Submitter : **Date: 08/22/2007**

Organization :

Category : **Local Government**

Issue Areas/Comments

Background

Background

Please do not cut the administrative claims for schools. These funds are essential to the lea finances

Submitter : **Mr. Chris Campilii** **Date: 08/22/2007**

Organization : **Center for Physical therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

I have extensive experience and very unfortunate situations regarding the loop hole in Stark laws. I am private owner of a Physical Therapy Center and have seen first hand the abuse of MD's referring to their own site.
Case one - A father -in-law of one of the physical therapist who works for us was told by his MD that he is not allowed to go anywhere but their own PT.
#2 A police officer begged to come to our facility. When he was persistent enough, the MD threw the referral at him.
#3 The MD's now walk the patient down to their own clinic with script in hand and schedule them tight there. The patient is not allowed to touch the script or go elsewhere.
#4 I personally asked the MD's if their therapists were doing a good job. Their response was "we don't know our PT's". Meanwhile I have 10-20 documented cases of patients who were told by the MD that they would check in on them.
#5 All the MD's would not send us patients for pre op physical therapy x 12 years. Now they send all their patients to pre surgical PT.
#6 The PTs see 8-10 patients per hour. No private clinic sees more than 3-4 / hour.

There is so much abuse because the MD's are so powerful. I could go on forever about the abuse, but it is just negative energy spent. I'm usually too busy to fight them, but these cases are examples of the biggest abuse of the Stark Law. I appeal to please rid MD's of their loop hole and return physical therapy to the physical therapists.

Thanks,

chris

Submitter :

Date: 08/22/2007

Organization :

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

please allow athletic trainers a place in physical rehabilitation. This profession as much to offer individuals of all ages, especially in the area of fitness and injury prevention. Health care costs less if there are healthier bodies and less to fix! Athletic trainers are healthcare providers and their serviees deserve reimbursement just the same as PTs and OTs.

Submitter : **Mrs. Amina Donna Kruck** **Date: 08/22/2007**

Organization : **Arizona Bridge to Independent Living**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

I want to comment on therapies only being covered by CMS if they restore functioning. Therapies should be covered for maintaining functioning to be in alignment with President Bush's New freedom Initiative, the Olmstead Supreme Court Decision and the Independent Living philosophy. For some disabiloties or medical conditions, periodic ongoing therapy is needed to maintain optimal functioning on an ongoing basis so the individual can function as independently as possible, potentially saving health care dollars for long term care services (attendant care, HCBS vs. nursing home), and federal cash benefits as a result be being able to maintain employment.

Submitter : **Mr. Jonathan Schauss** **Date: 08/23/2007**

Organization : **Therapeutic Concepts**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

8-22-07

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8018
Baltimorc, MD 21244-8018.
Rc: Physician Office PT/OT Services

Dear Mr. Weems;

I am writing this letter to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality physical and occupational therapy in the greater Cleveland area.

The in-office ancillary services exception has created a loophole which has resulted in many physician-owned arrangements & management agreements with larger national therapy providers that provide substandard physical and occupational services.

Physicians are in a position to refer Medicare beneficiaries to in-office physical and occupational services in which they have a financial interest. There is an inherent financial incentive to over utilize services under the in-office ancillary services exception.

Thcrapy treatments are repetitive in nature. Patients receiving outpatient physical and occupational therapy can just as easily return to a therapy clinic as to the physician office. Many patients have complained to me that the doctor s office therapy center was so busy they never saw the same therapist more than twice or I always saw someone different and they didn t know what exercises I was supposed to be doing . These are just a couple of complaints that we have heard with the largc incrcases in volume seen at physician offices, especially large orthopedic groups in our area. There is definitely a conflict of interest here on who is appropriate for in-office ancillary services and over utilization affecting small business PT/OT services statewide.

Thank you for considering these comments and eliminating this in-office ancillary services .

Sincerely,

Jonathan Schauss, MBA, PT, CSCS
Therapeutic Concepts

Submitter : **Kathy Scott** **Date: 08/23/2007**

Organization : **Resurgens Orthopaedics**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Patients should have the right to choose who provides this rehabilitation service, there is a benefit of competition in regard to cost, in house therapy provides the patient better outcomes with physicians closely follow their patients,

Submitter : Mrs. **Date: 08/24/2007**

Organization : Mrs.

Category : Physical Therapist

Issue Areas/Comments

Background

Background

Concern that there are some chiropractic services that are reimbursed against subscribers' physical therapy benefit.

GENERAL

GENERAL

I would like for CMS to close the loophole in the Stark physician self-referral law and protect physical therapy services as Congress originally intended. I would like for CMS to remove physical therapy frm the "in-office ancillary services" exeption to the federal physician self-referral laws.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

In the proposed rule for the 2008 Medicare physician fee schedule, CMS expressed concern that the in-office ancillary services exception to the Stark law is being "misconstrued" and created " a thriving environment for fraud and abuse," The agency said it received "hundreds of letters from physical therapists" warning of this situation and now seeks comments on "whether certain services should be included in the in-office ancillary services exception.

Submitter : Mrs. VJ R **Date:** 08/24/2007

Organization : autismnet.com

Category : Long-term Care

Issue Areas/Comments

Background

Background

LTC solutions for rehab cases of DDs of all kinds.

Avoiding placements outside of home for people who are afflicted w Autistic disorder or ASDs, MR, MI and other DDs like CP, Downs syndrome, etc.

10 hours of LTC care per day is proposed for each adult w a known Life long disability, regardless of severity. 1-10 hours is the choice and parent caregivers chose the hours to povide care, either in thier homes or outside thier homes but in a DAY PRGORAM only. No overnight or 24/7 programs for anyone.

Collections of Information Requirements

Collections of Information Requirements

People with Autistic disorder and certain other Developmental disabilities require LONG TERM CARE.

Sticking the families w minimal amount of hours in respite care or in-home support is not a LTC solution.

Parents/caregivers get older and they are at risk for LTC to care themselves, before they can care for thier adult children w DDs.

in IL state, kids w DDs, stay in special ed only till age 21 yrs. After that their parents quit their jobs to stay home to care for them. Which means, the State of IL, loses its revenue and parents often become sick or ill themselves from caregiving burnt out syndrome.

10 hours of support per day is a must, to reduce 24/7 care in a residential facility. All parents who have kids w disabilities must be able to avail or access a HCBS care after HS for thier children, regardless of the severity of thier disability. Some may require only 2 hours, while some others may need 6 hours a day, yet some other parents like myself will need 10 hours a day out of home in a day program, so that LTC occurs in a natural setting, which is both inclusive and integrative in nature and cost efficient.

GENERAL

GENERAL

CMS-2261-P - Rehabilitation Services: State Plan Option~Must address issues related to LTC for people w Developmental disabilities.

LTC must be provided starting from age 18 yrs. 10 hours of In-Home support per day or 10 hours of out of home support in a community DAY Program per day for each person w Autistie Disorder is a must.

Thank you for taking this notes from me. I speak on behalf of all people w all kinds of long term or life long Developmental disabilities.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The State of IL will collect 10% of Gross pay from all paychecks first.

use that money as "premiums" to create short term and Long term health care and related services for all people. For those who require LTC (disabled and elderly care), there will be two major options.

In-home care for 10 hours a day
or
Out of home care in a day program for 10 hours a day.

Some may require less hours than others.

BUT all those who need LTC, pay 10% for each hour service that they buy. The total charges are processed using one screen w a formula
which is 50% by insurance company, 40% by State of IL-DHS/ODD/DPA, etc
10% of remaining charges paid by consumer as OUT OF POCKET for the services that they purchase.

For medically fragile, the care will be at a nearby hospital holding (ER) or non-ER facility rooms for upto 70 hours, within which hours, they need to come up w a plan of treatment for each person who goes there.

For those who can not be moved out of bed, LTC will be home based only. A written plan of all activities per each 15 mts is required.
Which means there will be 10 hours Xevery 15 mts showing detailed structured plan of scheduled activities needed in LTC scheme or plan of events for each

consumer under care.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Evalutaion questionaires may be required to be filled out by families about the services that they receive in a 10 hours of in-home or out ofhome 10 hours in a Day Prgoram for LTC.

Each level of care will require explanations thru activity schedule or routines for each consumer or client that is being served under LTC plan. Reiumbursements are adjusted accordingly for each level of care received per hour.

10 hours is equal to one shift for workers. Training and educational backgrounds are also considered, when chosing workers for In-HOME LTC support or out of home in a DAY PROGRAM support for 10 hours maximum in a day. No overnight staff is allowed. Clients must retain guardianship and only in extreme situations, the consumer w a disability becomes a ward of the state.

If a parent/caregiver is unable to care for an adult over 18 yrs w a disability, they must provide 10% of thier total assets (whatever they have) when they hand over the disabled to the state as a ward.

All services must be covered and each adult who has a pay check will pay 10% of the gross income before taxes towards Premiums. For children under age 18 yrs, each parent will pay 2.5% from gross income towards premiums. Even Bill Gates will pay $4Billions in premiums, which of course will be useful for State of IL, if he lived here to provide care for all those who can't work for some reasons.

50:40:10%= All charges are processed using only one screen. Govt of IL may contract w various insurance companies that those employers chose rather than using bidding as in private contracts in a political way.

For those who are unemployed and under employed or poverty level groups, Faith Based Services thru thier churches come into picture to pick up Premiums and or 10% of out of pocket for the total chages incurred by those who need them. Elderly care is also imposed upon churches and faith based sectors, as they are tax excmpted already and they get a chance to show their real compassion thru charity of paying people's bills, when needed by them.

10% of all people will require LTC at some time or other for sure.
That is my rough estimate here.

Regulatory Impact Analysis

Regulatory Impact Analysis

I have not seen any responses so far for this topic. Please post some soon.

Response to Comments

Response to Comments

LTC must be part of SHort term Health care for all people in IL state. The regulatory commission may look into this option and analyze its importance and reliability. IT is the most practical way to make sure everyone is covered for LTC, regardless of severity of disability or age or condition or it gives an opportunity to simplify a very complex delivery system of services for all those need them.

Only one screen, all services covered. Parents get break, disabled gets services daily after HS time. This service is customized, as individual needs vary and people empower themselves to purchase what they need and manage it effectively.

any questions? Please post.

Submitter : **Dr. Alexander Hellinger** **Date: 08/26/2007**

Organization : **Hellinger Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

HELLINGER PHYSICAL THERAPY
88-01 Shore Road Apt 4FE
Brooklyn, NY 11209

August 25, 2007

Center for Medicare and Medicaid Services

To whom it may concern,

I have been made aware of the fact that in the proposed rule for the 2008 Medicare physician fee schedule, CMS expressed concern that the in office ancillary services exception to the Stark law is being misconstrued and has created a thriving environment for fraud and abuse. I would strongly agree with all these concerns mentioned. It is no secret that there is a loophole in the stark law which is allowing physicians to abuse the in office ancillary services exception to this law. The Stark physician self-referral law was originally written by Congress to protect the Physical Therapy profession and sadly it is not being followed as intended by eertain physicians.

I know of many thriving Physical Therapy (PT) practices that have had to sell out to physicians or close down all together. Physicians threaten private owned practices by letting them know that if they do not sell their practice to them; they will simply open up across the street and refer all of their patients to their own PT practice in their office. This practice has been going on for some time here in NY and it needs to stop.

Physical Therapists are struggling these days with rising costs and diminishing reimbursements. Not allowing physicians to find loopholes in our laws will definitely help. Our profession is so important in returning patients back to their prior level of functioning after injury or surgery and maintaining function where debilitating disease is present. Our services truly help the public and reduce cost on the healthcare system by reducing the need for expensive surgery and long term care housing not to mention numerous other benefits and health care savings. I believe that when therapists are working in physician s office, it creates a conflict of interest. Also just look to the OIG report concerning this issue to see a detailed list of Fraud that takes place in these types of settings.

I have plenty more to say concerning my profession and some of the problems concerning our current laws if anyone would like to listen. In my opinion Physical Therapists should have complete direct access to patients with the ability to order X-Rays, MRIs and DME equipment since the musculoskeletal system and function/movement are our areas of specialty. We should also be reimbursed by CMS for prevention/health and wellness treatments in the elderly. This Country would realize huge national savings with respect to healthcare.

Please contact me if there is anything that I can assist you with.

Respectfully,

Alex Hellinger, PT, DPT
Phone: (718) 833-1766
Fax: (718) 833-1766

Submitter : **Dr. Alexander Hellinger**

Date: 08/26/2007

Organization : **Hellinger Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

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Please contact me if there is anything that I can assist you with.

Respectfully,

Alex Hellinger, PT, DPT
Phone: (718) 833-1766
Fax: (718) 833-1766

Submitter : **Date: 08/27/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

Physician referral to a facility in which he or she has a financial interest is a conflict of interest and is unfair to the patient with regards to lack of choice and possibily not receiving the best or most appropriate care. The Stark rule needs to be addressed.

Submitter : **Ms. Diane Grieder** **Date: 08/27/2007**

Organization : **AliPar, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

The creation of a written rehabilitation plan, with the specificity as described in the proposed rule, should add clarity for behavioral healh field practitioners. There is much confusion about the requirements of the written plan and it now varies from state to state. Having this new rule in place, requiring a person-centered planning process, with person-driven, rehabilitation goals, makes sense, follows best practices as we know them today, helps individuals improve their status and move along in their recovery, and supports the work that practioners are trying to do. Hopefully, auditors from the OIG will also understand and support these new regulations. Thank you, Diane Grieder, M.Ed., AliPar, Inc

Submitter : **Ms. Linda Zoller-McKibbin** **Date: 08/27/2007**

Organization : **Alice Peck Day Hospital**

Category : **Critical Access Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I currently work at Alice Peck Day Hospital in Lebanon, NH. We are a 14 bed Critical Access Hospital with a 50 bed extended care facility. We have been short staffed 2-3 physical therapist for 4 years. It is getting more difficult to meet the demands of our patients with this chronic staffing issue. I am an Athletic trainer and a physical therapy assistant and use my athletic training skills with almost every patient that I treal. there are som many skills that over lap with both of my professions.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in CM-2261-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

XXXXXX, ATC (and/or other credentials)

Submitter : **Mr. Ron Forsythe** **Date: 08/28/2007**

Organization : **Baptist Health Systems**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

By excluding Certified Athletic Trainers from the list of providers in this document, you are rejecting years of hard work and outstanding service turned in by thousands of ATC's around the country. Certified athletic trainers are more than qualified to give quality rehabilitation services. In many cases ATC's are more qualified than the providers on this list. I believe the certification requirements of the NATABOC should be taken into consideration in regard to the exclusion of ATC's on this document. If the right to treat and care continues to be taken away from ATC's, the profession will suffer in numbers. If this happens, the high schools, colleges and clinics that need the services of ATC's will be the ones suffering.

CMS-2261-P-29

Submitter : **Mr. Scott Hopkins** **Date: 08/30/2007**

Organization : **North Central Orthopedics**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

CMS-2261-P-29-Attach-1.DOC

CMS-2261-P-29-Attach-2.TXT

#29

To: CMS
Re: PT/OT in-office self referral rules by physicians
Date 08/24/07

To Whom It May Concern,

This letter is in response to a troubling article that I recently read in the *Bones Society Legislative & regulatory Update* for August of 2007. In the article it states that CMS was considering restricting the ability of PT/OTs to work in a physician owned facility.

I have been a PT in the outpatient orthopedic setting for eight years. I have had the opportunity to work in both a hospital-based and physician owned outpatient setting.
In my experience, my patients have received a higher level of care in the physician owned clinic. There are several reasons that have led me to this conclusion.

With the physicians in the office throughout the day I have immediate access to them. When there is a change in the patient's status, I am able to confer with the referring physician, and make changes to the plan of care. The immediate access to the physician is a benefit to the patient. While employed at a hospital-based program, I typically would have to call and leave a message with the physician's office and wait. If it happened to be a non-office day for the physician, the patient would have to wait several days for the appropriate changes to be made.

There have also been emergent situations that have been managed promptly in the physician owned practice. For example: patient's that have developed post-op infections, have fallen over the weekend and had additional injuries, and have developed deep venous thrombus. All of these situations were able to be managed with much more quickly.

As an allied health professional, I see my role as an ancillary extension of the physician's treatment plan for their patient. I feel I have grown as a therapist by learning from the physicians. I have been able to learn more about the surgical techniques, differential diagnosis tools, and diagnostic imaging than at other jobs.

If the current regulations are made more restrictive the patients will be penalized along with the physicians and the therapists.

Sincerely,

Scott Hopkins, P.T.

