USPRA US Psychiatric Rehabilitation Association

SEP 13 2007

September 11, 2007

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

Re: CMS-2261-P

To Whom It May Concern:

The United States Psychiatric Rehabilitation Association (USPRA) is pleased to comment on behalf of its 1,400 psychiatric rehabilitation agencies, practitioners, and interested organizations and individuals who are dedicated to promoting and strengthening community-oriented rehabilitation services that support recovery from the disabling effects of serious mental illness. Based upon the collective experience of our members over the past 30 years, we offer the following comments on the provisions of the proposed regulations related to Medicaid's Rehabilitation Services Option.

USPRA enthusiastically supports the inclusion of a required rehabilitation plan and recovery-oriented goals that is developed with the individual and requires a signature to demonstrate involvement, approval and receipt of the plan [§440.130(d)(3)]. The creation of a rehabilitation plan is good practice and is necessary for shared decision making and accountability. It is our belief that quality rehabilitation services are strength-based and person-centered, and are built upon the values of choice and self-determination within the cultural context of the individual receiving services. We are pleased that these values have been applied in the proposed regulations, and hope CMS will consider making person-centered planning a formal requirement of the written rehabilitation plan [§440.130(d)(3)(iii)] beyond the proposed recommendation. In fact, we believe these values should apply to all Medicaid funded services, not just rehabilitation.

We also appreciate the recognition of psychosocial rehabilitation services as an integral component of mental health services and its role in an individual's recovery. The presence (or absence) of psychosocial rehabilitation services directly impacts the achievement of recovery-oriented outcomes. In this context, recovery refers to the process the individual goes through as they rebuild their lives, not just the treatment of symptoms. Certainly, treatment or medical activities should be incorporated within the rehabilitation plan, but are not necessarily the primary driver under the rehab option.

601 Global Way, Suite 106 ▪ Linthicum, MD 21090 ▪ 410.789.7054 *ph* ▪ 410.789.7675 *fax* ▪ info@uspra.org ▪ www.uspra.org

Unfortunately, because of prior negative experiences or stigma, some individuals may not be initially ready or willing to become engaged in an intensive and formally documented rehabilitation plan. Therefore, USPRA recommends that CMS consider including the following language to §440.130(d)(3) to recognize the need for and use of early engagement services: *In the event that an individual is initially unwilling or refuses to participate in the development of a rehabilitation plan, early engagement services may be used as a short-term reimbursable expense that encourages a sense of trust, hope and empowerment to improve an individual's participation in rehabilitation goal setting, assessment, planning and/or development activities. In the absence of a signed rehabilitation plan, early engagement services must document efforts to revise approaches and engage the person to build a mutually satisfying course of action, including documentation of engagement goals and related services.* Examples of early engagement services include opportunities to sit in on group activities and meet other people in recovery using the program; educating the individual about the recovery process, recovery outcomes, and the individual's rights and responsibilities; and motivational interviewing techniques or other explorations of personal interests and values.

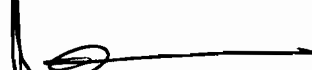
USPRA is pleased that the proposed regulations allow for flexibility in how rehabilitation services are paid. Allowing States to specify the methodology under which rehabilitation providers are paid [§441.45(a)(5)] will ensure the continuation of many highly effective programs, such as Assertive Community Treatment, Clubhouses, and Crisis and Transitional Residential Treatment Programs, that tend to bill through a single daily rate or case rate. If executed correctly, these services would focus on the improvement of the disability and achievement of specific rehabilitative goals, as specified in the rehabilitation plan, and not duplicate services that are intrinsic to programs outside of Medicaid.

Because of this, USPRA recommends that the term "intrinsic" be further clarified within §441.45(b)(1) of the regulations, and suggests that CMS consider defining it in the following way: *Intrinsic services are those that are the major focus of another agency based on their statutory requirements. This definition is NOT meant to preclude funding of services under the rehabilitation option which may mirror those by another agency (e.g., housing, employment) but which are provided pursuant to an approved rehabilitation plan as defined in these regulations [§440.130(d)(1)] and are consistent with medical necessity.*

USPRA supports allowing States the flexibility to set forth the qualifications for providers of rehabilitation services [§440.130(d)(1)(iii)]. However, while the proposed regulations imply a set of core competencies are required, USPRA recommends that CMS emphasize within the regulations the need to employ professionals who are competent in mental health rehabilitation practice (e.g., those with national certification as psychiatric rehabilitation practitioners), as well as persons in recovery trained as peer providers as indicated in the CMS guidance letter valuing Medicaid Peer Support services.

