1986 2006

2710

ICL

CORPORATE OFFICERS
Peter C. Campanelli, Psy.D., *President/CEO*
Stella V. Pappas, LCSW-R, ACSW, *Chief Operating Officer*

CORPORATE OFFICES
40 Rector Street, 8th Floor, New York, NY 10006
Telephone: 212-385-3030 • *Fax:* 212-385-2380
Website: www.ICLinc.net

Improving Lives, Building Hope, Empowering People

October 9, 2007

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

To Whom It May Concern:

Reference: **File code CMS-2261-P**

On behalf of **INSTITUTE FOR COMMUNITY LIVING, INC. (ICL)**, a community mental health provider located in **NEW YORK CITY**, I am writing to urge the CMS to please postpone implementations of the proposed Rule for Coverage for Rehabilitation Services under the Medicaid program, as published in the Federal Register, August 13, 2007 (CMS-2261-P). These proposed regulations will greatly increase costs to State and local governments as well as negatively affect the quality of necessary services provided to consumers by non-for profit community based organizations like ICL. As an alternative, ICL recommends that the CMS please consider the revisions suggested by the Coalition of Behavioral Health Agencies (see attached), an umbrella trade association and public policy advocacy organization for which ICL is a member.

Because of the reduction of federal funding for rehabilitation programs proposed by the regulations, States will have to decide between providing the same services at a higher cost or reducing the quality of services consumers receive. The lack of federal funding will encourage consumers to depend on emergency services- including hospitalization- and other Medicaid funded settings such as in-patient psychiatric beds, all of which are proven to be more costly than rehabilitation services.

ICL is dedicated to providing the best possible care to our consumers and the implementations proposed by the new rule for coverage for rehabilitative services under Medicaid, will pose additional barriers for providers. Most importantly these proposed regulations can harm the vulnerable beneficiaries with severe mental illness because of the lack of rehabilitation programs. I strongly urge you to please postpone implementing the regulations until further analysis is done on the financial impact it can have and to consider the revisions suggested by the Coalition of Behavioral Health Agencies, Inc.

If you have any questions, please contact Constance Y. Brown, Vice President of Corporate Community Relations at 212-385-3030 ext. 3192.

Sincerely,

Peter C. Campanelli, Psy.D
President and Chief Executive Officer

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

SPOP

Service Program for Older People, Inc.

272

ADMINISTRATIVE OFFICES/PROGRAMS
302 West 91st Street
New York, New York
10024

ADULT DAY SERVICES
188 West 88th Street
New York, New York
0024

.12.787.7120 TELEPHONE
212.580.0533 FAX
INFO@SPOP.ORG E-MAIL
WWW.SPOP.ORG WEB

October 2, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Service Program for Older People, Inc.(SPOP) is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

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

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

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

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

Comments re: PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130: Diagnostic, screening, preventive and rehabilitative services

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

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

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

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

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

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

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

The proposed definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function

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

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

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

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

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

Recommendation:
We urge CMS to indicate in the final rule that a child does not have to demonstrate that he or she was once capable of performing a specific task in the past if it were not possible or age-appropriate for the child to have done so. Specifically, the language should state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually have performed the activity in the past. (Note, this phrasing is taken from current CMS regulation of managed care plans at 42CFR

438.210(a)(4)(ii)(B)). An example of the above point may be a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate.

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

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

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

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

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

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

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

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

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

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

440.130(viii)(3) Written Rehabilitation Plan

The final rule should clarify the requirements of the written rehabilitation plan.

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

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

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

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

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

Recommendation:

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

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

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

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

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

- that the plan include intermediate rehabilitation goals;

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

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

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

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

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

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

440.130(4) Impairments to be addressed

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

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

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

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

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

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

Section 441.45: Rehabilitative Services

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

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

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

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

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

Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically

necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 1396d(r)). The result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other programs due to lack of resources (i.e. therapeutic foster care, foster care or child care institutions for a foster child). What is the legal basis for denying federal financial participation (FFP) for the Medicaid-covered individual? Thus, the rule effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

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

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

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

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

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

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

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

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

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

441.45(b)(2)

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

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

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

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

Recommendation:

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

441.45(b)(3)

The final rule should clarify when recreational and/or social activities are a covered rehabilitation service.

The preamble includes examples of when recreational or social activities may be covered rehabilitation services due to a focus on skill building or other rehabilitative needs. However, the proposed regulations do not include any examples or any specific language explaining when

these activities are covered services. This is a serious omission, as the regulation alone may be interpreted in the field as denying any recreational or social activities no matter how therapeutic or focused they are on restoring functioning.

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

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

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

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

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

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

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

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

OTHER ISSUES

Payment and Accounting for Services

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

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

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

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

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

Recommendation:
We strongly urge CMS to do the following:

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

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

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

CONCLUSION

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

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

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

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

If you have any questions, please contact Nancy Harvey at (212) 787-7120 ext. 529.

Sincerely,

Nancy Harvey, LMSW
Executive Director

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

October 10, 2007

273-O

Michael O. Leavitt, Secretary
Centers for Medicare & Medicaid Services
Dept of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

Re: File code CMS-2261-P

Dear Secretary Leavitt:

I am writing on behalf of Vinfen Corporation and the thousands of individuals and families we serve, to submit comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

Vinfen is a 30 year old non profit community behavioral health and human services organization, which provides services to over 5000 individuals with disabilities annually, through 275 programs throughout Eastern Massachusetts and Connecticut. Our services include programs for individuals with psychiatric disabilities, and individuals with mental retardation and developmental disabilities, who would be impacted by the proposed rule changes. As part of our mission, we are actively engaged in policy discussions and debates regarding the funding and regulations which impact those whom we serve. We welcome this opportunity to provide comments.

PROVISIONS OF THE PROPOSED RULE

440.130(d)(1)(vi) Definition of Restorative Services
According to the proposed rule's definition, restorative services help an individual regain the ability to perform a function, regardless of whether they actually performed the function previously. We urge you to clarify this section, especially taking into consideration that restorative services for children should include age-appropriate growth and development. Children may not have had the ability to perform certain in the past simply because they were not yet age- or developmentally-appropriate.

The proposed definition also 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 goal." While we agree that progress toward a rehabilitation goal is ideal, it is not always realistic for individuals with mental illness. Rehabilitative services are sometimes necessary to simply maintain current function levels and to prevent deterioration. If services are denied, their illness may become more acute, necessitating higher, costlier levels of care. Maintenance of functional levels for certain individuals who would otherwise lose function should be considered an appropriate rehabilitation goal and allowed under restorative services.

Finally, if tied to the rehabilitation goal, pre-vocational services should be considered allowable services as long as they are associated with specific rehabilitation goals. Pre-vocational services, such as cognitive interventions, communication and social skills, and skills for daily living are often essential components toward regaining a specific function. We also urge you to clarify the definition of pre-vocational services to include more examples in order to ensure compliance.

440.130(viii)(3) Written Rehabilitation Plan
While we do not dispute the importance of documenting rehabilitation goals, we are unclear as to the relationship between the rehabilitation plan and the treatment plan, and we feel that the development of a written rehabilitation plan is duplicative of the treatment plan process. The development of a separate written plan will require significant staff time, diverting resources away from direct care.

In addition, while we support efforts to more fully engage consumers in treatment goals, we have concerns that this may not always be possible. According to the proposed requirements of the written rehabilitation plan, it must be documented "that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the plan." There may be times that an individual who is mentally ill, due to the nature of his/her illness, may refuse to participate or sign the plan. This may occur when treatment is most needed. In the event that an individual has not appointed a representative, or cannot identify his/her representative, the provider should be able to document that the client or his/her representative was not able to sign the rehabilitation plan.

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 those that are considered intrinsic elements of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from one in which 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.

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 another 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.

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

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

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

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

441.45(a) Requirements for Rehabilitative Services
This section states that rehabilitative services must include "freedom of choice of qualified providers." This is problematic for Massachusetts as the state's Department of Mental Health has a closed referral system. The Massachusetts Department of Mental Health controls referrals and determines when the need for service exists. We urge you to reconsider this requirement and take into consideration state systems such that of as Massachusetts.