Submitter : **Mrs. Carrie Bloss** **Date: 08/30/2007**

Organization : **North Central Orthopedics**

Category : **Occupational Therapist**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-30-Attach-1.DOC

#30

To: CMS
Re: Stark self-referral rule (Phase II)
Date: 8/27/07

To Whom It May Concern,

I am writing this letter to express my concern regarding proposed restrictions to orthopaedic practices with in-office ancillary OT/ PT services. I am an OT with 6 years of experience working part –time in both a hospital-based facility & physician-owned orthopaedic rehab clinic. This has given me a unique perspective on the differences in quality of care between these two environments. This difference can be summed up in one simple phrase - ***CONTINUUM OF CARE.***

It is my understanding that CMS places high value on the quality ***CONTINUUM OF CARE*** that each beneficiary receives. If fact, in May of 2005, the CMS Administrator formed a Policy Council for Post-Acute Care Reform. The CMS Policy Council included the following principles to guide beneficiary care reform....

> "- Providing a seamless ***CONTINUUM OF CARE*** for beneficiaries through improved coordination of acute care, post-acute care and long-term services, including better management of transitions between care settings.
>
> "-Increasing consumer choice and control of PAC services by Medicare beneficiaries, their family members and caregivers."
>
> "Providing high-quality PAC services in the most appropriate setting based upon the patient needs... "

In addition, the CMS' Vision for Post-Acute Care in the 21st Century states, "A more beneficiary-centered system of post-acute care services has the potential to improve quality of care and ***CONTINUITY OF CARE*** in a cost efficient way."

Should these principles and vision not also stand true for post-acute orthopaedic care?

The patients I serve at the physician –owned rehab clinic are provided a seamless ***CONTINUUM OF CARE.*** This environment enables the best communication between physicians, therapists, nursing, patients & their families to coordinate the best quality care for your beneficiaries.

For example, the physicians will often call on me to make a specific, customized splint for patients with healing fractures or tendon repairs. This service is needed at the time of the office visit in order to assist the physician in the patient's treatment. I am able to have face to face communication with the physician to make sure we are in agreement with the treatment plan. In other offices, this communication may take 2-3 days and even then, is often miss-communicated. The gap in care continuity that occurs between the physician's office and independent or hospital-based rehab clinics can create a detrimental effect on the patients overall quality of care.

In addition, at the physician-owned rehab clinic, I have the opportunity to call on the doctors at any time for consultation regarding any change in the patient's status. If my patient has symptoms of infection, excessive pain, or medication questions, I am able to consult with the patient's doctor or nurse instantly. In other facilities, I may need to refer the patient to another doctor on call or the patient may need to wait several days to receive the care they need. As an OT at the physician's office, I have also had an excellent opportunity to learn more from the physicians regarding surgical procedures, clinical reasoning and treatment protocols. At other facilities, therapists must rely only on textbooks and patients to learn these skills. In short, the physician-owned rehab facilities provide the best ***CONTINUUM OF CARE*** envisioned by the CMS Policy Council.

In accordance to the next principle set by the CMS Policy Council, physician-owned outpatient rehab should be an option for each beneficiary. It is understood that patients should always be given an option of where they will have their rehabilitation. However, in 21st century healthcare, patients are more informed than ever before regarding their choices for healthcare. If we envision a beneficiary-centered healthcare system, we must also give them a choice to have their rehab at a clinic where the physician's are on-site and the therapists have one on one communication with the physicians. Beneficiaries should be able to choose this type of excellent care.

The CMS Policy Council also aims to provide high quality services in the most appropriate setting based on the patient's needs. In a physician-owned rehabilitation clinic, the OTs/ PTs have the most appropriate skills and experience to treat specific orthopaedic diagnoses. In other clinics, therapists often rotate from in-patient care, neurological, cancer, and general de-conditioning patient treatments. The skills of these therapists are more general and cannot compare to the specialized orthopaedic skills of the specifically - orthopedic therapists. When patients attend therapy at the physician-owned rehab facility, they are getting the highest quality of service that is most appropriate based on their specific needs.

In conclusion, OT/ PT services at physician-owned, on-site rehabilitation clinics have a unique opportunity to provide the best ***CONTINUITY OF CARE*** and most appropriate, specialized care for a beneficiary-centered healthcare system. It is my request that CMS should consider how the OT/ PT services provided at physician-owned practices best embody the principles already determined by the CMS Policy Council. It would be a dis-service to your beneficiaries to remove this from their healthcare options.

Thank you for your consideration to continue your provisions for beneficiaries who chose to receive their therapy services at physician-owned practices.

Sincerely,

Carrie Bloss
MS, O.T.R., CLT

*Quotations from Policy council Document, September 28, 2006, Post-Acute Care Reform Plan

Submitter : **Mr. Antony Young** **Date: 08/30/2007**

Organization : **A.P.T.A.**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

THE STARK ACT

I graduated from Physiotherapy School in New Zealand in 1949 and immediately came to this country December 1949.
My first positions under supervision were in Washington D.C.at the George Washington Hospital 1950. In 1951-54 I was employed at the Anderson Orthopedic Hospital and the University Hospital in Charlottesville Va.
On February 4th 1954 I was asked to open a Physical Therapy Department at the Lynchburg General Hospital having successfully completing my period of supervision as required by the A.P.T.A., a position I held for 33 Years before going into private practice.
The first 2-3 years were extremely difficult having to almost go down on bended knees to obtain a referral especially from the orthopedists who felt I was an intruder into their profession, since, they had been doing it their way long before I came along.
After world war 11. the population and medical graduates and practices exploded and each group was looking for a way to increase income and improve lives and style of living. No longer was the country doctor and house calls the image of medicine.
Group practices were formed and integration of ancillary service became the norm including in-house pharmacies, labs, Physical and Ot Therapies just to mention a few. There was another incentive to group practice and that was the creation of increased payment by Medicare and private insurance.
Lost in all of these changes and which rapidly became apparent was the abuse of patients rights of choice and decision. This produced the Stark Referral Act of 1993.
This Act Provided
1. Physician cannot refer Medicare or Medicaid patients to an entity providing designated health services if the physician has a financial relationship with the entity.
2. An entity cannot bill Medicare or Medicaid for services provided pursuant to an illegal referral.
There are still loop-holes and the most flagrant one is office within an office Physical Therapy
It was realized that physical therapy was a viable and lucrative profession as well as being an extremely important ancillary service to the orthopedic and medical professions as a whole, for Rehab in improving medical treatments for all types of ailments in the medical field from infants to the elderly Thus prompting some physicians to expand their income possibilities in spite of the Stark Act.
Thus began the employment of enough Physical Therapist to set up an office within an office because of a loop-hole in the Stark Referral Program consequently contributing to abuse the system by overcharging and overuse, the hidden agenda was to cover their increasing mal-practice expenses This NOT how the majority of Physicians have behaved. It is the few who have taken advantage of this loop-hole.
I have been a very proud and dedicated Physical Therapist 60 odd years and would like to see this very honourable profession along with other professionals including but not limiting OTs, nurse practitioners, optometrist just to mention a few, be freed from the yoke of this loop-hole that some physicians have abused and who will continue to abuse this Stark Referral Loophole for their own gains. Medicaid and Medicare plus private insurances have been plundered enough.

Antony A Young RPT (retired}
A.P.T.A. # 73293

Submitter : **Mr. John Painter** **Date: 08/31/2007**

Organization : **Mr. John Painter**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2261-P-32-Attach-1.RTF

#32

JohnPaintercommentsMCS-2261-P

John L. Painter, MS CPRP
765 College Street
Lewiston, ME 04240
(207) 777-7482
paintervecsey@roadrunner.com

CMS, DHHS
Attention CMS-2261-P
7500 Security Blvd,
Baltimore, MD 21244-1850

Re: Mediacid Program: Coverage for Rehabilitative Services CMS-2261- P

August, 31 2007

Please accept the following comments I make after review of the CMS proposed rule (noted above) in Federal Register Vol. 72 No 155 / Monday, August 13, 2007 pp. 45201 - 45213.

I applaud the CMS proposed inclusion of language to the CFR such as "person centered" and "rehabilitation plan would include recovery goals" as significant for means to a process allowing the amelioration of mental illness, and in so doing, also paints a more clinically realistic and hopeful message that "recovery from mental illness" is the expectation not the exception of this great nation.

However I must comment and suggest for consideration, amending the following:

Proposed definition § 440.130(d)(1)(iii)

1) "individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories"

to

"individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other rehabilitative benefit categories"

I propose this as a further qualifier that "rehabilitation" is distinct from habilitation.

Submitter : **Mr. Dan Cady**

Date: 08/31/2007

Organization : **HealthQuest Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-33-Attach-1.DOC

#33

Date: August 31, 2007
Re: In-Office Ancillary Services Exception
Abolish the Stark Referral Loophole
Submitter: Dan Cady
Category: Physical Therapist

As a physical therapist I care about patients and have a vested interest in their rehabilitative outcome; personally, professionally and financially. We treat patients in our practice primarily by word of mouth referrals- friends and family of current or former patients. Our physician referrals have continued to decline over the years as more and more physicians steer/force patients into their own privately owned facilities with the false promise of superior physical therapy services.

My primary concern is with providing appropriate patient care and with the survival of my current business. The original provision was mandated to avoid the inherent risk of physicians profiting from referrals. This seemed to work until the exceptions were put in place for various services, including physical therapy. I can only speak to *this* exception because of my direct and personal experience. By allowing physicians to refer and bill patients and their carriers for physical therapy treatment in their (physician-owned) facilities, the ground has been laid for fraud, abuse and inadequate patient care. As a provider of these services, I and every one of my partners and employees have encountered the drawbacks and consequences of this exception. This has propagated into an arena of over-utilized, over-charged services and an inexcusable level of patient care.

A study conducted in 1992 by the New England Journal of Medicine found POPTS generated more charges and higher utilization than independent rehabilitation facilities. In addition, elevated costs were associated with physical therapy care under the CA workers compensation program in POPTS. Another revealing study established that physicians initiated physical therapy 2.3 times more often when referring in-house than before they opened their own PT facilities. Suddenly their patients' need for therapy more than doubled!? The financial incentive behind this overwhelming increase seems obvious.

I know we provide every patient that walks through our doors with the best quality care, state of the art equipment and an environment that encourages proactive healing and education. I also know, based on feedback from patients and the aforementioned statistics, this level of care is not provided in POPTS. After all, what is their motivation? Care is often compromised and over prescribed. Regardless of rehab results and/or patient satisfaction of services, a physician has the luxury of a never-ending built-in referral base, their own patients. Herein lies, yet another, conflict of interest. In 1991, Florida Health Care Costs Containment Board found both licensed and non-licensed therapy workers spent less time with each patient in POPTS, resulting in reduced levels of care for all patients. I have personally spoken to patients who tell me they only saw a physical therapist once or twice, usually working with a trainer or aide throughout treatment (at POPTS facilities). One area Orthopedic surgeon makes us jump through every possible hoop to service patients with a valid prescription and basically bullies them to go to his facility- sometimes forcing unwilling patients to drive almost an hour for appointments.

Our profession will survive these setbacks, but what happens to the patients stuck in the middle? Patients who truly trust their physicians to make altruistic recommendations about their health care; Patients who believe the choice is not really theirs to make; Patients who are often unaware their physicians financially benefit from their physical therapy care; Patients who trust their insurance carriers and government to protect them from conflicts of interest. That is my concern.

I do hope these points and other related studies will be taken into consideration when making the final decision about the application of this exception to physical therapy services. I want to restate the real victims in all of this, the patients. In order to provide the best quality of care, the only option is to remove the temptation. If it does not exist, there is no temptation to sneak it and no opportunity to abuse it.

Thank you,

Daniel Cady MPT, OCS, CSCS

Submitter : **Mrs. Carol Langley** **Date: 09/01/2007**

Organization : **Mrs. Carol Langley**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Atn: I am very concerned about the closing of the Piedmont Pioneer House in Gastonia, NC. This clubhouse is a lifline to many with mental and physical issues. If, you could only know, my first cousin;who was born with celebral palsy; you would have a better understanding of the importance of a place like this. David is 47 years old; has completed through GED a high school education and also has gone on for a degree at Gaston College, in Dallas,NC David has played a role in tutoring other members at the clubhouse. Many social skillls as well as academic have been achieved through having a place like the Pioneer House as a lifline to be with those; you can relate and work with. Please everyone needs meaningful relationships and a social outlet. My cousin has parents that are very elderly and the clubhouse also gives them a feeling of support in their day in and day out of caring for a handicapped son. Knowing someone, one on one as I do; who benefits so much in having this clubhouse; I would think, one may not understand the anxiety felted by those who love these people so. Please do not close the Piedmont Pioneer House doors. That is the only life outside the doors of these peoples home. Please don't take that interaction and support away from the handicapped but also their families.

Thank You,
Mrs. Carol Y. Langley

Submitter : **Mrs. Michelle Martin** **Date: 09/05/2007**

Organization : **North Central Orthopedics**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2261-P-35-Attach-1.DOC

#35

August 29, 2007

To CMS:

This letter is in response to the article in the August 2007 issue of *BONES* regarding CMS considering tightening PT/OT in-office self-referral rules.
I am a practicing physical therapist with 8+years of experience and have been employed in home health, long term care, transitional care, and several outpatient therapy clinics. I have been with my current employer, an orthopedic physician group, for almost 3 years.

Out of all the different therapy settings I have worked in, my current employer, which would be considered a physician-owned practice, is the most consistent and expedient in providing the patient with a high quality continuum of care. In this setting, the patient gets a more timely response in regards to questions for the physician related to patient's therapy, as well as other issues. Any concerns the patient or therapist may have regarding patients care are answered quickly as we are in the same building as the physician. This may include prescription questions or refill requests, questions regarding surgery or post-op instructions/precautions that may be unique to the patient. The proximity of the physicians also allows for immediate access for the patient if any emergent care issue arises.

In my opinion, it is in the patient's best interest to receive therapy from such a setting. Any questions or concerns the patient has are addressed immediately, instead of several days later due to wasted time on the phone attempting to reach a physician and then waiting for a reply. In a physician owned practice, the answer to the question or concern is expedient and the patient and therapist can move on and progress towards patient's therapeutic goals.

If I were to receive therapy as a patient, I would choose an outpatient clinic such as the one at which I am employed. Being in the health care field, I understand the benefits and necessity of consistent and expedient care. An outpatient physician owned therapy practice is the best of both worlds.

Thank you for considering my input regarding this issue.

Michelle Martin, PT

Submitter : **Mr. Matthew Glogowski** **Date: 09/05/2007**

Organization : **Progressive Step Rehabilitation**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that thesc proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Matthew Glogowski, MBA, ATC, LAT

Submitter : Mr. Steven Kossor **Date:** 09/06/2007

Organization : The Institute for Behavior Change

Category : Other Practitioner

Issue Areas/Comments

Background

Background

Young children, including those with Autism and related disorders of development, almost always display some sort of development of social skills in infancy. When these skills fail to develop at an age-appropriate rate, developmental delay occurs. Children with such delays in Pennsylvania have been receiving tremendously helpful treatment via the EPSDT "Behavioral Health Rehabilitation" services covered in 440.130(d) and the delivery of such necessary, effective treatment services should not be obstructed by calling them "habilitative" when they are clearly "REhabilitative." These services are among the few that have a 10 year documented history of effectiveness that can be seen at www.ibc-pa.org/research1.htm As such they are "empirically validated practices" in the field of psychology and should be available to children who need them. With an epidemic of Autism spreading across the nation, this is not the time to withdraw help from children with autism -- especially help that has been proven to be successful!

Collections of Information Requirements

Collections of Information Requirements

I am a licensed psychologist and certified school psychologist with 30 years' experience in helping children with developmental delays, including autism. I have been supervising the delivery of "Behavioral Health Rehabilitation Services" (BHRS) in Pennsylvania since 1981 and was one of the first psychologists in this state to join the EPSDT provider network. I am alarmed that CMS-2261P will jeopardize the funding for BHRS when children have autism or other developmental delays because the BHRS treatment program will be misunderstood to be "habilitative" in nature, when it is actually "REhabilitative" (when it's done properly, of course). I am heartily in favor of the other provisions of CMS-2261P related to improving the professional oversight, record keeping and documentation requirements (recording treatment outcomes, etc) but the elimination of funding for BHRS would harm children by taking away one of the very few proven treatment modalities. When it is done correctly (supervised closely by licensed professionals, etc), BHRS is an extremely cost-effective treatment modality. See www.ibc-pa.org for more information about how I and my staff have implemented BHRS in Pennsylvania with tremendous success.

GENERAL

GENERAL

Additional information about how we have delivered Behavioral Health Rehabilitation Services (BHRS) to children in Pennsylvania under the EPSDT program can be found at www.ibc-pa.org We have achieved a tremendous level of success -- 86% to 93% in regard to treatment of children between the ages of 2 and 17 with aggression, socialization, communication, safety and compliance issues. More than half of these children had developmental delays of various kinds, and all responded well to our treatment programs. More than 90% of the children we've treated have completed their treatment program in less than 5 years. These results are unheard-of elsewhere in the psychological treatment literature. All because of Behavioral Health Rehabilitation Services delivered to these children via the EPSDT program under Medicaid.