Thank you for considering these comments. We hope you will find them consistent with the spirit and intent of the generally excellent draft regulations that have been promulgated. USPRA believes CMS has done a good job in delineating the appropriate use of the Rehabilitation Services Option.

Sincerely,



Marcie Granahan
CEO

SEP 11 2007 2 September 9, 2007

It really is a shame that this is an area government wants to cut more money. The grip continues to become tighter and tighter around the necks of the elderly and the mentally ill. Mental illnesses are just as important, if not worse, than physical illnesses. There is so much out there still left unexplained about mental issues due to the fact of how they must be studied. It's really difficult to examine the processes of the brain when there's no activity, therefore, majority of conclusions must be derived through observation and trial and error. How can this possibly be measured if all means of research, treatment and rehabilitation is exhausted? Can you answer that question? Did not think you could.

Government has plenty of other methods to spend money, waste money, and make money. Why not go to some of those areas instead of the areas, such as this one mentioned, to get some financial relief. There are dozens of areas government should crack

claim, however, this account being one of them. Furthermore, this letter is not intended to voice concerns about stupid decisions our government makes but to address the ignorance to those who make these decisions because they simply don't understand the psychological realm & believe it's a bunch of nonsense. Well, I'm here to say, "It's very real!" I have worked with troubled youth and adults for almost 8 consecutive years and have witnessed first hand the devastating effects these problems can have on the individuals who possess them, as well as their families. Now, "Government" proposes to just leave them roaming the streets without any assistance to starve or commit a crime because they are "mentally bothered"? Little unfair, don't you think?

You know if "Government" wants to get involved, might I suggest researching further into the population taxpayers support who can and are able to work, but won't. OR what about limitations on foreigners living in the U.S who don't pay taxes and use emergency rooms for a doctor's office simply because they

have learned how to work the systems to be completely provided for when in actuality they are a complete waste of space. OR what about prisoners who are obviously guility of the crime in which they are accused & sit on their butts everyday receiving warm meals, roof over their heads, clothes on their backs, education, use of gym equipment, etc, etc... The list goes on and on. How about cutting some of that CRAP out. Many criminals live better than hardworking, law abiding citizens but for some stupid reason, "government" wants or chooses to continue to hold the hands of the worthless and forces the "willing & able, trying to do their best" population to support those who don't care about anything. Cut MONEY THERE. There's an idea.

In regards to the article, "Pioneer House fears funding loss," printed in the Charlotte Observer on September 9, 2007, this idea should not even be entertained. This population discussed deserves to be helped. Believe it or not, their lives are worth it and can be normal, in many cases, with appropriate treatment. There are also people out there, such as myself, whose passion is to work with

such people. I really enjoy my work and get great satisfaction when I see an individual overcome an obstacle or limitation and know that I was a part of their success & did all I could to make their life a bit better. I have been involved with the mentally limited among youth as well as adults and have also worked with youth on probation and in residential treatment in Charlotte North Carolina. I am sad to say, their conditions were caused by abuse or a medical / mental shortcoming such as ADHD, Bipolar, Tourette Syndrome, Multiple Personality Disorder, Autism and ~~several~~ several other diagnoses, these just to mention a few. I sincerely hope what I have written will help in someway. I do apologize for the nature of this letter. My computer is broken and I'm sure there are many imperfections enclosed such as incorrect grammar and misspelled words. However, I was so enraged after reading the article, I felt it more important to get the comments across rather than be concerned with formalities.

If there is any other way I can be of help. I can be contacted at

1916 Goodman Circle NE
Concord, NC 28025

Thank you for your time.

Sincerely,

Jennifer Nutt

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AUG 30 2007

Susan Baker
2152 Whispering Dunes Dr.
Holland, MI 49424

August 29, 2007

Centers for Medicare $ Medicaid Services
P. O. Box 018
Baltimore, MD 21244

Re: CMS 2261

"This rule would amend the definition of Medicaid rehabilitative services . . .providing that ***Medicaid rehabilitative services . . .do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs.*** *These services and programs include . . . prevocational and vocational services, housing, other non-Medicaid services from Federal, State, or local programs."*

I am writing to oppose passage of the above stated rule change. I am a direct provider for Medicaid recipients who receive services for the developmentally disabled adults and children. This change would basically eliminate the support services that my consumers need in order to be able to continue to function in the community and have quality of life. There are no other community services and programs that would be able to provide these services that are now only funded by Medicaid. Our consumers need habilitation services, not rehabilitation, thus Medicare does not cover services. The state of Michigan has no funds to provide these services. Losing skill building programs, OT/speech/psych/nursing services would only result in an increase in medical and mental health costs because the health and safety of these individuals would be at risk.

