necessary recovery focused services that would no longer be "covered" by Medicaid. The plan must not exclude people with mental illness from psychosocial services needed to maintain their recovery progress, such as ICCD Certified Clubhouses and other clubhouses using this model.

It is a mistake to re-organize funding for long approved services in an effort to reduce short term spending. A poorly developed strategy will result in unnecessary - and more costly emergency spending and over-reliance on emergency services.

Most importantly, these changes will have a tragic impact on the lives and futures of millions of people struggling to recover from the long term effects of serious mental illness. In the interest of short term spending cuts, these changes will quickly erode the essential support networks that have allowed Americans with serious mental illness to begin the long and difficult process of rebuilding their lives. In my opinion, that would be an unconscionable mistake.

Sincerely,

Esther Thompson
3841 S. Emerson Ave. #C
Indianapolis, IN 46203

Submitter : Mr. Tim Nanof **Date:** 10/12/2007

Organization : American Occupational Therapy Association

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

See attached

Collections of Information Requirements

Collections of Information Requirements

See attached

GENERAL

GENERAL

See Attachment

#1018

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

lease note: We did not receive the attachment that was cited in his comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

CMS-2261-P-1019

Submitter : Ms. Irina Tuchina **Date:** 10/12/2007

Organization : Ms. Irina Tuchina

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

As a person involved in working with people 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

CMS-2261-P-1020

Submitter : Mr. Francis Drake **Date:** 10/12/2007

Organization : Pathways Clubhouse

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1020-Attach-1.DOC

#1020

PATHWAYS CLUBHOUSE
A Part of: ADULT&child

October 17, 2007

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

To Whom It May Concern:

I am submitting the following opinion in response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

Some of the proposed rule changes simply reduce this population's access to needed services - without any back up plan to fund services or programs. Many of these services have been working effectively with CMS approved Medicaid funding for more than ten years, However, with the recent changes in CMS practice, they now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need. The net result is that vast numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.

To create, or suddenly start enforcing, bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial cut in services for people who already have more than their fair share of burdens. A reduction or elimination of services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse in our prison system.

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of functioning.' Because recovery from mental illness is often a long term process, this definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent

funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses and other clubhouses using this model more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

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Most importantly, these changes will have a tragic impact on the lives and futures of millions of people struggling to recover from the long term effects of serious mental illness. In the interest of short term spending cuts, these changes will quickly erode the essential support networks that have allowed Americans with serious mental illness to begin the long and difficult process of rebuilding their lives. In my opinion, that would be an unconscionable mistake.

Sincerely,

Francis Drake
3841 S. Emerson Ave. #C
Indianapolis, IN 46203

CMS-2261-P-1021

Submitter : Ms. Anne Jackson **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-1021-Attach-1.RTF

#1021

Reference: File Code CMS-2261-P

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

Anne Jackson
Club Nova
103 West Main Street
Apt-3B
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 the
services.

Club Nova has given me job references in which I was able to go out and work
impendent jobs. If Club Nova was under funded and were to no longer exist, I f
would be a tragedy. Club Nova offers me services, resources, and practical thi
like food, and lately community support. Without Club Nova, my life would be
difficult.

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

Experience tells us that creating barriers and excluding vital services will no
money in the long run. Rather, it will increase the costs for hospitalization,
incarceration and other negative outcomes that result from a failure to o
needed treatment. We disagree with rules that lead to a solely crisis-orien

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

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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,

Anne Jackson

Submitter : Meri Krassner **Date:** 10/12/2007

Organization : Meri Krassner

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a mother of a disabled boy I urge urge urge you to withdraw the proposed regulations. These services are what make life possible for the disabled. The regulations are onerous, arbitrary and awful.Don't continue to turn back the clock and bring back the bad old days.

#1023

Reference: File Code CMS-2261-P

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

Kwami Jackson
401 Hwy 54 Bypass
Apartment C-10
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 is a place to go where I meet other club members that are dealing with the same illness I am dealing with. It helps me to be humble, to have meaningful work to do, and reduces my isolation. I would feel like I'd be missing something if club nova were to close. Club nova is a place that is helpful with what's going on in life and helps me explore different places. I would like it if Medicaid would help us to continue to receive money. Club Nova changes peoples lives!

