**Submitter :** **Mary Makarski** **Date: 10/03/2007**

**Organization :** **NAMI**

**Category :** **Individual**

**Issue Areas/Comments**

**Collections of Information Requirements**

Collections of Information Requirements

File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services.

**GENERAL**

GENERAL

September 27, 2007

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

Re: File Code CMS-2261-P. Proposed Regulations on Coverage for Rehabilitative Services.

Dear Sir or Madam:

The National Alliance on Mental Illness (NAMI) is grateful for the opportunity to comment on the proposed rules regarding coverage for rehabilitative services under the Medicaid program. With 1100 affiliates, NAMI is the nation s largest grassroots organization representing individuals living with serious mental illnesses and their families. Many of our members have personally experienced the effectiveness of rehabilitation services and have been able to live, work and participate in their communities as a direct result of these services.

Research confirms that individuals with serious mental illnesses who receive rehabilitation services achieve better outcomes, such as stable housing and employment. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for the vast majority of individuals with mental illnesses and their families.

NAMI conducted a survey of the 50 state mental health agencies and found that evidence-based practices funded by Medicaid under the rehabilitation services option were woefully inadequate in the states. In our 2006 Grading the States report, the average state grade was a D. For every poor grade NAMI gave, we know that there are hundreds of thousands of individuals who are being jailed, living on the streets or dropping out of school because they were unable to access the services that we know work. For this reason, we are particularly concerned that any new regulations governing rehabilitation services facilitate the provision of these services and in no way discourage systems and providers from increasing the availability of these critical services. Many of our members are very troubled by the estimate in the proposed regulation that these rules would remove 2.2 billion dollars from an already under-resourced service system.

NAMI is very appreciative of the effort in the proposed rules to encourage states to use rehabilitative services to meet the goals of the New Freedom Commission. We particularly agree with the quote from the Commission referenced in the preamble to the rules, [m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs.

We believe that the emphasis on recovery and person-centered planning and the inclusion of the individual, their families and other individuals in treatment planning is a very positive development that will further improve access to treatment. However, other sections of the proposed regulations have the potential to frustrate the ability to engage individuals in the process of recovery and provide evidence based and tailored services. We are particularly concerned about the prohibition on billing for services that may maintain a person s functioning and the broad exclusion of services that are intrinsic to other programs. We will describe these concerns in greater detail below.

Overall, NAMI believes that a system of rehabilitative services must follow these principles:

" Services should attain a high degree of accessibility and effectiveness in engaging and retaining persons in care.
" The effects of these services shall be sustained rather than solely crisis-oriented or short-lived.
" Services must be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one s recovery.
" Whenever possible, services should be provided within the person s home and/or community, using the person s natural sup

**Submitter :** Mr. Ronald Soloway **Date:** 10/03/2007

**Organization :** UJA-Federation of New York

**Category :** Religious Nonmedical Health Care Institution

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-324-Attach-1.DOC

# 324



UJA-Federation of New York

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October 2, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

UJA-Federation of New York, Inc. is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

UJA-Federation of New York, Inc. a major New York philanthropy that supports a network of over 100 health and human service agencies. Last year, we raised over $290 million to help support services to those individuals who are vulnerable and in need.

UJA-Federation's network agencies sustain some of New York's most vulnerable citizens: persons with HIV, struggling families, the fragile elderly, people living with co-morbid health conditions, people discharged from psychiatric hospitals and detoxification units, prison discharges and troubled children. They provide a full continuum of behavioral health services including: ACT, AOT, case management, clinic treatment programs, community residential programs, continuing day treatment programs, crisis outreach and intervention services, drop-in centers, family support services, home and community based services, homeless outreach, mobile crisis intervention programs, on-site rehabilitation, psychosocial clubs, school based programs, supportive housing, transitional employment placement , transitional management services, vocational and social rehabilitation and vocational services for adolescents.

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

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

Comments re: PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130: Diagnostic, screening, preventive and rehabilitative services

**440.130(d)(1)(i)**
**The final rule should clarify the requirements of an acceptable "individualized recovery goal."**

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

Recommendation:
We urge CMS to clarify the requirements of a Medicaid reimbursable "individualized recovery goal".

**440.130(d)(1)(v) Definition of Rehabilitation Plan**
**The final rule should clarify the definition of an individual providing "input" and "active participation".**

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

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

**440.130(d)(1)(vi) Definition of Restorative Services**
**The final rule should clarify the meaning of restorative services.**

The proposed definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. The regulation needs modification to make the meaning of this section clearer.

