Submitter : **Mr. David Sholly** **Date: 10/05/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

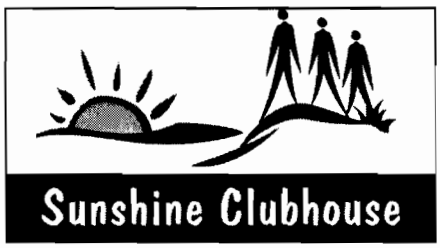
GENERAL

GENERAL

"See Attachment"

CMS-2261-P-410-Attach-1.DOC

#410



October 11, 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,

David Sholly
803 North Twyckenham Drive
South Bend, Indiana 46617

Submitter : **Mr. McKinley Jones** **Date: 10/05/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-411-Attach-1.DOC

#411

October 11, 2007

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

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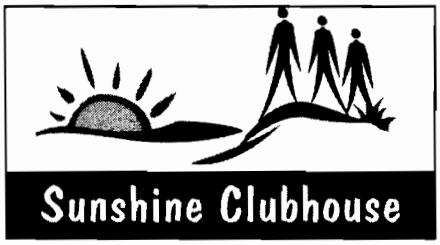
sunshineclubhouse@sunshineclubhouse.com



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Sincerely,

McKinley Jones
500 Lincoln Way East
Mishawaka, Indiana 46544

Submitter : **Mr. Dale Patterson** **Date: 10/05/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-412-Attach-1.DOC

#412

October 11, 2007

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

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Sincerely,

Dale Patterson
1505 Liberty
Apartment 5
Mishawaka, Indiana 46545

Submitter : Mr. Herbert Cromwell **Date:** 10/05/2007

Organization : Community Behavioral Health Association of MD

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-413-Attach-1.DOC

#413

October 5, 2007

Centers for Medicare & 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
Comments on 42 CFR Parts 440 and 441: Medicaid Program: Coverage for Rehabilitative Services

The Community Behavioral Health Association of Maryland (CBH) is the professional association for Maryland's network of community mental health programs operating within Maryland's public mental health system (PMHS). Our member agencies deliver outpatient mental health treatment, rehabilitation and related services to the majority of the 92,000 children and adults who use the PMHS. We appreciate the opportunity to comment on the proposed Medicaid rehabilitation option regulations.

We have significant concerns about the regulations as currently proposed. They will create new barriers to the recovery process for the persons we serve and could inhibit rather than support their ability to maximize functioning in the community. We request attention to four specific areas:

1. Section 440.130(1)(vi) and (3)(xiv)

"Restorative services" and the regulation's overall definition of rehabilitation fail to account for the non-linear nature of psychiatric disability. Relapse is common with severe and persistent mental illnesses and ongoing rehabilitation – medication monitoring, community living skill training, illness management and related services – is often necessary even during periods of relative stability to prevent decompensation and rehospitalization. For many individuals, the functional deficits caused by illnesses such as schizophrenia are so profound that rehabilitation is needed to support and sustain community tenure. For them, prevention of reinstitutionalization – accomplished through the day to day achievement of what may appear to be very modest short-term goals such as taking medication daily and engaging in delineated life skill activities – is a very appropriate, concrete and worthy long-term goal.

The precedent for a more comprehensive definition is in CMS's Medicare definition of "reasonable expectation of improvement" which reads: "It is not necessary that a course of therapy has as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. 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."

Therefore, we strongly urge the addition of the following language to the end of the sections indicated:

Section 440.130 (1)(vi) (definition of "restorative services")

"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."

Section 440.130 (3) (xiv) (requirement of "Measurable Reduction of Disability")

"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."

2. Section 440.130 (3)(xi)

We urge *deletion of this section*, which 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."

It is inappropriate and potentially damaging to discuss alternate providers in the context of a rehabilitation plan. It is disruptive to the therapeutic relationship and sends a confusing message to the consumer that he/she may not be the right fit for the provider or that the provider is not the right fit for the consumer. The issue of alternate providers is not part of a somatic practitioner's treatment planning process or a dental practitioners treatment planning process, and it certainly shouldn't be part of a psychiatric treatment planning process. Consumer choice of providers is a matter of information and referral at the mental health authority or care management level but *not* as part of a treatment plan.

3. Section 440.130 (3)(xvi)

We urge *deletion of this section*, which reads "Document that the services have been determined to be rehabilitative services consistent with the regulatory definition."

The purpose of this section is unclear in the context of a rehabilitation plan. It is understood that a provider is bound by all Medicaid requirements, from documentation of

medical necessity to regulatory and billing compliance. It is generally the state or local mental health authority's responsibility to carry out a process for ensuring regulatory compliance through, for example, its service authorization process. The rehabilitation plan is just that, a plan for an individual, and it should not have a regulatory function.

