Submitter : Ms. Nancy Collins **Date:** 10/03/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

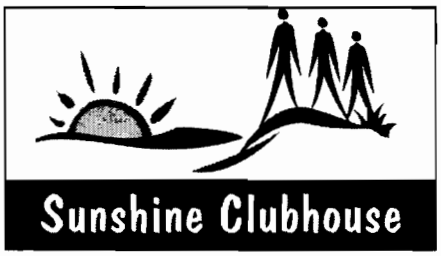
GENERAL

GENERAL

"See Attachment"

CMS-2261-P-297-Attach-1.DOC

#297



October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

To Whom It May Concern:

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

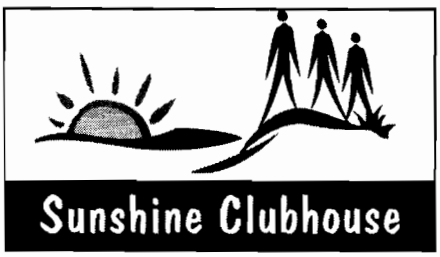
The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice 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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com



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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 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,

Nancy Collins
5319 Kingsmill Court
South Bend, Indiana 46614

Submitter : Miss. Phyllis Stoycher **Date:** 10/03/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

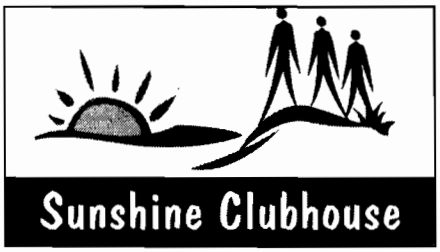
GENERAL

GENERAL

"See Attachment"

CMS-2261-P-298-Attach-1.DOC

#298



October 10, 2007

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Department of Health and Human Services
Attn: CMS-2261-P
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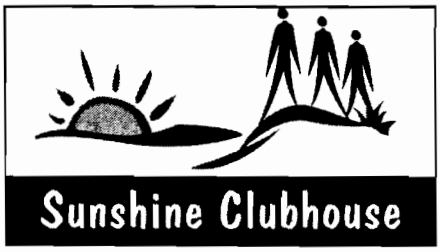
Sincerely,

Phyllis Stoycher
3016 Portage Avenue
South Bend, Indiana 46628

#299



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Sincerely,

Lori Renner
513 Widener Lane
South Bend, Indiana 46614

Submitter : Mr. John Barnes **Date:** 10/03/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"See Attached"

CMS-2261-P-300-Attach-1.DOC

#300

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com

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Sincerely,

John Barnes
1421 Northside Blvd.
South Bend, Indiana 46615

Submitter : **Ms. Susan Murphy** **Date: 10/03/2007**

Organization : **Breakthrough of Sedgwick County**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

In response to the proposed Rehabilitation Plan:
Dear The Centers for Medicare and Medicaid Services:
I have been employed and paid taxes since 1988. I was diagnosed with Bipolar in 2000. In order for me to stay employed full time, I am required to take medication for the rest of my life to keep my mental illness stable. I utilize many services to stay stable, which include support systems needed to decrease rehospitalization and provide social activities, employment supports, medication management, and therapy. This gives me the ability to live independently. I ask that you do not support the proposed regulations, so people with a mental illness will be able to utilize their support systems so that they may live independently and become a productive member of their community. Without these needed supports, I would not be a productive, tax paying citizen today. I would be very depressed at home and would continue to be receiving disability payments. Therefore, I urge you not to support these proposed changes.
Sincerely,
Susan Murphy
Staff of Breakthrough of Sedgwick County

Submitter : **Miss. Ann Zubler** **Date: 10/03/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attached"