440.130(d)(1)(iii) Definitions
In keeping with the priorities of the New Freedom Commission and the movement toward a recovery-oriented focus, we recommend that the definition of "qualified providers of rehabilitative services" be broadened to include key providers of recovery-oriented services such as certified peer specialists.

Regarding proposed changes to the "under the supervision" requirements, the proposed language is unclear, and may be interpreted to require that licensed or certified or registered professionals of allied health disciplines be involved in all initial assessments, and periodic face to face assessments throughout services. If that is the intent of this rule, we strongly oppose it, as such requirements would add enormous costs to rehabilitation services without adding reasonable value, and would be likely to result in reduced access to rehabilitation, due to shortages of service providers.

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

These new shifts in rate-setting methodology are not efficient and moreover, are extremely detrimental to the provision of evidence-based mental health services which are increasingly being offered as a package of intertwined interventions delivered in a flexible manner. These services include assertive community treatment, multi-systemic therapy, day rehabilitation services, therapeutic foster care, as well as residential services. Residential services—a traditional mainstay of rehabilitation services—are not operated on a fee-for-service basis nor is it commonsensical to do so.

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 which remove the currently imposed extreme administrative burden. In addition, because residential treatment is milieu-based and rehabilitative services are provided along with specific therapeutic activities, clarification of covered services and documentation is needed to ensure compliance.

Regarding Day Habilitation services, we strongly oppose the provisions related to excluded federal financial participation (FFP) for habilitation services. We urge you to withdraw this proposed rule.

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

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

274-O

ADMINISTRATION

5965 South 900 East, Suite 420
Salt Lake City, Utah 84121

Phone: (801) 263-7100
FAX (801) 263-7123

www.vmh.com

Debra Lynn S. Falvo, MHSA, R.N.C.
CEO/President

October 11, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

Valley Mental Health 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.

Valley Mental Health in celebrating its 20th year is the sole source provider of community behavioral health services for the counties of Salt Lake, Summit, and Tooele counties in the state of Utah. We serve approximately 45% of the Medicaid population in the state. Our organization serves 20,000 individuals a year and employees over 1200 employees. We also maintain a wide range of subcontracting agencies to allow clients the ability of choice when possible. The service delivery system is such that our clients treatment needs for all levels of care, from outpatient to hospitalization, help with supported housing, employment, education, access to physical health care is considered in the overall recovery plan.

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. We applaud CMS for including requirements that are designed to ensure the individual's participation in this process.

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

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

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

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

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

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

> For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context

is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."

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

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

Recommendation:

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

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

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

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

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and

meaningful plan of services without an assessment of the person's functional capacity – clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

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

Recommendation:

Add to section (vii) the word "assessment" before the word "diagnosis" and replace the word "care" with the word "rehabilitation."

440.130(d)(1)(viii)(2)Scope of Services

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

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

Recommendation:

Insert the word "restorative" after "medical" in the first sentence of the definition of scope of services. The same change is needed to (d)(3)(vi).

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

The preamble phrase "services are to be provided at the least intrusive level to sustain health and ensure the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level" should be added to the definition of the scope of services, and additionally, services should also be required to be provided in the most integrated, appropriate setting.

440.130(viii)(3) Written Rehabilitation Plan

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

individuals in need of rehabilitative services.

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

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

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

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

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

<u>Recommendations</u>:

We recommended inclusion of the following requirements regarding the written rehabilitation

plan:

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

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

440.130(4) Impairments to be addressed

The regulation states that services may address an individual's physical impairments, mental health impairments and/or substance-related disorder treatment needs. In describing this section in the preamble, the agency also states that because rehabilitative services are an optional service for adults, states have the flexibility to determine whether they will be limited to certain services for specific populations.

Limiting services to only one group, based on diagnosis or disability violates Medicaid's requirement that services be furnished in sufficient amount, duration and scope to reasonably achieve their purpose. Excluding coverage of rehabilitative services needed by individuals with mental illnesses would also violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132.

Recommendation:

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

440.130(5) Settings

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

Recommendation:

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

Section 441.45: Rehabilitative Services

441.45(a)(2)

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

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

Recommendation:

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

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

441.45(b) Non-covered services

This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered "intrinsic elements" of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

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

The regulation makes no acknowledgment that therapeutic foster care is a mental health service, provided through mental health systems to children with serious mental disorders who need to be removed from their home environment for a temporary period and furnished intensive mental health services. This mental health intervention is designed for children both in and outside of the foster care system; it is not a service exclusively for children in the foster care system.

Recommendation:

Therapeutic foster care should be listed as a covered rehabilitation service for children with serious mental disorders at imminent risk of placement in a residential treatment facility. Covered services should not, however, include room and board costs.

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

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

441.45(b)(2)

The Omnibus Reconciliation Act of 1989 (OBRA 89) prohibited CMS (the HCFA) from disallowing claims for day habilitation services until such time as a regulation was issued by the Agency that specified the types of habilitation services that would be covered. Therefore, CMS' action to categorically exclude coverage for Habilitation services for persons with mental retardation and related conditions is unprecedented, inconsistent with Congressional intent, and not justified.

It should be noted that the exclusion of habilitation services does and should not equal exclusion from FFP for any rehabilitative services provided to persons with mental retardation or related conditions. Related conditions include such illnesses as cerebral palsy, and epilepsy and it is clear that individuals with these illnesses can gain and lose functionality and would benefit from rehabilitative services. Some individuals with serious mental illnesses may also experience periods of extreme cognitive impairment as a result of their illneses.

Recommendation:

Clarification should be provided as to the difference between exclusion for habilitation services as opposed to the exclusion from FFP for rehabilitative services provided to persons with mental retardation and related conditions.

441.45(b)(3)

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

In addition, personal care services are not considered a rehabilitation service. However, some services related to personal care, such as skills training in personal care, are covered rehabilitative services. It would be helpful if CMS would clarify this and also explain to providers how they document that a service was personal care skill building, even though the provider may have had to demonstrate (and therefore provide) personal care in the process.

Recommendations:

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

The regulation should clarify how personal care furnished as an integral part of personal care skills training is covered and how it is to be documented.

Individuals in Secure Custody and Residing in Public Institutions

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

Recommendation:

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

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

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

Recommendation

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

OTHER ISSUES

Payment and Accounting for Services

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

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

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

To the extent that any of these proposals become final, CMS must work with States to develop implementation timelines that account for legislative review of waivers in states where this is necessary, as well as adequate time for administrative and programmatic changes at both the state and provider agency level. The development of new forms as well as staff training, administrative processes all pose significant challenges at the

Agency level. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of the State Plan Amendments by the Agency.

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

Sincerely,

Debra Lynn S. Falvo, MHSA RN C.
CEO/President
Valley Mental Health

CC: Members of the Utah State Congressional Caucus
The Honorable Jon Huntsman, Jr., Governor of the state of Utah

Holy Family Services
adoption & foster care
when you care enough to consider adoption

275

October 3, 2007

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

To Whom It May Concern:

I am the Executive Director of Holy Family Services adoption & foster care, a California non-profit community-based human services agency serving our state's at-risk and in-need children and their families. Our organization provides adoption and foster care services for children 0-18 years of age in the counties of Los Angeles, Orange, San Bernardino, Riverside and Ventura.