4. Section 441.45 (b) (1)

The "intrinsic elements" section distinguishes services that are rehabilitative and thus reimburseable under Medicaid from those that are not. But *the distinction must be made more clear and must take into account the importance of blending and coordinating services.*

Three of the six evidence-based community mental health practices endorsed by SAMHSA (assertive community treatment, integrated dual disorders treatment, and supported employment) emphasize integration and coordination. The regulation should not prohibit, and should not be interpreted to prohibit, federal financial participation (FFP) for mental health rehabilitation services provided as part of an integrated service such as supported employment, a program that SAMSHA considers to be an important and effective, evidence-based practice.

To put it another way, while teaching a person to perform a job at a worksite is vocational and thus not a covered service, working with the individual to improve personal hygiene and the skills connected with interacting with peers is clearly rehabilitative, and should be considered so by CMS, even if the improvement is manifested at a worksite.

Therefore, we recommend adding 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 the non-covered services."*

Thank you for considering these recommendations.

Sincerely,

Herbert S. Cromwell
Executive Director

Submitter : **Mr. Richard Faden** **Date: 10/05/2007**

Organization : **Mr. Richard Faden**

Category : **Individual**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

(1) strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. Urge that this proposed rule be withdrawn.

The proposed rule would severely harm people with intellectual and other developmental disabilities in two major ways:
(1) it eliminates longstanding programs for providing habilitation services to people with developmental disabilities, and
(2) it imposes a discriminatory and arbitrary exclusion from receiving many rehabilitative services for people with intellectual disabilities/mental retardation and related conditions.

We take issue with the assertion that there are more appropriate coverage authorities (i.e. waiver services, etc.) In particular, waiver programs operate as discretionary alternatives to our State's core Medicaid program under the state plan. We believe that states should have the flexibility to continue operating habilitation services under the longstanding state plan options in addition to having the waiver options, but should not be forced to utilize only one option.

(2) The definition creates a discriminatory and arbitrary exclusion from receiving rehabilitative services for people with mental retardation and related conditions

We strongly oppose the proposed rule s definition of habilitation services [?441.45(b) (2)] as including services provided to individuals with mental retardation and related conditions.

Defining clinical service eligibility by excluding individuals with mental retardation is discriminatory and is based on false presumptions of individual needs, abilities, etc.

Submitter : **Ms. Courtney Chaffee** **Date: 10/05/2007**

Organization : **Networks Employment Service/Sunshine Clubhouse**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-415-Attach-1.DOC

#415

Sunshine Clubhouse

October 11, 2007

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

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Sincerely,

Courtney Chaffee
920 Autumn Lake Circle
Apartment 2-A
Mishawaka, Indiana 46544

Submitter : **Danny Sevier** **Date: 10/05/2007**

Organization : **Hale o Lanakila**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-416-Attach-1.DOC

#416

October 11, 2007

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

To Whom It May Concern:

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Sincerely,

Danny Sevier
111 Kahului Beach Road #D414
Kahului, Hawaii 96732

Submitter : Dr. Steven Daviss **Date:** 10/05/2007

Organization : Dr. Steven Daviss

Category : Physician

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

O=======> Enactment of the proposed rule will mean that potentially hundreds of thousands of Medicaid recipients will have REDUCED ACCESS to rehabilitation services. O=======> The 'intrinsic element' provision will result in DECREASED COORDINATION of care and INCREASED INTERAGENCY FINGER-POINTING about who is responsible for a service, resulting in consumer frustration and apathy, and ultimately, no one being responsible. O=======> The 'restorative services' requirement will mean -- for the many consumers who use these services to maintain their current level of functioning -- that instead of just continuing to tread water, THEY WILL DROWN. O=======> The end result will be INCREASED COSTS in emergency room and hospital expenses, in addition to the increased social costs of increased homelessness and poverty and the consequences of worsening backups in emergency rooms. O=======> ULTIMATELY, the effects of the above provisions appear to be PENNY-WISE and POUND-FOOLISH.

=Steven R Daviss MD DFAPA

Submitter : Joyce Garcia **Date:** 10/05/2007

Organization : Hale o Lanakila

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-418-Attach-1.DOC

#418

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 11, 2007

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

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

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

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

1765 Wili Pa Loop Wailuku Maui Hawaii 96793 Tel 808.984.2156 Fax 808.984.2159 Email: haleolanakila@hawaii.rr.com

Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

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

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

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

Sincerely,

Joyce A. Garcia
31 Nihi Place
Paia, Hawaii 96779

Submitter : Mrs. Susan King **Date:** 10/05/2007

Organization : Hale o Lanakila

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-419-Attach-1.DOC

#419

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 11, 2007

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

To Whom It May Concern:

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 needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

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

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

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

1765 Wili Pa Loop Wailuku Maui Hawaii 96793 Tel 808.984.2156 Fax 808.984.2159 Email: haleolanakila@hawaii.rr.com

Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

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

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

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

Sincerely,
Susan C. King
493 Pio Drive #319
Wailuku, HI 96793

Submitter : **Ms. Ann Jones** **Date: 10/05/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-420-Attach-1.DOC

#420

October 11, 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,

Ann Jones
107 Old Stable Lane
Apartment A-1
Mishawaka, Indiana 46544

Submitter : Mr. GARY MAFFEI **Date:** 10/05/2007

Organization : QSAC, INC

Category : Intermediate Care Facility for the Mentally Retarded

Issue Areas/Comments

Background

Background

strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. this proposed rule needs to be withdrawn.