CMS-2261-P-302-Attach-1.DOC

#302

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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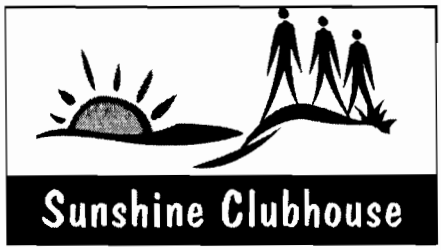
sunshineclubhouse@sunshineclubhouse.com



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Sincerely,

Ann Zubler
118 S. Williams
South Bend, Indiana 46601

Submitter : Mr. John Tillery **Date:** 10/03/2007

Organization : Remi Vista Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-303-Attach-1.TXT

#303

October 3, 2007

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

To Whom It May Concern:

I am the Executive Director of Remi Vista, Inc. a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides therapeutic services for youth and families who have either been placed in out-of-home care or who are considered to be at risk for such placement.

Remi Vista, Inc. is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

PROVISIONS 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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation 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 children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will 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 children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. 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 was not developmentally 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.

2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful

3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary 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 rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet 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 the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as 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 and localities should be excluded from this provision.

3. Some subsections of Section 441.45(b) include language that ensures that children in other settings 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 subsections (i) through (iv).

4. 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 rule should include this language.

5. It is especially important that mental health providers be able to work with children with mental health conditions 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.

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

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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 the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (530) 245-5805.

Sincerely,

John W. Tillery
Executive Director

Submitter : **Ms. Vicky McClention** **Date: 10/03/2007**

Organization : **Partners in Policymaking**

Category : **Consumer Group**

Issue Areas/Comments

Background

Background

Rehabilitation Services regulation, CMS 2261-P.

GENERAL

GENERAL

Kids in State Custody are Different: In many instances, the proposed regulation does not speak with child welfare in mind. These children have already been abused and neglected and by definition, have no family to provide proper care and health care for them. Medicaid should not be stepping out of the picture, when their situation is so dire and vulnerable.

Regulatory Impact Analysis

Regulatory Impact Analysis

Another example of the proposed regulations not being written with children in mind. While an adult in an IMD most likely has pretty significant needs, kids are not necessarily in such a bad state. Kids therefore shouldn t be categorically excluded from access to these services. Rehab services were in fact meant to address this exact population children who need temporary, community-based services to help reduce physical and/or mental disabilities.

We suggest repealing proposed IMD provision, at least in regards to children in state custody. Instead, child welfare/foster care should be required to clearly and separately document room and board versus treatment.

Submitter : **Ms. Diane S. Cross** **Date: 10/03/2007**

Organization : **Fraser**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Please see my comments in the attached letter to CMS Administration

CMS-2261-P-305-Attach-1.PDF

#305

FRASER
Special needs ★ Bright futures®

October 1, 2007

CMS Administration

Re: File Code-CMS-2261-P
Proposed Rules for Rehabilitation

To Whom It May Concern:

As the Director of Fraser, a nonprofit serving children and adults with special needs, I am writing in response to the proposed rule referenced above.

1. Non-covered services—441.45(b). It is critical that licensed mental health providers be able to work with children in the setting that will best accomplish their goals. Where the service is provided should not dictate whether the service is covered by MA. (For example, for some children, it may be more cost-effective to provide the service at their child-care site (thus eliminating the need for transportation costs); for others the clinic setting is best, etc.).
2. Restorative Services—440.13(d)1(vi). Research on early intervention is un-refuted when it comes to children making the greatest gains in the earliest years of their lives. If a child is not progressing developmentally, it does not mean that the child cannot be assisted to reach his/her potential. Young children may not have yet gained the skill, but clinical intervention to "habilitate" this skill is critical to their ability to function as normally as possible. Furthermore, "maintaining" functioning is also critical, especially for young children who develop in stages.

I am concerned that these proposed rule changes are occurring at a time when children's mental health is in crisis and at a time when mental health parity is a goal.

Although this letter does not address every nuance in the proposed rule changes, the objective is to support the clinical provision of mental health services to children that best maximizes their abilities.