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

GENERAL COMMENT

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

PROVISIONS OF THE PROPOSED RULE

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

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

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

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

☐ LOS ANGELES COUNTY
P.O. Box 26368
Los Angeles, CA 90026
(213) 202-3900 • (213) 202-3942 fax

☐ ORANGE COUNTY
P.O. Box 9
Placentia, CA 92871
(714) 528-6300 • (714) 528-6305 fax

☐ VENTURA COUNTY
80 Hillcrest Drive, Suite. 206
Thousand Oaks, CA 91360
(805) 374-6797 • (805) 379-3088 fax

☐ INLAND EMPIRE
1441 North "D" Street, Suite 201
San Bernadino, CA 92405
(909) 885-4882 • (909) 888-7065 fax

HFSAdopt@aol.com • www.hfs.org

Recommendation:

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

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

440.130(3) Written Rehabilitation Plan

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

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

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

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

Recommendations:

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

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

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

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

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

discretion to identify the rehabilitation components that constitute therapeutic foster care, define therapeutic foster care as a single service, and pay through a case rate, daily rate or other appropriate mechanism.

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

441.45(b)(2) Habilitation services

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

Recommendation:

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

OTHER COMMENTS

Payment and Accounting for Services

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, do not hesitate to contact me at (213) 202 3900 x 12.

Sincerely,

Debra E. Richardson, LCSW
Executive Director

PSYCHOTHERAPEUTIC SERVICES, INC.
TOGETHER HOUSE
405 RUDD STREET
BURLINGTON, NC 27217
(336) 513-4229/4230 OFFICE
(336) 513-4228 FAX

October 3, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

Together House is submitting the following comments on the Proposed Rule to amend the definition of Medicaid Rehabilitative Services as published in the Federal Register, August 13, 2007 (Volume 72, Number 155). Together House is a Day Rehabilitation Program based on the Clubhouse Model, located in a rural community of North Carolina. We serve adults with severe and persistent Mental Illness. We have been in business for 10 years, relying on Medicaid and state funding to provide needed services in our community. We currently have 48 active Members, with an average daily attendance of 25.

It is clear from the published "Summary" of this proposed Rule, that the intent of CMS is to severely restrict rehabilitative services to Medicaid eligible individuals with long term Mental Illness, through increased documentation requirements for already overburdened Providers and through extremely restrictive service definitions. CMS appears to want to cut funding for medically necessary services to the most vulnerable segment of this country's citizens- those with long term Mental Illness. We know these cuts will far exceed the projected reduction in Medicaid spending of $2.2 billion over five years, through putting small Providers out of business and through "Paybacks" as a result of audits of larger providers. It is shameful for CMS to refer to "important beneficiary protections," as having anything to do with the maintenance of case records. Our Members rely on Medicaid as their only health insurance and are alarmed by the degree to which their coverage could be reduced by the proposed Rule change.

Like it or not, Medicaid has become the single largest funding source for Mental Health services in this country. If CMS truly wants to cut Medicaid funding, the agency needs to stop blaming the states for viewing rehabilitation benefits as a "catch-all category" and accept responsibility for their approval of all state plans. CMS should then begin

working with other federal, state and local agencies to develop alternative funding sources and develop a transition plan that will prevent the disruption of vital services to adults with severe Mental Illness. For CMS to proceed with their current strategy of a "Rule change," will result in precious funding being wasted on challenging the creative writing skills of Mental Health Professionals to document needed services in a manner that Medicaid will pay for. Or, worse yet, the funds will be misused to provide specific, time limited, and ineffective interventions to adults with Mental Illness in a misguided effort to at least offer them something, rather than abandoning them to isolation in the community, only to decompensate. Much more intensive and expensive services will then be needed to stabilize the individual only to again be abandoned. In my 15 years of community mental health work, the most effective program to stop this revolving door, the Clubhouse Model, is being directly threatened by the proposed Rule changes. We can not be effective under these proposed Rules as specified below.

PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130(d) (3)

The requirements outlined in this section focus on documentation. Taken individually, they all make sense from an accountability stand point. But CMS knows that such requirements are utilized not to improve services, but to extract large "Paybacks" from Providers. The more requirements there are, particularly vague requirements (such as "recovery goals" and "reasonable plans") that can be open to interpretation, the more Paybacks that can be imposed.

With private insurance, a claim is filed by the provider and the insurance carrier pays or rejects the claim. If rejected, the Provider corrects errors and provides additional documentation needed for reimbursement. If the claim is still denied, the patient is then billed for the "uncovered services."

Under Medicaid, the claim is paid. The Provider is then vulnerable to federal, state, and local auditors who require a 100% payback if they believe the documentation is inadequate. The proposed Rule arms these auditors with many more avenues to extract a payback. A simple oversight or clerical error results in a 100% payback. If the written rehabilitation plan contains an error, then all services provided under that plan are subject to payback. Put simply, Medicaid plays the "gotcha game," with no lesser penalty in their arsenal than a 100% payback. The Provider cannot then turn to the indigent patient and expect payment, nor can they payback the funds they expended providing the service. The result is that the Provider's focus is shifted from the client to the record as the most important element of their job. Clients become a bothersome interruption to the mandated and critical documentation work of the professional staff. This is already happening and can be seen in the dramatic increase in workshop offerings to Mental Health staff on record keeping and "Audit Proofing Your Records." "Quality Improvement" refers to records, not services, and the client suffers.

Recommendation: Develop a Rule change that would stop the "gotcha" game and truly benefit the clients served. Develop "fines" short of full paybacks and work to reduce the paper work demands on Providers so that they can focus on service delivery to their clients. Surely there is a way to pursue unscrupulous Providers without overwhelming good Providers with paper work.

Section 440.130(d)(l)(vi)

This section, and others, has to do with the expectation that there will be a "measurable reduction of disability and restoration" and the exclusion of services to "maintain a level of functioning." Severe and Persistent Mental Illness, such as schizophrenia, has a devastating effect on a person's whole life. One can not chop that life up into specific measurable goals, prescribe a specific intervention, in a predetermined amount and expect to impact that life. The proposed Rule goes even further in the wrong direction by disallowing most of the elements of that life as billable under Medicaid. In fact, I'm hard pressed to even think of an intervention that could not be interpreted as being vocational, prevocational, educational, social or recreational. Even "Housing" is listed, which may be interpreted as any intervention to support a person in living more independently. Then there are "services that are intrinsic elements of programs other than Medicaid" which are also disallowed. How can this be considered "Person Centered?"

I understand that CMS provides an example of what might appear to be a "social activity" which may in fact be addressing the rehabilitation goal of social skills development as identified in the rehabilitation plan. They go on to state that such an activity would need to be specifically related to an identified rehabilitative goal as documented in the rehabilitation plan with specific time-limited treatment goals and outcomes. Furthermore, the social activity would need to be provided by a qualified provider, be documented in the case record and meet all requirements of this proposed regulation. Can CMS not see the absurdity in this? How did CMS staff develop their social skills without all of the above? Do they really think that a person with mental illness is so different from them as to require all of the above? Why would a Provider even attempt such billing, knowing that the goal must be time limited and the individual would often have no place to use the social skills developed upon goal attainment?

I am not trying to make the case that Medicaid should pay for playing Bingo. But, under the proposed Rule, Providers could bill Medicaid for Bingo, TV watching, horseback riding and practically anything else, as long as they met all the above requirements. CMS can not stop such abuse by increasing documentation requirements. Instead, CMS will further shift the focus on the requirements and the documentation and not on the clients, who would most likely exhibit good social skills if given the opportunity, or develop those skills (as most people have) by being provided with the opportunity to participate in a social setting.

Rehabilitation as it applies to adults with severe Mental Illness can not be seen as picking out a narrowly defined and measurable segment of a person's disability and then

providing an intervention, in some kind of prescribed formula, which should be administered in calibrated dosages by qualified professionals to their ill patents. The rehabilitation services must be in some context that provides meaning and purpose. What good are measurable goals and allowable interventions to impact budgeting skills, when there is nothing in this world that the client can envision as worth budgeting for. Don't we understand that there is no reason to save to buy new clothes, when there is no place to go in them, or for a vacation, when there is no one with whom to go and nothing from which to take a vacation? Providing that context, that purpose, is the best way I have found to reduce the disabling effects of a major Mental Illness.

