CMS-2261-P-432

Submitter : Lawrence Bacorn

Date: 10/05/2007

Organization : Hale o Lanakila

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-432-Attach-1.DOC

#432

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

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,

Lawrence Bacorn
111 Kahului Beach Road #A404
Kahului, HI 96732

Submitter : **Patricia McGrath** **Date: 10/05/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-433-Attach-1.DOC

#433

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

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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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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,

Patricia L. McGrath
111 Kahului Beach Rd. #A320
Kahului, Hawaii 96732

Submitter : **Mr. Stephen Major** **Date: 10/05/2007**

Organization : **Hale'Oluea Clubhouse**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-434-Attach-1.DOC

CMS-2261-P-434-Attach-2.TXT

It would be 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 mental illness. 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, and that would be an unconscionable mistake.

Sincerely,

Members and Staff of Hale'Oluea Clubhouse

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

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-435-Attach-1.DOC

#435

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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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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Sincerely,

Carol Lopez
934 Anohea Way
Wailuku, HI 96793

Submitter : **Nicole Shotola** **Date: 10/05/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-436-Attach-1.DOC

#436

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

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A Program of the Maui Community Mental Health Center

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Sincerely,

Mark H. Matsunaga
325 Mahalani St. #3B
Wailuku, HI 96793

Submitter : **Jennifer Kaleikau** **Date: 10/05/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-437-Attach-1.DOC

#437

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

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Sincerely,

Jennifer Kaleikau
61 Hoauna St.
Wailuku, HI 96793

Submitter : **Jennifer Uemura** **Date: 10/05/2007**

Organization : **Haie o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-438-Attach-1.DOC

#438

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
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Sincerely,

Jennifer Jo Uemura
61 Hoauna St.
Wailuku, HI 96793

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

Submitter : **Pauline Keanini** **Date: 10/05/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-439-Attach-1.DOC

#439

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 11, 2007

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Sincerely,

Pauline Keanini
111 Kahului Beach Road #A406
Kahului, HI 96732

Submitter : **Raymond Delos Santos** **Date: 10/05/2007**

Organization : **Hale o Lanakila**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-440-Attach-1.DOC

#440

Hale o Lanakila Clubhouse

A Program of the Maui Community Mental Health Center

October 11, 2007

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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

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,

Raymond B. Delos Santos
111 Kahului Beach Rd A-406
Kahului, Hawaii 96732

Submitter : Mr. Leo Sarkissian

Organization : The Arc of Massachusetts

Category : Consumer Group

Date: 10/05/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-441-Attach-1.DOC

#441

The Arc **ADDP** **MDHC**

October 5, 2007

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

Re: File Code CMS–2261–P

To Whom It May Concern:

We are writing to comment on the notice of proposed rulemaking (NPRM) with respect to Medicaid coverage of rehabilitative services that was published in the *Federal Register* on August 13, 2007. These comments are submitted on behalf of three organizations:

1. The Arc of Massachusetts which represents more than 120,000 individuals with intellectual and developmental disabilities and their families,
2. The Association of Developmental Disabilities Providers which represents more than 90 providers of disability services in Massachusetts, and
3. The Massachusetts Day Habilitation Coalition which represents more than 40 agencies which provide day habilitation services.

All three of these organizations have seen the impact of the program on the lives of individuals with disabilities. This program is the only clinical community day option in Massachusetts and its placement in the Rehabilitation Option insures that individuals who require clinical supports to improve their functioning and capabilities are able to do so without fear of enrollment caps or other barriers.

The program helps further individual's independence by assisting them to:

- develop effective communication skills
- increase physical strength, mobility, balance, and flexibility
- grow emotionally furthering adaptive behaviors
- increase their independence in activities of daily living
- expand their cognitive abilities
  improve their functional abilities through sensory integration, fine motor training, assistive technology and through the receipt of Physical, Occupational, and Speech Therapies

We are commenting on the impact of the proposed rule on people with intellectual and other developmental disabilities and access to habilitation services.

We strongly oppose the provisions related to excluding federal financial participation (FFP) for habilitation services. We urge you to withdraw this

proposed rule. We believe that it discriminates against individuals with intellectual disabilities.

The proposed rule would severely harm people with intellectual and other developmental disabilities in two major ways: (1) it eliminates longstanding programs for providing day 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.

(1) Elimination of FFP for habilitation services provided under the rehabilitative and clinic options - We believe that this proposed restriction violates the intent of the Congress to protect access to day habilitation services for people with developmental disabilities when it enacted Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 (OBRA '89). This section reads:

> (g) DAY HABILITATION AND RELATED SERVICES-
>
> (1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--
>
> (A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or
>
> (B) withdraw Federal approval of any such State plan provision.
>
> (2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--
>
> (A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and
>
> (B) any requirements respecting such coverage.
>
> (3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

In enacting this provision of law, the Congress was clearly intending to protect access to day habilitation programs for people with intellectual disabilities/mental retardation and related conditions. It establishes that the Secretary may not deny federal financial participation (FFP) for habilitation services unless the Secretary promulgates a final regulation that *"specifies the types of day habilitation and related services that a State may cover…on behalf of persons with mental retardation or with related conditions."*

In contradiction to the plain language of Section 6411(g) of OBRA '89, the proposed rule **does not** specify which day habilitation services that a state may cover. Instead, the proposed regulation would prohibit provision of *any* habilitation services under

paragraphs (9) and (13) of section 1905(a) of the Social Security Act. We believe that this NPRM exceeds the regulatory authority granted by the Congress and must be withdrawn. At a minimum, since the regulation does not comply with the OBRA '89 language, the Secretary would not have authority to deny FFP for habilitation services provided in those states with approved state plan coverage prior to June 30, 1989.

We also oppose the prohibition of habilitation services on policy grounds. We believe the proposed rule represents a missed opportunity for the Secretary to specify the types of services that may be provided in a way that ensures that individuals receive the highest quality habilitative and rehabilitative services according to current standards of treatment. The preamble of the proposed rule states that the rehabilitative option is not a "custodial" benefit. We agree with the Secretary that state programs operated under the rehabilitative and clinic options should set high standards for delivering active treatment and for innovating to develop programs for people with intellectual and other developmental disabilities that enhances their ability to attain, maintain, and retain their maximum ability to function, consistent with the original conception of rehabilitation, as found in section 1901 of the Social Security Act.

The preamble to the proposed rule also states that the Secretary intends "to work with those states that have habilitation programs under the clinic services or rehabilitative services benefits under their state plans to transition to appropriate Medicaid coverage authorities, such as Section 1915(c) waivers or the Home and Community-Based Services State plan option under Section 1915(i)." We take issue with the assertion that these are more appropriate coverage authorities. In particular, waiver programs operate as discretionary alternatives to their core Medicaid programs, which operate under the state plan. We believe that states should have the flexibility to continue operating habilitation programs under the longstanding state plan options. Further, Section 1915(c) waivers and Section 1915(i) are not equivalent to the rehabilitative or clinic options. Section 1915(c) waiver programs require individuals to meet a nursing facility level of care requirement, something which is not required for rehabilitative or clinic option services. Further, the 1915(c) and 1915(i) coverage authorities have different financial eligibility standards. Most significantly, these coverage authorities do not extend an enforceable entitlement to services. Indeed, the disability community opposed the aspects of section 1915(i), established in the Deficit Reduction Act of 2005, that permit enrollment caps and that do not extend an entitlement to services. Nonetheless, this option was enacted to give states added flexibility and was not intended to supplant the rehabilitative and clinic options by requiring states to shift to more restrictive coverage authorities. It should also be observed that the 1915(c) waiver programs are notable for their long and large waiting lists. In 2004, more than 206,000 people were on Medicaid waiting lists for community services, an increase of roughly 50,000 people in just two years. In some cases, average wait times to receive waiver services are more than two years (Kaiser Commission on Medicaid and the Uninsured, 2006).

We strongly recommend that the proposed exclusion of FFP for habilitative services under the clinic and rehabilitative options not be implemented.

(2) 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 [see Section 441.45(b) (2)] as including "services provided to individuals with mental retardation and related conditions." Coupled with the prohibition on habilitation services, this effectively excludes a population from services in violation of a fundamental principle of Medicaid, that medical assistance provided to one Medicaid beneficiary shall not be less in amount, duration, and scope than the medical assistance made available to any other Medicaid beneficiary [see Section 1902(a)(10(B) of the Social Security Act].

The proposed rule also states that, "Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitative services may be appropriately provided." This policy would, at a minimum, create uncertainty that states can receive FFP for medically necessary rehabilitative option services for people with intellectual and other related disabilities. Additionally, it exposes a false premise that people with intellectual disabilities and those with "related conditions" have achieved no prior capacity to function for which a rehabilitative service would be appropriately furnished under the rehabilitative option. That sweeping assumption includes those defined by CMS elsewhere in regulations as having "related conditions" – people who have cerebral palsy, epilepsy, or any other conditions, other than mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation, with similar treatment needs; which manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

We urge the Secretary to rescind this constraint on rehabilitative and clinic option services that is so blatantly stigmatizing and discriminatory to people with intellectual and other developmental disabilities.