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
>
> Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

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

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

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

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

**440.130(d)(1)(vii) Definition of medical services**
**The final rule should include diagnosis as a covered rehabilitation service.**

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

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

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

**440.130(d)(1)(viii)(2)Scope of Services**
**The final rule should clarify the definition of scope of services.**

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

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

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

**440.130(viii)(3) Written Rehabilitation Plan**
**The final rule should clarify the requirements of the written rehabilitation plan.**

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

For example, how does CMS expect providers to indicate progress towards the goals in the rehabilitation plan? Need there be a progress note for every encounter? (Since CMS is currently requiring providers to account for and

bill services in 15-minute increments, a progress note for every encounter will become a major burden, especially when services are delivered to a group.) We would recommend that progress notes be required at least monthly, leaving it to states to require, or providers to make, more frequent notes in cases where that may be appropriate. The guiding factor should be that the service record include information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

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

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

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

- that the plan be written plainly in multiple languages so that it is understandable to all individuals;
- that the plan indicate the individual's level of participation, as well as his or her concurrence with the plan;
- that the plan allow for a qualified provider to sign the treatment plan when the client or their representative is unable to do so or has no family or designated representative;
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that the plan include, if necessary, provisions for crisis intervention;

- that the plan include individualized anticipated review dates that correspond with the anticipated achievement of long-range and intermediate rehabilitation goals;

- provide certification that the individual has been informed about their rights regarding advance directives;

- that the plan allow providers to provide information on potential alternate providers of the same service instead of listing all of the alternative providers in the treatment plan.

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

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

**440.130(4) Impairments to be addressed**
**The final rule should state that all individuals are eligible for coverage of rehabilitation services.**

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

Limiting services to only one group, based on diagnosis or disability violates Medicaid's requirement that services be furnished in sufficient amount, duration and scope to reasonably achieve their purpose. Not providing coverage of rehabilitative services to individuals with a mental illness would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:
We urge CMS to delete the word "or" after the word "and" in Section 440.130(4).

**440.130(5) Settings**
**The final rule should include a more extensive list of settings where rehabilitative services can be provided.**

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

**Section 441.45: Rehabilitative Services**

**441.45(a)(2)**
**The final rule should clarify the definition of a rehabilitative service.**

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

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

**441.45(b) Non-covered services**
**The final rule should not deny Medicaid coverage for services provided to Medicaid-covered individuals if such services are furnished through another program.**

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

Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r)). The result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other programs due to lack of resources (i.e. therapeutic foster care, foster care or child care institutions for a foster child). What is the legal basis for denying federal financial participation (FFP) for the Medicaid-covered individual? Thus, the rule effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

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

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

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

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

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

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

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

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

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

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

**441.45(b)(2)**

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

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

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

epilepsy) that would gain functionality from rehabilitative services. Individuals with serious mental illness may experience periods of cognitive impairment as a result of their illness. If they do experience cognitive impairment, will the rehabilitation services they receive be covered?

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

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

**441.45(b)(3)**
**The final rule should clarify when recreational and/or social activities are a covered rehabilitation service.**

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

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

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

**Individuals in Secure Custody and Residing in Public Institutions**
**The final rule should not include the phrase "in secure custody" and "system".**

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

Recommendation:
We urge CMS to delete the phrase "in secure custody" and "system".

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

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

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

Recommendation

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

**OTHER ISSUES**

**Payment and Accounting for Services**

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

This new shift in rate setting methodology is inconsistent with evidence-based mental health practices that are based on delivering services together in a flexible and coordinated way. The shift in documentation and billing procedures significantly increases the amount of time that clinicians must spend completing paperwork, thus reducing the amount of time available to spend with clients. Furthermore, if providers are asked to bill services individually, they will be moving away from the evidence-based model (i.e. therapeutic foster care). Current evidence-based practices include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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

Recommendation:

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

**EPSDT Mandate**

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

Recommendation:

We strongly urge CMS to do the following:

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

- Clarify Section 441.45(a)(5) to state that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically-necessary.

- To reference the federal EPSDT mandate in Section 441.45(b)(4), which refers to services having to be targeted under the State's plan.

**CONCLUSION**

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

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

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

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

Sincerely,

Ronald Soloway
Managing Director of Government and
External Relations

**Submitter :** Mr. Phillip Saperia **Date:** 10/03/2007

**Organization :** The Coalition of Behavioral Health Agencies, Inc.

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-325-Attach-1.PDF

#325

THE COALITION OF BEHAVIORAL HEALTH AGENCIES, INC.

October 2, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

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

The Coalition of Behavioral Health Agencies, Inc. is the umbrella trade association and public policy advocacy organization of New York's behavioral health community, representing over 100 non-profit behavioral health agencies. Take together, these agencies serve more than 350,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of a diverse New York City and its environs.

The Coalition's member organizations sustain some of New York's most vulnerable citizens: persons with HIV, struggling families, the fragile elderly, people living with co-morbid health conditions, people discharged from psychiatric hospitals and detoxification units, prison discharges and troubled children. They provide a full continuum of behavioral health services including: ACT, AOT, case management, clinic treatment programs, community residential programs, continuing day treatment programs, crisis outreach and intervention services, drop-in centers, family support services, home and community based services, homeless outreach, mobile crisis intervention programs, on-site rehabilitation, psychosocial clubs, school based programs, supportive housing, transitional employment placement , transitional management services, vocational and social rehabilitation and vocational services for adolescents.