The recommendations referenced above will keep children out of higher cost settings; i.e., hospitals and institutions, and will provide them with the best chance to be productive tax-paying citizens.

Thank you for taking these recommendations into consideration.

Sincerely,

Diane A. Cross

Diane S. Cross
President and CEO
www.fraser.org

Submitter :

Date: 10/03/2007

Organization :

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment."

CMS-2261-P-306-Attach-1.PDF

#308

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

To Whom It May Concern:

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

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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com

Our example of the inappropriateness of theses 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 an supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective will and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such a 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 Clubhouse more than 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 governmental) has a plan in place to provide the necessary recovery focused services that would 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 Clubhouse.

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 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,

Chris Anderson
3001 Hope Avenue Apartment #205
South Bend, Indiana 46615

Submitter : **Mr. Paul Kendall** **Date: 10/03/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-309-Attach-1.DOC

#309

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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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 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.

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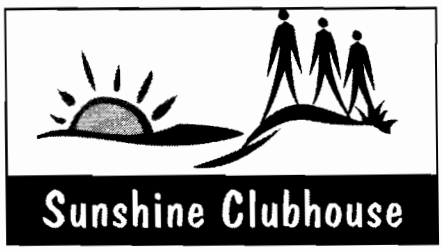

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Sincerely,

Paul Kendall
180 Quebec Court
Mishawaka, Indiana 46545

Submitter : Mr. Carlos Buckingham **Date:** 10/03/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

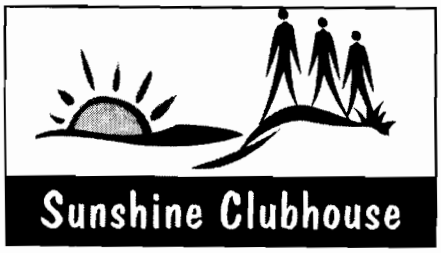
GENERAL

GENERAL

"See Attachment"

CMS-2261-P-310-Attach-1.DOC

#310



October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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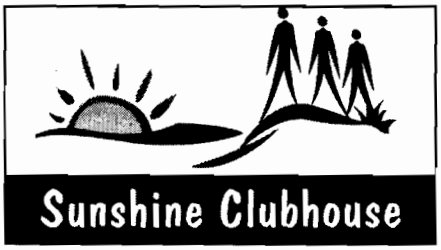

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Sincerely,

Carlos Buckingham
262 North Illinois Street
South Bend, Indiana 46619

Submitter : **Mrs. Julie Deka** **Date: 10/03/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-311-Attach-1.DOC

#311

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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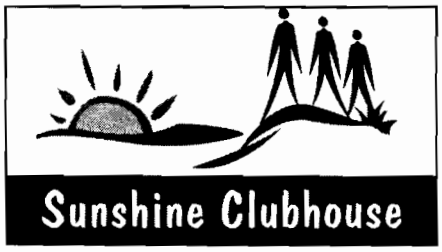

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Sincerely,

Julie Deka
618 West Colfax Apartment A
South Bend, Indiana 46601

Submitter : **Mr. Richard Nims** **Date: 10/03/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-312-Attach-1.DOC

#312

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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Sincerely,

Richard David Nims
623 West Washington Apartment D
South Bend, Indiana 46601

Submitter : **Miss. Tammy Taylor** **Date: 10/03/2007**

Organization : **Dynamic Interventions, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Please re-consider how Medicaid is designed and distributed instead of continuing to carve out or restrict certain populations ability to access Medicaid funded mental health services. At the same time, stop placing the state and federal dollars for mental health care into Medical-Modeled Care Management Organizations requiring only medically indicated-services. Those of us in the field realize that there are some biological-based causative factors involved with mental health disorders such as schizophrenia, mental retardation, etc. However, to best represent the psychology side of most mental health treatment, our Diagnostic and Statistical Manual of Mental Disorders defines or psychologically indicated service needs. These needs should then be authorized for treatment through evidence-based programs supported by the federal Department of Health and Human Services, which already exist. Psyicaid if you will!