I OPPOSE THE PASSAGE OF RULE 2261.

Susan Baker, Licensed Clinical Social Worker
Qualified Mental Health Professional

SEP 13 2007

Date: August 27, 2007

Re: Proposed Medicaid change for Rehabilitation Services

Hello, my name is Stephanie Falls. I am writing in response to the recent announcement from Medicaid of the possibility that psychosocial rehabilitation services may no longer receive funding.

I am a concerned citizen of Gaston County. I am responding with great concern over the proposed changes in Medicaid's rehabilitation definition. If this change occurs, Piedmont Pioneer House, Inc. (PPH) in Gastonia, NC will have to close its doors unless another funding source can be found. PPH has been in operations since 1977 and has provided excellent services for people who have a mental illness in Gaston and Lincoln counties. If this program closes because of non-funding from Medicaid, then there will be many people in our community in crisis situations therefore, causing our community to be a crisis situation. Many with mental illness will be have to be hospitalized or mis-placed in jails. This will cost tax payers **more money** not to mention the toll on human lives and even deaths that could be prevented. A one night stay in a psychiatric hospital can cost up to $2000 so therefore a 10 night stay would cost Medicaid around $20,000 and a person could receive two years of psychosocial rehabilitation for that price. So if a person had three to four hospitalizations per year then that would amount to three or four times the cost of psychosocial rehabilitation. Clubhouses certified by the International Center for Clubhouse Development (I.C.C.D.), such as , Piedmont Pioneer House have been proven to reduce hospitalization rates by up to 85% in the severe and persistent mentally ill population.

I.C.C.D. clubhouses also assist its members in finding employment and to pursue educational goals. PPH currently has two members attending college courses and two members working on their GED's. PPH has successfully helped several people return to work full time who have been able to discontinue receiving Social Security Disability benefits.

In closing, I ask that you please take into consideration how this proposed change would affect the mental health population. I assure you the outcome would not be good. I would also like you to ask yourself if you had a family member with mental illness would you not want them functioning at their highest potential in the least restrictive environment with friends and a support system?

Thank you for your attention to this important matter.

Sincerely,

Stephanie Falls
5014 Lewis Rd.
Gastonia NC 28052

www.adultlifeprograms.com

Conover Center
P.O. Box 275
Conover, NC 28613
828-464-0078 (p & f)
alpcbs1@charterinternet.com

Hickory Center
1265A 21st Street NE
Hickory, NC 28601
828-324-1313 (p)
828-322-9174 (f)
alpamanda@chartertinternet.com

Lenoir Center
P.O. Box 715
Lenoir, NC 28645
828-758-5855 (p & f)
alplen@charter.net

Maiden Center
3390 Shepherd Road
Maiden, NC 28650
828-428-9010 (p)
828-428-9991 (f)
alpmdn@twave.net

Taylorsville Center
5300 Church Road
Taylorsville, NC 28681
828-635-0544 (p)
828-635-0545 (f)
alplisa@charterinternet.com

Geriatric Specialty Team, Geriatric Mental Health, Psychiatry Services & Administrative Office
P.O. Box 807
Hickory, NC 28603
828-326-9120 (p)
828-327-2661 (f)
alped@charter.net
alpbm@charter.net
deanna@charterinternet.com
alpcm@charter.net
alpcbs2@charterinternet.com
alpgtsw@charterinternet.com

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SEP 10 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
September 10, 2007

To Whom It May Concern:

I am writing to express my concerns about the proposed changes in regulations on rehabilitative services.

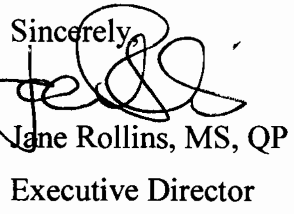
Adult Life Programs operates a psychosocial rehabilitation program, primarily for elderly individuals with severe and persistent mental illness.

If the proposed changes are implemented, it would be a serious threat for the continuation of services for the individuals we serve. Many of the individuals we serve do not presently have the necessary skills to live independently or semi – independently and they never have possessed these skills as they, largely, have not been taught. These are elderly individuals who have lived the vast majority of their lives with a severe mental illness and often times, in large state institutions. If regulations prohibit habilitation or even maintaining a current level of functioning, most of these individuals will not be eligible for any services.