Submitter : Ms. Shahnaz Mazandarani **Date:** 10/05/2007

Organization : A Better Way, Inc.

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-422-Attach-1.DOC

#422

3200 Adeline Street • Berkeley, California 94703
Tel 510.601.0203 • fax 510.601.4002 • email mail@abettterwayinc.net

October 8, 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 Founder and Executive Director of A Better Way, Inc., writing on behalf of the entire staff of A Better Way. We are a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides therapeutic foster care, adoption, and mental health services to children and youth in foster care.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is particularly important for children, as some functions may not have been possible (or age-appropriate) at an earlier date given the child's developmental process. The regulation needs modification to make the meaning of this section clearer.

This definition also includes rehabilitation services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for children with mental health conditions, continuation of rehabilitative services is at times essential to retain their functional level. Most mental health conditions are marked by cyclical periods of sharp symptom exacerbation and remission.

Failure to provide a supportive level of rehabilitation will result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as

maintaining the highest possible functional level, leading children to deteriorate to the point where they will again be eligible for services. This serves no one's interest.

Recommendation:

1. Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it was not developmentally possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past.

2. Revise the definition of when services may be furnished to maintain functioning to include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

440.130(5) Settings

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

Recommendation:

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

441.45(a)(2) Covered services requirements

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

Recommendation:

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

441.45(b) Non-covered services

This section introduces an entirely new concept into Medicaid, one that conflicts with federal statutory requirements. The concept denies Medicaid coverage for medically necessary covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There is little clarity in the rule about how CMS would apply this provision. More specifically, there is no guidance on how to determine whether a service is an intrinsic element of another program.

There seem to be only two situations in which Medicaid might be paying for services that meet this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by the EPSDT program. The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies covered individuals medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

2. Alternately, this section should be clarified and narrowed to specifically focus on situations where an entity such as an insurer has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states and localities should be excluded from this provision.

3. Some subsections of Section 441.45(b) include language that ensures that children in other settings cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all subsections (i) through (iv).

4. The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The rule should include this language.

5. It is especially important that mental health providers be able to work with children with mental health conditions in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child's functional impairments should be a covered service.

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

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

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

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

Recommendation:

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

2. In discussing therapeutic foster care, the preamble provides that states must define all of the services to be provided and the payment methodology for a covered service. Accordingly, give states the discretion to identify the rehabilitation components that constitute therapeutic foster care, define

therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at the state, county, and provider agency level. The development of new forms, staff training, and administrative processes all pose significant challenges at all levels. At a minimum, CMS should grant States a one-year planning and implementation period from the time of approval of the state plan amendment by CMS.

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (510) 601-0203 ext. 121.

Sincerely,

Shahnaz Mazandarani; Executive Director
& The Staff of A Better Way, Inc.

Submitter : Ms. Tonya Perkins **Date:** 10/05/2007

Organization : Ms. Tonya Perkins

Category : Individual

Issue Areas/Comments

Background

Background

Habilation vs. Rehabilation

Collections of Information Requirements

Collections of Information Requirements

Services to children and adults should not be cut. Government exists to help the needest people get the quality of care that citizens need to help them function. Indeed a society is judged by history and God by how it treats its most under priviledged members. The social and emotional skills that a child learns today in therapy can save teh lives of people tommorow by ensuring that the child is sufficiently habilitated to be a functioning member of society.

Sadly, we have seen SCHIPs cut and now this proposal to hurt our children by taking away methods that can help them to function in the world around them. Is this how the Republican party wants to be rememberd? The Gay-War Party

Provisions of the Proposed Rule

Provisions of the Proposed Rule

If cuts need to be made, leave Iraq. If that is not enough places like Philadelphia offer services to children regardless of immigration status. Maybe illegal immigrants should be restricted on services. This would encourage legal immigration.

Submitter : Mr. Paul Meggett **Date:** 10/05/2007

Organization : Threshold, Inc.

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-424-Attach-1.DOC

#424

5 October 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

As a concerned citizen and member of the Board of Directors of Threshold, Inc., I write to submit the following comments on the proposed new regulations to govern Medicaid's rehabilitation service category that were recently published in the August 13, 2007 Federal Register (Volume 72, Number 155). Threshold Inc. is a Day Rehabilitation Program, located in Durham, North Carolina. Threshold operates a psychosocial rehabilitation program based on the Clubhouse Model for adults in Durham with severe mental illness. Established in 1985 by concerned parents, Threshold is committed to facilitating personal well-being and community involvement through meaningful work and relationships. Some members work at the clubhouse in their chosen unit (kitchen, snack bar, member services, or clerical). Others work in Threshold's transitional employment program, which offers supported work opportunities and real work experience in the community.