CMS-2261-P-37-Attach-1.DOC

#37

The Network for Behavior Change, pc

Steven A. Kossor, Director Federal EIN: 23-2967070 phone or fax
848 West King's Highway Coatesville, PA 19320-1714 (610) 383-1432

There are no obstacles, only hurdles of varying heights. None is so great that it cannot be overcome, gotten around or gone under. Even mountains disintegrate with time.

Behavioral Health Rehabilitation (BHR) Services Summary

The Network for Behavior Change provides BHR Services to children (anyone under the age of 21) in their homes, schools and community under the supervision of licensed psychologists. These services include psychological testing, behavior treatment programs, psychological counseling and consultations with parents, medical doctors, teachers and others in the child's interest. We are allowed to deliver these services only if at least one parent (or guardian) is *actively* involved in the planning and delivery of the treatment program. If a parent is not actively participating in the treatment program, services must be stopped. Here is how we plan and deliver services. If you have any questions about this process, please call 610-383-1432 anytime. We will return your call as quickly as possible but certainly within 24 hours, or on Monday following a weekend. You can leave an emergency message and receive an *immediate* response by leaving your message at extension #40.

The written Treatment Plan that describes and governs a child's treatment program is always developed with input from the child, parent(s), teacher(s) and other adults who have roles in the child's life. The child's strengths, weaknesses, and treatment needs will be reviewed on an ongoing basis by a **Behavior Specialist** who will consult with parents (and others, if necessary) at least once weekly to gather data about the child's progress. A **Therapeutic Staff Support** (TSS) provider may be assigned to work directly with the child to implement the child's treatment plan on an intensive, one-to-one basis for several hours each week. A **Mobile Therapist** may meet with the child at home, in school, or elsewhere in the community to provide psychological counseling on one or more occasions each week. The Mobile Therapist and Behavior Specialist may also meet with the child's teachers, extended family members, or other adults who interact with the child, so that all adults in the child's life can "be on the same page" regarding the child's strengths, weaknesses and treatment needs. A licensed psychologist assumes full and complete responsibility for all services provided.

A new authorization for BHR Services must be re-approved every four months. Prior to each re-authorization request meeting, the parent/guardian (and teacher, if services are rendered in a school) will be asked to *carefully* review the psychological evaluation, treatment plan and plan of care -- to make sure that all of these documents contain accurate, up-to-date, and complete information about the child. Accurate and complete information makes it possible to obtain re-authorization of services from Managed Care Organizations (MCO) as efficiently as possible. Without an MCO authorization to continue delivering services, it is not possible to continue providing services.

BHR Service providers are required by law to make prompt reports of suspected child abuse or neglect to state authorities. If a child is suspected of being the victim of abuse or neglect, the BHR Service provider must make a report of this suspicion to state authorities. If this becomes necessary, the child's parent or guardian will be notified promptly that a report has been filed. Parents or guardians are invited to contact the Director of the Network for Behavior Change, Steven Kossor, at 610-383-1432 to discuss questions about this or any other aspect of the BHR Service treatment delivery process. BHR Services are delivered without charge to the children and families who receive them. Because public funds are used to provide these services, it is important that careful records are kept to document the dates, times and types of services rendered. Parents must take care to sign documentation for services only if those services *were actually delivered as written*. Our goal is to create two things in children and the adults who care for them: **hope** and **courage**. Hope that the future can be better, and the courage to do what is necessary to make it better. We will apply our resources conscientiously toward those two goals, and look forward to working together to accomplish them.

Behavior Specialist Name: ______________________ **Call 610-383-1432 anytime & ext. #** ______

Submitter : **Eric Herrmann** **Date: 09/09/2007**

Organization : **Eric Herrmann**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

In my understanding this proposed changes in the rulemaking will stop funding of Behavioral Health Rehabilitation Services ("wraparound") unless it's for RE-habilitation services. This is totally unacceptable as it leaves no help for future development for individuals with Autism and other mental deficiencies whou have not yet developed skills to be rehabilitated. The current guidelines under OBRA '89 permitted funding for "habilitation" services (teaching new skills to people who lack them) which should be maintained. With the massive expansion of Autism diagnosises nationwide we have a large growing population on individuals who with proper training and education can become productive members of society. Without this help society will find that they will become a burden needing group homes for their entire lives. I speak from experience as the parent of an autisic child. With current programs we are seeing him develop skills which would not be expected. With several years of continued training and education we forsee him not being a burden on society or himself but rather a productive, self sufficient individual which currently he is not. Several years of cost is far less than a lifetime of support. In addition, he is aware of his capabilities and thrives and celebrates his victories. He as well as all individuals with this malidy deserves the chance to continue developing his potential.

CMS-2261-P-39

Submitter : Dr. Patrick Minges

Date: 09/09/2007

Organization : Dr. Patrick Minges

Category : Individual

Issue Areas/Comments

Background

Background

The proposed policy change in federal rules that would tighten Medicaid money for participants in the clubhouse model for psychosocial rehanbiliation. The more strict definition of psychosocial rehabilitation could exclude some services and shut down programs such as Piedmont Pioneer House.

Collections of Information Requirements

Collections of Information Requirements

My brother is one of the participants in such a program. It has been a tremendous help to him. Any changes that would affect his eligibility or deleteriously affect a program such as this would be terribly destructive to his welfare and the welfare of others. In the long run, the coverages for other services would have to be picked up for many of these clients and would ultimately cost the state more money. It is neither a moral or practical. solution to put through these changes. I will be contacting my representatives and encouraging them to defeat any potentially destructive changes to the policy.

Submitter : **Ms. Mary Jo Whitfield** **Date: 09/10/2007**

Organization : **JFCS Behavioral Health, LLC**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-40-Attach-1.DOC

Comments Regarding Medicaid Program Coverage for Rehabilitation Services

http://www.cms.hhs.gov/eRulemaking
file code CMS-2261-P

Please find my comments below regarding the proposed Medicaid Program Coverage for Rehabilitation Services.

Overview

In the preamble reference is made to the use of Medicaid funds to fund services that are included in foster care and in the Individuals with Disabilities Education Improvement Act. Please clarify when it is appropriate for Medicaid to pay for covered services identified on a child's individualized educational plan.

Intrinsic Element Standard

This is the most problematic section of the proposed rule on p. 66:

(1) The services are furnished through a non medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. Examples of services include but are not limited to the following:

> **Comment:**
>
> ***The proposed rule provides a few examples of services that are intrinsic to other programs but is silent on the criteria used to make the determination. It is necessary that the criteria used be made public as the current situation provides CMS and the Auditor General too much latitude in interpreting this standard, thereby putting the states and/or providers at risk over what services will qualify for Federal Financial Participation. It is also troubling that the list of included services in this section includes both prevocational services and packages of therapeutic foster care. Prevocational services are provided to help clients establish recovery goals. Their exclusion could actually inhibit the stated goal of helping individuals achieve recovery. Requiring therapeutic foster care to "unbundle" their services will result in driving up the "indirect cost" of providing this evidence based practice.***

Restorative Services

The proposed rule establishes a restorative standard for rehabilitation services as follows:

(vi) *"Restorative services"* means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past. For example, a person may not have needed to take public transportation in the past, but may have had the ability to do so prior to having the disability. Rehabilitation goals are often contingent on the

individual's maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services.

Comment: ***Further clarification of this rule is required. How will maintenance of therapeutic gains be addressed under this rule? It could be interpreted to mean that once a person with serious mental illness achieves their rehabilitation goals Medicaid funds may no longer be used to maintain their level of functioning. Is it the intent of CMS to withdraw the services requiring the client to decompensate in order to have said services reinstated?***

Requirement for a Written Rehabilitation Plan (p. 61-63)

The proposed rule describes the rehabilitation plan as follows:

"*"Rehabilitation plan"* means a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals. The plan is developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family, individual's authorized decision maker and/or of the individual's choosing in the development, review, and modification of the goals and services. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition. The plan must have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. The plan must be reasonable and based on the individual's condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individual's condition(s)."

Comment:

The regulation is silent on the relationship of the Rehabilitation Plan and the Treatment Plan. Is it the intent of CMS to require two separate plans or can the Treatment Plan and the Rehabilitation Plan be combined? Additionally, there are17 highly prescriptive elements required in the Rehabilitation Plan that must work together to demonstrate that the services provided are rehabilitative according to the new standard established in order to be Medicaid reimbursable. Requiring two separate plans will make coordination of care extremely difficult and create a barrier to clients receiving medically necessary services. There will be some recovery goals that will not be related to Medicaid reimbursable services. How will this be addressed by practitioners and agencies?

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

Comment:

This may signal an expectation that the rehabilitation planning will be a separate activity from the service provision. In many treatment and rehabilitation settings, the clinicians that provide the services are the same individuals who complete the plans. Forcing a separation will result in an unnecessary increase in the cost of delivery of the service. In addition, if the purpose is to ensure client choice this is an unwieldy and costly method of doing so.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

No comment.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

Comment:

This requirement would appear to parallel the requirement that treatment services be "medically necessary". Clarification is needed to further outline how this requirement would be met without becoming duplicative with the treatment requirements.

Limitation on State Payment Approaches (p. 66)

If a state provides rehabilitative services it must specify the methodology under which rehabilitation providers are paid.

Comment:

CMS in relation to the approval of State Plan Amendments has forced at least 6 states to change their case rate or other bundled approaches to paying for services in favor of billing for services in 15 minute increments. Please provide clarification on this requirement. Is the expectation that every 15 minutes of service will have corresponding documentation? If so, that will greatly increase the amount of provider time spent on paperwork at the expense of direct service provision and have the unintentional effect of driving up the cost of delivery the services.

Positive Aspects:

The explicit instruction regarding the treatment of substance abuse disorders as allowable under the Rehabilitation Services Option is very positive. The requirement that clients and families be active participants in the development and implementation of their treatment and rehabilitation is also very positive.

Additional Concerns:

The lack of integration between the treatment requirements and rehabilitation requirements could easily result in an unintended consequence of duplication of effort in the planning, execution and documentation of treatment and rehabilitation services.

Submitter : Carol Ciliberti **Date:** 09/10/2007

Organization : Carol Ciliberti

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The increase of diagnoses of Autism Spectrum Disorder demands these services been available to individuals in PA.

Submitter : **Mr. wayne williams** **Date: 09/11/2007**

Organization : **sacks, trotta, koppelman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Francisco Roman** **Date: 09/11/2007**

Organization : **Childrens Crisis Treatment Center**

Category : **Social Worker**

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

I have worked with children and families for over 20 years as a mental health professional and bear witness to the gains resulting from increased funding for treatment in least restrictive and community based settings. There are certainly areas for improvement, but this will not be achieved through returning to an ineffective system of inadequate services.

GENERAL

GENERAL

The federal government would make better use of current spending and as a result save dollars, through vigorous oversight of current spending. Waste, Fraud and Abuse prevention is critical in any program in which large sums of money are available for a specified purpose.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The proposed rules appear to be a back door method of limiting treatment to the most vulnerable of populations and to roll back one of the more effective use of dollars in recent history. It is ridiculous to assert that these services are some how a loopole. The proposal also appears driven by concern over dollars, a serious concern, but not the only issue here. The outcomes produced through treatment should at least recieve a cursory review and the interest of the public be whether or not the dolloars spent are achieving positive outcomes in the lives of the suffering. The Federal government would save more dollars to being outcome focused and rewarding achievement than on focusing on processing of regulations.

Response to Comments

Response to Comments

Proposing to discontinue services for habilitation seems to be contrary to gains made in the treatment of mental health disorders. Current regulation emphasizes the need to use evidence based practices to treat children with conduct disorders and depression, which in both cases are alleviated through problem solving techniques. For children with autism functional communication skills are critical in preventing abberant behavior. Placing obstacles to obtaining treatment would be counter productive and have desparate social impact. The savings presented in the proposed regulation would most certianly be wiped away when those suffering illness worsen as a result of lack of care and neglect.

Submitter : **Mrs. Halina Dziewolska** **Date: 09/11/2007**

Organization : **St. Joseph's University**

Category : **Academic**

Issue Areas/Comments

Background

Background

Habliation versus rehabilation services

Collections of Information Requirements

Collections of Information Requirements

I am a board certified behavior analyst (www.bacb.com) and faculty at St. Joseph's University in its applied behavior analysis program within its Criminal Justice Department. I have worked with children with autism, as well as children with conduct disorder, oppostional definat disorder, post traumatic stress disorder, depression, and attention deficit disorder.

GENERAL

GENERAL

It appears to me that much more money would be saved in federally funded programs with better oversight of the program. This oversight should include a focus on collection of outcome measures to determine if children and adults are making progress on their psychosocial functioning. In addition, money would be saved if programs only used state licensed or board certified professionals to render treatment rather then nonclinically trained professionals. For example, in Pa and in NJ many practioners work with families as therapists who have no license. Indeed, most "behavior specialists" in Pa, who are supposed to be experts in behavior modification are not certified or even eligible to meet the certification requiremes to practice.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

It appears that the department should survey over the list of evidenced based practices offered by APA in 1995 and the Surgeon Generals report. It will find that skill training programs (such as Anger Replacement Training), compose a major portion of the list of evidenced based practices for children and adults with mental illness.

Response to Comments

Response to Comments

In my opinion much of the proposed regulation is needed to curb the tide of abused spending in programs. In Pa. the BHRS program is poorly oversighted, as is the community based program in New Jersey. However, the blanket banning of habiliative services is flawed. Such a ban would cut of critical psychosocial skills from being aquired. For example, under the proposed plan an adolescent sex offender would be deprived from funding to train him in self-control skills because he has not displayed such skills in the past. Skill based programs such as behavior therapy and cognitive behavior therapy have years of documented success in treatment. In addition, the proposed regulations would prevent a schizophrenic from receiving social skills training, which has been shown to produce better life functioning because they have not had the skill in the past. Children with conduct disorder and depression would be prevented from receiving training in problem solving skills, which have a strong evidence base for preventing future conduct problems and decreasing suicide risk. Cognitive and behavioral skills which make the core of evidenced based practices with children and adults for a host of problems from anxeity to zoophila would be denied. The developmentally disabled would be of particular concern. Children and adults with autism would be denied functional communication training, which is an evidenced based approach for lessening everything from self injury to improving functioning because they have never had the skills prior to the intervention. This would be sad and an egregious error. It would eliminate any potential savings by increasing hospitalization and residental placement. As well as increasingthe overall misery index for these populations.

To me this does not seem to be the best way to save money. Indeed, it would not save as much as waste fraud and abuse programs would or creating an outcomes vs. a process based oreintation to providers. Three steps to improving quality and reducing costs are:
1. Accountability- outcome measures and evaluation (including customer satisfaction)
2. Demand for evidenced based practices to be used
3. Only use highly qualified staff (Licensed staff members, or in the case of things like addictions or behavior analysis where no license is present- certified personal) similar to what has ben proposed for the school system under No Child Left Behind.

Submitter : Dr. Jay Carter **Date:** 09/11/2007

Organization : Dr. Jay Carter

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

I have a doctorate, and four best selling books. I read all 60-some pages. I don't understand what it means in the big picture of things. If I don't understand the big picture, it is difficult to ask specifics, but I will try. Is Bipolar disorder going to be covered the way it is now, if the person is disabled and can't work? Are the kids in the Wraparound program going to be covered with their needed services by a government agency (whether it be medicaid or another)? What is the purpose for the change? Is it to reduce the medicare/medicaid burden? Will funding be given to another agency to provide these services, or is it the intent to drop the services?

This document seems to give a lot of details without giving the context for the details. So, for the most part, I don't know what we are talking about here?

The biggest definitions are 'habilitate' and 'rehabilitate'. So if someone has a brain injury, do we keep trying to rehabilitate this person, forever? If a college kid developes schizophrenia, do we rehabilitate him to the point he can attend college again, or habilitate him into a job?

If I knew the intent, purpose, or bigger picture with good examples, I would be able to understand these 60 some pages of details. Was it purposely written this way? If so, why?

Collections of Information Requirements

Collections of Information Requirements

I don't know what "background" is requested. MY background? See jaycarter.net for that.

CMS-2261-P-46

Submitter : **Date: 09/12/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am against the proposed rule to limit coverage for support groups. If we treat only part of the problem, we treat nothing. In the instance of children requiring emotional therapy, their caregivers need support in order to best serve the child while preparing them for adulthood

Submitter : **Dr. Gregory Bailey** **Date: 09/12/2007**

Organization : **Children's Research Triangle**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

I do not support the proposed changes.

Submitter : **Date: 09/12/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I do not support the changes that proposes federal legislation to cut Medicaid rehab monies to states.