These are people who can learn, maintain their current level of functioning and many can become more independent in their lives, but they are not going to "get better" as there is no cure for their condition and in my opinion, it is wrong to expect them to. (Remember, the population I am speaking of is aging as well.) Just as it is not reasonable to think someone will "recover" from or be "rehabilitated" from diabetes, as an example. The person with diabetes can learn to manage, live with and reduce symptoms of their condition, but they will always have the condition that may flare up and require treatment but regular treatment can keep the individuals from crisis.

Thank you for this opportunity to offer my comments.

Sincerely,



Jane Rollins, MS, QP
Executive Director

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SEP 2 1 2007

09/20/2007

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by **Anna Kvinta, 86 E. Stafford Avenue, Worthington, OH 43085**

Non-covered services: 441.45(b)

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There is little clarity in the regulation on how this provision would be applied, as the regulation provides no guidance on how to determine whether a service is an "intrinsic element" of another program.

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

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

Recommendation:

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

Alternatively, the section should be clarified and narrowed so as to focus on

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

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

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

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

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

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

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

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

Recommendation:

Therapeutic foster care should be listed as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. States should be given the discretion to define therapeutic foster care as a single service and pay through a case rate, daily rate

or other appropriate mechanism.

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

Rehabilitative Services : 441.45(a)(2)-

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

It would also be valuable to include the language now 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.

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

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

This definition also includes as appropriate rehabilitation services 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 is at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services. There is concern that states and providers will interpret the current proposed regulation as prohibiting coverage of services necessary for retention of improved functioning

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

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

Recommendation:

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

Second, 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.

Related Medicaid Rehabilitation Issues:

1) Payment and Accounting for Services

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

These new shifts in rate-setting methodology are not efficient and, moreover, are extremely detrimental to the provision of the evidence-based mental health services that are increasingly being offered as a package of intertwined interventions delivered flexibly. These services include assertive community treatment, multisystemic therapy, day rehabilitation services, therapeutic foster care and others.

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

covered activities, but that remove the currently imposed extreme administrative burden.

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

Recommendation:

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

2) EPSDT Mandate

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

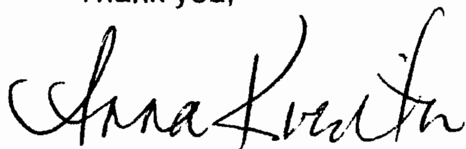
Recommendation:

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

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

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

Thank you,



Anna Kvinta

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SEP 20 2007

Discover the Excellence

WILLIAM C. CALA, Ed.D
Interim Superintendent of Schools
Rochester City School District
131 West Broad Street
Rochester, New York 14614
Phone: 585-262-8378
Fax: 585-262-8381
Email: William.Cala@rcsdk12.org
www.rcsdk12.org

September 19, 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: Medicaid Program, Coverage for Rehabilitative Services

To Whom It May Concern:

The Rochester (NY) City School District expresses concern with and objection to Proposed Rule CMS – 2261 – P published in the August 13, 2007 **Federal Register** (pp. 45201 – 45213). As requested, two copies of our comments are enclosed with this original document.

Implementation of this rule would effectively and unconscionably deny Medicaid reimbursement for eligible services provided to eligible participant / students simply because those participant / students are being served through our schools. It would establish a virtual presumption of ineligibility with respect to school-based services As a sound public policy, utilizing schools – institutions that have prolonged and intensive interaction with children from ages 5 to 18 – to efficiently and effectively deliver services to this population cannot be argued. Proposed Rule CMS – 2261 – P seems intent on doing just that.

The critical flaw is that the proposed rule inadequately defines that which is "included in programs with a focus other than that of Medicaid" and thus would be ineligible for financial support. It is far too vague and provides no practical guidance.

The Rochester School District is one of a handful in New York State that lacks the legal authority to generate its own revenue through the levying of real property or other taxes. It depends almost completely upon other units of government – the City of Rochester, New York State, and the Federal Government – for its resources. In fulfilling our duty of care to over 30,000 children each year, many of whom present multiple, complex needs, we are forced to weave together funds from a multitude of sources so that we may meet the multi-faceted needs of

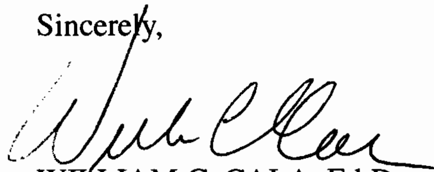
our students. As challenging as that can be, we accept the responsibility and undertake it with resourcefulness, integrity, and respect for the eligibility requirements and standards of complimentary programs. The proposed rule would unravel this network and ultimately deprive needy students of valuable services.