I commend CMS for undertaking to attempt to "provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records," as is stated in the summary in the Federal Register. As a taxpayer, I think it is important that to ensure the fiscal integrity of the Medicaid program. The proposed rule changes are comprehensive and would significantly affect the public provision of services to children and adults with serious mental disorders and people with physical or developmental disabilities. As I understand it, the net effect of the changes would be to save the federal government an estimated $180 million in one year and $2.2 billion over a five-year period. However, the states and localities would see none of those dollars, which means they would have to either reduce services or pick up the slack for the lost federal revenue. I believe the proposed rules will do more harm than good, and I urge you to reconsider the sweeping changes you are about to make. I offer the specific comments concerning the proposed rules below.

Non-covered services: 441.45(b)

This section appears to introduce an entirely new concept into Medicaid, one that conflicts with current federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. More clarification is needed to show how this provision of the proposed rules would be applied,

as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

Moreover, few of the cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r). The result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute. This cannot be what CMS intended.

Recommendations:

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

Alternatively, the section should be clarified and narrowed so as to focus on situations where an entity (e.g. an insurer) has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded from this provision.

The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. Whether in a classroom or clubhouse setting, mental health rehabilitation services to address these problems should be covered.

Rehabilitative Services: 441.45(a)(2)-

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level, as defined in the law. However, it would be helpful to reiterate here when services may be furnished to retain or maintain functioning.

Recommendation:

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

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

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. Similar to the concerns raised regarding the Rehabilitation Services section are concerns that the definition of Restorative Services focuses on achieving a rehabilitation goal and not maintaining a functional level necessary to avoid the need for more intensive and expensive medically necessary and covered services. It is our understanding the CMS had both the authority and obligation to fund needed "rehabilitation and other services" for helping covered individuals "retain" improved functioning and that allows for independence from more intensive and expensive services.

Recommendation:

There should be clear language in this section that allows for funding services that are determined thorough approved rehabilitation plans to be necessary to achieve and maintain the least intensive service level and most independence possible, to include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

Conclusion

Unfortunately, Medicaid has become the single largest funding source for mental health services in this country today. Sweeping mental health reform may indeed be needed, but essentially taking away the only funding source for mental health services on the ground will greatly damage the progress that has been made to provide critical services for some of our nation's most vulnerable citizens. The proposed rules would: over time only increase Medicaid costs due to more expensive psychiatric hospitalizations; effectively disallow important aspects of psychosocial rehabilitation by removing any long-term solutions; and create such needless and burdensome paperwork that it will adversely impact service delivery to those that Medicaid is charged with protecting. Cutting corners now will only make things worse in the long run. I strongly urge you to carefully reconsider the proposed changes or to at least carefully consider the comments here and from others who provide services in the mental health area.

Sincerely,

Paul A. Meggett
Member, Threshold Board of Directors

Submitter : **Mr. Paul Meggett** **Date: 10/05/2007**

Organization : **Mr. Paul Meggett**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-425-Attach-1.PDF

#425

5 October 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

As a concerned citizen and member of the Board of Directors of Threshold, Inc., I write to submit the following comments on the proposed new regulations to govern Medicaid's rehabilitation service category that were recently published in the August 13, 2007 Federal Register (Volume 72, Number 155). Threshold Inc. is a Day Rehabilitation Program, located in Durham, North Carolina. Threshold operates a psychosocial rehabilitation program based on the Clubhouse Model for adults in Durham with severe mental illness. Established in 1985 by concerned parents, Threshold is committed to facilitating personal well-being and community involvement through meaningful work and relationships. Some members work at the clubhouse in their chosen unit (kitchen, snack bar, member services, or clerical). Others work in Threshold's transitional employment program, which offers supported work opportunities and real work experience in the community.

I commend CMS for undertaking to attempt to "provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records," as is stated in the summary in the Federal Register. As a taxpayer, I think it is important that to ensure the fiscal integrity of the Medicaid program. The proposed rule changes are comprehensive and would significantly affect the public provision of services to children and adults with serious mental disorders and people with physical or developmental disabilities. As I understand it, the net effect of the changes would be to save the federal government an estimated $180 million in one year and $2.2 billion over a five-year period. However, the states and localities would see none of those dollars, which means they would have to either reduce services or pick up the slack for the lost federal revenue. I believe the proposed rules will do more harm than good, and I urge you to reconsider the sweeping changes you are about to make. I offer the specific comments concerning the proposed rules below.