Sincerely,

Leo V. Sarkissian	Gary Blumenthal	Anne Marie Bajwa
Executive Director	Executive Director	Chair
The Arc of Massachusetts	Association of Developmental Disabilities Providers	Massachusetts Day Habilitation Coalition

Submitter : **Dr. Jane Sachs** **Date: 10/05/2007**

Organization : **Jane E. Sachs, JD, PhD**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

1) Intrinsic Elements provision New language would mean Medicaid would not pay for services that CMS deems intrinsic elements of other programs, including foster care, child welfare, education, child care, vocational and prevocational training programs, housing, parole and probation, juvenile justice and public guardianship. The term intrinsic elements is not defined and it is not clear when Medicaid would use that language to avoid paying for services. This provision may exclude services to consumers served by more than one State agency. I fail to understand why those who are most in need and least able to pay must take the brunt of cost saving measures. The vagueness of this requirement only makes this more likely.

2) Restorative services The regulation promotes services that help someone function at a higher level, instead of maintaining their current level of functioning. Medicaid may deny payment for medication monitoring, basic community living skills, and other services that help someone function in the community (and prevent relapse), but do not necessarily improve their day-to-day functioning.
This is, at best, a complete misunderstanding of the nature of serious mental illness. Many people afflicted with these disorders cannot hope for more than maintenance of day-do-day functioning.

3) Therapeutic Foster Care -- The regulation requires that each part of therapeutic foster care be billed separately instead of billing as a single service. Billing separately would result in uncoordinated care, additional paperwork for providers, and some services being denied while others are not. Ultimately, it may force children into residential treatment or inpatient services.

Finally, the regulations place emphasis on recovery and include provisions to increase the involvement of consumers and family members in treatment planning. I support both elements of the proposed regs.

Submitter : **Brooke Stout** **Date: 10/06/2007**

Organization : **Meli Development center**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

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 Bazelon Center for Mental Health Law 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.

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, but believe the wording could be improved. There is a real difference between an individual providing Ainput@ and an individual having Aactive participation.@ By including both terms in different places, the regulation confuses this issue. Further, by requiring the plan to be developed by the provider significantly diminishes the role of the individual. In mental health service delivery, it is a better and far more common practice to have a service planning team working with the active participation of the individual than to have a single provider develop the plan.

In the preamble, CMS recommends the use of a person-centered planning process. There is, however, no reference to person-centered planning in the regulation

itself.

Providers should also be encouraged to be flexible in response to the individual=s needs. Serious mental illness is often a cyclical disorder and, in the course of their recovery, individuals may suddenly deteriorate, requiring a change in services. Service planning and goal setting should anticipate this need and crisis plans need to be developed as part of the rehabilitation plan.

Rehabilitation providers should also be encouraged to inform individuals that they have the right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated. All Medicaid providers are required under federal law to inform individuals about advance directives, although state law governs how those directives are to be developed and implemented.

Recommendation:

Revise the language under paragraph (v) so as to require the plan to be developed by a team that is led by a qualified provider working within the State scope of practice act, with the active participation of the individual (unless it is documented that the individual is unable to actively participate due to their medical condition), the individual=s family (if a minor or as the individual desires), individual=s authorized decision maker and/or of the individual=s choosing and following the guidance of the individual (or authorized decision-maker), in the development, review and modification of the goals and services.

This change should also be made to section 440.130(d)(3)(ii) and (xiii).

Add languagc to Section 440.130(d)(1)(v) to the effect that CMS encourages the use of person-centered planning processes.

Encourage providers to take into account the possibility of relapse, and incorporate within individuals rehabilitation plans provisions for how they will respond should crit

GENERAL

GENERAL

Please allow Illnois providers to have a say in how we provide services to children in Illinois. Our children deserve the best mental health services regardless of their insurance type. Please revise these rules. Thanks again for read over these comments.

Submitter : **Mr. Craig Saft** **Date: 10/06/2007**

Organization : **Mr. Craig Saft**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-444-Attach-1.DOC

#444

It is imperative that CMS withdraw, revise and re-issue the regulations proposed under Section 441.45(b)(2), with greater clarity as to the implications for children and adolescents with special needs who are currently receiving necessary medical services here in Pennsylvania.

As written, these proposed regulations raise questions as to whether the federal government will use them to force Pennsylvania to restrict these vital services for our children.

It is also urged that CMS provide opportunity for public comment.

Our son David, has benefited greatly from these services and in all likelihood would not have any hope of being a productive citizen without having received these services. It is unfortunate that the services are not more readily available and the rules in place make it hard to receive these services in an effective manner. However, this is better than the alternative of not having them at all. We would like to see theses services be easier to access and have more input from parents in choosing providers and delivery methods.

Sincerely,

Craig E. Saft
Kathy Saft
131 Chinaberry Drive
Lafayette Hill, Pa. 19444

CMS-2261-P-445

Submitter : Miss. Amanda Brinkley **Date:** 10/06/2007

Organization : NAMI

Category : Health Plan or Association

Issue Areas/Comments

Background

Background

Please consider all those affected by decreasing any benefits for Medicaid and foot stamps. I don't know where I would be without these. I am a smart young woman, but like many of the disabled, am unable to uphold a job at this time. I rely on these things to get me my medicine, doctor visits, and food. Please remember all those less fortunate. Thanks so much for your time.

Submitter : **Ms. Theresa Sandoval** **Date: 10/07/2007**

Organization : **I am an Independat voter and belong to Depression**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

I am a patient of Dr. Richard Heidenfielder. Mental Illness is terribly difficult to live with and people in that profession only try to help. It is still intimidating when we have to deal members of humanity that are coarse, ignorant, uncaring, mean, heartless, etc. The Housing Commission also needs to train their workers on these areas to improve the way they handle us or at least allow us with a doctors note to change workers! They are NOT all terrible but I've been told we are not allowed to change! The San Diego Housing Commission needs Rehabilitated and trained, maybe even just a select few to work with us so it's not so devastating when we need or think we should call to report something.

GENERAL

GENERAL

I have been on psychiatrict medications since 1972. Currently I'm under treatment for Major Depression and Anxiety. These are terribly limiting problems for me. I prefer to stay in bed and never have to deal with public. Meetup.com has been a life saver. I belong to their Depression group and the Shyness group. I currently belong to the SDHC and calling my worker is absolutly stressful and nauseating because she makes me feel like an idiot and like I'm brainless or 12 years old. I can't change workers and that is NOT a good thing! I'm terrified I will do something or NOT do something right and be kicked off the SDHC. Mental issues should aslo be brought to their attention so they are understanding when we don't IMMEDIATLEY remember every word they say and every rule we are supposed to know forever!

Provisions of the Proposed Rule

Provisions of the Proposed Rule

PLEASE include the San Diego Housing Commission in this information. Some of their employees are totally ignorant when it comes to communicating with the mentally challenged, they are or come across as iron hard and uncaring, treating us like idiots for NOT just knowing everything and reporting just exactly what they want when they want it!

Submitter : **Ms. Amber Ward** **Date: 10/07/2007**

Organization : **West Birginia University**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-447-Attach-1.TXT

#447

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

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

Dear Sir or Madam:

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

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

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

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

We believe that the emphasis on recovery and person-centered planning and the inclusion

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

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

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

Specific comments on sections of the preamble and regulations follow:

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

Section 440.130(d)(1)(iii) – Definition of qualified providers of rehabilitative services

This section provides general requirements for providers of rehabilitative services. While NAMI fully supports choice for consumers of services, we request clarification that schools and other systems could be reimbursed under Medicaid for services provided by employees of that system who meet Medicaid provider requirements. For example, it is often most efficient for schools to hire a therapist or behavioral aide rather than contract with an outside provider. This also allows for proper training and accountability.

Our members report great barriers to coordinating their services and supports so we would like to ensure that the burden is not shifted to consumers and their families to find service providers who will accept Medicaid because other systems such as education are no longer providing someone to give the service. Nothing in the current regulations prohibits schools and other systems from using their own employees, but CMS should clarify in the preamble that such practices are permissible as long as individuals are informed of their choice to seek another Medicaid provider if they wish to do so.

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

NAMI commends CMS for the emphasis on a person-centered planning process including the individual, the individual's family and others of the individual's choosing. The active participation of the individual is an essential part of the recovery process. In

addition, research indicates that recovery is greatly facilitated by support from an individual's family.

NAMI also applauds the requirement that the plan include goals for the rehabilitation services, the services to be provided, and a timeline for assessment of the effectiveness of the provided services. It is important that individuals and their families have clear information about the services that are being made available so they can ensure that the services are actually received. It is also necessary for a treatment plan to have clear goals and for providers and the individual to periodically review whether goals and services need to be altered.