Submitter : Ms. Beth Faggins **Date:** 09/12/2007

Organization : North East Treatment Center

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Habilatation Services

Collections of Information Requirements

Collections of Information Requirements

I am a practioner with over 10 years experience in the Behavioral Health Feild.

GENERAL

GENERAL

It would appear to me that your exclusionary requirement is overly broad and maybe be better handled by a clearer defination of what is a behavioral health intervention and what is not a behavioral health intervention covered under medicaid. If the goal is truely treatment, then one needs to look at all aspects of treating holistically.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

It seems to me that Habilation is a critical part of evidenced based behavioral health services, which were endorsed by the Surgeon General's 1999 report. For example, Dialectical Behavior Therapy for the treatment of borderline personaility disorder uses habiliation (it teaches skills never had) to borderlines such as emotional regulation skills, relaxation skills, social skills and problem solving skills. It would be far better for a borderline personaility disorder to get this evidenced based behavioral health treatment then programs with no skills training and no supportive evidence such as many of the psychodynamic therapies and the "trauma" therapies, whhich have no empirical support.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Regulatory Impact Analysis

Regulatory Impact Analysis

It would appear to me that the public would be better served by requiring providers to clearly follow practice guidelines in Behavioral Health rather then experimenting on each person who comes in the doors, as if the evidenced based practices were never researched. This is particularly true in child psychiatry, where of lable usage of medication is rampent and no-one seems concerned.

Submitter : **Mrs. Kathleen Gordon** **Date: 09/12/2007**

Organization : **North West Human Services**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

Habilation vs. Rehabilation

Collections of Information Requirements

Collections of Information Requirements

I have been a social worker for 3 years. I am very interested in children services and I believe that the above regulation goes to far in its constriction of services. Many program that show considerable promise for improving children's behavioral health are habilative (that is they build psychosocial skills that that the child did not previously have).

GENERAL

GENERAL

In general the medicare and medicaid system would be better served with greater focus on outcomes and ensuring that the outcomes in behavioral health are actually behavioral health outcomes and not a back door way to fund educational services.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

While I generally tend to agree with the constriction of services, especially in teh Philadelphia area, where it seems that Medicare services have been reduced to free baby sitting for the poor and most of the supposid behavior specialists seem to only specialize in one behavior- defruading the goverment. The proposed legislation goes way to far by eliminating habilative services for children. Indeed, working with children with developmental disabilities, habilation seems to be the clearest way to reduce problem behavior such as self injury. After the completion of a careful functional assessment it become readily apparent that many of these children do not have the skill to request what normal children request. Since that is the case, they act out by engaging in aberrant behavior.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The impact, not just on immediate fianances but on the pain to children and on eventual cost to the system need to be observed. Less costly alternatives need to be explored such as a greater focus on using behavioral objectives to create clear discharge criteria and a standardizing the assessment process.

Submitter : Mrs. Cynthia Curet **Date:** 09/12/2007

Organization : CATCH

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Habilation vs. Rehabilation

Collections of Information Requirements

Collections of Information Requirements

I am an intensive case manager. I was trained as a behavior analyst and I am very concerned that this regulation will have negative impact on children.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

It has been long known that children with deficits in communication are more likely to have challenging behaviors (Goldstein, 2002). This proposed regulation seems to decide that habilation of the deficit is not as important as a program based purely on behavior management principles. Without the attempt at habilation, the client will need to continue behavior management or to chemically restrained indefinately. This is much more costly to the system.

Reference

Goldstein, H. (200). Communication intervention for children with autism: A review of treatment efficacy. Jounal of Autism and Developmental Disorders, 32, 373-396.

Submitter : Dr. Joseph Cautilli **Date:** 09/12/2007

Organization : St. Joseph's University

Category : Academic

Issue Areas/Comments

Background

Background

Docket: CMS-2261-P - Rehabilitation Services: State Plan Option- Habilatative vs. Rehabilatative Services

Collections of Information Requirements

Collections of Information Requirements

I am a licensed professional counselor and a board certified behavior analyst with over 20 years of experience working with children with emotional and behavioral disorders and adults with behavioral health problems and addictions. I am currently waitng tosit for my licensing exam to become a psychologist. In addition, I serve as faculty in St. Joseph's University in the Criminal Justice Department within its applied behavior analysis program.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The expansion of medicaid and medicare services for the treatment of psychological disorders within a host of systems has been impressive. However, I understand the importance for the money to be spent on issues relevant to the system for which it was proposed. It is crictical as stated in the proposed document not to have abuse of funding. Behavioral health as a system has a mission. The New Freedom commission report defined it as to promote resilency in children and recovery in adults from mental illness. It is a recognized fact that often the promotionof resilency is through habiliatation (parent training, social problem solving, etc.). One of the best and most effective ways to promote recovery has been through the use of behavior analysis/behavior therapy interventions (see Flora, 2007). These programs have been found to reduce conduct and oppositional defiant disorder in children (These are DSM IV diagnoses) and even to reduce the recividism rate in adolescents and adults (Illescas, Sanchez-Meca and Garrido Genoves, 2001). Many of these programs were reviewed favorably in the 1999 Surgeon General's report on mental health. However, these interventions require the acquisition of new skills- habiliatation and under your new regulation would not be funded. For example, the parent training program originally studied by the Oregon Social Learning grouptrains parents in the skills to manage children with oppositional defiant and conduct disorder. Since parents have never had these skills under your proposal funding this type of program for the treatment of a mental health condition would be eliminated. Highly effective programs like Teaching Family Homes (Kingsley,2006) would be crippled because they are strongly based in skill building. Many of these children would burden the system by being placed in residental treatment centers. Other programs such as the use of Anger Replacement Training for juveniles, which teaches them better methods to control their anger or impulsive behavior (many of these children are diagnosed as Intermittent Explosive Anger Disorder) would be eliminated. Sadly, with these well established practices removed, mental health professional would turn to non-empirically based practices with even greater focus then they currently do. These hockus pokus approaches are in no-ones best interest and really turn children and adults into lab rats. Indeed, the system needs to move to having practice standards. and guidelines.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

References

Flora, S.A. (2007). Taking American off drugs: Why behavior therapy is more effective for treating ADHD, OCD, Depression, and other psychological problems. State University of New York Press. www.sunypress.edu

Santiago Redondo Illescas, Julio Sanchez-Meca and Vicente Garrido Genoves (2001). TREATMENT OF OFFENDERS AND RECIDIVISM: ASSESSMENT OF THE EFFECTIVENESS OF PROGRAMMES APPLIED IN EUROPE Psychology in Spain,Vol. 5 47-62.

David E. Kingsley (2006): The Teaching-Family Model and Post-Treatment Recidivism: A Critical Review of the Conventional Wisdom - IJBCT, 2.(4), Pg. 481 -492 www.behavior-analyst-online.org

Jaime L. Milford, Julia L. Austin, and Jane Ellen Smith (2007): Community Reinforcement and the Dissemination of Evidence-based Practice: Implications for Public Policy - IJBCT, 3.(1), Pg. 77 -92 www.behavior-analyst-online.org

Response to Comments

Response to Comments

Three methods that I believe will reduce cost without harming children and even increasing service quality are:

1. Creating of practice standards like insurence companies do -detailing policies of what is an effective -evidenced based practice for a particular behavioral health problem and what is still considered experimental and better funded through grant sources.
2. Moving providers to greater accountability by requiring the collection of outcome data and this data should be easily accessable by the public.
3. Reduction of waste fraud and abuse through greater enforcement, as well as demanding that states only use practioners at the bachelor, master degree level and Ph.D. level who are state licensed or duelly certified by a state board. TriCare has already begun to take these steps for public protection. This will provide families with options of ethics boards toturn to if problems with servicing arise.

Submitter : **Mrs. Susan F Rzucidlo** **Date: 09/13/2007**

Organization : **Mrs. Susan F Rzucidlo**

Category : **Individual**

Issue Areas/Comments

Background

Background

I am the parent of a young man with autism who has made significant progress with services provided through Medicaid and the PA BHRS system. If these changes occur scores of young children will not receive the necessary services and the cost to the country of lower functioning ADULTS with SEVERE disabililties will be astronomical.

Collections of Information Requirements

Collections of Information Requirements

Young children, including those with Autism and related disorders of development, almost always display some sort of developmental of social skills in infancy. When these skills fail to develop at an age-appropriate rate, developmental delay occurs, and the child needs REhabilitation services to resume development of those latent skills. Unfortunately, not all administrators of State Medicaid plans will appreciate this, and will use the revised Medicaid rules in CMS-2261P to cut Medicaid funding for services to developmentally disabled childre

Submitter : **Ms. Kelly Jenkins** **Date: 09/13/2007**

Organization : **WES**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

CMS-2261-P - Rehabilitation Services: State Plan Option - Habiliatative vs. Rehabilatative Scrivices

Collections of Information Requirements

Collections of Information Requirements

I am a professional counselor with over 5 years of expereince in working with children with emotional and behavioral disorders. While I see the need for cost containment- particularly in New Jersey and Pennsylvania, where the over perscription of services remains a problem, the eliminate of habilatative services is not warrented.

GENERAL

GENERAL

The federal government would save much more money by looking into perscribing practices of psychologists and psychiatrists for services in the system. Placing a greater emphasis on the use of evidenced based practices such as skills training programs and contingency management systems. In addition, need exists to limit providers of services to those who are licensed as professionals. Far to many "behavior specialists" in Pa have barely four courses in behavioral health, in comparison to peole like myself who graduated from 60 credit programs in behavioral health. This makes a major difference in the quality of practice, as well as an understanding of role and function. Far to many well meaning people try to help in Pa but just wind up feeding into the family system's problems. Many are unable to be reasonablly assertive with the clients and wind up doing unethical things because of it.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The adverse impact created by failing to habilatate children with emotional and behavioral disorders, through evidenced based practices such as behavioral skills training will be far more costly to the medicare system as a whole then the money saved by habilatation. For example, children with communication difficulties often develop patterns of disruptive behavior. If the underlying skill deficit is not addressed, they are at greater risk for hospitalization and out of home placement.

Submitter : **Mr. Daniel Kill** **Date: 09/13/2007**

Organization : **Family Service & MHC of Oak Prk & River Forest**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-2261-P
To Whom It May Concern:
I am pleased to
comment on behalf of Family Service & MHC of Oak Park & River Forest staff, board and clients recovering from mental health disabilites. Based upon the past 35 years in working with clients in recovery, I offer the following comments on the provisions of
the proposed regulations related to Medicaid s Rehabilitation Services Option.

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

The presence (or absence) of psychosocial rehabilitation services directly impacts the achievement of recovery-oriented outcomes. In this context, recovery refers to the process the individual goes through as they rebuild their lives, not just the treatment of
symptoms. Certainly, treatment or medical activities should be incorporated within the rehabilitation plan, but are not necessarily the primary driver under the rehab option.

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

Family Service is pleased that the proposed regulations allow for flexibility in how rehabilitation services are paid. Allowing States to specify the methodology under which rehabilitation providers are paid [?441.45(a)(5)] will ensure the continuation of many highly effective programs, such as Assertive Community Treatment, Clubhouses, and Crisis and Transitional Residential Treatment Programs.

Sincerely,

Daniel J. Kill, LCSW, BCD
President/CEO

Submitter : Mr. Devon Bauer **Date:** 09/14/2007

Organization : Children Crisis Treatment Center

Category : Other Practitioner

Issue Areas/Comments

Background

Background

I hae been a social worker for 7 years. I am a strong believer in the positive influences of services for chilren under the EPSDT funding stream. I have seen many children profit from social skill training.

Collections of Information Requirements

Collections of Information Requirements

Docket: CMS-2261-P - Rehabilitation Services: State Plan Option- Habilatation vs. Rehabilation

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Under the proposed changes, children needing anger managemetn skills would be covered to restore them to a good relationship with others. However, many if not most of the children I have worked with have never had good relations with others. This rule blociking habilation will require provider to search long and hard for proof that the child had previously had skills. The searching mind often sees things that are not there. The effect of this will be to weaken clinical case conceptualizations. I see this bill as being the cornerstone of denial of services for children with emotional and behavioral disorders such as conduct disorder and developmental disabilities such as autism. This is sad. Increased provider accountability through the use of licensed personal, evidened based practices, and more outcomes focus can reduce waste and cut costs in a more efficient manner.

Submitter : **Mr. Michael Machiewicz** **Date: 09/14/2007**

Organization : **Community Treatment Solutions**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

CMS-2261-P - Rehabilitation Services: State Plan Option

Collections of Information Requirements

Collections of Information Requirements

I am a Mental Health Clinician, who as worked in home based services for 6 years. I have a master's degree in counseling psychology and currently persuing licensure.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

In general I support the movement of regulations that move providers from a service oreintation (provide services) to a treatment orientation (accountability for outcomes). Thus, I will restrict my comments to the area of disagreement that I have with the proposed change. It appears that the regulations are overly restrictive. Children with developmental disabilities would be denied from the Fed programs to build social, communication and emotional skills only because they have never had the skill before. Emotional, social, and behavioral skills are not the duty of education. In fact these children tend to lnaguish in teh educational system because they do not have the skill necessary to habilitate these children.

This seems like the CMS department a backdoor way of going around congresses intent in OBRA.

Submitter : **Mr. Thomas Chase, M.S., CAC** **Date: 09/15/2007**

Organization : **North East Treatment Center**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Docket: CMS-2261-P - Rehabilitation Services: State Plan Option- Habilation vs. Rehabilation

Collections of Information Requirements

Collections of Information Requirements

I am a certified addictions counselor.I have worked in addictions for 15 years. The citiy of Philadelphia pays massive amount of money on the addictions field. Most of the treatment is conducted by poorly trained counselors, with only one claim to fame that they are former addicts themselves. Recently, the field has moved to evidenced based practices. Many of these practices are focused on building skills that patients do not have and never had. Indeed, this is the core of relapse prevention. This bill would set addictions counseling back to the bad old days of confronting and yelling at clients. The supposed savings would disappear as addicts would require additional hosptializations and burden the system.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The proposed rule would eliminate training in relapse prevention skills because the client has never had such skills previously. Thus, they would be considered habilatative and not rehabilatative. In addition, programs with strong evidence in the treatment of addiction such as community reinforcement approach and behavioral couples therapy would be denied to those suffering from addietion because they never previously had the skills. It would be very sad to bring back the bad old days...

Submitter : **Mr. roy Young** **Date: 09/16/2007**

Organization : **Mr. roy Young**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned about the closing of Piedmont Pioneer House in
Gastonia, NC. This house is a lifeline to many with mental and physical problems. If you could only know my first cousin David Minges who was born with celebral palsy you would have a clearer
understanding of the importance and necessity of a facility like this. David is 47 years old,has completed his GED high school
requirements attaining a diploma. Also he has gone on for a degree at
Gaston College in Dallas, NC. Many social skills as well as academic
have aeen achieved through having a facility like the Pioneer House as a lifeline to achieve a style of living as close to normal as
possible, working and being able to relate with people. Everyone in
life needs meaningful relationships and a social outlet and Pioneer
House contributes greatly in meeting some of his needs. David has
parents that are very elderly and Pioneer House also gives them a
feeling of support in their day in and day out of caring for their
handicapped son. Knowing someone, one on one as I do, who benefits
so much by going to Pioneer House, I pray that one might understand
better the need for such a place. The possiblity of the closing of
this facility creates anxiety to his parents that is not needed at
their age as well as others in his group are surely feeling. Please
do not close Pioneer House doors. That is the ONLY LIFELINE that these wonderful people deserve. It is their only hope to their world
outside their homes. It is ours and yours as well to help these
that are under-privileged because of mental and physical problems.
They need the support that Pioneer House gives to the handicapped of
this area. PLEASE DON'T TAKE AWAY SOMETHING THAT IS SO DEAR TO THEIR
HEARTS AND THEIR FAMILIES. GOD EXPECTS AND DEMANDS US TO HELP THOSE TRULY IN NEED. CLOSING PIONEER HOUSE WILL TAKE AWAY FROM THEIR LIFE
SOMETHING THAT CAN'T BE SUBSTITUTED.

Thank you, Mr. Roy G. Young

Submitter : **Ms. Kandy Templeton** **Date: 09/17/2007**

Organization : **VBHCS**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

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Collections of Information Requirements

Collections of Information Requirements

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GENERAL

GENERAL

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Submitter : **Edna T Elkins** **Date: 09/17/2007**

Organization : **Alliance House**

Category : **Individual**

Issue Areas/Comments

Background

Background

A time limit on rehabilitation for mentally ill adults is not reasonable. An understanding of the nature of mental illness seems to be missing in this plan option.