Submitter : Mr. Jay Clark **Date:** 10/03/2007

Organization : Hiawatha Valley Mental Health Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Non-covered services: 441.45(b)

This section introduces a brand new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage 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 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?

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), 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:

It is 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 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.

The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service 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.

Therapeutic Foster Care: 441.45(b)(1)(i)-

The regulation denies payment for therapeutic foster care as a single program, requiring instead that each component part be separately billed.

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious mental disorder. Therapeutic foster care is a widely covered evide

Submitter : Mrs. Gloria Wade **Date:** 10/03/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"See Attached"

CMS-2261-P-315-Attach-1.DOC

#315

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

To Whom It May Concern:

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

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 care needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supporters; 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 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.

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com

Our example of the inappropriateness of theses 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 an supports.

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective will and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such a 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 Clubhouse more than 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 governmental) has a plan in place to provide the necessary recovery focused services that would 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 Clubhouse.

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 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,

Gloria Wade
514 South Liberty
South Bend, Indiana 46619

Submitter : **Ms. Melissa Richey** **Date: 10/03/2007**

Organization : **Sunshine Clubhouse**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-316-Attach-1.DOC

#316

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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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 numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.
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Sincerely,

Melissa Richey
51746 Emmons Road
South Bend, Indiana 46637

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Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com

Submitter : Joseph Costa **Date:** 10/03/2007

Organization : Sunny Hills Services

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-317-Attach-1.PDF

317

Sunny Hills
SERVICES™
Better and Brighter Futures

Sunny Hills Services
300 Sunny Hills Drive
San Anselmo, CA 94960
Ph: 415.457.3200 Fax: 415.456.4679

October 3, 2007

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

To Whom It May Concern:

I am the Chief Executive Officer of **Sunny Hills Services**, a California non-profit, community-based child welfare agency serving California's at-risk and in-need children and their families. Our organization **provides intensive treatment for the most troubled children and adolescents in the state.** I am also an active member of the California Alliance of Child and Family Services, which represents more than 140 nonprofit agencies similar to my own.

Sunny Hills Services is submitting comments on the Proposed Rule for Coverage of Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007. Because our expertise lies in the area of children and families, we have limited our comments to aspects of the proposed rule that will have a particular impact on that group of Medicaid Beneficiaries.

GENERAL COMMENT

We have significant concerns about the proposed regulations, as they will create barriers to the treatment and rehabilitation of the children our agency serves. We support the extensive comments made by the California Alliance of Child and Family Services, the National Council of Community Behavioral Healthcare, and the Child Welfare League of America.

PROVISIONS 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 particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation 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 children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will 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 children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. 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 was not developmentally 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.

2. 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.

440.130(3) Written Rehabilitation Plan

A number of changes are necessary to ensure the rule is clear and the plan can be completed efficiently to minimize adding to the already substantial administrative burden and expense agencies providing these services face.

Can a service planning team create a single service plan that addresses both treatment issues and rehabilitation issues? Requiring two separate planning processes and two separate planning documents is burdensome not only for providers but also for the child and family. Moreover, multiple service plans do not facilitate coordination or accountability. The rule does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS clarifies that this is allowable.

Why does the plan require information on alternate providers of the same service? Expecting staff with the skill to complete the plan to also become familiar with alternate providers is a poor use of these staff and an unreal expectation.

Requiring the signature of the child or representative may sometimes not be possible. Therefore, CMS should allow the provider to document that reasonable efforts were made to obtain the child and family's participation and signature and why that was not accomplished.

Recommendations:

1. Clarify that a single, combined treatment and rehabilitation plan with a single planning team is acceptable

2. If the child and/or family did not participate in the development of the plan and/or sign the plan, allow the provider to document the reasonable efforts made and why they were not successful.