Several of our members have raised concerns, however, about the relationship between a rehabilitation plan and other service plans. CMS should clarify that plans produced by other entities, such as an individualized education plan or provider treatment plan, can be the rehabilitation plan as long as they meet the requirements of Section 440.130(d)(3).

Recommendation:

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

Section 440.130(d)(vi) Definition of Restorative Services:

The proposed regulation and the preamble indicate that services that provide assistance in maintaining functioning may only be reimbursed as a rehabilitative service when necessary to help an individual achieve a rehabilitative goal. They further clarify that rehabilitative goals must be designed to assist with the regaining or restoration of functional loss. We have received overwhelming feedback from our members regarding their concern with the exclusive emphasis on restoring functioning rather than maintaining functioning. Many of our members describe their personal recovery process as varied, with periods of maintenance as well as periods of restoration. As one NAMI member stated, "recovery is not a linear process trending upward." Instead, consumers and family members describe their illnesses as up, down and stable depending on the period of time. In addition, many times these fluctuations did not depend on the rehabilitation services, but rather on outside events, changes in the course of the illness, or changes in medication effectiveness.

Moreover, our members noted that a person's history and severity of illness could be such that a period where the person is not regressing is meeting a rehabilitative goal. For example, an individual with schizophrenia who has experienced multiple hospitalizations and contacts with law enforcement and who has gained sufficient living skills to maintain stable housing may need services to continue those skills. Withdrawing services as soon as the person's living skills were sufficiently restored to allow him or her to live in home for a brief period is inadvisable because the person's history and severity of illness

indicate that he or she is likely to regress without further support.

Requiring that a person deteriorate before services can be provided is not cost effective For individuals with serious mental illnesses, a break in services and support can lead to a downward spiral and long period of acute illness. Thus, NAMI recommends that the proposed rule be amended to allow provision of rehabilitative services if the rehabilitation plan documents that based on the individual's history and severity of illness, such services are needed to prevent regression. The provider would be required to periodically review whether the history and severity of illness continue to merit rehabilitative services to prevent regression as part of the review of the rehabilitation plan.

Moreover, NAMI recognizes the value of consumer run services such as clubhouses and peer support services. Many of our members find these services to be instrumental in their recovery. These programs also recognize that progress is not always linear and prohibiting services to prevent regression can be a barrier to their ability to serve people in need of services.

CMS has full authority to allow rehabilitation services which will prevent regression or deterioration. Section 1901 of the Medicaid Act clearly authorizes expenditures for rehabilitation and other services to help families and individuals "attain and **retain** capability for independence and self-care."(emphasis added).

In addition, NAMI commends CMS for specifying that rehabilitative services enable an individual to perform a function, but the individual is not required to demonstrate that they actually performed the function in the past. This is particularly true for children, who will not necessarily have had the ability to perform a function in the past due to their level of development and acquisition of age appropriate skills. It would be helpful for CMS to further clarify that rehabilitation services may be provided to children to achieve age appropriate skills and development.

Medicaid is a critical funding source for evidence based practices for children with serious mental illnesses. For example, multi-systemic therapy has been funded under Medicaid and has been proven in multiple clinical trials to produce good outcomes for children, including reduced psychiatric symptoms, decreased substance use and abuse, decreased hospitalizations and out of home placements, less contact with law enforcement, and increased school attendance. However, NAMI hears from many of our members regarding their inability to access MST and other services. The proposed regulations should encourage the further dissemination of evidence based services for children by clarifying that rehabilitative services are available to allow children to gain age appropriate skills and development.

Recommendation:

Amend the language of restorative services to add: In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when

begin a recovery process. Assertive community treatment teams (ACT) for example, is an evidence based practice based on an outreach model and a team approach to providing services to individuals with serious mental illness who also have a history of multiple hospitalizations and/or involvement with law enforcement. ACT teams report that they often will need to provide services for a period of time before an individual is ready to sign a treatment plan. However, they can develop the plan and provide services with the goal of developing social and living skills such that the individual is able to more actively participate and sign a treatment plan.

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

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

In addition, a mental health provider does not always have knowledge of alternate providers of the same service and it may be confusing to the individual being served if the provider attempts to give this information. However, the rehabilitation plan should indicate that the person has been given information about any available resource listing alternative providers. We suggest adding language that clarifies this obligation and recognizes that in some circumstances, such as an emergency intervention, it may not be feasible to do so.

Recommendation:

Amend the proposed rule to add bolded language:

(xi) indicate the anticipated provider(s) of the service and **when feasible document that the individual was informed of any available resource for identifying alternate providers of the same service**.

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

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

Section 440.130(d)(4) Impairments to be Addressed

The regulation states that services "may address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs." NAMI appreciates the express inclusion of mental health and substance-related treatment needs. However, NAMI is concerned about the explicit omission of developmental disabilities from the list of impairments to be addressed in this section and in other parts of the rule and preamble. NAMI believes that a categorical exclusion of a particular disability is disability-based discrimination and should not be included in the proposed regulations. We urge CMS to allow all individuals regardless of disability to be eligible to receive rehabilitative services if the requirements for provision of the service are met.

Recommendation:

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

Section 440.130(d)(5) Settings

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

We also recommend adding to the settings listed in the proposed regulations to clarify that rehabilitative services can be provided in setting such as schools, workplaces and in the community. Assertive community treatment and mobile crisis, for example, often take place in the community and outside of a home or facility. The preamble includes some of these settings, but it would be helpful to also have them in the regulation itself.

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

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

Section 441.45 Rehabilitative Services

Section 441.45(a)(1) – Assurance of compliance with other federal regulations

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

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

Recommendation:

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

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

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

Many states find it administratively efficient to combine services provided in these evidence based treatment programs, a practice commonly known as "bundling." Services can be bundled into a case rate, daily rate or similar arrangement. This allows a provider to predict revenue and facilitates its ability to hire the extensive teams of individuals required to provide these services with fidelity to the model. ACT services, for example, will often be provided by a 10 member team, including nurses, a psychiatrist, a peer specialist, a substance abuse specialist and others. Numerous research studies have

confirmed that good outcomes are dependent on fidelity to the model, including the active participation of a full team. States should be given the flexibility to choose the method that they believe will best allow them to ensure fidelity to the evidence based practice and replication throughout the state.

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

Recommendation:

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

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

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

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

Furthermore, the current language in the proposed rule can be read to disallow rehabilitative services that are furnished through a non-medical program as either a benefit or an administrative activity, including those that are intrinsic elements of other programs. However, under the Medicaid statute, a Medicaid eligible individual who resides in a state that has chosen the rehabilitation option is entitled to rehabilitative services paid for by Medicaid regardless of their participation in another program. The proposed language in Section (b) (1)(i) regarding therapeutic foster care acknowledges this distinction and provides an exception for "medically necessary rehabilitation services for an eligible child." This language should be included in Section (b)(1) to clarify the

agency's intent.

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

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

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

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

Finally, the President's New Freedom Commission report decried a fragmented service system that denied hope and opportunity to adults and children with serious mental illnesses. They wrote:

> The promise of the New Freedom Initiative-a life in the community for everyone-can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic-the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of

mental illnesses for individuals, their families, and our communities.

NAMI strongly urges CMS to reconsider the current language in this section of the proposed rule which furthers fragmentation by discouraging other systems from offering treatment to individuals with serious mental illnesses. NAMI is deeply concerned that this provision will move us in the wrong direction at a time when states are showing progress in moving toward systems' coordination.

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

If CMS is unwilling to strike this section, add:

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

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

Sections 445(b)(i) and (ii) Exclusion of Therapeutic Foster Care Services

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

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

The preamble to the regulation indicates that CMS is promulgating this regulation because some states have packaged services within therapeutic foster care which are not medically necessary rehabilitative services. CMS should clarify in the regulation that states may only provide medically necessary rehabilitative services as part of any bundling of services, but should allow states to use a case rate, daily rate or other

categorical exclusion of people with mental retardation and related conditions from eligibility for rehabilitation services.

Section 445(b)(3): Exclusion for recreation or social activities that are not focused on rehabilitation.

NAMI applauds CMS's statements in the preamble that specifically note that "for an individual with a mental illness, what may appear to be a social activity may in fact be addressing the rehabilitative goal of social skills development as identified in the rehabilitation plan." We also appreciate earlier clarification that an activity that may appear to be recreational may be rehabilitative if it is addressing a particular impairment and functional loss. NAMI urges CMS to include this clarifying language in the regulation itself in addition to the discussion in the preamble.

We also urge CMS to clarify that personal care services that are performed to teach the individual some independent living skills are coverable services. For individuals with mental illness, modeling and cuing are often used to teach these skills and personal care services may be provided as part of the process in furtherance of the rehabilitation goal. The purpose of the service is to achieve a rehabilitative goal, rather than to provide personal care to the individual. The preamble recognizes this distinction by specifying that teaching an individual to cook a meal to re-establish the use of her or his hands or to restore living skills may be a coverable rehabilitation service. It would be helpful to provide that clarification in the regulation as well.