Submitter : **Terri Reuvers** **Date: 09/18/2007**

Organization : **South Central Human Relations Center**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

Regarding file code CMS-2261-P
As treatment director for Adult Rehabilitative Mental Health Services (ARMHS)and having worked directly with individuals who have serious and persistent mental illness for the past 16 years, I would like you to consider amending the service rule. In an attempt to provide quality rehabilitative mental health service to our clients, it has been my observation that working closely with the clients psychiatrist, is beneficial. Most often, clients needing rehabilitative services, have difficulty understanding clearly, and following psychiatirc recomendations. ARMHS staff may be better able to assist by attending the psychiaric appointment with the client, to ensure that recomendations are being reinforced appropriately. I do not see this as a duplication of service, as the ARMHS staff and the psychiatrist are providing completly different services. It is also more efficient to attend with the client, rather than staff attempting to communicate at a later point with a psychiatrist who is quite busy. This situation was discussed at a training I attended, and I am aware that the time coaching before and after the appointment are billable. This system is not nearly as effective for the client, so in essence, staff could attend the appointment and not bill for this. But is this a reasonable and fair practice? I appreciate your time and would be willing to discuss this further if it may be helpful. Terri Reuvers Mental Health Practioner/ARMHD Treatment Director South Central Human Relations Center, Owatonna, MN 55060

Submitter : **Mrs. Dorthy Cassidy** **Date: 09/18/2007**

Organization : **North East Treatment Center**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

Docket: CMS-2261-P - Rehabilitation Services: State Plan Option Habilation vs. Rehabilation

Collections of Information Requirements

Collections of Information Requirements

I am a clinical social worker who has practiced as an addictions counselor for 2 years. I think that the proposed regualation change would be a problem because many of the new interventions used to combat and treat addictions rely on a skills training approach. Most of the cognitive therapy programs train patients to recognize cogntive distortions and to change those distortions. Since these skills were not present in the past, this bill seems like an attack on cognitive behavior therapy, which is one of the few approaches that has shown to have lasting impact on those suffering from addictions.

GENERAL

GENERAL

One way to save money would be to have better oversight and supervision requirements for those treating addictions. In addition funding sources should audit programs more for irregularities in billing practices.

Submitter : **Ms. Sarah Eckels** **Date: 09/18/2007**

Organization : **UPMC**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Currently I am working full time at a Intermediate School and part time in a phyiscal therapy clinic. With the laws in effect about our duties in a physical therapy clinic, my services are limited. I help with as much as I can but if we as Athletic Trainers were allowed to do more in the clinic it would lessen the load on the physical therapist. Thus allowing a smooth and increased patient flow. I have a BS in Athletic Training have been certified for one year. Since this past year has gone by I decided to go back to college to get a teaching certificate.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Sarah Eckels ATC

Submitter : **Mr. Jeremy Christensen Christensen** **Date: 09/19/2007**

Organization : **Alliance House, Inc.**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

September 18, 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 the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country s most vulnerable citizens. Some of the rule changes seem to specifically target people living with mental illness and attempt to reduce their access to needed services without any back up plan to fund services or programs. Some of these services have been working effectively and supported by CMS approved Medicaid funding for more than ten years.

To create or suddenly start enforcing bureaucratic clinical and administrative processes without additional or alternative funding from states is the equivalent of a substantial services cut for people who already have more than their fair share of burdens.

A NAMI 2007 publication states that Medicaid has increasingly funded mental health services, and its share of the mental health funding by states has increased substantially over the years to become the largest source of public mental health spending. In addition the Urban Institute analyzed 2004 Medicaid data and concluded that 73% of Medicaid beneficiaries receiving rehabilitative services had mental health treatment needs, and these beneficiaries are responsible for 79% of rehabilitation services spending. For these reasons, these regulations will have a critical effect on individuals with serious mental illness.

One example of a negative impact is the narrow redefinition of the term rehabilitative services to emphasize returning a person to previous levels of functioning. Although there is provision for those who never achieved an adult level of abilities it is likely that this definition will be used to reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

Another example is that although I wholeheartedly support the idea of person centered services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the needed other recovery focused services such as education, employment, housing and pre-vocational services.

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

It is a mistake to re-organize funding for long approved services in an effort to reduce short term spending. A poorly developed strategy will result unnecessary and more costly and emergency spending in the long run. More importantly though it will cost the lives and futures of those insensitively denied the comparatively inexpensive services they currently have.

Sincerely,

Jeremy Christensen, LCSW
Executive Director
Alliance House, Inc.

Submitter : **Mrs. Lynda Cook** **Date: 09/19/2007**

Organization : **Autistic Children Support Group of Worcester Cty**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

I am a parent of a seven year old son diagnosed with high functioning autism. I am also on the board of directors of a local autistic support group in Worcester Cty, MD. EPSDT services were a very important part of our sons recovery from severe autism (3 years) until now (7 years) where he has improved dramatically and his diagnosis has been changed to "high functioning autism". My son is now included full time in a regular classroom. My son was a normal baby and lost his speech at 18 months. With the access of EPSDT services for three years, my son now has unlimited speech, only minor articulation and pragmatic issues that we still continue to work on both at school and at home. We no longer access EPSDT services, but many people I know still use this service and the child and family benefit from this service. Society benefits as a whole with a proactive approach to behavior intervention. Early intervention is imperative to the success rate of children overcoming autism. All families effected from developmental issues need as much support as they can get in order to get access to the help needed for their children with special needs. Has our society sunk so low as to forget these families and take away services that are much needed and appreciated. Please continue to offer EPSDT services to children with developmental delays.

Sincerely, Lynda Cook (Autistic Children Support Group of Worcester Cty)

Submitter : **Mrs. Christine Christiansen** **Date: 09/19/2007**

Organization : **Mrs. Christine Christiansen**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am a parent of a 4 1/2 year old boy who attends MiChild Enrichment Center in Russellville, Arkansas and receives services in the classroom 4 days per week as well Speech, OT, and PT. This facility and the staff have made a tremendous impact in the life of my son over the past 2 years. He has improved in his social and emotional skills as well as in the academic and therapy areas. I just can't imagine what would happen to all the children (and adults) who benefit from the day hab programs. Many of these children would have no other place to go if these facilities shut down. These facilities are so beneficial in preparing young children for school and preparing adults to function in the community. Besides hurting the children and adults who benefit from these programs, it would also result in many people losing their jobs. It almost seems like this proposal is just "casting off" people with disabilities and leaving them to fend for themselves. However, costs for these programs without government assistance is much too high for most of these individuals and families. They can become extremely productive members of society as well if given the opportunities and resources.

Submitter : **Ms. Loretta Cochran** **Date: 09/19/2007**

Organization : **Ms. Loretta Cochran**

Category : **Individual**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am writing today to express my distress and concern regarding the proposed rule change for Medicaid Program -Coverage for Rehabilitative Services 42 CFR Parts 440 and 441. According to the Federal Register (72 FR 45201), there is a notice of proposed rule making that would eliminate Medicaid funding for Developmental Day Treatment Clinic Services in Arkansas.

Our Story
My 5 year old son has an Autism Spectrum Diagnosis. He started attending MiChild Developmental Daycare in May 2006. Other daycare facilities in the area were not equipped with staffing or training to eare for him. At MiChild, he received occupational and speech therapy along with classroom instruction. In addition, we have spent countless hours and thousands of dollars for treatment at the Dennis Developmental Center at UAMS/Arkansas Children's Hospital. Today, he now is in a regular kindergarten classroom at Pottsville Elementary with occupational, physical, and speech therapy. He is performing at grade level in most areas. This would not have been possible without the services provided at and through MiChild.

The impact of this rule change would be devastating to the children of Arkansas. Research shows that early intervention has the greatest dollar return of any investment for individuals with developmental delays and disabilities. I would guess that individuals with disabilities do not vote-but as a parent, you better believe that I do.

These funding cuts apparently target those most likely to not have a voice. It attacks those that need help the most and endangers the very lives that my husband is in Iraq sworn to protect. While I do not understand the original intent of the rule change, the apparent outcome is unacceptable. I am sure the deficit can be reduced without harming the children of Arkansas. If not, it is time for a complete change in leadership of this country and Congress.

Submitter : Ms. Kristi Torres **Date:** 09/19/2007

Organization : Ms. Kristi Torres

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Eliminating day treatment would be a deterimental mistake to the our entire community. Day treatment provides people with disabilities a purpose and a way to contribute to the community. Taking money away from them people to pay for services for "normal" children is criminal. These people are being punished for being disabled and I suggest you come and see how day treatment facilities impact our community. What do expect these people to do when you take away everying they live for?

Submitter : **Mrs. Amber Pettit** **Date: 09/19/2007**

Organization : **Mrs. Amber Pettit**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachments

CMS-2261-P-70-Attach-1.DOC

#70

Nicholas R. Tarte
803 N. Denver Ave.
Russellville, AR 72802
(479) 223-1981

Re: Proposed Bill CMS-2261-P: "Habilitation Services, Settings, Requirements and Limitations for Rehabilitation Services"

September 19, 2007

Dear Arkansas Senator/Representative,

It is my understanding that this bill would eliminate such facilities as the MiChild Enrichment Center located here in Russellville. This facility provides invaluable services to children with developmental disabilities in the surrounding Arkansas River Valley between the ages of 6 weeks old and 5 years old. They receive physical therapy, occupational therapy, speech therapy, and developmental therapy. To remove these services would create an increased burden on the school system, the medical facilities, and the private care services that the communities provide. In addition to this, the families would no longer be receiving vital services they are incapable of administering themselves.

It is my wish that you vote against this bill and keep these facilities intact. It will in turn keep our communities intact, our families intact, and will remain a benefit to the surrounding areas, the federal budget, and the state budget by providing such services.

Sincerely,

Nicholas R. Tarte

Submitter : **Mr. James Emerson** **Date: 09/19/2007**

Organization : **Mr. James Emerson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

James Emerson, Arkansas-----

It has recently been brought to my attention that the federal agency that oversees Medicaid is proposing a rule that would eliminate funding for day habilitation services to children and adults with developmental disabilities. Currently this is covered by the Arkansas Medicaid program and if this is eliminated it would be very detrimental to not only the disabled children and adults, but also to their families.

Day habilitation services provide a very important service to children and adults with developmental disabilities and a very important service to their families. These services help the disabled child be allowing them to enter into the public school system with fewer delays and to be more age equivalent to their peers. These services are also very important and needed for the adults also.

Eliminating Medicaid services to these families with children and adult members who have developmental problems would create a hardship on their families.

Please help us prevent this federal agency from eliminating Medicaid assistance to the DDTCS program in the state of Arkansas. So many people rely on these services and to eliminate Medicaid would be a severe blow the health and development of their disabled family member and would also create a very extreme financial hardship for the family.

Thank you very much for your support in helping assure the Medicaid help they are currently receiving is not taken away.

James A Emerson

Submitter : **Ms. Anita Van Winkle** **Date: 09/19/2007**

Organization : **Ms. Anita Van Winkle**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachments

#72

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter :

Date: 09/19/2007

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Becky Butler
71 Opper Lane
Russellville, AR 72802

Dear Mr. or Mrs. United States Representative/Senator,

I am a concerned United States citizen and I want you to vote against terminating the dayhabilitation services of our children ages birth to five. Dayhabilitation provides a wonderful atmospherc for these children to work on improving the deficits they have shown in their development. They are surrounded with children their own age who have shown these same deficits and also children who are typically developing. Dayhabilitation provides one-on-one instruction at a learning speed they can handle. They also get to interaet with their peers, improving their much delayed social skills. If you make the decision to end dayhabilitation, you would not only be ending their progress they could make before entering public school, but you would be affecting their families as well. These children s families rely on dayhabilitation to provide physical therapy, speech therapy, occupational therapy, and developmental therapy. It also provides the parents with a place their children can go where they know a positive environment, full of stimulation, is.

I have seen the positive affects dayhabilitation has had on the community I live in. There is a DDTCS center in the area and I ean testify that they work miracles. I can t imagine how much further the children they serve would be behind if this service didn t exist. I have heard stories of children qualifying with a severe delay and being transitioned into the public school requiring little to no special education. If you are truly concerned about the well-being of these children, you will say NO to ending dayhabilitation and DDTCS!!

Dayhabilitation services provide an important safety net for children and adults with developmental disabilities and their families. If you end these services, these children will have more problems and will cost more money in the long run. If dayhabilitation services are no longer covered by Medicaid, many persons with developmental disabilities will no longer be eligible for services and will be forced to fend for themselves. It s in your hands now. Please vote against ending dayhabilitation services in this state and nation. We can t afford to let these children down!

Sincerely, Becky Butler

Submitter : **Mrs. Elisa Brown** **Date: 09/19/2007**

Organization : **Friendship Community Care- MiChild Enrichment Cen.**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-74-Attach-1.DOC

CMS-2261-P-74-Attach-2.DOC

CMS-2261-P-74-Attach-3.DOC

CMS-2261-P-74-Attach-4.DOC

CMS-2261-P-74-Attach-5.DOC

CMS-2261-P-74-Attach-6.DOC

CMS-2261-P-74-Attach-7.RTF

CMS-2261-P-74-Attach-8.RTF

CMS-2261-P-74-Attach-9.RTF

Larry Fitzgerald
P.O. Box 37
Bellville, Arkansas 72824

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

Recently, I was informed that there is a bill that may pass that will eliminate all DDTCS programs from our communities. This affects the lives of so many children and adults. My son, Tyler Kieth, attended MiChild Enrichment Center in Russellville, Arkansas, and I would like to share with you how he would not have made as much progress as he did if he was not able to attend preschool at MiChild.

Tyler learned what he would have learned in other daycares, but he also took so much more away with him from MiChild. They provided him the care that he needed and took the extra effort to meet his special needs. He received individualized assistance and tailored goals. Additionally, we live out in a rural location where there is no place for him to go. MiChild even provides transportation to those children who are located away from any large city. And for a lot of kids, MiChild is their only means of support. Most of them do not even have supportive parents. What will they do without that? Tyler is no longer needing these services, but I just can not believe that there is even a question whether or not these services are worth our money. If MiChild and other centers like it are not worth it, nothing is.

Sincerely,

Larry Fitzgerald

#74-b

Kim Wilson
205 Avenue 10 Northwest
Atkins, Arkansas 72823

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

This letter is on the behalf of my son, James Wilson, who receives services at MiChild Enrichment Center in Russellville, Arkansas. I was informed that there was a possibility that his preschool could be shutting down. I would like to urge you to listen to my story and make the best decision for the children whose lives you are affecting.

My son has been in and out of daycares, and no other center can handle him as well as MiChild can. When he was attending a different daycare, I would leave daily with tears in my eyes and disappointment in my heart. Every bad day would equal his expulsion. His behavior was so severe that I was constantly switching daycares, until he was enrolled at MiChild. There the staff understand my son and know how to handle his temperament. They are all so sweet, kind, understanding, and accepting of his condition. They work with me as a team to help give James the best education and loving environment possible. If he could no longer attend, my life would be completely turned upside down. I have no other place to take my son, so I would have to stay home during the day with him and work at night. Not only would I be exhausted, but you would be removing him from a place that has helped him make so much progress and learn so much. Please do the right thing and keep all DDTCS centers open. They are needed more than you think.

Sincerely,

Kim Wilson

#71

September 19, 2007

To Whom It May Concern:

I just received word that the federal government is considering the closing of many of the special needs pre-school programs that currently exist. I personally feel this would be a grave mistake. As any decision maker knows, it is best to weigh your gains and losses before making such a major decision a final one. I would like to point out several things that must be considered when weighing these options:

1. Children with disabilities require one-on-one instruction. With the current special needs preschool programs, the children not only receive one-on-one instruction, but they also receive any special therapy that they might require. It is also important to note that the one-on-one instruction is very individualized and tailored to the needs of each child.

2. Most regular day care and preschool facilities do not understand the requirements of a special needs child. With the current special needs preschool programs, the instructors are trained in classroom management for the special needs child. No guess work is going on with the welfare of these children.

3. In the current program, the staff are specially trained to care for these children both physically and mentally. Unfortunately, this will not be the case for the typical day care or preschool that is found in most cities.

4. Many parents of special needs children report that the day cares and preschools they live close to will not accept their special needs child, leaving the parent with few options. In some cases, they may even be forced to quit their job in order to care for their child.

I am sure that there are other issues to consider, but these are the most obvious and most serious issues at hand. Please consider everything that is at stake before stopping such a wonderful program for our citizens.

Sincerely,

M. Nanette Harrell, MSCIS, BSE, PMP

DIS ADE Program Manager

Project and Enterprise Program Management Office

Arkansas Dept. of Information Systems

Desk: (501) 682-5201 Cell: (501) 837-9149 Fax: (501) 682 9465

"Never, never, never, never give up!" (Winston Churchill)

#74

Jenny Simmons
200 Caballo Ranch Road
Russellville, Arkansas 72802
479-331-4188

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

I have three children- Hannah, Sarah, and John Paul- who attend MiChild Enrichment Center in Russellville, Arkansas. Their teacher informed me today that their program is in danger of shutting down due to a bill that is trying to pass in Congress. I would like to let you know why I think that this would be a huge mistake.