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

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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,

Kwami Jackson

CMS-2261-P-1024

Submitter : Dr. Balaji Oruganti **Date:** 10/12/2007

Organization : Block Institute

Category : Speech-Language Therapist

Issue Areas/Comments

Background

Background

Excludes provision opf habiliation services from Medicaid reimbursement thereby directly affects the provision of rehabilitation and habiliation services such as those provided in day treatment, article-16 and article-28 clinics for individuals with MR/DD in the state of New York

Collections of Information Requirements

Collections of Information Requirements

The new prososed rule defines services to be reimbursable only if it would result in the reduction fo the individual's physical or mental diabliity and retoration th the best possbile functional level of the individual. Non covered services would include, vocation, pre-vocational, etc.

Regulatory Impact Analysis

Regulatory Impact Analysis

Day habilitational services are needed to provide a structure in terms of schedule and place, as a starting point. A reduction on federal funding to rehabiliation services would force states to make a choice between continuing services provision at the same level at a greater cost in state/local dollors; decreasing the amount and quality of essential serrices indiviudals 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 combinaiton of all of the above. Clearly this impacts providers.

CMS-2261-P-1025

Submitter : Mr. Isaac Lee **Date:** 10/12/2007

Organization : Club Nova

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1025-Attach-1.RTF

#1025

Reference: File Code CMS-2261-P

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

Isaac W. Lee II
303 Smith Level Rd.
Apartment D 14
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. Clubhouse is more than just a place to hang out at; it provided me with a job when I needed it the most and with mental health services when I was in dire need of them. I was living with a difficult roommate and had to move out because of him. Therefore, there is a need for clubhouses to exist. Without them I do not think I would have a job and would likely be stuck with the same roommate who was threatening me and would not have had matters dealt with appropriately.

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.

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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,

notice the absurdity of this position, whereby one demands automaticity, and the other demands authenticity; there should be no question as to the associations that are being drawn between these signifiers. We are now at a crossroads, where the responsibility lies in the acknowledgment of a defunct state of affairs, and if pleas of the heart are not being recognized, then one's ears should perk up at the recognition of how cost effective psychosocial rehabilitation truly is.

We continue to provide a service that keeps individuals with severe and persistent mental illness out of the hospital, and participating in their own growth as their self-efficacy is constantly validated and strengthened. We provide this service at a very low reimbursement rate, despite the incredulities that are faced as a result of astronomical documentation requirements, and the lofty goal that one will actually recover fully from their illness.

It is imperative that the current state of affairs is greatly altered so that "people living with..." are still treated as "people," people that are often overlooked, and/or discounted, yet people nonetheless. Let us not make the mistake of creating a divide between madness and civilization, for they are truly one and the same, and our efforts to curve the appetite of stigmatization should encompass all areas of society.

Fingers should be pointed, not to the heavens, but to each and every soul responsible for the welfare of humanity and its progress. We are all on trial.

Sincerely,

Jacob S. Long
Associate Director of Administration
Club Nova Community, Inc.

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

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 : Alan Flory **Date:** 10/12/2007

Organization : ReDiscover

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-1029-Attach-1.DOC

#1029

ReDiscover

901 NE Independence
Lee's Summit, MO 64086
816-246-8000

October 12, 2007

Centers for Medicare & Medicaid Services
Dept 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

ReDiscover 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.

ReDiscover is a Community Mental Health Center, and provides comprehensive services to seriously and persistently mentally ill clients, particularly those who are unable to function in the community without long term rehabilitation and support. We have provided services for 38 years.

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 states and providers 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.

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 agencies 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 puzzled by the requirement that the plan include information on alternate providers of the same service. In almost all communities, the number of providers willing to accept Medicaid

reimbursement is small. This reality is even more problematic in rural and frontier areas of the country. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation.

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. 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.

Recommendations:

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

- that this plan be written in plain English so that it is understandable to the individual.
- 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.
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- 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.

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

Sincerely,

Alan Flory
President