3. Allow the plan to include provisions for unplanned crisis intervention

4. Eliminate the requirement that providers identify alternate providers of the same service because freedom of choice requirements already exist

5. Allow the plan to include individualized review dates relevant to the anticipated achievement of rehabilitation goals instead of a yearly requirement

440.130(5) Settings

In addition to the settings cited in the rule, it would be helpful to add some of the settings where other sections of the rule limit coverage, in order to clarify that those prohibitions are not absolute. It would also be helpful to add to the rule settings described in the preamble.

Recommendation:

1. Add to the list of appropriate settings for rehabilitation services schools, therapeutic foster care homes and other child welfare settings.

441.45(a)(2) Covered services requirements

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of individuals to their best possible functional level, as defined in the law. It would be helpful to reiterate here when services may be furnished to retain or maintain functioning (see comments above).

Recommendation:

1. Insert additional language into 441.45(a)(2) to describe when services may be furnished with the goal of retaining or maintaining functioning.

441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary 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 rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet 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 the EPSDT program. 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 covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as 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 and localities should be excluded from this provision.

3. Some subsections of Section 441.45(b) include language that ensures that children in other settings 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 subsections (i) through (iv).

4. 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 rule should include this language.

5. It is especially important that mental health providers be able to work with children with mental health conditions 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.

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

Therapeutic foster care is the least restrictive out-of-home placement for a child with a serious emotional disturbance. Therapeutic foster care is a widely covered evidence-based practice with more than half a dozen controlled clinical trials demonstrating improved outcomes (see the Report on Mental Health from the U.S. Surgeon General). The alternative for these children is immediate placement in a congregate care setting or an institutional setting, such as a residential treatment center or psychiatric hospital, at significantly higher expense.

The fact that the name of this service includes the phrase "foster care," which is sometimes a covered child welfare service, should not lead to the assumption that this service is a child welfare service. This service combines a board and care component, sometimes paid by child welfare funds if the child is a federally eligible adjudicated foster child, and a mental health rehabilitation component. The regulation makes no acknowledgment that therapeutic foster care is, in part, a mental health service that is provided through mental health systems to children with serious emotional disturbances who need to be removed from their home environment for a temporary period and who need intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system. It is not a service exclusively for children in the foster care system.

If states are not able to create a package of covered medically necessary rehabilitation services as a component of therapeutic foster care and pay on that basis, the result will be inefficiencies and substantial administrative costs.

Recommendation:

1. List therapeutic foster care as a covered rehabilitation service for children at risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.

3. Include language in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care and other child welfare services.

441.45(b)(2) Habilitation services

It should be noted that the exclusion of habilitation services does not and should not equal exclusion from FFP for any rehabilitative services for mental health conditions provided to persons with mental retardation or related conditions.

Recommendation:

1. Clarify the difference between FFP exclusion for habilitation services and allowable FFP for rehabilitative services provided to persons with mental retardation and related conditions.

OTHER COMMENTS

Payment and Accounting for Services

Although not specifically described in this regulation, recent CMS insistence on accounting and billing for services in 15-minute increments and the denial of payment for daily rates, case rates and similar arrangements are supported by language in the rule, at least by inference.

These changes in rate setting methodology are administratively and clinically inefficient. They are also detrimental to the provision of evidence-based mental health services that are more and more frequently designed as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multisystemic therapy, therapeutic foster care and others.

Recommendation:

1. We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support accountability, best practice, and positive outcomes for children and adults with mental disorders without diverting substantial provider time and financial resources to administrative requirements. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

The rule appears to ignore the Title XIX mandate that children under age 21 are eligible for all federal Medicaid-covered services, regardless of whether that service is defined in the state plan or covered for adults. CMS needs to amend the rule in several places to reflect the EPSDT provision.