We come to this conclusion with regret, but as we review a proposal that touts near-term savings of $180 million per year, yet acknowledges that its fiscal impact on consumers and local government agencies (among others) cannot be determined, we cannot avoid this conclusion. The most likely consequence of this initiative would be a pitting of schools against Medicaid administrators, each claiming that the other has the responsibility for funding a given service. We also recognize who would win and who would lose in such a dispute.

Regulatory rule-making is being used to mask out-and-out budget cutting. From our reading of this proposal, its only motivation is to cut spending by $180 million or more per year and not to further the objectives of the Social Security Act. Proposed Section 441.45(b) (1) would irrationally terminate Medicaid coverage simply because eligible services are provided through the education system. The Centers for Medicare and Medicaid Services should encourage and reward effective service delivery methods, not impoverish them as it is now proposing.

The Rochester City School District encourages that Proposed Rule CMS – 2261 – P be set aside.

Sincerely,



WILLIAM C. CALA, Ed.D.
Interim Superintendent of Schools

xc: Members of the Board of Education

Date: August 27, 2007

Re: Proposed Medicaid change for Rehabilitation Services

Hello, my name is William Chase. I am writing in response to the recent announcement from Medicaid of the possibility that psychosocial rehabilitation services may no longer receive funding.

I am on the Board of Directors of Piedmont Pioneer House, Inc., (PPH) in Gastonia, North Carolina. I am responding with great concern. If this change occurs, PPH, Inc. will have to close its doors unless another funding source can be found. PPH has been in operations since 1977 and has provided excellent services for people who have a mental illness in Gaston and Lincoln counties. If this program closes because of non-funding from Medicaid, then there will be many people in our community in crisis situations therefore, causing our community to be a crisis situation. Many with mental illness will be have to be hospitalized or mis-placed in jails. This will cost tax payers **more money** not to mention the toll on human lives and even deaths that could be prevented. A one night stay in a psychiatric hospital can cost up to $2000 so therefore a 10 night stay would cost Medicaid around $20,000 and a person could receive two years of psychosocial rehabilitation for that price. So if a person had three to four hospitalizations per year then that would amount to three or four times the cost of psychosocial rehabilitation. Clubhouses certified by the International Center for Clubhouse Development (I.C.C.D.), such as , Piedmont Pioneer House have been proven to reduce hospitalization rates by up to 85% in the severe and persistent mentally ill population.

I.C.C.D. clubhouses also assist its members in finding employment and to pursue educational goals. PPH currently has two members attending college courses and two members working on their GED's. PPH has successfully helped several people return to work full time who have been able to discontinue receiving Social Security Disability benefits.

In closing, I ask that you please take into consideration how this proposed change would affect the mental health population. I assure you the outcome would not be good. I would also like you to ask yourself if you had a family member with mental illness would you not want them functioning at their highest potential in the least restrictive environment with friends and a support system?

Thank you for your attention to this important matter.

Sincerely,

William Chase

Piedmont Pioneer House Board Member

9

Quality of Care for Quality of Life

August 21, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8018
Baltimore, MD 21244-8018

Re: CMS-2261-P

To Whom It May Concern:

As a provider of services to individuals with severe psychiatric disabilities, we, at Valley HealthCare System, would like to offer the following comments on the proposed regulations related to the Rehabilitation Option.

Section II. C.
We have no objection to the inclusion of a required rehabilitation plan and all of the attendant parts of the plan. The creation of a rehabilitation plan is good practice and necessary for accountability.

Section II.D. Page 45205
In speaking to the review of a state plan amendment and the consideration of ""'whether the proposed scope of rehabilitative services is "sufficient in amount, duration and scope to reasonably achieve its purpose"", it is suggested that CMS give guidance to states as to how this might be practiced for individuals with psychiatric disabilities. For example, here in West Virginia, authorizations for Community Focused Treatment and Supported Living (rehabilitation services), for example, are so limited in time, that they are practically worthless. Individuals with severe psychiatric disabilities can achieve skill growth, but authorizations for skill development and skill practice need to be of a reasonable length to accomplish that growth.