Non-covered services: 441.45(b)

This section appears to introduce an entirely new concept into Medicaid, one that conflicts with current federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. More clarification is needed to show how this provision of the proposed rules would be applied,

as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

Moreover, few of the cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r). The result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute. This cannot be what CMS intended.

Recommendations:

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

Alternatively, the section should be clarified and narrowed so as to focus on situations where an entity (e.g. an insurer) has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded from this provision.

The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. Whether in a classroom or clubhouse setting, mental health rehabilitation services to address these problems should be covered.

Rehabilitative Services: 441.45(a)(2)-

This section limits rehabilitative services to those furnished for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level, as defined in the law. However, it would be helpful to reiterate here when services may be furnished to retain or maintain functioning.

Recommendation:

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

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

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. Similar to the concerns raised regarding the Rehabilitation Services section are concerns that the definition of Restorative Services focuses on achieving a rehabilitation goal and not maintaining a functional level necessary to avoid the need for more intensive and expensive medically necessary and covered services. It is our understanding the CMS had both the authority and obligation to fund needed "rehabilitation and other services" for helping covered individuals "retain" improved functioning and that allows for independence from more intensive and expensive services.

Recommendation:

There should be clear language in this section that allows for funding services that are determined thorough approved rehabilitation plans to be necessary to achieve and maintain the least intensive service level and most independence possible, to include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

Conclusion

Unfortunately, Medicaid has become the single largest funding source for mental health services in this country today. Sweeping mental health reform may indeed be needed, but essentially taking away the only funding source for mental health services on the ground will greatly damage the progress that has been made to provide critical services for some of our nation's most vulnerable citizens. The proposed rules would: over time only increase Medicaid costs due to more expensive psychiatric hospitalizations; effectively disallow important aspects of psychosocial rehabilitation by removing any long-term solutions; and create such needless and burdensome paperwork that it will adversely impact service delivery to those that Medicaid is charged with protecting. Cutting corners now will only make things worse in the long run. I strongly urge you to carefully reconsider the proposed changes or to at least carefully consider the comments here and from others who provide services in the mental health area.

Sincerely,

Paul A. Meggett
Member, Threshold Board of Directors

Submitter : Ms. Linda Rosenberg **Date:** 10/05/2007

Organization : National Council for Cmty Behavioral Healthcare

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-426-Attach-1.PDF

#426

NATIONAL COUNCIL
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October 5, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The National Council for Community Behavioral Healthcare 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 National Council for Community Behavioral Healthcare is a not-for-profit, 501(c)(3) association of 1,300 behavioral healthcare organizations. Our members offer medical, social, psychological, and rehabilitation services in community settings to help people with mental illnesses and addiction disorders recover and lead productive lives. Each year, members serve almost six million adults, children and families in communities across the country.

The National Council is a voice for safe, effective, appropriate, accessible, efficient, consumer-centered and timely behavioral healthcare services. Established in 1970, with roots in the community mental health center movement, we remain committed to the principle that those with mental illnesses or addiction disorders should have access to the full spectrum of services they need, in their own community.

The National Council's commitment to quality is evidenced by its efforts to provide state-of-the-art educational services to its membership on the recovery from mental illness, psychosocial rehabilitation and medical interventions, as well as training to ensure compliance with applicable state and federal laws and regulations governing the Medicaid program.

The Centers for Medicare and Medicaid Services (CMS) first proposed changes to the Rehabilitative Services under the Medicaid program in 2005 when Congress began consideration of the Deficit Reduction Act. Before offering our comments on the Proposed Rule, the National Council wishes to lodge two procedural objections. First, during congressional consideration of the Deficit Reduction Act, the Department of Health and Human Services submitted proposed Medicaid statutory changes to the Senate Finance Committee and the House Energy and Commerce Committee. On page 3 of an August 2005 document entitled "Summary of Administration Proposals," the department proposed to "...amend the definition of "rehabilitative services" to clarify that such services are those necessary for the achievement of specific, measurable outcomes related to restoration of an individual to his or her best possible functional level, so long as they are prescribed and furnished by....a physician or licensed practitioner and are not provided as an intrinsic element of another program." The proposed statutory language went on to describe other specific disallowances for State expenditures on rehabilitation services.

The National Council notes that the Congress rejected this language and the DRA has no new definition for the rehabilitative services option whatsoever. Given this unambiguous expression of congressional intent, and since no

state optional program in the 47 year history of the Medicaid program has been modified without prior legislative enactment, CMS's authority to proceed with this rule making process is unclear.

Second, it is further noted that in Section V, Regulatory Impact Analysis, B. Anticipated Effect, CMS states:

The actual impact to the Federal Medicaid program may be different that the estimate to the extent that the estimate of the amount of rehabilitative services spending subject to this rule is different than the actual amount and to the extent that the effectiveness of the rule is greater than or less than assumed. *Because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services, particularly as it relates to this rule, there is a significantly wide range of possible impact.* (emphasis added)

Given the uncertainty by the Agency as the need for, and potential scope of impact of these Proposed Rules, the National Council urges Proposed Rulemaking be halted until such time as the Agency can produce a comprehensive review of current spending on rehabilitative services, can quantify the impact of the proposed changes, as well as costs associated with administrative expenses related to implementation.