Recommendation:

1. Insert a new paragraph in Section 441.45(a) clearly stating that states must ensure that children receive all federally-covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

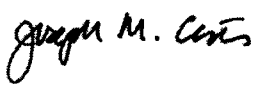
2. Clarify in section 441.45(b)(4), that children under age 21 are eligible for all federal Medicaid-covered services when medically necessary to correct or ameliorate a physical or mental health condition regardless of whether their medical condition is targeted under the state's plan.

3. Clarify in section 441.45(a)(5) that even when the state plan does not include certain rehabilitative services, these services must be made available to children when medically-necessary as part of EPSDT.

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 the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, - do not hesitate to contact me at **(415) 457-3200, ext 119**

Sincerely,



Joseph M. Costa
Chief Executive Officer
Sunny Hills Services

Submitter : Ms. Donna Harris **Date:** 10/03/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"See attached"

CMS-2261-P-318-Attach-1.DOC

#318

October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD. 212440-8018

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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 numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.
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Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com

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Sincerely,

Donna Harris
525 South Albert
South Bend, Indiana 46619

Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com

Submitter : Ms. Monica Glatt **Date:** 10/03/2007

Organization : St. Luke's House

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-319-Attach-1.PDF

#319

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Ms. Laura Schultz** **Date: 10/03/2007**

Organization : **Ms. Laura Schultz**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am the Program Director for a Massachusetts Day Habilitation program. I witness how much of an impact our services have on the daily lives of the individuals we serve. It would be a great loss to them if they were denied the services we provide such as nursing, PT, OT, or Speech therapy. Day Habilitation services need to stay on the State Plan so that these individuals will be able to continue to lead healthy, fulfilling lives. Thank you.

Submitter : Mrs. Leigh Thompson **Date:** 10/03/2007

Organization : Benton County Sunshine School

Category : Speech-Language Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-321-Attach-1.DOC

#321

To: Department of Human Services-Center for Medicare & Medicaid services (CMS)

From: Leigh Thompson, MS, CCC-SLP

Date: October 3, 2007

Re: CMS-2261-P and 42 CFR Part 441.45

I am writing on behalf of Benton County Sunshine School and many other DDTCS centers. I am a speech-language pathologist at the Sunshine School and I work with wonderful children who face challenges daily that you and I would struggle to comprehend. I cannot begin to express in words how important it is that these children continue to receive day habilitation services. My responsibilities are primarily teaching these children how to communicate and achieve adequate swallowing and feeding skills. Our methods of teaching range from sign language and motivational techniques to electronic "words to communication devices". The purpose of my therapy is to give these children skills that they can then carry over into various environments in order to not only communicate their wants and needs but become an asset to society. Our teachers and staff are trained to facilitate the development of these skills and carryover into a classroom environment. Our classrooms are modified to assist these children in such tasks. Our teachers and staff are trained in how to work with these children and our facility provides for their dietary and functional feeding needs. If you spent one day in our school and mapped the progress of a child within their therapy, classroom, and playground environment, I assure that you would also agree that our services are not only a medical, but also a social and academic need for these children. Through these efforts we are striving to prepare them for public school and attempting to equip them with skills that will assist them in becoming an independent working individual.

Children are our future and regardless of challenges which they are given to face, we hold the responsibility in providing them with the resources they need to continue making progress. These children have and will continue to bless our state and country more than we could ever begin to imagine! Please consider this letter as an open invitation to visit our facility and view first hand the accomplishments and the potential we experience daily.

Thank you for your attention to this very important matter.

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Submitter : Ms. Karen Mann **Date:** 10/03/2007

Organization : St. Luke's House, Inc.

Category : Nurse

Issue Areas/Comments

GENERAL

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I am a nurse and I work with mentally ill clients who receive vocational rehabilitation services. Working is such an important part of treatment. There are many statistics that show people who have mental illness and work have fewer hospitalizations, have better self esteem, remain stabilized longer and enjoy being part of the community. Please help fund rehabilitation services that are so desperately needed.