NAMI further urges CMS to clarify that supportive services furnished to address rehabilitative goals may be provided in community settings, including employment and academic settings or in the context of preparing to enter employment or academic settings as long as the primary purpose of the services is to achieve a rehabilitative goal rather than to assist the person with gaining employment or education. Employment and education settings or contexts can be therapeutic because the individual must interact or prepare to interact with others and manage symptoms in an increasingly challenging environment. As long as the service is directed at achieving the rehabilitative goal rather than retaining a job or furthering an education, the services should be reimbursable as rehabilitation services.

Recommendation:

Add: **Recreational and social activities that are addressing a particular impairment or functional need, such as social activities addressing a goal of social skills development, are reimbursable as rehabilitation services.**

Add: **Services, however, that are directed at achieving a rehabilitative goal may be provided in the context or setting for work or education if the purpose of the service is to address a functional impairment rather than to assist with employment or academic enhancement.**

Add bolded language: Personal care services, **except for those which are furnished to teach a skill in furtherance of a rehabilitative goal.**

<u>Section 441.45(b)(4): Exclusion of services provided by public institutions.</u>

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

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

NAMI also strongly urges deletion of language indicating that community services can only be reimbursable if they are not used in the administration of other non-medical programs. This language is ambiguous and the preamble gives no guidance to determine whether services are used in the administration of a non-medical program. NAMI believes that a Medicaid eligible individual should receive rehabilitative services if medically necessary to address a functional impairment regardless of any involvement in another program. This point is included in the preamble language noting "enrollment in these non-Medicaid programs does not affect eligibility for Title XIX services." NAMI seeks similar language in the final regulation.

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

<u>Section 441.45(b)(8): Exclusion of services that are not provided to a specific individual.</u>

NAMI applauds the discussion in the preamble recognizing that "effective rehabilitation of eligible individuals may require some contact with non-eligible individuals." The preamble further explains that counseling sessions for the treatment of the child may include the parents or other non-eligible family members and concludes that "contacts with family members for the purpose of treating the Medicaid eligible individual may be

covered under Medicaid."

NAMI appreciates this recognition of the importance of family relationships in supporting recovery. Recent research studies have confirmed that family support leads to better outcomes from treatment. NAMI urges CMS to amend the rule to add language from the preamble to be clear on this point.

Recommendation:

Add: **Contacts with and services to family members and other non-eligible individuals for the purpose of treating the Medicaid eligible individual may be covered as a rehabilitative service.**

Thank you for the opportunity to comment on the proposed regulations. We appreciate your consideration of our recommendations.

Sincerely,

Amber N. Ward

Submitter : **Ms. Linda Kuzmack** **Date: 10/07/2007**

Organization : **Ms. Linda Kuzmack**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

The proposed amendment to the Medicaid provisions would remove critical services to mentally ill clients. These provisions are not duplication of services. To prevent clients from receiving wrap-around services, for example, would deny services that help them remain stable enough to benefit from therapy and medication. To deny medication funding is to deny even the possibility of recovery for clients for whom medication is an essential adjunct to therapy, especially clients with severe depression, schizophrenia, and bipolar disorder. The costs to the governemtn of denying these services will ultimately be much greater, because more clients will die and more will become hospitalized more frequently as a result.

Submitter : **Mr. David Weikel** **Date: 10/07/2007**

Organization : **Mental Health America of the Central Valley**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

It is important to keep a flexible definition for this part of the Medicaid law. We are beginning to implement new services that are helping people to recover from mental illness at a greater rate than ever before. In addition, if the law is too restrictive, it will pose a barrier to implementing these new specialty services, and possibly cause a significant delay in stepping people down from higher levels of care. Many of these new services are community based, so tightening the definition of rehabilitative services and prohibiting federal Medicaid payments for similar services that could be furnished through other programs, would not be helpful as those services are not population specific, and would not be able to accommodate the unique needs of those people experiencing mental illness. As mental health services are a specialty service, even Primary Care providers and Hospitals often defer to community based providers with expertise in helping people to rehabilitate and recover from mental illness. As the Surgeon General has identified that 20% of the general population need mental health care in any given year to rehabilitate from mental illness, and approximately 6%-8% of the general population are considered severely and persistently mentally ill, rehabilitation services are vital to helping people to return to healthy productive lives. Lastly, it is a fact that mental illnesses co-occur with a significant portion of general medical conditions and if the mental illness is not effectively treated, the person is also likely to not recover well from the general medical condition as well. This of course is more costly to the individual and society in general.

CMS-2261-P-449-Attach-1.PDF

#449

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

Reference: File Code CMS-2261-P

Mental Health America is submitting the following comments on the Proposed Rule for Rehabilitative Services under the Medicaid program published in the Federal Register, August 13, 2007.

Background: Overarching Concerns
As one considers the significance and implications of the proposed rule, it is critical to understand the importance of the Medicaid program, and in turn, the Rehabilitative Services option to low-income individuals with mental health needs, especially those with significant disability related to mental illness. In short, adoption of the proposed rule would have a sweeping and profoundly detrimental impact on millions of very vulnerable Americans, particularly children. Additionally, the proposed rule would likely result in overall increased cost to Medicaid since its constraints on community-based services would place many beneficiaries at risk of functional deterioration, with resultant greater use of Medicaid-reimbursed hospital and nursing home care. Overall, the proposed changes would be regressive. They make no sense in terms of the science of community-based care, the desires of Medicaid enrollees or their families, or the experience of thousands of individuals whose rehabilitation and recovery has been greatly assisted through the rehab option.

It is fair to say that the Medicaid program provides a lifeline of support for millions of Americans who need mental health care. Medicaid enables them to access critical mental health services ranging from inpatient hospital care to psychologist and psychiatrist services, rehabilitation, and prescription drug coverage. Importantly, many of these Medicaid-covered services and benefits enable individuals to remain in their homes and communities instead of costly institutions. Without Medicaid, most of these individuals would have no other treatment options, given the very limited support available through other programs.

The rehabilitation services option (rehab option) in the Medicaid program is a primary source of funding for community-based mental health services, and nearly every state uses it to provide services and supports for individuals with mental illness. This option enables states to offer a wide range of services in community-based settings that foster an individual's rehabilitation and recovery far more effectively than services offered in traditional clinical facility settings. The rehab option was intended to be flexible, in contrast to a funding category like the **clinic option** where services must be provided in a medical setting to receive Medicaid reimbursement.

The rehab option currently authorizes Medicaid reimbursement for "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." Examples of community-based services funded through the rehab option include supported employment services, case-management services, consumer-run services, and day treatment –which enable individuals with mental illnesses to remediate functional disabilities that are directly associated with their illness and reach desirable levels of community participation in terms of employment and residential status.

In short, this important option has provided the kind of flexibility so vital to realizing the widely supported goals and recommendations of the President's New Freedom Commission on Mental Health, fostering the recovery of people with mental illness. Although the preamble to the proposed rule cites the Commission approvingly, adoption of major changes in the proposed rule would almost assuredly thwart realization of the Commission's recommendations and realization of its vision. There is inherent tension in the Notice of Proposed Rulemaking (NPRM): first, conflict in the Preamble between passages that reflect understanding of the rehabilitative needs of individuals with chronic mental illnesses and other text that almost invites the imposition of arbitrary barriers to continued rehab coverage, and second, conflict between supportive passages in the preamble, and new limitations (or ambiguities that invite the imposition of new limitations) in the body of the proposed rule.

Catch- 22: The Intrinsic Element Test, Section 441.45(b)(1)

The NPRM proposes to eliminate Medicaid payment for services through the rehab option "when the services are furnished through a non-medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing parole and probation, juvenile justice, or public guardianship."

With this language, the NPRM would create an irrebuttable presumption, namely that if rehab services could be funded through another mechanism those services are otherwise available and, accordingly, that Medicaid shall not be a payer for them. The proposed rule would deny enrollees the provision of medically necessary services by eliminating the entitlement to those services and subjecting enrollees to state and local capacity constraints and idiosyncratic eligibility requirements. This sweeping regulatory step is at odds with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan and for children those covered by 42 USC section 1396d(a). Indeed Congress' rejection (in developing the Deficit Reduction Act of 2006) of the Administration's recommendation that it enact a provision reflecting this policy underscores the tenuous nature of this exercise in rulemaking authority.