My children have benefited in every way since they were enrolled in the program at MiChild. They have been able to improve their social skills as well as their speech development, simply from attending a classroom that is specialized to cater to their delays. Also, they are now acting more age appropriate. Therapy has been beneficial as well, but MiChild offers so much more than just therapy alone. I have been pleased with everything that they have done for my children. I feel very fortunate to have a facility as effective as MiChild here in Russellville, and it would be a shame if we were to lose it. I do not want my children to attend a private daycare, so I would have to resort to home-schooling them, which is not enough alone. I urge you to think of the children when you cast your vote.

Sincerely,

Jenny Simmons

Elisa Brown
213 Heather Lane
Russellville, Arkansas 72802

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

I am sure that this letter is one of many that you have received concerning the elimination of all DDTSC programs by removing the coverage paid for by the Medicaid Program. However, I would like to help you realize that each individual letter is a testimony to how important DDTSC programs are to our communities as a whole. When these services are not available to those who need them, there are consequences that affect the majority of the population.

Children who attend day habilitation facilities and require special needs or methods are in risk. When the can no longer afford to attend, they will be forced to either stay at home with a parent who will have to quit their job or attend a mainstreamed daycare costing them a large amount of money on top of their therapy expenses and not receiving the appropriate care. Mainstream daycares are good at what they do, but they are NOT experienced at taking care of children with disabilities. Many children will require hand feeding, special chairs that must be stored and rotated for the child to use several times a day, daily notes sent home to parents, and most importantly individualized plans tailored to target their specific delays. Are mainstreamed daycares going to create these plans? Do they have the training or the time to complete them? The children are currently placed in facilities that understand their special needs and work daily with helping them overcome obstacles. While they are reaping the benefits of an education, they have the convenience to be pulled out of the classroom and walk down the hall to a therapy room. Will they be able to have as much therapy without this much needed accessibility? If not, they will not make as much progress and the weight will fall on the public school when they start Kindergarten. Which is okay, but isn't early intervention the key to helping these children keep up with their peers? What a mistake it would be to leave some of these children high and dry without any educational support, and for some it is the only support system that they have.

Not only are the children at risk, but you are damaging the support and hope that these centers provide to the families. Resources are abundant and the parents do not feel as if they are the only ones having to raise a child with special needs. They have others who feel the way they do and are going through the same life transitions. Will they have that comforting feeling when the majority of the preschool is developing normally? Will their families feel accepted and understood? The families will hurt emotionally, but even more so financially. They will be forced to pay daycare fees as well as for the therapies that their child needs, and some will have to quit their jobs in order to stay home with a child who has been expelled from other daycares in the community. I know several families that are in this position. Families are praying that you will make the right

decision. There are also the families of all of the employees that will be out of work. How will our community's economy handle all of the unemployed people?

The adults with disabilities are probably the least spoken for, and probably will be hurt the most. Programs such as Friendship Community Services in Arkansas provide them with positive activities and homes that keep them safe. They are monitored and given assistance daily in order to keep them from making mistakes that could injure them or someone around them. They would be homeless and left to cause problems without anyone to turn to. Think of what that is going to do to our communities.

The proposal that is being presented is ungrounded and unjust. It is going to have a tremendous negative effect on our communities. Please do your part to ensure that our communities remain a place that people with disabilities are cared and provided for. They have had to fight for their rights before, and now they are fighting again. Remember that they have rights that need to be honored, and they need care much more than those without disabilities. Please do not let this happen to them. It is our duty to protect them and help them live a life that is a close to a normal one as possible. Do not take that away from them.

Sincerely,

Elisa Brown

#74-6

Casey Michelle Dortch
10304 Cobalt Lane
Danville, Arkansas 72833

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

My son, Drew Dortch, attends preschool and speech therapy sessions at MiChild Enrichment Center in Russellville, Arkansas. His teacher informed us that there is a chance that his center may be closed due to the amount of children who receive services that are covered by Medicaid. I wanted to write to tell how important this program is to my son and why you should reconsider passing this bill.

MiChild's impact on our family is immeasurable. The progress that Drew has made turned him into a new little boy. He has learned so much that I could not teach him. He communicates better and is socializing with other children when he never would before. I did not think that he would come so far so quickly developmentally. Honestly, I do not know what we would do if he could no longer attend MiChild. We would struggle as a family, and Drew would struggle most of all. My son needs this program desperately! There would be no way for him to fully develop the way that he needs to, therefore he would always be behind. Please don't destroy this amazing program. It would be a shame to see such a great program closed down. They are amazing at what they do, and they work very hard. I appreciate all that they do, and our lives would not be the same without them.

Sincerely,

Casey Michelle Dortch

#74-7

Ben Smith
928 East Norristown
Russellville, AR 72802

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

I am writing this letter to inform you of the importance of DDTCS within our community in Russellville, Arkansas. Recently, I have heard that there is a chance that these programs could be in jeopardy, which causes me a great amount of concern. There are many benefits to keeping these centers and few disadvantages.

I am personally familiar with MiChild Enrichment Center, and from what I have witnessed, they go far beyond just any normal daycare service. I want to tell you about a young boy named Hayden, who is a part of my extended family. He had a short life expectancy, and when he first attended MiChild he couldn't even smile. MiChild provided Hayden and those around him with emotional support, information, advice, and comfort. Unfortunately he died six months ago, but he survived long past his life expectancy due to the loving and nurturing environment that MiChild provided him. They gave him the attention and neccessary drive to push himself to higher expectations and goals. He was provide with goals to push for and to dream for. I really don't feel that he would have made it as far as he did, if he wasn't receiving the best care available. Hayden is just one child that has proven standard expectations to be too low. Other children are given a chance to catch up on the basic skills that the children in the mainstream are far beyond, which not only prepares them for Kindergarten but gives them a shot to succeed. They have not only met those goals, but reached higher and surpassed all of their developmentally appropriate goals. If that extra effort from their education is taken away from them, the childrens' education suffers from the moment it is gone and into their futures. Isn't the ultimate goal to teach these children to be productive, contributing members of society? Children are not the only ones who benefit from these services. Parents have access to resources that they would not have had. Please reconsider any decision that you may make in regard to discontinuing the services that make such a difference in the lives of so many.

Sincerely,

Ben Smith

#74-8

Julia Duran
221 South Enid
Russellville, Arkansas 72801
479-747-4986

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

I am the mother of a child who attends MiChild Enrichment Center in Russellville, Arkansas. My son, Kristopher, has made so much progress since he started attending this program. Please take the time to hear why it would be devastating to our family if you were to discontinue the day-habilitation services that he receives.

Kristopher is on medication that makes his behavior unpredictable. Receiving preschool at MiChild has help his behavior tremendously. Because of their expertise, I have been given the opportunity to attend college. If their services were exterminated, I would be forced to drop out of school. Also, other daycare centers can not control his behavior. They lack the methods and procedures that keep him calm and focused. I honestly believe that, without MiChild, Kristopher would not be able to start Kindergarten in August in 2008. I would have to spend much more time and effort preparing him for public school. MiChild has helped Kristopher calm down not only in their classroom, but also at home and at church. His self-control has developed to the point that I no longer have to worry about any unexpected outbursts or emotional breakdowns. Please do not take that stability and structure away from my child.

Sincerely,

Julia Duran

#71-9

Tamara McKellar
221 South Laredo Avenue
Russellville, Arkansas 72801
479-857-2666

September 19, 2007

Dear Mr. or Ms. Senator/US Representative:

My sons, Jacob and Ethan McKellar, attend preschool at MiChild Enrichment Center in Russellville, Arkansas. Recently, I have been informed that there is a bill in proposal that will eliminate the Arkansas Medicaid Program day hibilitatation services to children and adults with developmental disabilities. I would like to give you some information to base your vote off of, in order to best serve the people who need you most.

Both of my children are more effective at their communication efforts than they were when they first began receiving services at MiChild. I never could understand what they were saying, and it frustrated all of us. I tried everything at home, and nothing worked until they were enrolled at MiChild. They also were not good at socializing. Now, they interact with other children better. If you are reluctant to give my children the necessary education that they deserve, I will be forced to either pay $85 each week for regular daycare (which does not individualize their education or understand their needs) or quit working (which provides money for our family to survive). What a hard decision to have to make. I would also have to pay for therapy for both of my sons, including Speech and Physical Therapy. Please do not put me in such a lose-lose situation. I know that you see the benefits enough to recognize what the best decision would be. I trust that you will make the best of the power that we have bestowed upon you.

Sincerely,

Tamara McKellar

File Code: CMS-1399-GNC

TITLE: Medicare Program; Criteria and Standards for Evaluating
Intermediary and Carrier Performance During Fiscal Year 2008

ACTION: General notice with comment period.

SUMMARY: This general notice with comment period describes the criteria and standards to be used for evaluating the performance of fiscal intermediaries (FI) and carriers in the administration of the Medicare program.

The results of these evaluations are considered whenever we enter into, renew, or terminate a FI agreement, carrier contract, or take other contract actions, for example, assigning or reassigning providers or services to a FI or designating regional or national intermediaries. We are requesting public comment on these criteria and standards.

Publication Date: October 1, 2007

Comment Period Ends: November 30, 2007

ISSUES:

- Background
- Analysis of and Response to Public Comments Received on FY 2007 Criteria and Standards
- Criteria and Standards--General
- Criteria and Standards for Fiscal Intermediaries
- Criteria and Standards for Regional Home Health Intermediaries
- Criteria and Standards for Carriers
- Action Based on Performance Evaluation Performance Evaluation

Please provide names of staff who should receive electronic comments:
Irene Ruby
Kara Lockwood

File Code: CMS-4129-P

RIN: 0938- A077

TITLE: Medicare Program; Special Enrollment Period and Medicare Premium Changes

ACTION: Proposed Rule

SUMMARY: This proposed rule would provide a special enrollment period (SEP) for Medicare Part B and premium Part A for certain individuals who are sponsored by prescribed organizations as volunteers outside of the United States and who have health insurance that covers them while outside the United States. Under the SEP provision, qualifying volunteers can delay enrollment in Part B and premium Part A, or terminate such coverage, for the period of service outside of the United States and reenroll without incurring a premium surcharge for late enrollment or reenrollment.

Publication Date: September 28, 2007

Comment Period Ends: November 27, 2007

Effective Date: N/A

ISSUES: General

Please provide names of staff who should receive electronic comments:

Sam Dellavecchia (410) 786-4481

Submitter : **Ms. Audra Hankins** **Date: 09/19/2007**

Organization : **Ms. Audra Hankins**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Audra Hankins
1707 East O Street Apt C
Russellville, AR 72801
479-880-1845

September 19, 2007

Dear Mr. or Ms. US Senators/Representatives;

I was recently informed of a rule change (CMS-2261-P) that will impact the Medicaid system and it s funding of day habilitation services for people with developmental delays. I am concerned that the full ramifications of this issue have not been reviewed. These day habilitation services are not merely babysitting programs. They provide a means of independence for a percentage of the population often left without a voice.

The day habilitation programs in my community provide options to parents who, otherwise, have faced the possibilities that their child may never lead a normal life. The ability of these programs to integrate children with even severe disabilities and delays into the community is reason enough to stop this charge, but it is not the only reason.

Imagine if the only independence in your life was provided through adult day habilitation/work programs and then suddenly having these programs torn away by people you have never met and a government you do not understand. How do we justify taking the only means of independence for a portion of the population when our country was founded on the principle of independence. Before enacting this change, please remember we are guaranteed life, liberty and the pursuit of happiness. These day habilitation programs provide people with delays and disabilities just that& life beyond institutions, the ability to utilize their given liberties, and a pursuit of happiness we are all entitled to. Before allowing this piece of legislation to pass, please put yourself in the place of those receiving these services and their families. From childhood to adulthood, everyone deserves a chance to lead productive and independent lives.

Thank You,

Audra Hankins

Submitter : **Mrs. Cindy Crow** **Date: 09/19/2007**

Organization : **Mrs. Cindy Crow**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Cindy Crow
3019 Hwy 124
Russellville, AR 72802
479-967-0579

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

I am the mother of three healthy children all of whom have attended the MiChild Enrichment Center in Russellville, AR. MiChild is a DDTCS facility and worked on their individual strengths and weakness to help them have successful school experiences. My children have thrived since attending the day habilitation service. They learned to cut and write their names. The school provided a safe, helpful place where my children could get the help they needed along with love and attention while I worked.

They attended small groups to get instruction that included communication, gross motor, self help skills and would not have the social skills that they have today if it hadn t been for MiChild Enrichment.

Both my girls were slow to walk, but the teachers that worked with them in the classroom (day habilitation) took the extra time to let them push toys/carts to gain strength, where other childcare centers would have just let them crawl around. Please don t let the day habilitation service disappear in Arkansas. Children and Adults all over the state depend on these services everyday to help make their world a better place.

Sincerely,

Cindy Crow

Submitter : Mrs. connie Freeman **Date: 09/19/2007**

Organization : Mrs. connie Freeman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Connie Freeman
1106 East 9th Street
Russellville, AR 72801
479-967-0893

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

I am writing this letter as a parent of a child who would have benefited from day habilitation services. I think if they take day habilitation away a lot of children would not get the extra help that such services provide and would fall severely behind before they reach kindergarten. Having to fight the school system for help for my child is an uphill battle. He would have benefited from the services at our local DDTCS. I have seen many children make tremendous progress because the staff works with them and receives continuous training to know the most up to date research to help these children succeed.

Keep day habilitation on with Medicaid services.. Day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. Please DON T let the federal government take away the only chance our children have to catch up and perform to the best of their ability.

Sincerely,

Connie Freeman

Submitter : **Mrs. Glyn Satterfield** **Date: 09/19/2007**

Organization : **Mrs. Glyn Satterfield**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Glyn Satterfield
2102 South Ithica Ave.
Russellville, AR 72802
479-967-1642

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

I am writing this letter as a grand parent and a member of a community with a day habilitation center. I have seen many children improve with the help of MiChild Enrichment Center. They get one on one help with feeding skills and socialization. Heaven only knows what would happen if not for the day habilitation services that they receive everyday. One particular child that I have the pleasure of knowing, can sit and pay attention for longer periods of time; which was impossible only a few short months before.

I have learned that last month, the federal agency that oversees Medieaid proposed a rule that will eliminate from the Arkansas Medicaid Program day habilitation services to children and adults with developmental disabilities. The federal government has gone too far. These services help these individuals lead more productive and fulfilling lives, remain in their homes and communities, and in many instances, avoid the high cost of institutionalization. DON T let day habilitation services disappear in Arkansas.

Sincerely,

Glyn Satterfield

Submitter : **Ms. Leslie Hesselbein** **Date: 09/19/2007**

Organization : **Ms. Leslie Hesselbein**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie Hesselbein
80 Coffman Drive
Dover, AR 72837
479-964-4009

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

My son, Dakota, receives day habilitation services at a DDTCS center. My Child has developmental delays in certain areas. I am a working mother and know his individualized needs are being in the day habilitation center where he is enrolled. If you take away his classroom (day habilitation) services, he will be forced to attend a regular daycare where his individualized needs will only be addressed if they interrupt the group. Dakota s vocabulary has increased tremendously in his brief stint at MiChild Enrichment Center.

I understand that last month, the federal agency that oversees Medicaid proposed a rule that will eliminate from the Arkansas Medicaid Program day habilitation services to children and adults with developmental disabilities. Please DO NOT let this happen. You must help us stop day habilitation services from disappearing in Arkansas.

Sincerely,

Leslie Hesselbein

Submitter : **Ms. Natalie McCormick** **Date: 09/19/2007**

Organization : **Ms. Natalie McCormick**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Natalie McCormick
P. O. Box 10353
Russellville, AR 72812
479-890-5899

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

I have recently learned that the federal government agency wants to pass a rule that will eliminate day habilitation services from the Arkansas Medicaid Program to children and adults with developmental disabilities.

This would be a horrendous mistake. I know so many families with children who have benefited from the DDTCS in my community that I can t imagine what will happen to the children if services were no longer available to them. One of many testimonials to the success of day habilitation is of a baby born at 26 weeks gestation and weighing just over one pound. He had many medical diagnoses and started attending our local DDTCS (MiChild) almost as soon as he was released from the hospital. He received all services along with day habilitation. He just turned three and is a true miracle. He has come so far and has overcome so much. He is walking with the help of a walker. He watches and learns and has an amazing drive to do everything his friends are doing. I know that if it wasn t for the individualized goals and instruction from the day habilitation center he attended he wouldn t be the child he s going to become.

The government has gone too far. Day habilitation services help persons with developmental disabilities to lead more productive and fulfilling lives, remain in their homes and communities, and in many instances, avoid the high costs of institutionalization. Please DON T let the federal government take away the only chance these children have to catch up and perform to the best of their ability.