The proposed Regulations threaten our ability to provide a context within which real Rehabilitation happens. If CMS applied these regulations to persons who are not diagnosed with a Mental Illness, I truly believe they would become disabled. Their lives would be fragmented into measurable pieces. Large areas of their lives would be ignored because we are not able to identify measurable goals nor can we specify an anticipated outcome that would reasonably impact those areas. We <u>can</u> impact those areas! We do it every day with our friends, family and co-workers. We just can't document what we do to accomplish this under the requirements set forth in this proposed Rule change and to try would risk audit repercussions.

This objection to the proposed rule is IMPORTANT. In the Federal Register, CMS describes ball throwing as a billable service for a stroke victim needing to improve balance and coordination. There is an assumption here that the client has a life in which balance and coordination are needed and that this life includes activities that will sustain balance and coordination long after the professional intervention.

The same assumptions can not be made for an adult with a long term Mental Illness. Members have reported being in time limited programs where they hid improvement for fear of being discharged from the very service that helped them improve. They report having no where to go upon discharge, nothing meaningful to do and no one with whom to share any goal attainment they may have made. They also fear the return of depressive and psychotic symptoms that they know may reoccur despite compliance with medications. The words "Recovery goals" appear to have been inserted into the proposed regulation, with no understanding of what that means. It appears to be just another documentation requirement to CMS. People rarely recover from severe Mental Illness. It is a biological illness with no known cure. The word "Recovery" as it applies to Mental Illness refers to the often life long struggle of an individual to recover their lives to the greatest extent possible despite the illness. To set recovery goals means to provide supports and services specifically listed as not covered under the proposed Medicaid rule. The exclusion of services that are "prevocational" is particularly troublesome, as many interventions and supports necessary for "recovery" fall within this realm.

CMS can not simply make a Rule and abandon the Medicaid eligible people with Mental Illness. We have discharged these people from institutions with promises of providing community based services that were nonexistent or grossly under funded. Now, the single largest funding source used to develop those services in the community is threatening to

make a Rule change. It is inhumane and unethical to hide what CMS is doing behind the stated purpose of "rectifying the improper reliance on the Medicaid rehabilitation benefit" without identifying/developing an adequate and alternative funding source.

CMS has allowed or has looked the other way while states have utilized Medicaid funding to sustain and maintain the highest possible functional level for adults with severe Mental Illness. This MUST remain as an acceptable goal for delivering services under Medicaid.

Section 440.130(vii)(3)

In North Carolina, we know how CMS expects Providers to document progress towards goals in the rehabilitation plan. They expect a progress note for every encounter. CMS imposed a daily note requirement on Psychosocial Rehabilitation (PSR) programs last year, claiming that this was not new, but a long standing requirement that most states have failed to meet. They stated that they are now "cracking down on states to comply" and will expand this "crackdown" to other states as their State Plans are reviewed. CMS officials failed to explain how the state was at fault, when CMS has allowed monthly documentation for PSR services in North Carolina for over 17 years. Didn't CMS have to approve our State Plan?

I can not state this strongly enough. A progress note requirement for every encounter is an unnecessary and major burden, especially for services, like PSR, that are delivered to groups. This requirement has rendered our service record useless. The record can no longer be used to track the course of services being provided or for any clinical purpose due to the sheer volume of notes. Instead of producing 48 progress notes per month, Together House professional staff must now write over 500 notes per month, at a cost of $14,000 per year.

WE STRONGLY RECOMMEND that progress notes be required on a monthly basis, leaving it to the Provider to make more frequent notes in cases where that may be appropriate!!

Sincerely,

Vivian G. Meyers

Vivian G. Meyers, CSW, QMHP
Together House Coordinator

277

Marty Sears
631 Crestview Drive
Burlington N.C. 27215

October 2, 2007

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

To whom it may concern:

Reference: File code CMS-2261-P

To Whom It May Concern:

I am a member of Psychotherapeutic Services or as we call it, Together House. This facility is a program that is highly beneficial to people with Mental Illness. I want to share about how and why this organization has been tremendously helpful to me. I would also like to say it would be an awesome mistake for you to interfere with, or to limit the services, programs, and procedures of rehabilitative services. I've had wonderful counselors and case managers at Together House that have helped me grow my self-esteem. My counselors have helped me to exhibit and publish my art work. We have a Newsletter that we write articles in about trips we take for learning and recreation. We also write about the different units in Together House which teach independent living skills. These units are a major function of Together House. We have four units that teach different independent living skills. We have a kitchen unit, where we learn important things like how to cook. We have a clerical unit, where we learn how to keep records and use computers. We have an environment unit for training in cleaning skills and we have a snack bar for learning important things like operating a cash register and counting money. I am in the clerical and kitchen units. I 'm learning important independent living skills. I'm sure the experience I'm receiving in computer and classroom education at Together House will help me in college.

Another achievement that Together House helped me with was getting one of the articles I wrote in the Local Newspaper, here in Burlington, N.C. Together House provides us with our need for fun and recreation. They take us Bowling and to many other enjoyable activities. The counselors and staff also work with our members to help them get jobs in our community.

My life began with a very hard road. I suffered from terrible peer pressure that gave me a severe inferiority complex. It was so bad that I had to leave school and face a horrible life

of social deprivation and loneliness. Finally, I found Together House and it gave me a new start. It has given me a chance to make friends and progress again. I've seen people at Together House move out on their own and receive their independence, I've seen people learn new skills, and I've seen people, here dealing with their problems through work and self achievement. It certainly is true that Together House has given us a strong self-confidence. It has also given us access to medical and psychological help.

I believe I have more than demonstrated why this crucially important organization, with all it's help, support, and services that it provides must be allowed to stand!

Together House Must Survive!

Sincerely,

Martin C. Sears

Martin C. Sears

278

1116 Dixie st.
Burlington NC 27217

October 2, 2007

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

To whom it may concern:

Reference: File code CMS-2261-P

To Whom It May Concern:

Please do not close down Together House. It has become a home away from home for me. When I'm at home the walls close in on me and set me up for severe depression. Community Support has also been a good support system for me. They take me to get my medicine and any other needs I may have.

I've learned a lot going to class during the week. Everybody is so very friendly; we are like a Family here.

Don't take away the only source I have of getting out of my house. If I don't have these services anymore, I'm sure to end up back in the hospital. I would also lose my transportation with community support.

Sincerely your,

Carolyn Willis

Carolyn Willis

279

Tracy Banks
405 Rudd Street.
Burlington NC 27217

October 2, 2007

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

To whom it may concern:

Reference: File code CMS-2261-P

Together House means a lot to me. I 've attended Together House for a couple of years now. I really feel like it has helped me during the years, when I attended the program. I'm trying to get my GED so that I can work at getting a nurses certificate and later becoming a peer counselor.

If I lose Together House I would not be able to live in my new apartment. I would have to get a job which I'm not ready for right now. But one of my goals is to gain some prevocational skills so I can eventually work. If I lose my services I would have no place to go and I would likely go to the hospital.

Sincerely yours,

Tracy Banks

Tracy C. Banks

Beverly R. Jones
1720 St. Marks Ch. Rd.
Burlington, NC 27215

October 4, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8010

Re: CMS-2261-P

To Whom It May Concern:

My name is Beverly Jones; I am a Rehabilitation Specialist at Together House, a psychosocial rehabilitation program in Burlington, NC. I am extremely concerned about the proposed rule changes. The proposed changes may be appropriate for person's who do not experience mental illness but our program deals with adults with severe and persistent mental illness. This population is very fragile and is at risk for repeated institutionalizations.

The clubhouse model serves people that need lifelong support to maintain stability. I am concerned about the change in providing services to maintain current level of functioning only when it is necessary to help an individual achieve a rehabilitation goal. Continuation of rehabilitation services is at times essential to retain a person's functional level. Failure to provide such services could lead to further deterioration which might lead to reinstatement of intensive services including hospitalization. I believe it is very important that this section include language that determines when and how to determine if a rehabilitation service or services is necessary to maintain a desired functional level. If these new rules go into effect without any consideration of how they will effect the population they're forcing them upon, lives will be lost, people will be hospitalized, homeless and misplaced in jails. Thank you for considering my request.