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

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

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**440.130(d)(1)(vi) Definition of Restorative Services**
**The final rule should clarify the meaning of restorative services.**

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

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

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
>
> Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

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

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

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

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

**440.130(d)(1)(vii) Definition of medical services**
**The final rule should include diagnosis as a covered rehabilitation service.**

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

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

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

**440.130(d)(1)(viii)(2)Scope of Services**
**The final rule should clarify the definition of scope of services.**

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

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

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

**440.130(viii)(3) Written Rehabilitation Plan**
**The final rule should clarify the requirements of the written rehabilitation plan.**

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

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

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

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

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

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

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

- that the plan indicate the individual's level of participation, as well as his or her concurrence with the plan;

- that the plan allow for a qualified provider to sign the treatment plan when the client or their representative is unable to do so or has no family or designated representative;

- that the plan of services be based on a strengths-based assessment of needs;

- that the plan include intermediate rehabilitation goals;

- that the plan include, if necessary, provisions for crisis intervention;

- that the plan include individualized anticipated review dates that correspond with the anticipated achievement of long-range and intermediate rehabilitation goals;

- provide certification that the individual has been informed about their rights regarding advance directives;

- that the plan allow providers to provide information on potential alternate providers of the same service instead of listing all of the alternative providers in the treatment plan.

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

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

**440.130(4) Impairments to be addressed**

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

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

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

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

Recommendation:
We urge CMS to delete the word "or" after the word "and" in Section 440.130(4).

**440.130(5) Settings**
**The final rule should include a more extensive list of settings where rehabilitative services can be provided.**

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

**Section 441.45: Rehabilitative Services**

**441.45(a)(2)**
**The final rule should clarify the definition of a rehabilitative service.**

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

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

**441.45(b) Non-covered services**
**The final rule should not deny Medicaid coverage for services provided to Medicaid-covered individuals if such services are furnished through another program.**

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

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

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

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

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

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

**441.45(b)(1)(i) Therapeutic foster care**
**The final rule should list therapeutic foster care as a covered rehabilitation service for children with serious mental disorders.**

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

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

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

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

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

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

**441.45(b)(2)**
**The final rule should clarify the difference between "exclusion for habilitation services as opposed to the exclusion from Federal Financial Participation (FFP) for rehabilitative services."**

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

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

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

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

**441.45(b)(3)**
**The final rule should clarify when recreational and/or social activities are a covered rehabilitation service.**

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

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

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

**Individuals in Secure Custody and Residing in Public Institutions**
**The final rule should not include the phrase "in secure custody" and "system".**

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

Recommendation:
We urge CMS to delete the phrase "in secure custody" and "system".

**441.45(b)(7) Services for individuals who are not Medicaid eligible**
**The final rule should clarify when services for individuals who are not Medicaid eligible are a covered rehabilitation service.**

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

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

**OTHER ISSUES**

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

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

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

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

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

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

Recommendation:
We strongly urge CMS to do the following:

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

- Clarify Section 441.45(a)(5) to state that even when the state plan does not include certain rehabilitative services, these services must nonetheless be made available to children when medically-necessary.

- To reference the federal EPSDT mandate in Section 441.45(b)(4), which refers to services having to be targeted under the State's plan.

**CONCLUSION**

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

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

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

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

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

Sincerely,

Phillip A. Saperia
Executive Director

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

**Submitter :** Suzanne Yoculan **Date:** 10/03/2007

**Organization :** Suzanne Yoculan

**Category :** Individual

**Issue Areas/Comments**

**Background**

Background

Rehabilitation services can change the course of a person s life. Rehab is extremely effective in reducing symptoms, keeping people out of hospitals, and allowing people to live better lives in the community.

I ask you to be clear in doing everything possible to encourage states to provide more effective services for people living with mental illnesses.
We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

We ask that you revise these regulations to make sure that the federal government encourages any state system to do all they can to provide effective treatments to people with serious mental illnesses.

**Submitter :** Mrs. Ruth Castleberry **Date:** 10/03/2007

**Organization :** Faulkner County Day School, Inc.

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#327



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.

**Submitter :** **Tiffany Sampson** **Date: 10/03/2007**

**Organization :** **Benton County Sunshine School**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**GENERAL**

GENERAL

CMS-2261-P and 42 CFR Part 441.45
In Arkansas, the program in jeopardy under CMS s proposed rule is the Developmental Day Treatment Clinic Services ( DDTCS ) Program. The services and benefits provided through DDTCS permit individuals with developmental disabilities to lead more productive and fulfilling lives, remain in their homes and communities, and in many instances, avoid the high costs of institutionalization. If this program is eliminated, many of the recipients will no longer be eligible for medically necessary services and will be forced to fend for themselves.

We ask you to support and to protect Arkansans with developmental disabilities. Doing so will serve the best interests of the State of Arkansas and her citizens who have developmental disabilities. Thank you.

Sincerely, Tiffany Sampson

**Submitter :** Mrs. Ruth Castleberry **Date:** 10/03/2007

**Organization :** Faulkner County Day School, Inc.

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#329



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.