Sincerely,

Natalie McCormick

Submitter : **Mrs. Nicole Prather** **Date: 09/19/2007**

Organization : **Mrs. Nicole Prather**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Nicole Prather
1200 S. Denver
Russellville, AR 72801
479-890-9328

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

I am a working mother whose son gets classroom services (day habilitation) in Russellville, AR. Joshua has been doing well since he started in the classroom a year ago. He doesn t have other children in the neighborhood and this is the only chance he gets to interact with children his own age. He now seeks out children to play with and it has improved his social development greatly.

Joshua also receives speech, occupational, and physical therapy. He is able to receive all his services including day habilitation in one place. I don t have to take time off from work to shuttle him back and forth for outpatient services. Without the classroom services he has been exposed to day in and day out, Joshua would not have made as much progress as he has. They teach him how to play with his friends and share.

Joshua s communication has been very much improved. He doesn t throw as many fits because he can let us know what he wants. He has learned a lot from being in small groups of children his own age; please don t take that away from him. It is a fact that persons with developmental disabilities who don t receive day habilitation services will have more problems and it will cost more in the long run. The day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. Please don t let them take it away.

Sincerely,

Nicole Prather

Submitter : **Ms. Robynne Jackson** **Date: 09/19/2007**

Organization : **Ms. Robynne Jackson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Robynne Jackson
P. O. Box 594
Dover, AR 72837
479-858-8108

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

My son has been enrolled in a DDTCS center in Russellville, AR since he was 6 weeks old. He has been nurture and loved by everyone there. I could return to work knowing my child was in a safe and happy place that was addressing all of his individualized needs. Whether it was playing with his friends correctly and nicely or working on his sensory issues with textures, I know Noah is getting what he needs. He is developing well and it gives me peace of mind to know that he is receiving all the services he needs to continue to grow and prosper.

If Noah didn t attend the local DDTCS, I would lose hours of work that keep the government from having to pay welfare and food stamps for my family. I think it is a worthwhile program for all the children and adults in Arkansas.

I have been told that in Arkansas, the DDTCS is in jeopardy. The federal government has gone too far. If Day Habilitation services are no longer covered by Medicaid, may persons with developmental disabilities will no longer be eligible for services and will be forced to fend of themselves. This program is designed to help prepare children for kindergarten and the earlier that they get recognized and helped the less time and money they will need to catch up in the long run.

Sincerely,

Robynne Jackson

Submitter : **Mrs. Shirley Judkins** **Date: 09/19/2007**

Organization : **Mrs. Shirley Judkins**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Shirley Judkins
1010 East 47th Street
Russellville, AR 72802
479-880-1014

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

I am a US citizen and live in a community with a DDTCS center. I have seen many children, including my own granddaughter benefit from day habilitation services. A family I know has a son diagnosed with autism who recently started kindergarten. Because of the classroom services provided by day habilitation, this child has surpassed everyone s expectations. Before he started day habilitation services he was withdrawn and only played by himself. He has social skills that he acquired through classroom day habilitation s individualized goals taught him how to work and play in a social setting. If it weren t for MiChild s services he wouldn t have done as well in public school as he has.

I have been informed that in Arkansas, the DDTCS center is in indanger. The federal government can t do this. If Day Habilitation services are no longer covered by Medicaid, may persons with developmental disabilities will no longer be eligible for services and will be forced to fend of themselves.

Sincerely,

Shirley Judkins

Submitter : **Mrs. Danielle Tarkington** **Date: 09/19/2007**

Organization : **Mrs. Danielle Tarkington**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Danielle Tarkington
606 North Erie
Russellville, AR 72802
479-880-1845

September 18, 2007

Dear Mr. or Ms. US Senators/Representatives;

My son, Hunter, attends the MiChild Enrichment Center in Russellville, AR. He receives day habilitation and other therapies in one building. This has been a blessing for my family. Without this DDTCS center I would have had to quit my job and stay at home to see to Hunter s unique needs. He has learned more being in this center than he would have at home. They are constantly being trained in the most current methods to improve children s learning ability. Because Hunter is being helped with his individual needs, I feel comfortable going to work and providing for my family.

I have learned that the federal agency overseeing Medicaid has proposed a rule that will eliminate day habilitation services to children and adults with developmental disabilities from the Arkansas Medicaid Program. These services help these individuals lead more productive and fulfilling lives, remain in their homes and communities, and in many instances, avoid the high cost of institutionalization. DON T let day habilitation services disappear in Arkansas. Help our individuals with disabilities stay strong.

Sincerely,

Danielle Tarkington

Submitter : **Mr. Bryan Link** **Date: 09/19/2007**

Organization : **Agape Villa**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

file code CMS-2261-P There maybe a need for clarification of rehabilitative services yet the intent appears to be to isolate the service due to a conclusion the service is offerred in other programing such as therapeutic foster care. This is not true. TFC was never defined with a skills training component. The core of TFC emphasized training and support to the primary caretaker by a therapist or social worker trained in children's mental health. In addition, developing a relationship with the child through intensive case management and collaboration with other providers. The intensive case management role does provide skills training, however, this often took place in response to a negative behavioral situation at school or in the home. There is also skills training occurring in the home by the parent and this training is akin to daily functioning, self care etc.. At our program Agape Villa in Las Vegas, NV, we operate a core treatment program using the Multidimensional Treatment Foster Care program developed in Oregon. In addition, we have taken rehabilitative skills trainng to a new level by developing a specific program for Impulse Control to reduce the number of aggressive episodes at home, school and community. The Basic Skills program targets teaching youth a problem solving process and goal setting. Essentially, by separating out rehabilitative skills, our program was encouraged to develop more intensive types of individual treatments that impact specific problems in foster care, such as aggression that results in placement disruption and delinquency. This type of training also has a positive residual effect on the therapeutic home environment as well. In my sixteen years working with seriously disturbed children, child welfare financing has not kept pace with changes in our communities. We can effect these problems and we need to have the tools to do so. I have nobody on my payroll who graduated from Harvard.

Submitter : **Mrs. Adtiane Iracheta Iracheta** **Date: 09/20/2007**

Organization : **Mrs. Adtiane Iracheta Iracheta**

Category : **Individual**

Issue Areas/Comments

Background

Background

CMS 2261-P

GENERAL

GENERAL

Adriane Iracheta
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

I am a parent of a child, who goes to MiChild Enrichment Center located here in Russellville, Arkansas. She attends this day habilitation at this center..
If it was not to day habilitation centers here in our area I would not be able to go to work. I would have to stay home with my daughter. It would affect me by not allowing me to be able to go to work to support my child. I would be very disappointed if these facilities were closed down. With these Developmental Day Treatment Clinic Services here in Arkansas in jeopardy of losing a substantial portion of there funding our children are at risk of not being properly integrated into mainstream classroom when they being kindergarten.
My daughter was born 12 weeks premature. She attends a day habilitation center in our town. This center has helped Sophie come so far. You can no longer tell that she was premature. She has improved her adjusted age equivalent just from coming to this center and being treated.

Sincerely,

Adriane Iracheta

Submitter : **Mrs. Adrianne Adams** **Date: 09/20/2007**

Organization : **Mrs. Adrianne Adams**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Adrianne Adams
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

Day habilitation has affected my family in the way that without it, my family could not afford other daycare. We are both in college and cannot afford to have our child in a regular daycare facility.
I have no idea what I would do if day habilitation was closed neither one of us work. We are both attending school right now. I would have to find a daycare, a job and quite school. My family would be very upset if this facility that my child attends closed down. Aiden loves it here, he love the staff and they therapy he receives here.
Aiden was not social and was told he did not hold his legs right. He did not sleep alone in his crib. Since coming to this facility he now sleeps in his own crib, and speech therapy has really helped him become more social and physical. We really love that we are able to use this facility. We need it be to have a place for our child to go during the day while we are at school. People like us, with children with developmental delays who receive day habilitation services will have more problems and will cost a lot more money and I really do not want to have to quit school.

Sincerely,

Adrianne Adams

Submitter : **Mrs. Alyssa Petty** **Date: 09/20/2007**

Organization : **Mrs. Alyssa Petty**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Alyssa Petty
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

I am an employee who works in a day habilitation center here in Arkansas.
Day habilitation helps so many people financially. People who are on Medicaid really rely on these types of facilities to help them so they are able to work and go to school. It really helps the children learn goals and how to better themselves in life.
Day Habilitation really helps these developmental delayed children by allowing them to enter the public school system with less delays and being more age equivalent with their peers. If not for these types of centers children would enter the schools with more delays then they already, have putting these children behind in school. Day habilitation services help children and adults with developmental disabilities to lead more productive and fulfilling lives, remain in their homes and communities, and in many instances, avoid the high costs of institutionalization.
I have seen children come from these types of facilities and go into kindergarten with little to no delays. I have also seen a child who had severe autism go into kindergarten with improved social skills and writing skills, without this facility these accomplishments would not have been possible.
We are asking you to consider what taking the day habilitation will do to so many families.

Sincerely,

Alyssa Petty

Submitter : **Ms. Angela Cotton** **Date: 09/20/2007**

Organization : **Ms. Angela Cotton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Angela Cotton
ARKANSAS

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Tylier, Natalie and Hayden who receive day habilitation services as younger children. As a parent I am very concerned with the possibility that the state of Arkansas may no longer be able to provide these services to children and adults in need as covered by Medicaid.

The day habilitation services my children received enabled them to go to kindergarten and be at the same level as the other children in their classes. My children received speech, occupational and physical therapies while at the facility. I would not have been able to work without the daycare services provided as I would not have been able to have them in a traditional daycare setting.

I was a young mother and my son was in MiChild Enrichment Center because he and I needed it. I would not have the family life or professional life that I have today had the services not been here. It has not only given my children a chance to grow to their own potential, but it reinforced to me that I was a good parent and allowed me the chance to help others.

The government has gone too far. The need for this type of service goes much further than my own children as I personally know many adults and children that benefit from day hab services. The United States government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Angela Cotton

Submitter : **Mrs. Angela Reeves** **Date: 09/20/2007**

Organization : **Mrs. Angela Reeves**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Angela Reeves
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Jacob and Caleb Reeves, children who receive day habilitation services here in Russellville. I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services have provided so much for my children. If there were no day hab services for them, they would certainly not be able to receive the services needed in a regular daycare. Parents would have to stay at home with their children and would not have the therapies or respite care available to them.

Jacob has autism and was not able to socialize. It helped him to integrate with other children and helped prepare him for kindergarten. Caleb was born premature and has been making great progress to catch up to other children his age.

Day habilitation service help persons with developmental disabilities and their families to lead more normal, productive and fulfilling lives. I am appalled by what the U.S. government is trying to do. Persons with developmental disabilities who don t receive day hab services will have more problems and will cost more money. These people would have to fend for themselves. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Angela Reeves

Submitter : **Mrs. Ashley Roach** **Date: 09/20/2007**

Organization : **Mrs. Ashley Roach**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Ashley Roach
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

I am a parent of a child who attends a facility funded by Medicaid. Carter receives his therapy at this facility. His doctors at Children Hospital are amazed at his progress. Me being a mother of a child with disabilities I have learned a lot about how to properly care and help my son make progress.
If these facilities were closed because funding was taken I would not be able to work to support my child. My debts would increase. My son has been at this day habilitation center for 6 weeks now; he has made so much progress he now sits up by himself at 5 months old, after I was told my doctor that Carter was not expected to be able to do this till around 2 years of age. So I am asking you to consider what this would do for all these children.

Sincerely,

Ashley Roach

Submitter : **Miss. Ashli Darter**
Organization : **Miss. Ashli Darter**
Category : **Individual**

Date: 09/20/2007

Issue Areas/Comments

GENERAL

GENERAL

Ashli Darter
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

I am an employee who works in a day habilitation center here is Arkansas.
Day habilitation helps so many people financially. People who are on Medicaid really relying on these types of facilities to help they are able to work and go to school. It really helps the children learn goals and how to better themselves in life.
Day Habilitation really help these developmental delayed children by allowing them to enter the public school system with less delays and being more age equivalent with their peers. If not for these types of centers children would enter the schools with more delays then they already have putting these children behind in school. Day habilitation services help children and adults with developmental disabilities to lead more productive and fulfilling lives, remain in their homes and communities, and in man instances, avoid the high costs of institutionalization.
I have seen children come from these types of facilities and go into kindergarten with little to no delays. I have also seen a child who had severe autism go into kindergarten with improved social skills and writing skills, without this facility these accomplishments would not have been possible.
We are asking you to consider what taking the day habilitation will do to so many families.

Sincerely,

Ashli Darter

Submitter : **Mrs. Barbara Campbell** **Date: 09/20/2007**

Organization : **Mrs. Barbara Campbell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Barbara Campbell
Arkansas

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the grandparent two children who recieved day habilitation services through MiChild Enrichment Center in Russellville. I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services have provided so much for my grand children. Three years ago my son, their uncle whom they were exceptionally close to, passed away. Because of his death the children developed many issues. Their behavior changed drastically. My grandson started acting out and had major sensory processing issues. My granddaughter stopped talking altogether. Because of their treatment, they were able to enter kindergarten as normal children. They are coping so well. They are wonderfully behaved and maintain their happy moods. They communicate on a level I never expected. They were able to receive their speech, occupational, developmental and physical therapies all in one location.

I am appalled by that the U.S. government is trying to do away with this service. Speaking just of our family, I have no idea what we would have done without it. I cannot even imagine where those children would be developmentally at this point. I know they are living to their potential because of the early interventions they received. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Barbara Campbell

Submitter : **Mrs. Brigitte Ann Martin** **Date: 09/20/2007**

Organization : **Mrs. Brigitte Ann Martin**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Brigitte Ann Martin
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As a citizen of the United States of America I am appalled that the federal government is trying to make day habilitation services disappear. Day hab services provide so much for children and adults with so many needs. These people have the opportunity to receive daily therapies, be around other people like themselves, and give them a chance to see that they are not different. Many of the children cannot attend a regular preschool or daycare because their medical needs, developmental needs, or behaviors cannot be accommodated.

I personally was touched by a child who received day habilitation services here in Russellville. Before Alexis started her treatments, she could not be understood, she was socially detached and could not function at an age appropriate level. Her intense therapies allowed her to enter kindergarten on a level closer to her peers. It allowed her family the respite care needed to give them an opportunity to work to provide for their family.

The U.S. government has gone too far. The need for this type of service goes much further than people can comprehend and the government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Brigitte Ann Martin

Submitter : **Mrs. Corina Reichert** **Date: 09/20/2007**

Organization : **Mrs. Corina Reichert**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Corina Reichert
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Gavin and Ethan Reichert who receive day habilitation services. As a parent of children with special needs I am very concerned with the possibility that the state of Arkansas may no longer be able to provide these services to children and adults in need as covered by Medicaid.

Ethan receives occupational and developmental therapies and I have seen a complete transformation in behavior and communication because of the treatments and therapies he has been receiving. Gavin receives speech and developmental therapies and is learning more than I ever expected. My children would not have been able to receive these therapies if it were not for Medicaid providing payment for their day habilitation.

Day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. Again, I cannot imagine where my children would be today if they had not received the treatments and therapies that were covered in this service. If they were not able to participate in the programs they was enrolled in, I would not have been able to work and provide for my family. The program allowed me care for them, in the setting that provides an appropriate atmosphere to enhance their growth and development.

The federal government has gone too far and they must be stopped from making day habilitation services unavailable in the state of Arkansas.

Sincerely,

Corina Reichert

Submitter : **Mrs. Dacia Petty** **Date: 09/20/2007**

Organization : **Mrs. Dacia Petty**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dacia Petty

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As an advocate for children with disabilities and as a United States citizen I am very concerned with the possibility that the state of Arkansas may no longer be able to provide day habilitation services to children and adults in need as covered by Medicaid. As a parent of a child who has overcome developmental delays, it infuriates me.

Day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. My son, Payton Wornick, received day habilitation through Friendship in Russellville as a younger child. These services provided an opportunity for him to receive the help in his fine motor skills he needed. It evened the playing field for him as he entered kindergarten.

The fact that my child was able to receive these services through his Medicaid helped greatly financially. I was able to continue to work to provide for my family and did not have to worry about privately paying for his child care. I cannot imagine what the cost would have been for me to pay out-of-pocket for the treatments and therapies he received. I also cannot imagine where Payton would be today had he not received those therapies. The United States government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Dacia Petty

Submitter : **Mrs. Faith Hudnall** **Date: 09/20/2007**

Organization : **Mrs. Faith Hudnall**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Faith Hudnall
Arkansas

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As an advocate for children with disabilities and as a United States citizen I am very concerned with the possibility that the state of Arkansas may no longer be able to provide day habilitation services to children and adults in need as covered by Medicaid.