Sincerely,

Beverly R. Jones, B.A., Q.P.

Beverly R. Jones, B.A., Q.P.

October 2, 2007

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

To Whom It May Concern:

Re: File code CMS-2261-P

When I began working in the Mental Health field almost 18 years ago, I had little understanding of just what a difference can be made in the lives of so many who suffer from severe and persistent Mental Illness – Schizophrenia, Bipolar Disorder and Major Depression. I have met and worked with many wonderful individuals with these Mental Illnesses and have learned so much from them. They face almost insurmountable issues with stigmas placed on them by society as a whole and have worked very diligently, with assistance from the Clubhouse Model Rehabilitation Program (our program is Adventure House), to live active and productive lives. I have observed withdrawn individuals make lasting friends; folks who are convinced that they are "broken" and have nothing to offer become leaders in their peer groups and encourage others to better themselves; some who have been totally illiterate read a newspaper article with pride in themselves; some have, with opportunities and encouragement provided by our day program, gone on to earn their high school diplomas and even their bachelor's degrees from a local university. I have watched as these individuals face each day with a determination that I sometimes do not even possess myself. We provide services that enable our Members to learn to dream and to attain those dreams. Isn't that what we all want? If you were to ask any of them, they would quickly and honestly tell you that our program has literally saved their lives. But their continued success is contingent upon consistency and continuation of services. And it is very frightening that, with your proposed changes, you will be taking this away and leaving them with nothing to sustain the degree of stability they have reached.

We are looking at people, **PEOPLE**, who have largely been isolated, disposed of by society and have nothing to do with their time but listen to the voices that plague them and to possibly act on what those voices tell them to do. Hospitalization to reach stability used to be an option but now the hospitals are full and they have a waiting list. How can we reasonably ask a person with a severe Mental Illness to wait for the help that they need? I have seen first hand that by offering real opportunities to get involved in activities and meaningful work, it helps them to focus on what they can do instead of what is wrong with them. But this is something that must be provided consistently and not piecemeal – we'll help you until you improve, then take it away until you get sick again and, if funding permits, we will run you through the system again until you are marginally able to exist on your own – and a vicious circle begins. Not only does this not make sense from a medical standpoint, it does not make sense from a business standpoint as well.

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

To Whom It May Concern:

I go to Adventure House everyday and do Prevocational work there. I have received very good services here through the Medicaid Insurance . I work in the Kitchen and a Snack Bar unit . I was sick and in and out of the mental hospital for a 30 year period before getting into Adventure House. I've only had one , one week hospitalization since starting at Adventure House in 1986. I appreciate the Medicaid coverage thus far it has help me sustain my present level of mental health and independence. In 1989 I entered into a supported Housing Apartment and have enjoyed quality living there. The Proposed regulation changes would remove my supports and leave me alone and would probably begin to be sick again .

Thank you for your consideration,

Paul D. Pouchoka

283

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

September 28, 2007

Reference: CMS-2261-P

To Whom It May Concern:

My name is Phyllis Stafford and I work for the Adventure House Community Support services in Shelby, North Carolina as a Para-Professional.
I am writing to you with concern about the proposed Medicaid cut of $ 2.2 billion dollars over five years. If this is passed it will have a BIG effect on the consumers we work with. Our consumers really need the services that we provide on a daily basis. Without them our consumers would not be able to live, or function. Here at the Adventure House Community Support we provide services to adults who have been diagnosed with Chronic Mental Illness. Everyday in our Jobs we try to help them live productive lives, and as much of an ordinary life as they possibly can. For example, I work with one Gentleman who is 52 years of age. He is diagnosed with Major Depression with a Traumatic Brain Injury. This Gentleman without our help could not make it on his own in the world. We offer help with budgeting his money, paying his bills, grocery shopping, and Medications. He is also half blind in one eye. This Gentleman also requires his Case Manager to be his Payee, due to not making good decisions on his own. This consumer also attends the Adventure House (Clubhouse) during the week to assist him with social skills.
I am asking that you please reconsider the plan to cut $2.2 billion from this special population of people who have mental illness. They deserve the support they get each and everyday from our office. If you make the decision to cut the money, our homeless population will grow and there will be no room in the hospitals which are already overcrowded. Please reconsider your decision.

Phyllis Stafford
Para-Professional

284

Gloria E. Lee
128 S. Lexington Ave.
Burlington, NC 27215

October 2, 2007

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

To whom it may concern:

Reference: File code CMS-2261-P

I'm writing concerning the issues about the proposed rules that would affect Rehabilitation Services.

When I first came to Together House, I was so afraid I was having anxiety attacks; I live daily with being afraid, and distressed and worrying about my future.

By coming to Together House it helps me cope with my mental illness. I have been diagnosed bipolar disorder and manic depression. I often hear voices and I am deathly afraid of being around a large group of people that I don't know. Often times I feel as if I want to hide from the world.

Together House helps me to cope with my mental Illness which is Bi-polar Disorder and manic depression, hear voices and afraid to be around people. I want to hide from the world.

Together House is a place where we feel loved and cared for. I attend the literary class three days a week and educational outings two days a week. I can only speak for myself. Please listen to the out cry from Together House. We need to stay open everyday. Here I have learned how to manage my illness. I have made close friendships and I am growing daily.

What would happen if I could not come to the Together House.

1. I would get depressed
2. Be lonely
3. No one to talk to about my mental illness
4. Possibility of getting suicidal

5. Won't be getting my G.E.D.
6. Be hospitalize again

If you had a thousand people just like me with my situation that is how much this proposed rule would affect them as well.

Sincerely your,

Gloria E Lee

Gloria E. Lee

285

October 1, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

As a friend and strong supporter of Adventure House of Cleveland County North Carolina, I am deeply concerned over the Proposed Rule to amend the definition of Medicaid Rehabilitative Services as published in the Federal Register, August 13, 2007 (Volume 72, Number 155). I feel very strongly (as do a large number of Citizens of Cleveland County from whom you will be receiving correspondence expressing their concerns as well) that these proposed changes, if accepted, will create a major risk to the quality of services currently provided by Adventure House. The impact for which I feel is most certain, will be that current and future Club House Members will not receive the level of managed care that is currently being provided. This will result in a major burden for other medical providers, more specifically Hospital Emergency Services, and the major increase in service cost will be passed on to the Tax Payer. My major concern however, is the overall impact that these Proposed Rule Changes will have on the Quality of Service currently provided by Adventure House.

I have been in contact with Mr. Tommy Gunn, Executive Director of Adventure House of Cleveland County, to express my concerns. Although I am certainly not as knowledgeable as Mr. Gunn on Mental Health, I do have a good understanding that an erosion of Mental Health Services through Adventure House would have a major negative impact on the individuals served as well as our community at large. Mr. Gunn has shared with me his overall concerns as well as his written response which he has give me permission to use. I feel Mr. Gunn has very systematically outlined why the Recommended Changes should not be accepted, therefore I very strongly endorse the following.

I would like to comment on the Proposed Rule to amend the definition of Medicaid Rehabilitative Services as published in the Federal Register, August 13, 2007 (Volume 72, Number 155). I am a friend and supported of Adventure House which is a Day Rehabilitation Program based on the Clubhouse Model, located in a rural community of North Carolina. We serve adults with severe and persistent Mental Illness, with 80% of our Members (clients) having a diagnosis of Schizophrenia. We have been in business as a Non-Profit Organization for over 20 years, relying on Medicaid and state funding to provide needed services in our community. We currently have 115 active Members, with an average daily attendance of 65.

It is clear from the published "Summary" of this proposed Rule, that the intent of CMS is to severely restrict rehabilitative services to Medicaid eligible individuals with long term Mental Illness, through increased documentation requirements for already overburdened Providers and through extremely restrictive service definitions. CMS appears to want to cut funding for medically necessary services to the most vulnerable segment of this country's citizens- those with long term Mental Illness. We know these cuts will far exceed the projected reduction in Medicaid spending of $2.2 billion over five years, through putting small Providers out of business and through "Paybacks" as a result of audits of larger providers. It is shameful for CMS to refer to "important beneficiary protections," as having anything to do with the maintenance of case records. Our Members rely on Medicaid as their only health insurance and are alarmed by the degree to which their coverage could be reduced by the proposed Rule change.