Were one to assume that some frail basis in law could be established to permit CMS on a purely technical level to consider adoption of this provision, its substantive implications

dictate that it be withdrawn. Federal law already protects Medicaid's financial integrity in providing that Medicaid does not cover rehab or other services for which another party (or program) is legally liable. The "intrinsic element" rule would establish a wholly different "principle," and constitute a dramatic shift in policy. Its adoption would greatly reduce access to community-based mental health services because of what the NPRM deems alternative sources of support that are widely recognized as totally inadequate. This new policy would also undermine one of the most helpful features of the rehab option with regard to mental health treatment – the capacity it offers states to cover a range of comprehensive community-based services that are fully coordinated with clinical services. This coordination would be lost if states are required to piece together what little alternative funding might be available for needed services from different programs, with resultant fragmentation of services. The President's New Freedom Commission on Mental Health singled out fragmentation of mental health services as one of the principal barriers to effective mental health service delivery and as a primary cause of so many people with mental illness "falling through the cracks." To adopt this proposed change would be to ignore the findings of this important Commission, whose views CMS cites approvingly in the Preamble to the NPRM, and to impose a devastating new barrier to recovery for low-income individuals with mental illness and persons with psychiatric disabilities. We strongly urge removal of this section or least clarification explaining that reimbursement will be denied only when another entity has legal liability for the service at issue and specifically excluding programs operated under capped or discretionary appropriations from being considered to have legal liability for providing services.

Maintaining Functioning as a Goal of Rehabilitation. Section 440.130(d)(1)(vi)

The Preamble states that the rehabilitation benefit "is not a custodial care benefit" and "should result in a change of status (emphasis added)." More specifically, it states that there must be "measurable reduction of disability and restoration of functional level." CMS does acknowledge that "rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning," but the proposed rule states that "services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan." Sec. 440.130(d)(1)(vi). These expressions of policy, read in light of the Preamble and its "should-result-in-a-change-of-status" posture, could be interpreted as barring use of this benefit to provide services to prevent deterioration. That would represent a fundamental and cruel change in policy wholly at odds with the rehabilitative goal of enabling an individual to function at the highest possible level and to slow or eliminate the functional decline that would occur without the provision of rehab services. We urge that the rule be clarified to state that services to maintain functioning may be reimbursed through Medicaid as rehabilitative services and that retaining the functional level for individuals whose functional level can otherwise be expected to deteriorate IS an acceptable goal of a rehabilitation plan.

Written Rehabilitation Plan: Benefit or Barrier? Section 440.130(d)

The NPRM introduces a potentially valuable new requirement in requiring a written rehabilitation plan that identifies the rehabilitative services each individual requires to achieve recovery goals. But without changes to the provision, its adoption could thwart rather than achieve the important policy objectives of fostering recovery and engaging the individual in the planning process.

Proposed section 440.130(d)(v) calls, on the one hand, for specifying individualized rehabilitation goals and services to achieve them, while, on the other hand, stating that "**[t]he plan must have a timeline...not longer than one year**," (emphasis added) a directive that could be read or misread to set arbitrary limits on the duration of covered services. Were the rule to have the effect of limiting to an arbitrary time period services that people need on a long-term basis, the establishment of a rehabilitation plan would be transformed from a recovery tool to a crude cost-containment mechanism. While rehab services associated with an injury or other "physical" condition may only be needed for a relatively brief time, rehab services for people with chronic mental illnesses may be needed for very extended periods. Given that a large majority of the services provided through the rehab option are for mental health conditions, we urge that the rule be clarified to take account of the range of circumstances in which rehabilitation occurs and specify that rehabilitation plan timelines must be flexible and may not be used to set strict time limits on coverage of needed services.

As acknowledged with sensitivity in the Preamble, it is critical that a rehabilitation plan be person-centered. (The Preamble itself reflects inconsistency on the point, however, stating at once that "the individual **must** be at the center of the planning process," while immediately reverting to "**recommend** the use of a person-centered planning process. Emphasis added.) The rule itself at section 440.130(d)(v) falls short of articulating the point with meaningful clarity and specificity. It employs vague language in stating that "the plan is developed by a qualified provider(s)...with **input** from the individual...." (emphasis added). The meaning and extent of so-called "input" appears limited given that the provision goes on to call for "active participation of the individual...in the development, review, and modification of the goals and services." We urge that the rule be clarified to ensure that input from the individual receiving services is central to the development of the rehabilitation plan.

Therapeutic Foster Care. Section 441.45(b)(1)(i)

The proposed rule at section 441.45(b)(1)(i) would prohibit Medicaid reimbursement for "therapeutic foster care services by foster care providers to children, except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers." Therapeutic foster care is recognized as an effective alternative to institutional care for children and adolescents with severe mental disorders. It is a widely covered evidence-based mental health service provided to children who need to be removed from their home environment for a period and furnished intensive mental health services. It is not a service solely for children in the foster care system. The final rule should list this important service as a covered rehabilitation service for children with

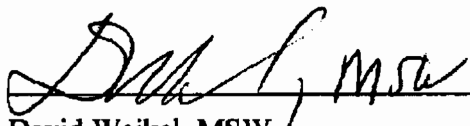
serious mental disorders who are at imminent risk of placement in a residential treatment facility.

Coverage of Community-based Services Provided as Alternative to Incarceration, Section 441.45(b)(4)

The proposed rule at section 441.45(b)(4) would specify that reimbursement for rehabilitative services provided to inmates of a public institution is prohibited. In an attempt, however, to clarify circumstances under which rehab services could be reimbursed notwithstanding that general rule, the provision states that such reimbursement would be available "on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system...." (emphasis added). We are concerned that inclusion of the underscored phrase could result in this provision being read to bar reimbursement where, for example, an adolescent with a mental health disorder receives services in a community-based facility instead of being incarcerated in a juvenile justice facility. We recommend that the phrase "that are not part of the public institution system" be deleted from this section of the proposed rule.

We urge careful attention to these comments, and thank you for the opportunity to comment on the proposed rule.

Sincerely,



David Weikel, MSW
Executive Director
Mental Health America of the Central Valley
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Submitter : **Ms. Nancy Behrendt** **Date: 10/07/2007**

Organization : **NAMI Mercer NJ**

Category : **Individual**

Issue Areas/Comments

Background

Background

Section 440.130(d)(1) Rehabilitation and Restorative Services:
Recommendation:

Clarify the provisions in the regulation to allow payment for outreach and emergency services. Under the proposed regulations and the preamble, rehabilitative goals have to be targeted at progress. They can t be used to maintain stability unless that is linked to another goal where they are still working on improvement. As in any chronic illness, maintenance is the key to preventing emergencies. Maintaining stability has to be a part of any provision for mental health services.

Section 440.130(d)(1)(iii) Definition of qualified providers of rehabilitative services

This section provides general requirements for providers of rehabilitative services. While NAMI fully supports choice for consumers of services, we request clarification that schools and other systems could be reimbursed under Medicaid for services provided by employees of that system who meet Medicaid provider requirements. For example, it is often most efficient for schools to hire a therapist or behavioral aide rather than contract with an outside provider. Also, caregivers are often unable to do the research required to find an appropriate provider due to lack of knowledge and watching over the ill individual.

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

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

Section 440.130(d)(vi) Definition of Restorative Services:
Recommendation:

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

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

Section 440(d)(1)(vii) Definition of Medical Services
Recommendation:

Add "assessment" in: services that are required for the diagnosis, assessment, treatment or care of a physical or mental disorder&

Section 440.140(d)(3) Definition of Written Rehabilitation PlanRecommendation:

Amend the proposed rule to add language in brackets[]:

(xi) indicate the anticipated provider(s) of the service [and when feasible document that the individual was informed of any available resource for identifying alternate providers of the same service].

(xiv) & if it is determined that there has been no measurable reduction of disability, [prevention of regression,] or restoration of functional level, any new plan&

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

GENERAL

GENERAL

I live in center city Trenton and go to the ER often due to Severe asthma. I see many mentally ill people homeless on the street and waiting in the ER because they are not receiving appropriate services. It is my hope that these Rehabilation Service regulations will prevent the higher cost of police and ER services attending to the mentally ill and allow those who are ill function well in society.

I appreciate the work that has been put into these provisions and thank you for time reading my notes.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

If CMS is unwilling to strike this section, add language in brackets:

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

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

Sections 445(b)(i) and (ii) Exclusion of Therapeutic Foster Care Services
Recommendation:

Revise these sections to read:

(i) Services that are packaged as part of therapeutic foster care services which are not medically necessary rehabilitation services for an eligible child. States are permitted to package medically necessary rehabilitation services to provide therapeutic foster care to an eligible individual child.

Section 445(b)(1)(iv): Exclusion for Teacher Aides
Recommendation:

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

Section 445(b)(2): Exclusion of habilitation services
Recommendation:

Delete the categorical exclusion for habilitation services. Additionally, delete the categorical exclusion of people with mental retardation and related conditions from eligibility for rehabilitation services.

Section 445(b)(3): Exclusion for recreation or social activities that are not focused on rehabilitation.
Recommendation:

Add: Recreational and social activities that are addressing a particular impairment or functional need, such as social activities addressing a goal of social skills development, are reimbursable as rehabilitation services.

Add: Services, however, that are directed at achieving a rehabilitative goal may be provided in the context or setting for work or education if the purpose of the service is to address a functional impairment rather than to assist with employment or academic enhancement.

Add language in brackets: Personal care services, [except for those which are furnished to teach a skill in furtherance of a rehabilitative goal].