**Submitter :** Mr. Robert Ketch **Date:** 10/03/2007

**Organization :** Five Acres

**Category :** Social Worker

**Issue Areas/Comments**

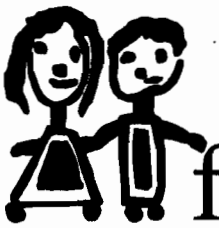
**GENERAL**

GENERAL

See Attachment

CMS-2261-P-330-Attach-1.PDF

#330



five acres

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 Five Acres – The Boys' and Girls' Aid Society of Los Angeles County, a non-profit, community-based child welfare agency serving California's vulnerable foster youth. Five Acres is a child and family services agency that strengthens families and prevents child abuse through treatment and education in community-based and residential programs.

Five Acres 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.

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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

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 (626) 798-6793, x2248.

Sincerely,

Robert A. Ketch
Executive Director

**Submitter :** Miss. Shellie Cox **Date:** 10/03/2007

**Organization :** Miss. Shellie Cox

**Category :** Nursing Aide

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-2261-P-331-Attach-1.DOC

# 331

To Whom It May Concern:

I strongly feel that Medicaid should continue to pay for mental health services in the community. Individuals with mental illnesses need the support of group homes and community centers to increase their social support, learn daily tasks, and to ultimately minimize their hospitalizations due to mental illness. It is extremely cost effective to continue funding community mental health centers. Hospital bills for mental health patients who lack social support and are in need of mental stabilization multiple times per year are extremely costly. I strongly urge Medicaid to continue funding community mental health services.

Thank you,
Shellie Cox

**Submitter :** Mrs. Birgit Rutledge **Date:** 10/03/2007

**Organization :** Mrs. Birgit Rutledge

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-2261-P-332-Attach-1.RTF

# 332

October 3, 2007

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

To Whom It May Concern:

*Reference: File Code CMS-2261-P*
*Comments on 42 CFR Parts 440 and 441: Medicaid Program: Coverage for Rehabilitative Services*

I concur and support changes submitted by St. Luke's House, Inc., which asks that you consider changing the following specific areas:

**440.130(d)(1)(vi) Definition of Restorative Services and 3(xiv) Measurable Reduction of Disability**

It is critical that these regulations fully recognize the nature of mental illnesses and the recovery process. The regulatory language must reflect the flexibility needed to help children grow and develop and to support adults in dealing with relapse and the challenges in sustaining levels of functioning. Therefore the following changes to language are recommended:

**Section 440.130 (d)(1)(vi) Definition of "restorative services"**

Recommendations:

- Include language that states 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.

- Add the following language to the end of section:

  *"Examples of acceptable rehabilitation goals in this context would include: living in the community without long-term or intermittent hospitalization; reduction or control of symptoms to avoid further deterioration or hospitalization."*

**440.130 (d)(3) (xiv) Requirement of "Measurable Reduction of Disability"**

Recommendation: Add the following language to the end of the section:

*"For some individuals, particularly those with serious mental illness, 'reduction of disability' and 'restoration of functional level' may be measured by comparing the effect*

*of continuing rehabilitation versus discontinuing it. Where there is reasonable expectation that if rehabilitation services had been withdrawn the individual's condition would have deteriorated, relapsed further, or required hospitalization, this criterion is met."*

**440.130 (3) preamble, (3)(xi), (xv), (xvi) Written Rehabilitation Plan**

There are four specific areas we would like this section to address. First, the preamble of this section refers to a written rehabilitation plan. While it does not prohibit an integrated treatment and rehabilitation plan, it also does not specifically allow for one. Since integrated planning and service delivery is in the consumer's best interest, we feel that the regulations should support an integrated plan. Second, (re: 3xi) while there is great value in consumers knowing their options for alternate providers, we think that information should be shared earlier in the process than during rehabilitation planning, at any time the consumer expresses a desire to consider other options or at specific progress review periods. The rehabilitation planning process is an important time of partnership. The routine inclusion of information about alternate providers during this process may disrupt the therapeutic bond, may cause confusion and anxiety for the consumer and also places an unnecessary burden on the provider. Third, (re: 3 xv) due to the episodic nature of serious mental illness and sometimes due to specific symptoms, some consumers may not be able or willing to sign the treatment/rehabilitation plan at a given time. The need for the services is still likely to be critical. The individual may not have appointed a representative who could sign on behalf of him/her. Therefore, CMS should allow for documentation of efforts of the provider to secure the signature and the reasons that the consumer or his/her representative is not able to sign the plan. Finally, (re: 3xvi) since the provider is already bound by Medicaid requirements, the inclusion of the statement in the last bullet below seems unnecessary and inappropriate for inclusion in the service plan and seems to add no real value. In the interest of time and clarity, we recommend it be deleted from this section.

Recommendations:

- Specifically clarify that a single integrated treatment and rehabilitation plan is acceptable (3 preamble)
- Delete the section that reads "Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." (3xi)
- Allow providers to document attempts to involve consumers in the development of their treatment/rehabilitation plans and to secure their signatures. (3xv)
- Delete the section that reads "Document that the services have been determined to be rehabilitative services consistent with the regulatory definition." (3xvi)

**441.45 (a) (2) : Rehabilitative Services**

This recommendation serves to reinforce what has been said regarding restorative services and "measurable reduction of disability."

Recommendation: Reiterate here when services may be provided to retain or maintain functioning.