OVERVIEW (PREAMBLE)

There is an incorrect statement in the preamble with respect to the availability of FFP for a Medicaid-covered service furnished to a child that is included in the child=s special education program under IDEA. Under the statute, Section 1903(c), Medicaid is not prohibited or restricted from paying for services that are included in the child=s individualized education program.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

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.

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

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

This definition also includes as appropriate rehabilitation services those services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services are at times essential to retain their functional level. Most severe mental illnesses are marked by cyclical periods of sharp symptom exacerbation and remission, and the long-term clinical course of these conditions is difficult to determine. As an illustration, *Mental Health: A Report of the Surgeon General*, notes that for people living with schizophrenia, "..a small percentage (10 percent or so) seem to remain severely ill over long periods of time (Jablensky et al., 1992: Gerbaldo et al., 1995). While these individuals can significantly improve, "most do not return to their prior state of mental function." (Mental Health: Report of the Surgeon General, 1999, pg. 274).

Given this sobering clinical data, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of intensive services. We are concerned that states and providers will interpret the current proposed regulation as prohibiting the coverage of services necessary for retention of improved functioning as well as maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

Section 1901 of the statute specifically authorizes funds for "rehabilitation and other services" to help individuals "retain" capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain an individual's functional level.

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

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

Medicare Hospital Manual, Chapter II, Section 230.5 Hospital Outpatient Psychiatric Services; Medicare Intermediary Manual, Part 3, Chapter II, Section 3112.7 Outpatient Hospital Psychiatric Services.

Additionally, The preamble and section 441.45(b) of the proposed rules exclude prevocational services. However, rehabilitative services should include prevocational services when they are provided to individuals that have experienced a functional loss has a specific rehabilitation goal toward regaining that functioning. Examples of these skills include cognitive interventions such as working at an appropriate pace, staying on task, increased attention span, increasing memory, as well as other communication and social skills that are necessary as pre-vocational work and for daily living, such as taking instructions and/or guidance, and asking for help.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR 438.210(a)(4)(ii)(B)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

Secondly, revise the definition of when services may be furnished to maintain functioning to include as an acceptable goal of a rehabilitation plan the retaining of functional level for individuals who can be expected to otherwise deteriorate.

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

440.130(d)(1)(vii) Definition of medical services

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person=s functional capacity B 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.

This 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 Amedically necessary@ is used in this regulation to indicate necessary rehabilitation services.

Recommendation:

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

Language is included in the preamble to the effect that services are to be provided at the least intrusive level to sustain health. Coupled with states' obligations to furnish care in the least restrictive setting, this wording can encourage providers to focus on delivery of the most effective community services that can improve the individual=s functioning within a reasonable time frame and discourage provision of restrictive levels of care that are unacceptable to the individual.

Recommendation:

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).

Insert into this section a requirement that rehabilitation services be delivered in a coordinated manner.

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, and additionally, services should also be required to be provided in the most integrated, appropriate setting.

440.130(d)(3) Written Rehabilitation Plan

We do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed. Without attention to our suggestions, this new requirement will add significantly to the administrative time and expense of agencies serving individuals in need of rehabilitative services.

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

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

We are puzzled by the requirement that the plan include information on alternate providers of the same service. In almost all communities, the number of providers willing to accept Medicaid reimbursement is small. This reality is even more problematic in rural and frontier areas of the country. Expecting staff responsible for planning to now become familiar with alternate providers is an unreal expectation.

Person-centered planning requires the active participation of the individual. CMS further recommends the involvement of the consumer's family, or other responsible individuals. However, requiring the signature of the client or representative in some rare cases may be problematic. There are two factors to consider.

First, severe mental illness is episodic, and it is not always possible to determine when an exacerbation of the illness may occur. There may be instances in which a person, because of the symptoms of their illness, may not believe they are sick or comply with the signing the treatment plan, and it is also true, that at this point in the individual's life, retention of services are critical to prevent hospitalization, incarceration, or other public or personal safety consequences. There is also no guarantee that the individual has appointed a representative, or that the consumer in crisis could identify this person. Therefore, CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.

Recommendations:

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

- that this plan be written in plain English so that it is understandable to the individual.
- that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan. CMS should allow for the documentation by the provider who meets state requirements of reasons that the client, or their representative is not able to sign the treatment plan.
- that the plan of services be based on a strengths-based assessment of needs;
- that the plan include intermediate rehabilitation goals;
- that, as indicated, the plan include provisions for crisis intervention;
- that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;
- substitute for the requirement that the plan list the potential alternate providers of the same service a requirement that the plan include an assurance that the individual has received this information (to the extent the service planning team is aware of all existing providers.