Section 441.45(b)(8): Exclusion of services that are not provided to a specific individual.
Recommendation:

Add: Contacts with and services to family members and other non-eligible individuals for the purpose of treating the Medicaid eligible individual may be covered as a rehabilitative service.

Submitter : **Ms. Janet Dobsovits** **Date: 10/08/2007**

Organization : **Road to Responsibility**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

I am the Health Care Supervisor for Road to Responsibility's Hingham Open Roads Day Habilitation Program. We provide therapeutic services, such as occupational therapy, speech therapy, physical therapy, behavioral therapy, and nursing services for over sixty individuals, with a wide variety of developmental disabilities and behavioral challenges. In the five and a half years that I have held this position, it has become very clear that, as our members get older, their needs are increasing. Many are facing serious medical issues, which impact both their functional ability, and quality of life. Since most of our individuals live in community based residences, without nursing supervision, the Day Hab is often the "front line" for identifying these issues, and recommending appropriate intervention. I feel very strongly that our members benefit from our services, and ask that you DO NOT support moving Day Hab Services from the Medicaid State Plan. Thank you very much for your attentionn to this critical matter.

Sincerely,
Janet Dobsovits, R.N.

Submitter : **Ms. Joanne Jandro** **Date: 10/08/2007**

Organization : **Big Stone County Family Services**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I strongly reject the proposed rule change. Our Family Services collaborative funds a children/family school based mental health program. Many of the participants in our program are MA eligible. Mental health services are not available in rural MN. The school based mental health program provides preventative mental health support that is accessible but not MA billable. Without this program many children would not receive services until their mental health problems become more serious and chronic. DO NOT MAKE THIS RULE CHANGE!

Submitter : Ms. Karen Simko **Date:** 10/08/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

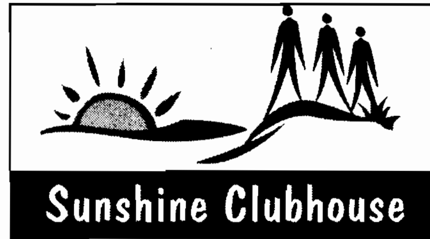
GENERAL

GENERAL

see attachment

CMS-2261-P-453-Attach-1.DOC

#453



September 26, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Atten: 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.

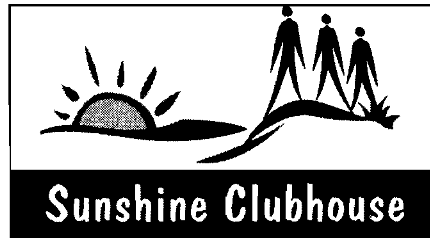
The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice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

Karen Simko
3016 Portage Ave.
South Bend IN 46628

Submitter : Mr. Demetrius Allen **Date:** 10/08/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

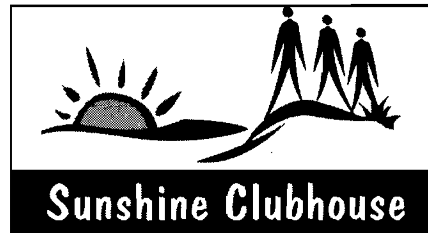
GENERAL

GENERAL

see attachment

CMS-2261-P-454-Attach-1.DOC

#454



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:

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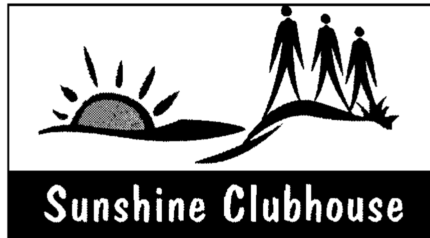

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Most importantly, these changes will have a tragic impact on the lives and futures of millions of people struggling to recover from the long - term effects of serious mental illness. In the interest of short term spending cuts, these changes will quickly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

Sincerely,

Demetrius Allen
520 Crescent Ave.
South Bend IN 46617

Submitter : **Mr. Robert Blackford** **Date: 10/08/2007**

Organization : **Bay Arenac Behavioral Health**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-455-Attach-1.PDF

#455

BEHAVIORAL HEALTH

Chief Executive Officer
Robert L. Blackford

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William L. Powell, Chairman
Boyd Boettger, Vice-Chairman
Richard Crete, Secretary
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Access Alliance of Michigan
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Saginaw, MI 48604
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Toll Free 1.800.448.5498

Assertive Community Treatment
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Children's Services
P 989.895.2240 F 989.892.4962
Psychological Services
Senior Services
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Staff Development Center
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1010 N. Madison
Bay City, MI 48708

Arenac Center
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Standish, MI 48658
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Toll Free 1.800.891.2472

Information Systems Alliance
5447 Hampton Place
Saginaw, MI 48604
P 989.497.1317 F 989.497.1310
Toll Free 1.800.288.5309
and
1441 East Maple - Suite 300
Troy, MI 48083
P 248.526.0488 F 248.526.0464

North Bay Center
1961 E. Parish Road
Kawkawlin, MI 48631
P 989.684.2531 F 989.684.8334

Recipient Rights Office
Behavioral Health Center
201 Mulholland
Bay City, MI 48708
P 989.895.2317 F 989.895.2715
Toll Free 1.800.327.4693

Riverhaven Coordinating Agency
5449 Hampton Place
Saginaw, MI 48604
P 989.497.1344 F 989.497.1348

William B. Cammin Ph.D. Clinic; Hispanic/Emergency/Outreach Servs.
Behavioral Health Center
201 Mulholland
Bay City, MI 48708-7683
P 989.895.2300 F 989.895.2390
Toll Free 1.800.327.4693

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

Reference: File code CMS-2261-P

To Whom It May Concern:

The purpose of this correspondence is to submit comments on behalf of Bay-Arenac Behavioral Health Authority (BABHA) regarding the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

BABHA is a community mental health services program in Michigan established under the Community Mental Health Centers Act of 1963. BABHA has provided services to persons with mental illnesses and developmental disabilities for the past 44 years. In 2002, BABHA was designated as a Pre-paid Inpatient Health Plan for Medicaid specialty mental health and substance abuse services. We serve approximately 6,500 persons annually and nearly 85% of our services are designed to protect the health and safety of Medicaid beneficiaries.

The overwhelming majority of Medicaid services provided to our most vulnerable adults and children are supported by the rehabilitation option. A significant change in these regulations will have a devastating effect on their ability to access medically necessary services and will create barriers to the recovery process. We submit the following comments for your consideration:

<u>440.130(d)(1)(vi) Definition of Restorative Services</u>

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. It would be very helpful if this part of the regulation would be modified in order to clarify this section.

web: www.babha.org

Board Administration P 989.895.2347 F 989.895.2357
201 Mulholland, Bay City, MI 48708

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 and prevent relapse. 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).

In light of this fact, failure to provide a supportive level of rehabilitation would result in deterioration necessitating a reinstatement of more 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 or relapse to the point where they will be eligible for services.

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. This is consistent with the ultimate outcome of rehabilitation services as stated in the new provisions of the proposed regulations:

> "In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health" (Federal Register, Vol. 72, No. 155, August 13 2007, Proposed Rules, 42 CFR Parts 440 and 441, CMS 2261-P, pg. 45203)

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.

Recommendations:

- The proposed language should clarify 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.

- 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. This is often a crucial element to the process of relapse prevention for persons with serious mental illness.

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

440.130(viii)(3) Written Rehabilitation Plan

This section establishes additional planning and documentation requirements in many cases duplicative of existing Medicaid regulations. The intent of these changes appears to be to establish non-contestable documentation requirements for future Medicaid audit activity. As an alternative, it is suggested that services under the rehabilitation option continue to be subject to existing documentation requirements included for Medicaid and as noted in individual state plans. This already provides CMS with sufficient oversight ability to ensure that existing Medicaid documentation requirements are also addressed by state plans using the rehabilitation option.

Recommendations:

- The requirements regarding the written rehabilitation plan should be excluded from the proposed regulation. CMS should continue enforce existing documentation requirements applicable to all services provided under the Medicaid program.

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 as noted in the comments above under section 440.130(d)(1)(vi).

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 fixed 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 intrinsic element of another

program.

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). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies them medically necessary Medicaid services, in direct contradiction of the statute.

Recommendation:

- It is strongly recommended that this entire proposed section be eliminated due to its direct contradiction with existing Medicaid statute.