**441.45 (b) (1) Non-Covered Services**

In order to strongly support the concept of integrated and coordinated services and to ensure that consumers have access to covered rehabilitation services, the following clarifications are recommended.

Recommendations:

- Add the following to the end of the first paragraph in Section 441.45(b) (1):

  *"...except for medically necessary rehabilitation services for an eligible individual that are clearly distinct from these non-covered program services and are provided by qualified Medicaid providers. One way to demonstrate this distinction is by clearly and reasonably distinguishing the funding stream for the rehabilitation services as being distinct from that of non-covered services."*

- Clarify that pre-vocational services are allowable services when appropriately tied to a rehabilitation goal.

Thank you for this opportunity for commenting and for your consideration of these recommendations.

Sincerely,

Birgit Rutledge, LGPC

**Submitter :** Mr. Charles Reed **Date:** 10/03/2007

**Organization :** Mr. Charles Reed

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

In reference to CMS-2261-P and 42 CFR Part 441.45, I oppose the proposed regulations that would eliminate Medicaid paying for habilitation 'services provide to individuals with mental retardation or related conditions'. These payments have had a profound impact on the life our 2 1/2 year old daughter with Down syndrome. Without these services our daughter has no chance to have a meaningful, productive life and to be able to be ready to start schooling with other students her age. These services including physical, occupational, speech and pre-school therapies and education all in one place enrich her life and ours. Without the money Medicare/Medicaid provide we would not be able to afford these services on our own and our health benefits provided by our employer does not cover all the services needed and that our daughter Carly deserves. Please continue to fund and protect habilitation services for individuals with mental retardation. Investing in our daughter now will reduce what we and other taxpayers will have to pay in the future if she does not develop the life skills needed to be independent.

**Submitter :** **Jack Otten** **Date: 10/03/2007**

**Organization :** **N/A**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I oppose the proposed rules to eliminate Medicaid paying for habilitation services to developmentally delayed individuals. My son is developmentally delayed (diagnosed with Autism). Eliminating funding for children such as these would be a tremendous disservice to those of us that may need these services. This is not an issue of poor/wealthy. Services such as these are incredibly expensive and most families cannot afford them. Don't short change our children.

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

**Organization :** Mr. Richard Lord

**Category :** Individual

**Issue Areas/Comments**

**Collections of Information Requirements**

Collections of Information Requirements

I am the father of an autistic son who receives Applied Behavioral Analysis in an effort to improve his function in the world. I believe this proposed rule change could make it impossible for Pennsylvania to receive federal reimbursement for the services provided to my son. This would in turn make it less likely that he will be a successful, independent, taxpaying citizen as an adult.

**GENERAL**

GENERAL

The draft federal regs (section 441.45(b)(2)) exclude habilitation services from the definition of rehabilitation services that can be covered under Medical Assistance. The problem is with the proposed federal definition of habilitation services which cannot be covered under the rehabilitation service category of Medical Assistance. Under the proposed federal regs, Habilitation services include services provided to individuals with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.) Does this mean that wraparound services provided to children and adolescents with mental retardation or autism (which is a related condition ) are habilitation services and therefore totally excluded from coverage? Autism is also considered a mental illness by psychiatrists (in the DSM IV). Does that mean it is not included in the scope of related conditions so rehabilitation services may be appropriately provided ? Does the proposed definition of habilitation mean that the state will have to deny wraparound for children with mental retardation for autism spectrum disorders whose treatment goals are to assist the child in learning new social skills or other positive behaviors the child never had before (which might be excluded as habilitation services )? Will each child s treatment plan or psych eval need to show that the child had a functional loss and has a specific rehabilitative goal toward regaining that function (part of the definition of rehabilitation services)?

**Submitter :** **Date: 10/04/2007**

**Organization :**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The elimination of Medicaid paying for habilitation 'services provided to individuals with mental retardation or related conditions' would affect me hard personally. My daughter was born with Down syndrome. She is my little angel. The day habilitation services she receives have helped her more than I can ever express. She has come so far where she wouldn't have if she hadn't had the services. It is a wonderful place and I have seen many children there who are thriving with their services. Most of us could not afford these services if it weren't for the Medicaid program. However, I know we would still try, because we want what is best for our children, and what is best are these day habilitation programs. I can't believe they are trying to cut the funding for these services. Doing that would be like moving backwards in time and we are too advanced as a society to be doing that. It just hurts my heart to think that these children might not have the same possibilities that other children have. They have a right to try to excel just as anyone else does. I was just reading an article by a journalist who has a 23 year old daughter with Down syndrome. She has been through a lot of the different changes in how these children have been treated. She said it wasn't until the 1980's that they really got any sort of medical care. I can't believe this ever happened. I don't know what I would do if my daughter was treated that way. Please don't let these cuts happen. There is too much life at risk!

By the way, we do have a typical child as well. She adores her little sister and doesn't see that she has any sort of disability. She loves her the way she is. We only have Medicaid on our daughter with Down syndrome because of the disability. It is secondary to our other insurance and we do also pay a premium on it. I am so thankful for it, because it allows us to push her to succeed. I have the same visions for her future as I do my typical daughter. I want her to grow up, graduate high school, go to college, get a job and get married. I truly believe all of this is possible with the right start.