CMS should also clarify that a single treatment and rehabilitation plan is acceptable and encourage a single planning team and service planning meetings.

440.130(4) Impairments to be addressed

The regulation states that services may address an individual=s physical impairments, mental health impairments and/or substance-related disorder treatment needs. In describing this section in the preamble, the agency also 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. Excluding coverage of rehabilitative services needed by individuals with mental illnesses would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:

Section 440.130(4) should be changed to delete "/or" after the word "and" in this sentence.

440.130(5) Settings

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

Recommendation:

Add to the list of appropriate settings for rehabilitation services "schools, therapeutic foster care homes, and mobile crisis vehicles."

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

It would also be valuable to include the language in the preamble (page 45204) regarding how to determine whether a particular service is a rehabilitation service, based on its purpose.

Recommendation:

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

Insert additional language into this section (from the preamble) to state that it is helpful to scrutinize the purpose of the service as defined in the care plan in order to determine whether a specific service is a covered rehabilitative benefit.

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There are many mechanisms that

states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an Aintrinsic element@ of another program.

We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service B in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396?? (1396d(r)). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

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

Alternatively, the section should be clarified and narrowed so as to specifically focus on situations where an entity (e.g. an insurer) has a specific legal obligation to pay for the services for the specific Medicaid-covered individual. Programs operated through capped or discretionary appropriations from states or localities should be specifically excluded from this provision.

Some subsections of Section 441.45(b) include language that ensures that children in the other settings that are cited (therapeutic foster care, foster care or child care institutions for a foster child) can nonetheless receive medically-necessary rehabilitation services if those services are provided by qualified Medicaid providers. This phrase should be inserted under paragraph (b)(1) so that it will apply to all of the subsections (i) through (iv).

The preamble states that Medicaid-eligible individuals in other programs are entitled to all rehabilitative services that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative services must be coordinated with services furnished by other programs. The regulation should include this language.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all appropriate settings. For children, the school day can be an especially critical time. While classroom aides may not be eligible mental health providers, the presence of a mental health provider in the classroom to address a specific child=s functional impairments should be a covered service.

Similarly, a child with a serious mental disorder being reunified with its family may have specific issues directly stemming from the mental disorder. Mental health rehabilitation services to address these problems (as distinct from generic reunification services) should be covered.

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 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). The alternative for most such children would be immediate placement in an institutional setting, such as a residential treatment program or psychiatric hospital, at significantly higher expense.

If states are not able to create a package of covered services as therapeutic foster care and pay on that basis, this will result in inefficiencies and raise administrative costs.

The regulation makes no acknowledgment that therapeutic foster care is a mental health service, provided through mental health systems to children with serious mental disorders who need to be removed from their home environment for a temporary period and furnished 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.

Recommendation:

Therapeutic foster care should be listed 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 provides 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.

Language should also be included in 441.45(b)(1)(i) to clarify that any covered rehabilitation service may always be furnished by mental health rehabilitation providers to children in therapeutic foster care.

441.45(b)(2)

The Omnibus Reconciliation Act of 1989 (OBRA 89) prohibited CMS (the HCFA) from disallowing claims for day habilitation services until such time as a regulation was issued by the Agency that specified the types of habilitation services that would be covered. Therefore, CMS' action to categorically 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. Related conditions include such illnesses as cerebral palsy, and epilepsy and it is clear that individuals with these illnesses can gain and lose functionality and would benefit from rehabilitative services. Some individuals with serious mental illnesses may also experience periods of extreme cognitive impairment as a result of their illneses.

Recommendation:

Clarification should be provided 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 Preamble includes examples of when recreational or social activities may be covered services due to a focus on skill building or other rehabilitative needs. However, the regulation does 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 and how 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 covered rehabilitative services. It would be helpful if CMS would clarify this and also explain to providers how they document that a service was personal care skill building, even though the provider may have had to demonstrate (and therefore provide) personal care in the process.

Recommendations:

Language that is similar to that in the preamble that describes when a recreational or social activity is appropriately considered a rehabilitation services should be included in the regulation at section 441.45(b)(3).

The regulation should 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 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:

Delete the phrases "in secure custody" and "system."

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

This section ensures that services furnished for the treatment of non-Medicaid eligible individuals are not covered. In the preamble (page 45207) there is an explanation of how services that are furnished through contacts with non-eligible individuals, but which are exclusively for the treatment of Medicaid-eligible individuals, are covered. No such explanation, however, is included in this section.

Recommendation:

The language in the preamble explaining when services may be furnished through contacts with relevant individuals who are not themselves Medicaid-eligible are covered rehabilitation services should be included in the regulation.