Like it or not, Medicaid has become the single largest funding source for Mental Health services in this country. If CMS truly wants to cut Medicaid funding, the agency needs to stop blaming the states for viewing rehabilitation benefits as a "catch-all category" and accept responsibility for their approval of all state plans. CMS should then begin working with other federal, state and local agencies to develop alternative funding sources and develop a transition plan that will prevent the disruption of vital services to adults with severe Mental Illness. For CMS to proceed with their current strategy of a "Rule change," will result in precious funding being wasted on challenging the creative writing skills of Mental Health Professionals to document needed services in a manner that Medicaid will pay for. Or, worse yet, the funds will be misused to provide specific, time limited, and ineffective interventions to adults with Mental Illness in a misguided effort to at least offer them something, rather than abandoning them to isolation in the community, only to decompensate. Much more intensive and expensive services will then be needed to stabilize the individual only to again be abandoned. In my 30 years of community mental health work, the most effective program to stop this revolving door, the Clubhouse Model, is being directly threatened by the proposed Rule changes. We can not be effective under these proposed Rules as specified below.

PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130(d) (3)

The requirements outlined in this section focus on documentation. Taken individually, they all make sense from an accountability stand point. But CMS knows that such requirements are utilized not to improve services, but to extract large "Paybacks" from Providers. The more requirements there are, particularly vague requirements (such as "recovery goals" and "reasonable plans") that can be open to interpretation, the more Paybacks that can be imposed.

With private insurance, a claim is filed by the provider and the insurance carrier pays or rejects the claim. If rejected, the Provider corrects errors and provides additional documentation needed for reimbursement. If the claim is still denied, the patient is then billed for the "uncovered services."

Under Medicaid, the claim is paid. The Provider is then vulnerable to federal, state, and local auditors who require a 100% payback if they believe the documentation is inadequate. The proposed Rule arms these auditors with many more avenues to extract a payback. A simple oversight or clerical error results in a 100% payback. If the written rehabilitation plan contains an error, then all services provided under that plan are subject to payback. Put simply, Medicaid plays the "gotcha game," with no lesser penalty in their arsenal than a 100% payback. The Provider cannot then turn to the indigent patient and expect payment, nor can they payback the funds they expended providing the service. The result is that the Provider's focus is shifted from the client to the record as the most important element of their job. Clients become a bothersome interruption to the mandated and critical documentation work of the professional staff. This is already happening and can be seen in the dramatic increase in workshop offerings to Mental Health staff on record keeping and "Audit Proofing Your Records." "Quality Improvement" refers to records, not services, and the client suffers.

Recommendation: Develop a Rule change that would stop the "gotcha" game and truly benefit the clients served. Develop "fines" short of full paybacks and work to reduce the paper work demands on Providers so that they can focus on service delivery to their clients. Surely there is a way to pursue unscrupulous Providers without overwhelming good Providers with paper work.

Section 440.130(d)(l)(vi)

This section, and others, has to do with the expectation that there will be a "measurable reduction of disability and restoration" and the exclusion of services to "maintain a level of functioning." Severe and Persistent Mental Illness, such as schizophrenia, has a devastating effect on a person's whole life. One can not chop that life up into specific measurable goals, prescribe a specific intervention, in a predetermined amount and expect to impact that life. The proposed Rule goes even further in the wrong direction by disallowing most of the elements of that life as billable under Medicaid. In fact, I'm hard pressed to even think of an intervention that could not be interpreted as being vocational, prevocational, educational, social or recreational. Even "Housing" is listed, which may be interpreted as any intervention to support a person in living more independently. Then there are "services that are intrinsic elements of programs other than Medicaid" which are also disallowed. How can this be considered "Person Centered?"

I understand that CMS provides an example of what might appear to be a "social activity" which may in fact be addressing the rehabilitation goal of social skills development as identified in the rehabilitation plan. They go on to state that such an activity would need to be specifically related to an identified rehabilitative goal as documented in the rehabilitation plan with specific time-limited treatment goals and outcomes. Furthermore, the social activity would need to be provided by a qualified provider, be documented in the case record and meet all requirements of this proposed regulation. Can CMS not see the absurdity in this? How did CMS staff develop their

social skills without all of the above? Do they really think that a person with mental illness is so different from them as to require all of the above? Why would a Provider even attempt such billing, knowing that the goal must be time limited and the individual would often have no place to use the social skills developed upon goal attainment?

I am not trying to make the case that Medicaid should pay for playing Bingo. In fact, Adventure House backs social activities out of the program time billed to Medicaid. But, under the proposed Rule, Providers could bill Medicaid for Bingo, TV watching, horseback riding and practically anything else, as long as they met all the above requirements. CMS can not stop such abuse by increasing documentation requirements. Instead, CMS will further shift the focus on the requirements and the documentation and not on the clients, who would most likely exhibit good social skills if given the opportunity, or develop those skills (as most people have) by being provided with the opportunity to participate in a social setting.

Rehabilitation as it applies to adults with severe Mental Illness can not be seen as picking out a narrowly defined and measurable segment of a person's disability and then providing an intervention, in some kind of prescribed formula, which should be administered in calibrated dosages by qualified professionals to their ill patents. The rehabilitation services must be in some context that provides meaning and purpose. What good are measurable goals and allowable interventions to impact budgeting skills, when there is nothing in this world that the client can envision as worth budgeting for. Don't we understand that there is no reason to save to buy new clothes, when there is no place to go in them, or for a vacation, when there is no one with whom to go and nothing from which to take a vacation? Providing that context, that purpose, is the best way I have found to reduce the disabling effects of a major Mental Illness.

The proposed Regulations threaten our ability to provide a context within which real Rehabilitation happens. If CMS applied these regulations to persons who are not diagnosed with a Mental Illness, I truly believe they would become disabled. Their lives would be fragmented into measurable pieces. Large areas of their lives would be ignored because we are not able to identify measurable goals nor can we specify an anticipated outcome that would reasonably impact those areas. We <u>can</u> impact those areas! We do it every day with our friends, family and co-workers. We just can't document what we do to accomplish this under the requirements set forth in this proposed Rule change and to try would risk audit repercussions.

This objection to the proposed rule is IMPORTANT. In the Federal Register, CMS describes ball throwing as a billable service for a stroke victim needing to improve balance and coordination. There is an assumption here that the client has a life in which balance and coordination are needed and that this life includes activities that will sustain balance and coordination long after the professional intervention.

The same assumptions can not be made for an adult with a long term Mental Illness. Members have reported being in time limited programs where they hid improvement for fear of being discharged from the very service that helped them improve. They report

having no where to go upon discharge, nothing meaningful to do and no one with whom to share any goal attainment they may have made. They also fear the return of depressive and psychotic symptoms that they know may reoccur despite compliance with medications. The words "Recovery goals" appear to have been inserted into the proposed regulation, with no understanding of what that means. It appears to be just another documentation requirement to CMS. People rarely recover from severe Mental Illness. It is a biological illness with no known cure. The word "Recovery" as it applies to Mental Illness refers to the often life long struggle of an individual to recover their lives to the greatest extent possible despite the illness. To set recovery goals means to provide supports and services specifically listed as not covered under the proposed Medicaid rule. The exclusion of services that are "prevocational" is particularly troublesome, as many interventions and supports necessary for "recovery" fall within this realm.

CMS can not simply make a Rule and abandon the Medicaid eligible people with Mental Illness. We have discharged these people from institutions with promises of providing community based services that were nonexistent or grossly under funded. Now, the single largest funding source used to develop those services in the community is threatening to make a Rule change. It is inhumane and unethical to hide what CMS is doing behind the stated purpose of "rectifying the improper reliance on the Medicaid rehabilitation benefit" without identifying/developing an adequate and alternative funding source.