**Submitter :** Dr. William Murray **Date:** 10/04/2007

**Organization :** Dr. William Murray

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

CMS-2261-P proposes to take money from services for children with disabilities. The government should take the money from wasted travel expenses rather than from children with disabilities.

**Response to Comments**

Response to Comments

CMS-2261-P proposes to totally eliminate habilitative services for many children with a variety of disabilities. This proposed bill erroneously contrasts habilitative and rehabilitative services, and essentially states that a person must previously demonstrate a skill in order to receive services - this is ridiculous! It appears that CMS-2261-P is designed to foster a cost savings of nearly 200 million dollars per year. Instead, this money could and should be saved in a host of other ways, such as through increased accountability and through ensuring the involvement (demanding) highly qualified personnel (for instance, licensing and employing Board Certified Behavior Analysts, who are supremely qualified in teaching basic learning principles and developing new skills and habilitative learning plans). This would result in a net plus for children through increasing adaptive skills, rather than removing services. It is also worthy to note that for the most part, as Medicare chooses a policy direction, this is also how most private insurance companies also choose to operate - again, this is a disastrous policy.

**Submitter :** **Mrs. Cindy Emmorey** **Date: 10/04/2007**

**Organization :** **Bentonville Teacher**

**Category :** **Academic**

**Issue Areas/Comments**

**GENERAL**

GENERAL

To: Department of Human Services Center for Medicare & Medicaid services
Attention: CMS-2261-P
Regarding: File Code CMS-2261-P and 42 CFR Part 441.45
From: Cindy Emmorey, Special Education Teacher

As a special education teacher, I know how importance of Day Habilitation Services for Persons with Developmental Disabilities. I cannot even fathom anyone not wanting to fund this program. A person needs to simply visit a facility to know the necessity or providing these services to families. After visiting a facility, I feel that no one could not fund this program and still have a clear conscience. Please take into consideration our family and families like ours, as you consider elimination of services provided to individuals with mental retardation or related conditions.

I urge you to support efforts to protect Medicaid services for children and adults with developmental disabilities in Arkansas and thirteen other states. Please do not allow critical services for these people to be eliminated.

In Arkansas, the program in jeopardy is the Developmental Day Treatment Clinic Services ("DDTCS") program. The services and benefits provided through DDTCS permit individuals with developmental disabilities to lead more productive and fulfilling lives, remain in their homes and communities, and in many instances, avoid the high costs of institutionalization. If this program is eliminated, many of the recipients will no longer be eligible for medically necessary services and will be forced to find for themselves.

I ask you to support the inclusion of the moratorium on CMS in the final SCHIP reauthorization bill to protect Arkansas with developmental disabilities. Doing so will serve the best interests of the citizens with developmental disabilities. Thank you.

Sincerely,

Cindy Emmorey (479) 426-6103

**Submitter :** **Mr. Michael Upton** **Date: 10/04/2007**

**Organization :** **Sunshine Clubhouse**

**Category :** **Individual**

**Issue Areas/Comments**

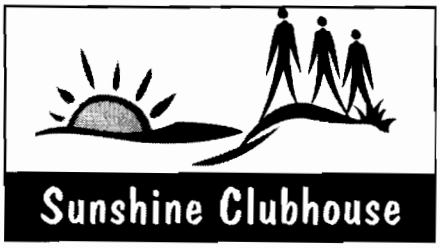
**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-339-Attach-1.DOC

# 339




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,

Michael Upton
1104 South 23rd Street
South Bend, Indiana 46615

**Submitter :** Ms. Trudy Leach **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-340-Attach-1.DOC

#340


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,

Trudy Leach
3197 Burlington Court
Carriage House 2, Apt. A
Mishawaka, Indiana 46545

**Submitter :** **Ms. Denise Keene** **Date: 10/04/2007**

**Organization :** **Sunshine Clubhouse**

**Category :** **Individual**

**Issue Areas/Comments**

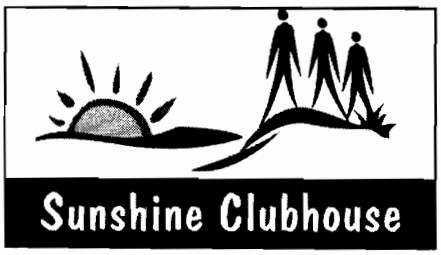
**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-341-Attach-1.DOC

#341




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:

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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.

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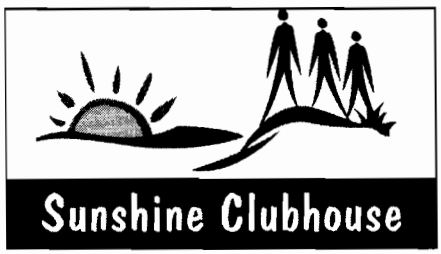
sunshineclubhouse@sunshineclubhouse.com

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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.

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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,

Denise Keene
3016 Portage Avenue
South Bend, Indiana 46628

**Submitter :** Mr. Mike Simmons **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-342-Attach-1.DOC

#342


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.