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. 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,

Robert L. Blackford
Chief Executive Officer

Submitter : **Ms. Melissa Holister** **Date: 10/08/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

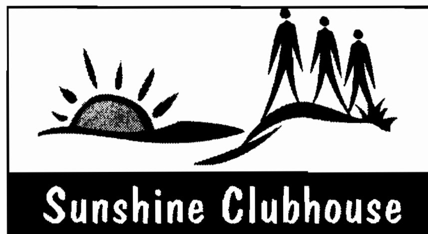
GENERAL

GENERAL

see attachment

CMS-2261-P-456-Attach-1.DOC

456



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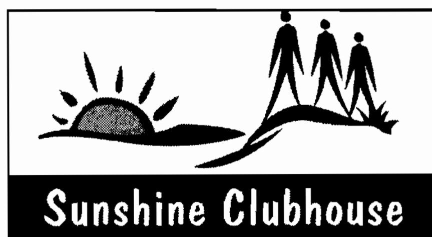
Sunshine Clubhouse - 520 Crescent Avenue - South Bend Indiana 46617
Phone: (574) 283-2325 Fax: (574) 283-2029

sunshineclubhouse@sunshineclubhouse.com



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

Sincerely,

Melissa Hollister
837 24th Street
South Bend, IN 46615

Submitter : **Ms. Kim Greer** **Date: 10/08/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

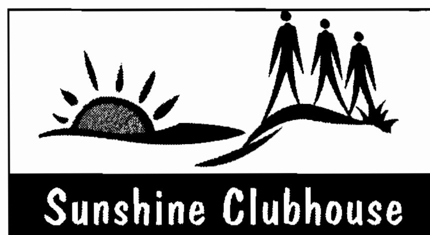
GENERAL

GENERAL

see attachment

CMS-2261-P-457-Attach-1.DOC

#457



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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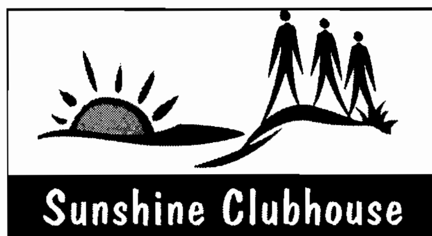
Some of the proposed rule changes simply reduce this population's access to needed services – without any back up plan to fund services or programs. Many of these services have been working effectively with CMS approved Medicaid funding for more than ten years. However, with the recent changes in CMS practice, they now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need. The net result is that numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.
To create, or suddenly start enforcing, bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial cut in services for people who already have more than their fair share of burdens. A reduction or elimination of services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse in our prison system.

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

sunshineclubhouse@sunshineclubhouse.com



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Sincerely,

Kim Greer
1613 South Walnut St.
South Bend, IN 46619

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

sunshineclubhouse@sunshineclubhouse.com

CMS-2261-P-458

Submitter : Ms. Carmen Hill **Date:** 10/08/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

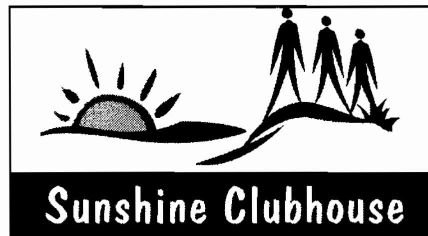
GENERAL

GENERAL

see attachment

CMS-2261-P-458-Attach-1.DOC

#458



October 11, 2007

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

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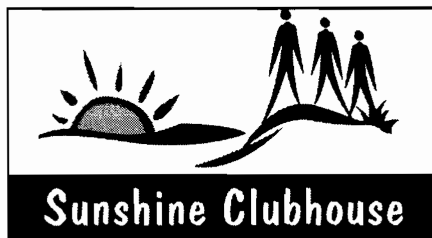

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Sincerely,

Carmen Hill

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

sunshineclubhouse@sunshineclubhouse.com

Submitter : **Ms. Carmen Hill** **Date: 10/08/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

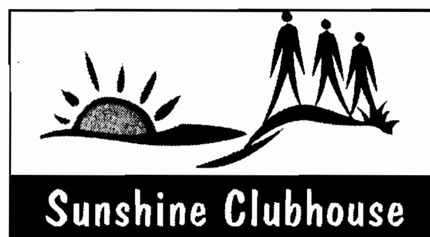
GENERAL

GENERAL

see attachment

CMS-2261-P-459-Attach-1.DOC

#459



October 11, 2007

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Department of Health and Human Services
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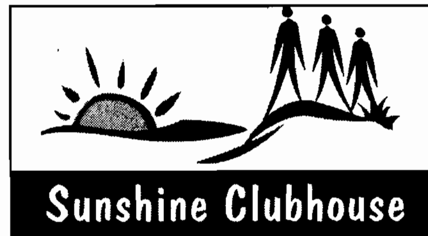

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Sincerely,

Carmen Hill
518 South St. Joseph St.
South Bend, IN 46601

Submitter : **Mr. Norman Pittner** **Date: 10/08/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

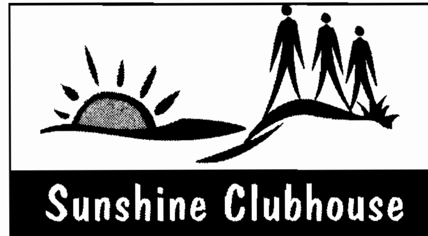
GENERAL

GENERAL

see attachment

CMS-2261-P-460-Attach-1.DOC

#460



October 11, 2007

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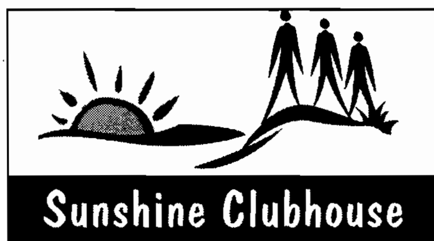

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Sincerely,

Norman Pittner
628 Western Ave. Apt. 609
South Bend, IN 46601

Submitter : **Dawn DiMarco** **Date: 10/08/2007**

Organization : **Dawn DiMarco**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-461-Attach-1.PDF

#461

To Whom It May Concern:

It is imperative that CMS withdraw, revise and re-issue the regulations proposed under Section 441.45(b)(2), with greater clarity as to the implications for children and adolescents with special needs who are currently receiving necessary medical services here in Pennsylvania.

As written, these proposed regulations raise questions as to whether the federal government will use them to force Pennsylvania to restrict these vital services for our children.

It is also urged that CMS provide opportunity for public comment.

Sincerely,

Dawn M. DiMarco
998 Penns Park Road
Newtown, PA 18940
215-598-8296
dawndimarco@msn.com

Submitter : **Ms. Yvonne Perret** **Date: 10/08/2007**

Organization : **Advocacy and Training Center**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

"Intrinsic elements" provision
Restorative services
Therapeutic foster care

I will comment on these below.

Collections of Information Requirements

Collections of Information Requirements

The State Plan Option currently is a vital tool to provide support services and to promote recovery for individuals with serious mental illness. As a psychiatric social worker who has worked in mental health for about 25 years, I have seen first hand the need for support services if individuals are truly going to recover. We have known for a long period of time that treatment alone does not lead to recovery; much is needed for linkage with other services, skills development, social skills enhancement, and other supportive services. We also know that ongoing episodes of mental illness make it difficult for individuals to function as well as they would like. These supportive services help promote community functioning

GENERAL

GENERAL

First of all, in general, these proposed regulations seem to reflect a lack of understanding of what it takes for individuals to recover from serious mental illness. Often, people are starting over and over again, as these illnesses mightily affect one's ability to think and do. In addition, the public system of benefits and services is one of the most complicated systems to navigate--for individuals with limited resources (if any) and cognitive impairment. Not covering services that link individuals to what they need (e.g., targeted case management) makes no sense. Instead of eliminating or restricting Medicaid coverage to the extent that these regulations do, why not simply ask state plans to be more specific about how they will determine if services are being appropriately provided and documented? That would, at least, likely enhance the quality of service and not "throw the baby out with the bath water" as these proposed regs do.
"Intrinsic elements" provision: Of particular concern in this provision is the limitations on and new language for Medicaid payment related to housing, education, and vocational and prevocational trainings programs. As those of us who work in the community know, a variety of housing options must be provided, often rquiring staff support. In addition, many individuals who have serious mental illness have as their only income SSI, a benefit that keeps individuals below the federal poverty level. For individuals to learn the skills to live independently and to move on from staffed housing, services are needed and are NOT provided by other agencies. In addition, vocational programs provided by the state are often focused on people with physical disabilities who do not have cognitive impairment. Serving individuals who have cognitive impairment vocationally requires specialty services; this is who supported employment, job coaching, etc. came to be. These are vocational and clinical services that are illness related and should be covered by Medicaid.
Restorative services: As episodes of acute illness recur, many individuals find it extraordinrily difficult to return to what was a baseline level of functioning, e.g., living independently, much less function at a "higher level." In addition, functioning is complicated. A person may move on to a higher level in some areas but not in others. How would this be assessed? Many individuals need medication monitoring to avoid expensive ER and inpatient stays. Not providing this clinical function under Medicaid makes no sense--fiscally or otherwise. Basic community living skills are often needed to assist with independent living. Because mental illness often occurs at the developmental age when individuals are becoming adults, these skills are often not acquired when others without these illnesses do. Relapse prevention is part of these services. Such prevention is critical not only to maintain current functioning but to prevent additional hospitalizations and further erosion of someone's ability to do.

Therapeutic foster care: The notion that one can bill separately for each aspect of therapeutic foster care suggests a lack of understanding of how such care operates. For children even more so than adults, seamlessness of services and coordination of comprehensive services are essential. Children's systems are even more complicated than adults. What would happen with this proposal is that providers would spend more time trying to figure out billing than coordinating and providing services.