CMS has allowed or has looked the other way while states have utilized Medicaid funding to sustain and maintain the highest possible functional level for adults with severe Mental Illness. This MUST remain as an acceptable goal for delivering services under Medicaid.

Section 440.130(vii)(3)

In North Carolina, we know how CMS expects Providers to document progress towards goals in the rehabilitation plan. They expect a progress note for every encounter. CMS imposed a daily note requirement on Psychosocial Rehabilitation (PSR) programs last year, claiming that this was not new, but a long standing requirement that most states have failed to meet. They stated that they are now "cracking down on states to comply" and will expand this "crackdown" to other states as their State Plans are reviewed. CMS officials failed to explain how the state was at fault, when CMS has allowed monthly documentation for PSR services in North Carolina for over 17 years. Didn't CMS have to approve our State Plan?

I can not state this strongly enough. A progress note requirement for every encounter is an unnecessary and major burden, especially for services, like PSR, that are delivered to groups. This requirement has rendered our service record useless. The record can no longer be used to track the course of services being provided or for any clinical purpose due to the sheer volume of notes. Instead of producing 115 progress notes per month, Adventure House professional staff must now write over 2,000 notes per month, at a cost of $35,000 per year.

WE STRONGLY RECOMMEND that progress notes be required on a monthly basis, leaving it to the Provider to make more frequent notes in cases where that may be appropriate!!

Sincerely,
Ray Jeffords
Ray Jeffords
Concerned Citizen.

cc:
Mike Leavitt, U. S. Secretary of the Department of Human Services
Mike Easley, North Carolina Governor
U.S. Senator Richard Burr
U.S. Senator Elizabeth Dole
U.S. Representative Sue Myrick
U.S. Representative Patrick McHenry
Senator Nesbitt, Co-Chair of the N. C. Legislative Oversight Committee
Rep. Verla Insko, Co-Chair of the N. C. Legislative Oversight Committee
NC Rep. Debbie Clary
NC Rep. Tim Moore
Dempsey Benton, N.C, Secretary of the Department of Human Services
Mike Mosley, Director of the N.C. Division of Mental Health
Leza Wainwright, Deputy Director of the N.C. Division of Mental Health
William Lawrence, Jr., Director of the N.C. Division of Medical Assistance
Tara Larson, N.C. Division of Medical Assistance
Jo Perkins, N.C. Division of Vocational Rehabilitation
Carl Britton-Watkins, Chair of the N.C. Consumer Family Advisory Committee
Debra Dihoff, Director, NC-Alliance for the Mentally Ill
John Tote, Director, Mental Health Association of NC
Yvonne Copeland, NC Council of Community Programs
Tisha Gamboa, Director, N.C. Mental Health Consumer Organization
Joel Corcoran, Director, International Center for Clubhouse Development
Renee Gray, Director, Cleveland County Mental Health Association
Rhett Melton, Director of Pathways (LME)
Regina Moody, Chair Local Provider Association
Adventure House Board of Directors

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

286

To Whom It May Concern,

The Adventure house has help me in many ways such as giving me a place to belong and giving me a new set of friends. And second of all they have gave me transportation to my doctors and important Appointments that I needed to go to. They also have gave me a part-time job to help give some spending money in my pocket. They also have helped me with an appartment to live in. They also have me with my medication when I have needed. The Adventure house means alot to me [redacted] because I would loose alot [redacted] that I have worked for to accomplish. I don't know where I would be at if it wasn't for the Adventure House.

Jenny Ramsay
531 Charles Road Apt J
Shelby, NC 28152
704 484-7148

September 28, 2007

Elizabeth Ward
809 North Lafayette Street, Suite H
Cleveland Psychosocial Services, Inc.
Shelby, North Carolina 28150

Centers for Medicaid and Medicare
Department of Health and Human Services
Baltimore, MD 212244-8018

To Whom It May Concern,

My name is Elizabeth Ward and I work with Adventure House Community Support Services. I am writing this letter in reference to the recent and future budget cuts that are and ultimately will affect my job but most importantly the lives of the people we serve.

I work with a variety of individuals with persistent mental illness that rely on our services on a daily basis to care for a array of basic needs such as medications, medical, housing and financial concerns. At this time, I work with a 47 year old male that within the last year has been able to obtain stable housing, has been able to receive the necessary medical, mental health and medication attention through community service providers within our area and actively participate in managing his finances. However even though these accomplishments are monumental as a whole the person served has little to no family contact and continues to depend on the services and supports that are provided through our company. He continues to be troubled with ongoing substance abuse problems and has been hospitalized due to ongoing physical and mental health issues. As an active and long time member he attends PSR during the day for positive socialization which provides structure and is vital to his support system. The proposed budget cuts will also affect PSR and prove to be a huge injustice to not only him but others as well.

If you put these plans into affect the person(s) served that ultimately depends on Community Support Services and Psychosocial Rehab and other supports such as these will suffer a huge disadvantage. In essence it will be like closing the door on those that have worked so hard to open it to begin with.

Elizabeth Ward, Paraprofessional

Teresa W. Woods
827 Lincoln Drive
Shelby, North Carolina
28152

288

September 26, 2007

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

Dear Sir,

I writting to let you know what the Adventure House means in my life. A woman of 53 years with mental health problem. I've been a couple of programs but they don't help to deal with daily "Life". The Adventure House make my days more meaningful and not just setting around home with nothing to do or going 25 mile one way to set in a session and talk for 3 to 4 hours a day. Here I have the chance of being positive and productive, I don't feel as stressed when I can come to the Adventure House it has mean the world to me. It's my family away from home

Teresa Woods
A Adventure House Member

289

September 26, 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 recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am Submitting the following opinion.

I am hearing impaired, I live in an Adventure House Supported Living Apartment and I attend the (ABE) Adult Basic Education course offered at Adventure House. Though others may have thought this would have never been possible for me to live independently, and further my education, it was through the help of the Clubhouse. I am working on completing High School Education. We have 24hr on call support available to the apartment residents, if needed. The Clubhouse is like family, they have been very supportive during; this year will be twenty-two years that I have been attending the program. By not cutting the Medicaid benefits, will help enable Tommy Gunn, our Clubhouse Director, not to have to close the door here at Adventure House. The Medicaid is needed to continue with our rehabilitative services. The Clubhouse is important to me.

Sincerely,

Martha Winston

Martha Winston

290

Kimberly McDaniel
152 Phifer Circle
Kings Mountain, NC 28086
kimberlymcdaniel@carolina.rr.com

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

September 27, 2007

Reference: CMS-2261-P

To Whom It May Concern:

My name is Kimberly McDaniel, and I am an Associate Professional at Adventure House Community Support Services in Shelby, North Carolina. I am writing to you today in response to the proposed Medicaid Rule changes for the Rehabilitation Option. North Carolina's state Medicaid plan is included under this proposed option and if passed it will have a detrimental effect on the community support services and psychosocial rehabilitation services that are being offered to the people we serve. As I have read in the proposed changes you are looking at a $2.2 billion cut in services over five years. This is not a change that my company can handle. After the budget cut of March 2006 we are barely meeting our monthly budget as it stands. If there is another cut in funding our company will definitely go under. But the reason I do not want my company to fold is not one of not wanting to lose my job, but is that of not wanting our people-served to go without services.

Here at Adventure House Community Support we provide services to adults who have been diagnosed with chronic mental illnesses. We try to help them live productive, ordinary lives in there community just as you and I live. Without our services most all of our people served will not be able to achieve this goal. For example, there is one female who is 46 years-old who for most of her adult life has lived in group homes or assisted living facilities until our sister company Adventure House Psychosocial Rehabilitation was able to offer her, her own apartment with 24/7/365 supports. She now has a sense of self worth and independence. We at Community support services provided the supports necessary for her to continue to live in that apartment and on her own. She has a diagnosis of schizoaffective disorder. Her case manger also acts as her payee because she can not make good decisions about how to spend her money. Our company has many people we serve whose case manager also serves as there payee. We make sure that their basic needs like shelter, electricity, water, food, and clothing are met first. Then we make sure their secondary needs are met. We also provided this 46 year-old client with resources for mental and physical health needs. Such as, seeing her psychiatrist/therapist, family physician, making sure she has medications in a pill planner, and that she has the diabetic testing supplies she needs.