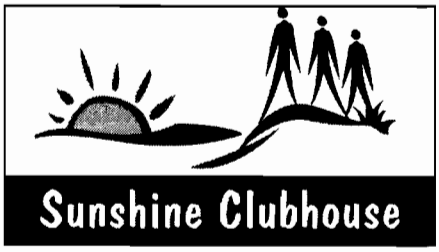
The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice 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.

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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,

Mike Simmons
513 Widener Avenue
South Bend, Indiana 46614

**Submitter :** Mr. Larry Allen **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-343-Attach-1.DOC

#343


October 10, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
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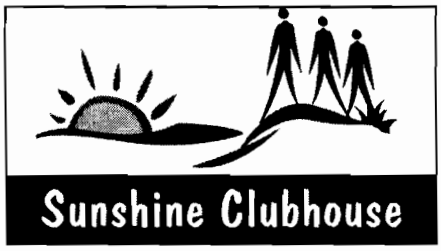


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Sincerely,

Larry Allen
1919 Kendall
South Bend, Indiana 46613

**Submitter :** Ms. Delores Hernandez **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-344-Attach-1.DOC

#344


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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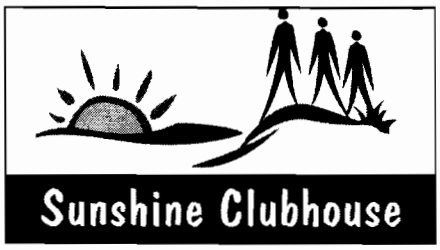


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Sincerely,

Delores Hernandez
903 California
South Bend, Indiana 46616

**Submitter :** Mrs. Cassandra Bryce **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-345-Attach-1.DOC

#345


October 10, 2007

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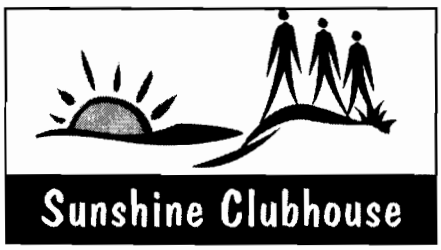


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Sincerely,

Cassandra Bryce
1121 East LaSalle
South Bend, Indiana 46601

**Submitter :** Mr. Gerald Ramsey **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

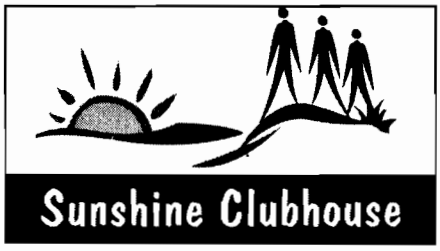
**GENERAL**

GENERAL

"see attachment"

CMS-2261-P-346-Attach-1.DOC

#346

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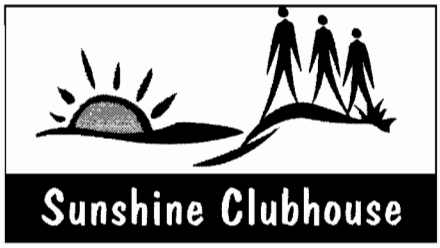


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Sincerely,

Gerald Ramsey
437 North Niles
South Bend, Indiana 46617

**Submitter :** Ms. Catina Fisher **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

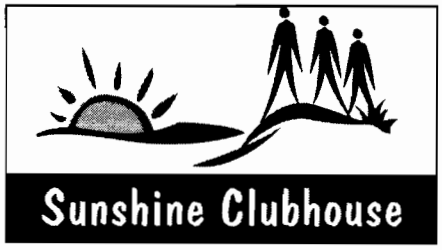
**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-347-Attach-1.DOC

#347




October 10, 2007

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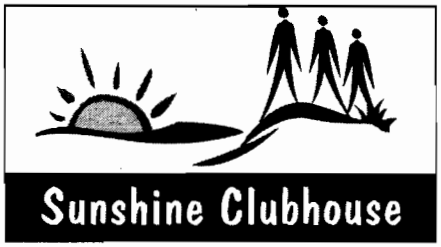


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Sincerely,

Catina Fisher
5024 Western Avenue
South Bend, Indiana 46619

**Submitter :** Mr. Stephen Dunn **Date:** 10/04/2007

**Organization :** AIM Center, Inc.

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

To Whom It May Concern:
State funded Medicaid programs, such as psychiatric rehabilitation, continue to become under-funded. The CMS budget proposal for cuts to Medicaid will severely restrict and/or reduce services that are currently provided by AIM Center--Chattanooga, Tennessee s only psychiatric rehabilitation services center.

Such a proposal would have disastrous consequences for individuals and families that depend on Medicaid and who receive psychiatric rehabilitation.

Currently, AIM Center budget is comprised of nearly one-third (1/3) Medicaid dollars. If federal Medicaid reform is passed, such is proposed by CMS, it would dramatically reduce our ability to provide services for persons with mental illness. If the reform is passed it would result in discontinuing some of our current services.