Section II.F.2.
Although we understand the distinction between those vocational services that might be covered under the option and which might, the tone of the vocational paragraph may dissuade state decision-makers from allowing **any** coverage for pre-vocational activity. For example, the literature demonstrates that individuals with psychiatric disabilities don't necessarily have problems doing a job; they have problems getting along on a job. The literature also suggests that the best indicator of an individual's potential success in a job is how they perform in a mock setting, such as a psychiatric rehabilitation program or clubhouse.

Assuming that a person needs assistance in learning or programming an emotional skill or an interpersonal skill to get along on a job, it appears that CMS' explanation of what might be

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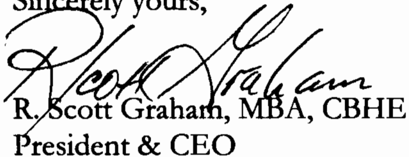
covered under the Rehabilitation Option would allow for the reimbursement of this kind of activity. If this assumption is correct, we would hope that CMS would emphasize the possibility so that state stakeholders entertain the possibility of putting such services in state plans.

Overall, despite these concerns and suggestions, we believe that CMS has done a good job in delineating the appropriate use of the Rehabilitation Option.

Sincerely yours,



R. Scott Graham, MBA, CBHE
President & CEO

cc
John Russell
Pat Winston
John Bianconi
Marcie Granahan
Jennifer Britton
Marsha Wallace
Linda Rosenberg
Phyllis Gore

Centers for Medicare&Medicaid Services,
Department of Health and Human Services, Attention:
CMS-2261-P,P.O. Box 8018, Baltimore,MD 21244-8018
September 13, 2007

Dear CMS

The proposed rule changes in Medicaid would have a very destructive effect to our Psychosocial Rehabilitation program. Our program "Adventure House" also is referred here as ''Clubhouse'' has been in existence for over twenty years, and serves residents of Cleveland County with persistent and chronic mental illness, with diagnosis of Schizophrenia, Bipolar and Clinical Depression. We, also have a Community Support Office with Case Management that serves approximately 110 adults with mental illness. The Clubhouse's average daily attendance is 60 members, and has an active membership of 96 members. We also have 33 apartment units where members live independently. The Clubhouse provides apartment residents with 24 hour on call services. We currently have 15 people working Transitional Employment Placements. Through Transitional Employment, many members have achieved the ability to go back to work and receive there own pay, partially supplementing their disability. A number have gone on to get off of disability and work fulltime jobs again through sustained efforts of work at the Clubhouse and the transitional employment program.

Our program is called the Clubhouse Model, and is a model designed after the very successful Fountain House of New York City. Fountain House was started in the 1940's in New York, and developed a program that uses "Work" in the Clubhouse as

Rehabilitation, instead of the more traditional methods of arts and crafts. It was found and still holds true of people who have been stricken with mental illness often become isolated and loose confidence to complete basis tasks. They often become more and more disabled by this loss of confidence and self-esteem. Persons with mental illness also can get caught in a cycle of hospitalization for psychotic episodes; can loose apartments, and thus an address to receive disability checks when they don't get proper support of a program like ours.

The Clubhouse through challenges to it's members of doing real needed work within the program helps people with mental illness begin to take care of themselves again, thus breaking the downward cycles of dependents on others and hospitalizations.

In Section 441.45 (b) (3) it states in part that vocational and prevocational services are not included or Medicaid billable. We can understand the reasoning of not wanting to use Rehabilitation monies to pay for the sole purpose of job training. In the Clubhouse we use "Work" as the rehabilitation tool. We do train people on Transitional Employment jobs and that portion is paid by Vocational Rehabilitation, as it should be. Unless CMS intent is to cut all monies to really help people with these diseases, then please reconsider this proposal to cut these needed funds.

Our program has proven to keep people out of the most costly "hospitals" and from becoming homeless, and in other helpless situations. There is not a cure for Schizophrenia, but we can restore a person to have a much better quality of life. It says much of our country when we take care of our mentally ill with dignity and respect. It is important to our small towns and big cities. What message does it convey to other

countries to see the United States the leader of the free world, will offer nearly nothing in the way of services for the mentally ill that wander our towns and city streets.

Our prisons are over burdened with misplaced and seemingly thrown away mentally ill people. Please do not further take away the hope of the ones we have successfully helped with your help (Medicaid) for all these years. If CMS wants to cut money that is wasted in programs that don't work and worse yet out right defraud the government, then go after them. The Folks in our program have been active participants in there own rehabilitation and gain confidence and independence through becoming real members of the working society.

Thank you for your consideration. The regulations must be carefully written to include those that use work as rehabilitation if you wish to see our type of program survive.

Sincerely,

Fred Mead,
Program Coordinator