Essentially, we must be extremely careful that what we do to save money does not lead to greater costs. Typically, when one limits outpatient and community supports and services, one pays more for the most expensive levels of care--inpatient and ER visits. Ture, Medicaid does not cover state hospital costs. But these are costs. Most importantly, these regulations will not serve individuals well--this should be the focus. Thank you.

Submitter : **Mrs. Ann Marie Moore** **Date: 10/08/2007**

Organization : **wrap-around services**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

October 8, 2007

To Whom It May Concern,

I have 4 children who receive wraparound services. They are needed because they all are on the Autistic Spectrum. Without these services, my children would be father behind in their development. They learn strategies to improve their daily lives. I also learn strategies to work with and care for my children. The person or persons who are trying to end these service do not know what it is like to live with children who have these disabilities. Otherwise, this topic would not be up for discussion.They need the support in the classroom as well. Teachers cannot do it all by themselves. They need one on one contact with in the classroom from a TSS.This is very important for each of my children to focus and behave within a classroom setting. The mobile therapist is needed for the development of the social piece at home and in the classroom. The BSC is needed to help the family and keep everyone on track to follow the wraparound guidelines.

I ask that these sevices do not end and are funded again. I challengc you to come and live in my home and understand what it is like without the services with my 4 children.

Sincerely,

Ann Marie Moore

Submitter : Ms. Linda Keenan **Date:** 10/08/2007

Organization : Ms. Linda Keenan

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I want to comment on the proposed rule about coverage for rehabilitative services under the Medicaid program.

Having family members with mental illness, I know how important rehab services are. The alternative to us helping those with brain disorders to participate as much as possible in society is for society to pay the costs of hospital treatments or even imprisonment.

Last year, The New York Times quoted a Justice Department survey that said that over half the imprisoned suffered from mental health problems (Inmates Report Mental Illness at High Levels, NYT September 7, 2006).

Reduction of rehabilitation programs will not save money and it will certainly not save the mentally ill from the fates of illness, crime or suicide.

Regarding Section 440.130(d)(1) Rehabilitation and Restorative Services, the regulation must acknowledge that there are ups and downs in the mental health recovery cycle. If programs are not in place to prevent mental deterioration, then recovery is more difficult later.

Regarding Section 441.45(b) Exclusion of Services, including those that are an intrinsic element of other programs, the purpose of Medicaid is to pay for healthcare services when people cannot pay themselves. I don t know what other programs provide, but Medicaid should focus on healthcare services. This regulation cannot address what other agencies may or may not be doing.

Regarding Section 441.45(b)(2) Exclusion for Mental Retardation and other conditions and Habilitation Services, I don't know why you would exclude any brain disorders from the rules.

Please revise the regulations. I want all levels of government to work together to support the treatment of people with brain disorders.

Sincerely,

Linda Keenan
8706 23rd Avenue
Hyattsville, MD 20783
301.434.9671

CMS-2261-P-465

Submitter : Ms. Sarah O'Neill **Date:** 10/08/2007

Organization : Sunshine Clubhouse

Category : Individual

Issue Areas/Comments

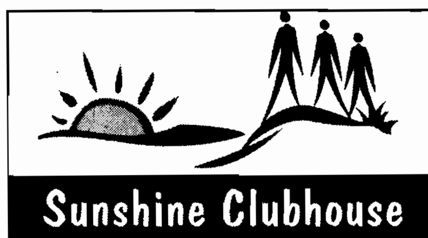
GENERAL

GENERAL

see attachment

CMS-2261-P-465-Attach-1.DOC

#465



October 11, 2007

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Attn: CMS-2261-P
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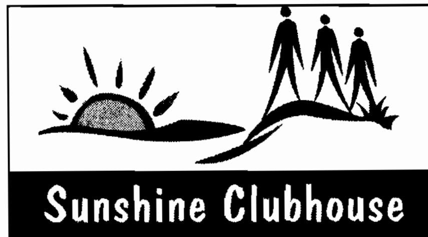
Some of the proposed rule changes simply reduce this population's access to needed services – without any back up plan to fund services or programs. Many of these services have been working effectively with CMS approved Medicaid funding for more than ten years. However, with the recent changes in CMS practice, they now find that they are no longer able to provide the crucial support network that people with serious mental illness so desperately need. The net result is that numbers of people with persistent mental illness are being deprived of a chance to build a meaningful future for them.
To create, or suddenly start enforcing, bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial cut in services for people who already have more than their fair share of burdens. A reduction or elimination of services puts individuals with severe and persistent mental illness at risk of unnecessary institutionalization in our hospitals or even worse in our prison system.

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.

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

Sincerely,

Sarah O'Neill
628 W.Western Ave. Apt. 521
South Bend, IN 46601

Submitter : **Miss. Junemarie Brandt** **Date: 10/08/2007**

Organization : **Miss. Junemarie Brandt**

Category : **Individual**

Issue Areas/Comments

Background

Background

Limits on Behavioral Health Rehabilitation Services

GENERAL

GENERAL

Please do not but more regulations on Behavioral Health Rehabilitation Services o r"wrap around" services for autistic adolcscents. My son depends on these to help him function in the world. His disability is such that he doesn't qualify for many aid programs. He is not "bad" enought to qualify for help, but not "good" enought to fit in with thc rest of society.

Submitter : **Mrs. Michele Harvey** **Date: 10/08/2007**

Organization : **parent**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that CMS withdraw, revise and re-issue the regulations proposed under Section 441.45(b)(2), with greater clarity as to the implications for children and adolescents with special needs who are currently receiving necessary medical services here in Pennsylvania.
As written, these proposed regulations raise questions as to whether the federal government will use them to force Pennsylvania to restrict these vital services for our children.
It is also urged that CMS provide opportunity for public comment.

Submitter : **Ms. Linda Burns** **Date: 10/08/2007**

Organization : **Sunshine Clubhouse**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-468-Attach-1.DOC

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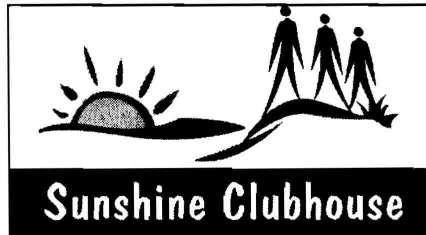

October 11, 2007

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:

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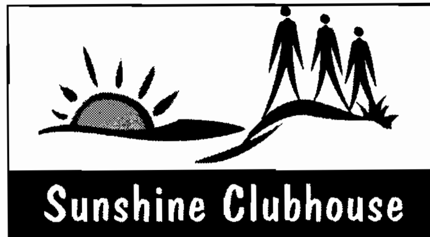

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Sincerely,

Linda Burns
52654 Ironwood Rd.
South Bend, IN 46635

Submitter : Mr. Kevin Smith **Date:** 10/08/2007

Organization : Mr. Kevin Smith

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

We have a six year old son the deals with seizures and has autism. Benjamin has had many medical issues since he was two years old. He is currently attending a public school. He has medical teams at both Childrens Hospital in Pittsburgh and at Geisinger Medical Center. We greally need his medical care to continue to be covered by the Medical Assistance program.

We are married with four children. As the dad, I have been self employed all of my life. I own a small service garage.

As the mom, I work part time at the local hospital in the lab. With four children it is not feasible for me to work full time, as we would have to pay a lot of money for child care. I work so our family could have some insurance coverage.

However the insurance carrier does not understand Benjamin's care, needed tests and drug requirements. It was a continuous battle trying to have them pay for his care.

Please understand many middle class working families truly need the help from the Medical Assistance program. With all the many other problems that our family has to deal with because of Benjamin's daily need, we need the support to help ease the major worry of paying for his necessary medical care. His condition affects our entire family and having to figure out how to pay for his medical care would be a major hurdle for all of us.

Thank you for your time. Please consider the victims of this terrible condition and the victims entire family.

Submitter : **Mr. Kevin Kershner** **Date: 10/08/2007**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

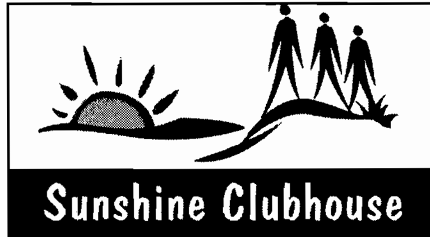
Response to Comments

Response to Comments

see attached

CMS-2261-P-470-Attach-1.DOC

#470



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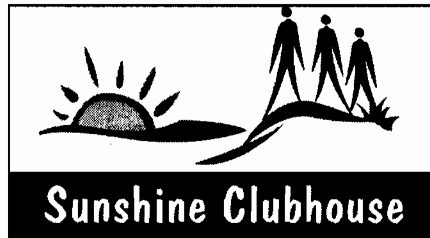

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Kevin Kershner
11046 Golden Pheasant Dr.
Osceola, IN 46561