Please note, that AIM Center provides life-time follow along employment services which are free to the mental health consumer (yet greatly UNDER-funded by Voc Rehab, DRS), free education services and wellness and recovery services with emphasis on certified peer specialists and evidence-based practices. These services are NOT funded by other sources and there are no other service providers within 100+ miles who provide these critical unmet needs.

The current Medicaid proposal would result in cuts in eligibility and coverage for both mandatory and optional populations and would be extremely harmful to children and adults living with mental illnesses. These proposals would inevitably threaten the viability of the already fractured public mental health care system.

I implore the CMS committees charged with the proposals to reconsider the reductions in rehabilitation services for persons with mental illness. AIM Center's Medicaid funding is absolutely necessary. Thank you.

Stephen Dunn, M.A. Regional Employment Facilitator AIM Center Chattanooga TN 37402

**Submitter :** Ms. Larry Rosenberg **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

#349



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.

**Submitter :** Dr. Robert Marra **Date:** 10/04/2007

**Organization :** Indiana Dept of Ed, Div of Exceptional Learners

**Category :** State Government

**Issue Areas/Comments**

**Background**

Background

See Attachment

CMS-2261-P-350-Attach-1.PDF

#350

# Indiana Department of Education
# Comments on Proposed Rule 2261-P
# October 4, 2007

The Indiana Department of Education strongly opposes changes in the Medicaid rehabilitation services definition recently proposed in Rule 2261-P. It appears the new definition could be interpreted to eliminate Medicaid reimbursement for rehabilitation services in cases where other coordinating programs, including education, are also responsible to pay for them. The proposed change would contradict existing law that allows Medicaid to be the primary payer for Medicaid services provided to Medicaid-eligible students under the Individuals with Disabilities Education Act. With passage of the Medicare Catastrophic Coverage Act of 1988, Congress clearly intended to preclude the Secretary of Health and Human Services from denying payment for Medicaid-covered services provided pursuant to a child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). We urge CMS to ensure continued availability of federal financial participation in the costs of Medicaid-covered services in eligible students' IEPs and IFSPs.

As the Bazelon Center for Mental Health Law points out, the fact that Medicaid-covered services are commonly available to Medicaid enrollees through other funding sources "has never been considered a reason to deny a Medicaid-covered person a Medicaid-covered service." [http://www.bazelon.org/issues/medicaid/9-05TalkingPoints.htm] Like Bazelon, 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.

Title XIX of the Social Security Act provides for annual appropriation of funds to enable state Medicaid programs to furnish "rehabilitation and other services to help ... families and individuals attain or retain capability for independence or self-care." Rule 2261-P proposes to make reimbursement available only for rehabilitation services necessary "to achieve specific, measurable outcomes." This would impose a definition more restrictive than that in federal law and ignores the reality that rehabilitation services can also be needed to maintain gains or prevent deterioration in an individual's condition and functioning.[1]

When enacting new Medicaid third party liability provisions in the Deficit Reduction Act of 2005, the U.S. Congress considered but rejected the Centers for Medicare and Medicaid Services' recommendation to prohibit Medicaid from paying for rehabilitation services that are an intrinsic element of another program.[2] More recently, federal law makers from both parties again expressed their strong opposition to such a policy by passing an SCHIP reauthorization bill (HR 3162, S 1893) that includes a one-year

[1] Bazelon Center for Mental Health Law web site, Medicaid Talking Points
[2] Crowley and O'Malley, Kaiser Commission on Medicaid and the Uninsured policy brief, August 2007

moratorium on any administrative action to restrict coverage or reimbursement for Medicaid rehabilitation services.

States are increasingly overburdened by under funded federal education mandates. If implemented, the Administration's recently proposed Medicaid policies, to limit reimbursement for services provided in schools, would significantly impede progress toward the President's stated education goal of "no child left behind." A full year before CMS proposed this ill-conceived rehabilitation services rule, Senators Harkin, Bingaman, Lautenberg, Murray, Stabenow and Wyden sent a letter to former CMS Administrator Mark McClellan objecting to restrictions on the scope of services reimbursable under the Medicaid Rehabilitation Option.[3] The letter expressed concern that a policy restricting funding for community-based rehabilitation services would "shift fiscal responsibility for [rehabilitation services] to hard pressed State programs, or beneficiaries themselves who can ill-afford them."

The Indiana Department of Education joins mental health, child welfare and other education advocates throughout the country in opposing the changes set out in Rule 2261-P. We respectfully request that CMS withdraw the rule and continue reimbursement at current levels and coverage criteria for rehabilitation services provided in the school setting pursuant to the IEP or IFSP of a Medicaid-eligible special education student.

Respectfully submitted,

Dr. Robert A. Marra, Associate Superintendent
Division of Exceptional Learners

[3] Letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, et al., dated July 7, 2006

**Submitter :** Mr. Larry Rosenberg **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-2261-P-351-Attach-1.DOC

#357


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.

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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,

Larry Rosenberg
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**Submitter :** Ms. Kathy Bailey **Date:** 10/04/2007

**Organization :** Sunshine Clubhouse

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

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Sincerely,

Kathy Bailey 62430 Locust Road
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