OTHER ISSUES

Payment and Accounting for Services

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

These new shifts in rate setting methodology are not efficient and are moreover extremely detrimental to the provision of evidence-based mental health services which are more and more frequently being offered as a package of intertwined interventions delivered in a flexible manner. These services 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, but that remove the currently imposed extreme administrative burden.

The requirements in this regulation regarding service planning and documentation are relevant here. These new rules should negate the need for overly prescriptive micro-management of Medicaid providers.

Recommendation:

We strongly urge CMS to work with other federal agencies, the states and the field to devise payment methodologies that support the best practice and the most successful outcomes for children and adults with mental disorders. Recent announcements about limiting payment to single fees for single activities and interventions should be withdrawn.

EPSDT Mandate

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

Recommendation:

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

Section 441.45(b)(4), which refers to services having to be targeted under the State=s plan should be amended to reference EPSDT for children.

Section 441.45(a)(5) should clarify 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 the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at both the state and provider agency level. The development of new forms as well as staff training, administrative processes all pose significant challenges at the Agency level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of the State Plan Amendment by the Agency.

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

Sincerely,

Linda Rosenberg, MSW, CSW
President and CEO

Submitter : Melisa Alaba-Yusouf **Date:** 10/05/2007

Organization : Melisa Alaba-Yusouf

Category : Social Worker

Issue Areas/Comments

Background

Background

Medicaid is meant to protect and help the children and families we serve. By changing the rules Mental health services will not be attainable by all children. Children should have the ability to be seen by any provider willing to accept medicaid. Research has shown that children that have Social-emotional stability do better in society. Social Workers should be able to provide services to all children and their should not be a cap on the severity of the child's illiness.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Private social workers and agencies should be able to accept Medicaid to provide services to children who have medicaid benefits. All kids deserve the best care.

Submitter : **Mrs. Paula Hulbert** **Date: 10/05/2007**

Organization : **Mrs. Paula Hulbert**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

It is of utmost importance that access to Medicaid-covered services are not curtailed. If anything, they should be expanded. Without Medicaid, I could not access primary care or mental health services and I would most likely end up hospitalized for an extended period of time because my Major Depressive Disorder would go untreated. Without my medications, I would quickly become deeply depressed, suicidal and be hospitalized in long-term care. It is also essential that access to primary care is maintained, as I have asthma, arthritis, hiatial hernia, significant degenerate disk disease, elevated liver enzymes, fatty liver, irritable bowel syndrome and hypothyroidism in addition to my psychiatric diagnoses. PLEASE- do not curtail my access to Medicaid services or reduce the services that Medicaid will cover. I would lose everything if I tried to pay for needed services myself. I live on SSI and there is nothing left over at the end of the month. Also, as I was recently discharged from the psychiatric unit of a local general hospital for my third attempted suicide, I am in need of case management services and have in fact, just been approved for supportive case management. Don't take these lifelines away from people like me. With the proper support, I hope to one day return to the workforce and use my two degrees and perhaps even complete my interrupted master's degree.

Submitter : Mrs. Julie Engelmann **Date:** 10/05/2007

Organization : Mrs. Julie Engelmann

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It is not clear how the proposed regulations will be interpreted in regard to wraparound services for autism.

I am a parent of an autistic boy (10) who has needed wraparound services for several years of his life. For anyone who has not had the shock of realizing you are the caregiver of a child with autism and you have no clue how to handle it or how to prepare for the future, let me tell you that you cannot get wraparound services fast enough.

The fear in your heart when you can't get through to your child nor understand what his problem is and he's been screaming for seven hours, you cannot get wraparound services fast enough.

The utter exhaustion when he sleeps only 2 hours a night and you can't take him on errands because he's a walking time bomb and you can't leave him with anyone else because they don't have a clue how to handle him either, you cannot get wraparound services fast enough.

Further, because only one parent can work (if you're lucky enough to have an intact marriage under these circumstances) and the strain of exhaustion and not being able to get even the simplest errands done, this is not the time that you can afford to pay for the amount of services needed - and the earlier you can get them the better, let me tell you. As early as possible you need the most services possible to get that child's brain rewiring. Time is of the essence.

Perhaps funding for services could titrate as the child gets to 2nd grade and older. I think the bulk of important work happens before that age, and other options kick in as the child picks up speech, potty training, and rudiments of communication.

Please withdraw the proposed regulations and republish them again for further comment only after they have been clarified as to how they would impact wraparound services for children with autism spectrum disorders.

Submitter : Carol Lopez **Date:** 10/05/2007

Organization : Hale o Lanakila

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#430

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 : **Dennis Kubo** **Date: 10/05/2007**

Organization : **Hale o Lankila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-431-Attach-1.DOC

#431

Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

October 11, 2007

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

To Whom It May Concern:

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 needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

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

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

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

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Hale o Lanakila Clubhouse
A Program of the Maui Community Mental Health Center

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

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

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

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

Sincerely,

Dennis H. Kubo
35 Hololea St. D110
Kahului, Hawaii 96733