See she not only has many mental health issues, but she also has many medical problems like high blood pressure, high cholesterol, and diabetes, that unless we address them they would never be under control. We are also proud of the fact that this particular person served has not been in the hospital for almost two years. This person has no other supports because her family has disowned her because of her mental illness and refuse to offer support or help. On most days her depression is a result of her family making promises that they never keep. Promises that are simply just to call her or stop by to say hello, not promises of help or support. That is the way it is with most of the people we serve. They either have no family or the families they do have don't want anything to do with them because of the stigma that comes along with a mental illness.

You see, she has for most of her adult life been in and out of mental hospitals. We try everything within our power and resources to keep our people served from being admitted unless completely medically necessary. If you do make the $2.2 billion cut in our services over five years we will not be able to provide this person with the services she needs. I can tell you without a doubt what ultimately will happen to her and most all of our other people served is she will get her check every month and it will be spent on frivolous things instead of her basic needs. She will not longer have housing and will probably be on the streets. She will not keep up with the medications that are prescribed to her and will not continue to see her psychiatrist to get the prescriptions needed because of no transportation and lack of caring. She will be hallucinating, hearing voices, cycling between mania and depression, and will be put back into a state mental hospital until she is well. That is until the cycle starts over again with the lack of housing, medications, and doctors that we make sure are taken care of. I can tell you that community supports will close across states and hospitals, jails, and state facilities will fill up, in which will cost Medicaid more money in the long run.

This 46 year-old woman also takes advantage of the Adventure House Psychosocial Rehabilitation program. She calls it her "structure". Once when she could not get to her "structure" for a few days because of an physical illness; she had more signs of depression, anxiety, and thoughts of suicide. Once back into her "structure" she leveled back out and was able to socialize and be productive. If you implement the changes that are laid out in the Medicaid Rule changed for the Rehabilitation Option then Adventure House PSR will cease to exist.

Why is it that the people who need help the most are always the ones to suffer? Those people whom we serve have chronic mental illnesses. They are not going to go away. When someone has chronic pancreatitis or chronic bronchitis or any other chronic disease they are expected to battle the illness for the rest of their life, but when you speak of it in terms of mental illness people expect you to be able to pick your self up and move on. This is not real thinking. Ask any doctor no matter what the illness if it is chronic you will battle it all your life. Some days, months, and maybe even years will be better than others, but it is still there and the symptoms will come back! Take away the supports that these people with chronic mental illness have and there symptoms will become more prevalent and they will not know what to do for help.

I am asking that you reconsider the plan to cut $2.2 billion from this special population of people who have chronic mental illnesses who need supports because they either have no family or the one they do have has disowned them. If you do make the changes Psychosocial Rehabs across America will close, Community Supports across America will close, the homeless population will rise, the prison population will rise, substance abuse will rise (because they will self medicate), and mental hospitals every where will

fill up. If you think that Medicaid is paying out too much wait until the hospital bills start to roll in as the community supports start to roll out of business.

Regretfully yours,

Kimberly McDaniel
Adventure House Community Support Services
Associate Professional

Centers for Medicare & Medicaid Services 297
Department of Health & Human Services
Attn: CMS-2241-P
PO Box 8018 Baltimore, MD 21244-8018

Dear Sirs,

I have been a member at Adventus House for almost a year. I enjoy coming. Since I have been coming here I have been feeling better, learning different things. I have not been in the hospital since I have been here. Before coming to Adventus House I was hospitalized a couple of times a year. I do feel bad at times but I try to still make it in. If it's so bad I stay home. I thank the Adventus House so much.

Joyce Lopp

709 Douglas St
Shelby N.C. 28150

September 25, 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:

I would like to respond to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services. I would specifically like to give my opinion on Definition of Restorative Services: 440.130(d)(1)(vi).

First off, my name is Genia Patterson and I work as a Rehabilitation Specialist for Adventure House, a Clubhouse model Psychosocial Rehabilitation Program. We serve people in Cleveland County, North Carolina that suffer from mental illnesses. We are a certified Clubhouse and follow the ICCD standards. This model psychosocial program started in New York City in the 1950's. The model now successfully serves people with mental illnesses throughout the world. Clubhouse utilizes guaranteed rights such as: a place to come; meaningful relationships; meaningful work; and the guaranteed right to a place to return. Education, housing, and Transitional Employment are also offered to our members.

In reference to the Definition of Restorative Services: 440.130(d)(1)(vi), the definition includes appropriate rehabilitation services designed to maintain a current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, 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. Without the guaranteed rights of Clubhouse, our members would surely deteriorate. Many who are absent from Clubhouse for as little as a few days come back with stories of deterioration caused by isolation, no meaningful activities, and loss of support network (by staff and peers). Section 1901 of the statute

Jack Cook
Sept. 26, 2007

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD 212-8018

To whom it MAY Concern:

Adventure House has helped me out. Before the Adventure House I used to set at home all day with nothing to do. I was in and out of the hospital. My doctor told me to try this new program called Adventure House. I'm glad that I came because to try it out. I've been coming five days a week for a longtime. They have helped me to stay out of the hospital. I have not been to the hospital since. I found something to do and I have had any trouble since. My nerves im-proved and my medicines was reduced. I need medicaid so that I can Keep Coming to Adventure House as long as I am still on earth. I like the way it is. Don't stop paying for

me to come because it gets me out of the house and I get to meet new people and make new friends. Don't Stop our Psychosocial Program

Thank You

JACK COOK
235 Wes Cook Rd
CASAR, NC 28020

9-26-07

Centers for Medicaid & Medicare Services
Dept. Of Health & Human Services
Attn: CMS-2261-P
PO Box 8018
Baltimore, MD 21244-8018

Dear CMS:

I am writing to you concerning your proposed rule Changes concerning Medicaid funding for Rehabilitation Services.

I attend a Psychosocial Rehabilitation program (Adventure House). We are a clubhouse model program. We need Adventure House to stay open so that I can stay out of the mental hospitals. Adventure House has moved me into a apartment since I am now Stable on my medicines. I didn't have anything until I came to Adventure House. I also now have a Transitional Employment job I've made a lot of friends. They make sure I get to my doctors appointments. I attend 5 days a week and I cook breakfast in the snack bar unit and I also serve in Kitchen unit. Please don't stop our funding. I would have no place to go and would lose my apartment. I would not be able to ride the public transportation van

I love Adventure House. We need our funding to stay out of Institutions.

Sincerely:

Donald Davis
833 Charles Rd.
Apt. A-1
Shelby, NC 28150

296

Willie M. Abram
P.O. Box 431, Heinz Drive
Earl, NC 28038

September 27, 2007

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

To Whom It May Concern:

I am writing to advocate against the recent proposed rule requirements surrounding Rehabilitation Services.

I am a Rehabilitation Specialist at the Shelby, NC Adventure House. I have personally witnessed the success stories from utilizing the benefits under consideration for this imposed change.

The proposed changes will drastically change the quality of life of those with Mental Illness that currently utilize these funds. Here at the Adventure House we offer rehabilitative services that have documented positive effects on members' mental abilities affording them the opportunity to unite appropriately within our communities.

It is my fear, without this funding, we will face severe consequences. The cost of a change of this nature will eliminate their support system potentially reverting them back to the revolving hospitalizations and or increasing our crime rate due to the elimination of their support structure.

I ask that you reconsider this proposal and do not eliminate the Medicaid funding on behalf of the members of the Shelby, NC Adventure House and all others suffering with the Mental Health disease.

Thank you,

Willie M. Abram

Willie M. Abram
Rehabilitation Specialist