The day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. These services provide so much for not only the child or adult who receives the service, but to their families as well. It prepares both minimally and severely delayed children for entering kindergarten. It allows the parents and families an opportunity to learn what their child is entitled to and encourages their involvement in their treatments, therapies and education.

The government has gone too far. Without the day habilitation services many children would continue to be environmentally deprived and would not have the chance to meet their own potentials. Research has shown that the age between 0-3 years old allows the best chance for positive growth and development. The United States government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Faith Hudnall

Submitter : **Mrs. Holly Dye** **Date: 09/20/2007**

Organization : **Mrs. Holly Dye**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Holly Dye
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Kayla Dye who received day habilitation services as a younger child. As a parent of a child with special needs I am very concerned with the possibility that the state of Arkansas may no longer be able to provide these services to children and adults in need as covered by Medicaid.

I cannot imagine where my child would be today if she had not received the treatments and therapies that were covered in this service. If Kayla were not able to participate in the program she was involved in, I would not have been able to work and provide for my family. The program allowed me respite care for her, in a setting that provides an appropriate atmosphere to enhance her growth and development.

The federal government has gone too far and they must be stopped from making day habilitation services unavailable in the state of Arkansas.

Sincerely,

Holly Dye

Submitter : **Mrs. Jennifer Metz** **Date: 09/20/2007**

Organization : **Mrs. Jennifer Metz**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Jennifer Metz
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Matthew Metz who received day habilitation services as a child. As a parent of a child with special needs I am very concerned with the possibility that the state of Arkansas may no longer be able to provide these services to children and adults in need as covered by Medicaid.

The day habilitation services he received enabled him to have intense instruction in areas he was deficient in so once he entered school, he was prepared for these situations. His treatment center provided a sense of normalcy and made available all the resources without having to search.

Day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. I cannot imagine where Matthew would be today if they had not received the treatments and therapies that were covered in this service. If day habilitation services are no longer covered by Medicaid, many persons with developmental disabilities will no longer be eligible for services and will be forced to fend for themselves. Not only did the program provide him with the therapies he needed to grow and thrive, but it allowed me to work to provide for my family. Day habilitation facilities also allowed me the opportunity to realize that I was not the only one out there with a child with disabilities. I realized I could trust people with taking care of Matthew after seeing how they were treating him. It gave me an emotional support group that I certainly would not have had otherwise. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Jennifer Metz

Submitter : **Mr. John Campbell** **Date: 09/20/2007**

Organization : **Mr. John Campbell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

John Campbell
Arkansas

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the grandparent two children who recieved day habilitation services through MiChild Enrichment Center in Russellville. I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services have provided so much for my grand children. Three years ago my son, their uncle whom they were exceptionally close to, passed away. Because of his death the children developed many issues. Their behavior changed drastically. My grandson started acting out and had major sensory processing issues. My granddaughter stopped talking altogether. Because of their treatment, they were able to enter kindergarten as normal children. They are coping so well. They are wonderfully behaved and maintain their happy moods. They communicate on a level I never expected. They were able to receive their speech, occupational, developmental and physical therapies all in one location.

I am appalled by that the U.S. government is trying to do away with this service. Speaking just of our family, I have no idea what we would have done without it. I cannot even imagine where those children would be developmentally at this point. I know they are living to their potential because of the early interventions they received. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

John Campbell

Submitter : **Mrs. Kathy Craig** **Date: 09/20/2007**

Organization : **Mrs. Kathy Craig**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Kathy Craig
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

I am a parent of a child, who goes to MiChild Enrichment Center located here in Russellville, Arkansas. He attends this day habilitation at this center. Cody also received therapy at this facility.
Cody, my son can not go to any other daycare because he has been kicked out of all other day care facilities in town. Cody is Bi-polar, ADHD and was not a very social child. Cody is now a more social person and is getting treated for his other diagnosis.
If Medicaid funded day habilitation centers were closed my son would not be able to go into mainstream public school. I think the federal government has gone too far by doing this. The people need these types of centers to help the children be ready for public school.
Michild Enrichment Center, the facility my child goes to for his day habilitation has helped my boy so much. Cody went from not playing with any kids to going to children and initiating play with them. He started to facility when he was 2 years old, after one treatment session Cody was able to sleep for 1st full night.
Day habilitation has helped my son a lot. Please don t take these services from these children who need them to better themselves. They must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Kathy Craig

Submitter : **Mrs. Katie Loyd** **Date: 09/20/2007**

Organization : **Mrs. Katie Loyd**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Katie Loyd
Arakansas

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As an advocate for children with disabilities and as a United States citizen I am very concerned with the possibility that the state of Arkansas may no longer be able to provide day habilitation services to children and adults in need as covered by Medicaid.

Day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. I personally know a young child who receives day habilitation right here in Russellville. Because these services were available to him and his family Aden is no longer isolated by his autism. He is interacting and talking with other children and adults. It has helped him, and many other children develop socially while giving them needed skills to entered kindergarten.

The United States government must be stopped from making day habilitation services disappear in Arkansas. Not only will Aden be affected by this, but a countless other children, adults and families. Day habilitation services provide and important safety net for many.

Sincerely,

Katie Loyd

Submitter : **Mrs. Laurel Howerton** **Date: 09/20/2007**

Organization : **Mrs. Laurel Howerton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Laurel Howerton
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As a citizen of the United States of America I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services provide so much for children and adults with so many needs. These people have the opportunity to receive daily therapies, be around other people like themselves, and give them a chance to see that they are not different. Many of the children cannot attend a regular preschool or daycare because their medical needs, developmental needs, or behaviors cannot be accommodated. Many parents are able to be educated by the professionals who service these children and it provides a support group for many families.

I am appalled by what the U.S. government is trying to do. Persons with developmental disabilities who don t receive day hab services will have more problems and will cost more money. These people would have to fend for themselves. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Laurel Howerton

Submitter : **Mrs. Lynda Steed** **Date: 09/20/2007**

Organization : **Mrs. Lynda Steed**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Lynda Steed
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Cameron Steed, a wonderful child who received day habilitation services. As a parent of a child with special needs I am very concerned with the possibility that the state of Arkansas may no longer be able to provide these services to children and adults in need as covered by Medicaid.

The day habilitation services she received allowed her to attend a preschool socially and allowed her to transition as well as she did upon entering kindergarten. The services she received gave Cameron confidence in social settings and within herself. Her delays were identified prior to public school and allowed for the early intervention to begin at an age that the benefits were most profound.

Day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. The concerns I have about where Cameron would have been without her treatments are vast. Cameron is big for her age and most people think her older than she is. If she had not had her day treatments I am certain she would have needed to repeat kindergarten. I cannot imagine the social aspects of that compounding her already present social deficiencies. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Lynda Steed

Submitter : **Mrs. Maureen Grace** **Date: 09/20/2007**

Organization : **Mrs. Maureen Grace**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Maureen Grace
Arkansas

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As an advocate for children with disabilities and as a United States citizen I am very concerned with the possibility that the state of Arkansas may no longer be able to provide day habilitation services to children and adults in need as covered by Medicaid.

The day habilitation services provide an important safety net for children and adults with developmental disabilities and their families. I personally know a young child who receives day hab services in Russellville. This sweet boy has changed tremendously. Prior to receiving the needed services he would not speak or interact with other children. Ethan could not express himself effectively and became very frustrated. The progress he has made has given him the ability to interact with other children his age and to be able to express something as simple as his likes and dislikes without any frustration. The program has also given Ethan s family a chance to see their child go to school in a setting that will not make him stand out as different

The government has gone too far. The need for this type of service goes much further than just Ethan The availability of services that are offered at Ethan s day habilitation site are not available in traditional daycare settings. The United States government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Maureen Grace

Submitter : **Mrs. Sarah Cogburn** **Date: 09/20/2007**

Organization : **Mrs. Sarah Cogburn**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sarah Cogburn
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

Day habilitation helps so many people financially. People who are on Medicaid really rely on these types of facilities to help them be able to work and go to school. These children and adults really need these kinds of facilities to better themselves and help reduce their delays. The children really need this so that they can start kindergarten without being behind the rest of their peers.
Day Habilitation really helps the developmental delayed children by, allowing them to enter the public school system with less delays and being more age equivalent with their peers. If not for these types of centers children would enter the schools with more delays then they already have, putting these children behind in school. Last month, as you already know the federal agency that oversees Medicaid proposed a rule that would eliminate from the Arkansas Medicaid Program, day habilitation services to children and adults with developmental disabilities. Day habilitation services provide an important safely net for children and adults with developmental disabilities along with their families.
I have seen children come from these types of facilities and go into kindergarten with little to no delays.
We are asking you to consider what taking the day habilitation will do to so many families right here in Arkansas. The federal government has gone too far by wanting to eliminate these types of facilities. These centers are only here to help, to be a safe harbor to encourage people with disabilities to know that they are not alone and do have someone to help them. If day habilitation services are no longer covered by Medicaid, many people with developmental disabilities will no longer be eligible for services and will be forced to fend for themselves.
So I ask you to consider what you would be doing for so many people out there with family members with disabilities. Give them the opportunity we all know that they deserve. Give them the chance to better themselves. Give them hope.

Sincerely,

Sarah Cogburn

CMS-2261-P-107

Submitter : Miss. Sherry Gooch **Date:** 09/20/2007

Organization : Miss. Sherry Gooch

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Sherry Gooch
Arkansas

September 18, 2007

Dear Arkansas Representative/Senator,

I am a parent of a child, who goes to MiChild Enrichment Center located here in Russellville, Arkansas.
Day habilitation centers made my oldest child whom had many delays ready to start school, she is now caught up and is starting school. Without these centers Savannah who attends MiChild now, would not have any interaction with other children it would severely limit her social growth. Cecilia, Savannah s older sister was 2 and couldn t talk coming to this center has helped her learn to sign and eventually talk.
These centers are a large portion of our children s lives. The government is going too far by trying to take this away.

Sincerely,

Sherry Gooch

Submitter : **Mrs. Sonya Roach** **Date: 09/20/2007**

Organization : **Mrs. Sonya Roach**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sonya Roach
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Peyton and Kameron Roach who receive day habilitation services. As a parent I am very concerned with the possibility that the state of Arkansas may no longer be able to provide these services to children and adults in need as covered by Medicaid.

The day habilitation services Peyton received enabled him to have treatment for his needs in a setting that allowed him to be around other children with special needs and learn acceptance. The program prepared him for kindergarten, emotionally as well as developmentally. He started school without any problems and I am sure the outcome would not have bee the same had he not received his therapies. His treatment center provided a sense of normalcy and structure for him. Kameron is still enrolled in his program and is doing exceptionally well.

The government has gone too far. The need for this type of service goes much further than my own children as I personally know many adults and children that benefit from day hab services. The United States government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Sonya Roach

CMS-2261-P-109

Submitter : Mrs. Stacy Anderson **Date:** 09/20/2007

Organization : Mrs. Stacy Anderson

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Stacy Anderson
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As a citizen of the United States of America I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services provide so much for children and adults with so many needs. These people have the opportunity to receive daily therapies, be around other people like themselves, and give them a chance to see that they are not different. Many of the children cannot attend a regular preschool or daycare because their medical needs, developmental needs, or behaviors cannot be accommodated. Many parents are able to be educated by the professionals who service these children and it provides a support group for many families.

I am appalled by what the U.S. government is trying to do. Persons with developmental disabilities who don t receive day hab services will have more problems and will cost more money. These people would have to fend for themselves. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Stacy Anderson

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As a citizen of the United States of America I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services provide so much for children and adults with so many needs. These people have the opportunity to receive daily therapies, be around other people like themselves, and give them a chance to see that they are not different. Many of the children cannot attend a regular preschool or daycare because their medical needs, developmental needs, or behaviors cannot be accommodated. Many parents are able to be educated by the professionals who service these children and it provides a support group for many families.

I am appalled by what the U.S. government is trying to do. Persons with developmental disabilities who don t receive day hab services will have more problems and will cost more money. These people would have to fend for themselves. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

CMS-2261-P-110

Submitter : Mr. Todd Wood **Date:** 09/20/2007

Organization : Mr. Todd Wood

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Todd L. Wood
Arkansas

September 19, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

I am the parent of Jarod Wood, one of the many children who have received day habilitation services here in Russellville. I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services have provided so much for my child. Jarod started at the center at about 6 months old and was there until he entered kindergarten a few years ago. He had major delays in his gross and fine motor skills and I saw progress on a daily basis with him. He can now communicate with other children of all abilities and adults in his life without frustration. The transition to kindergarten was so much easier for him because of the skills he received through Friendship.

Day habilitation service help persons with developmental disabilities and their families to lead more normal, productive and fulfilling lives. I am appalled by what the U.S. government is trying to do. Speaking just of our family, I have no idea what we would have done without it. I cannot even imagine where Jarod would be developmentally at this point. I know he is living to his potential because of the early interventions he received. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Todd L. Wood

CMS-2261-P-111

Submitter : **Ms. Vanesse Eddy** **Date: 09/20/2007**

Organization : **Ms. Vanesse Eddy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Vanessa Eddy
Arkansas

September 18, 2007

Dear Mr. or Ms. U.S. Senator or Representative:

As a citizen of the United States of America I am very concerned that the federal government is trying to make day habilitation services disappear. Day hab services provide so much for children and adults with so many needs. These people have the opportunity to receive daily therapies, be around other people like themselves, and give them a chance to see that they are not different. Many of the children cannot attend a regular preschool or daycare because their medical needs, developmental needs, or behaviors cannot be accommodated.

My grandson, Dustin Popejoy, received therapies at MiChild in Russellville and made such progress. All of his therapies were here in one location. I know he would not have been able to stay at a regular daycare because his needs were too extensive for them to accommodate. The expenses associated with raising a special needs child are high enough, it makes it impossible to afford to privately pay for all the needed services.

I am appalled by what the U.S. government is trying to do. Persons with developmental disabilities who don t receive day hab services will have more problems and will cost more money. These people would have to fend for themselves. I have seen children who would have been labeled as disabled the rest of their lives but because of their day hab program, have entered kindergarten as an equal to their peers. The government must be stopped from making day habilitation services disappear in Arkansas.

Sincerely,

Vanessa Eddy

Submitter : **Ms. Joanna Piker** **Date: 09/20/2007**

Organization : **Ms. Joanna Piker**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Joanna Piker
Arkansas

September 18, 2007

Dear US Representative and US Senator,

It has come to my attention that the federal agency that oversees Medicaid proposed a rule that will eliminate from the Arkansas Medicaid Program day habilitation services to children and adults with developmental disabilities. This must be stopped from making day habilitation services disappear in Arkansas.
I have many friends that have children in the DDTCS program in the state of Arkansas. These families have been helped and have shown great progress through the DDTCS programs in Arkansas. My friend was able to keep her job and make sure her child had services through the Day habilitation program.
Persons with developmental disabilities who don t receive day habilitation services will have more money throughout the child and adults life.
I do not want to see my friend forced to fend for herself to protect her child. The Day habilitation program has provided a loving caring environment for the child and mother. My questions to you is:
Will you help my friend and her family if the Arkansas Day habilitation program is eliminated?
My friend credits the day habilitation service for her child s progress in walking, speaking, moving towards developmental milestones. Our small support group is very upset and feels as if the federal government has gone too far to try to eliminate these services. It is not enough to have a child or adult with a disability.
We will continue to advocate for our friends that have children with disabilities.
I disagree and would like you to be against eliminating of Medicaid services to persons with development disabilities. I do not want out DDTCS programs to be in jeopardy.

Sincerely,

Joanna Piker

CMS-2261-P-113

Submitter : **Date: 09/20/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Heather Bean, Arkansas
SAY NO TO ENDING DAYHABILITATION AND DDTCS!!

CMS-2261-P-114

Submitter : **Date: 09/20/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Alicia Harmon, Arkansas
SAY NO TO ENDING DAYHABILITATION AND DDTCS!!

Submitter : Dr. Christopher Johnson **Date:** 09/20/2007

Organization : NASW

Category : Social Worker

Issue Areas/Comments

Background

Background

Non-covered services: 441.45(b)

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. ? 1396d(a). See 42 U.S.C. ?? 1396a(a)(10), 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:

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

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

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

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

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

GENERAL

GENERAL

Related Medicaid Rehabilitation Issues:
1) Payment and Accounting for Services

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

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

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

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

Recommendation:

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

2) EPSDT Mandate

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

Recommendation:

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

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

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

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

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

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

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

Recommendation:

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

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

Rehabilitative Services : 441.45(a)(2)-

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

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

Recommendation:

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

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

Recommendation:

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

managed care plans at 42CFR 438.210(a)(4)(ii)(B)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

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

Submitter : **Ms. Jean Anne Cipolla** **Date: 09/20/2007**

Organization : **Ms. Jean Anne Cipolla**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I agree in principal and theory with all comments, recommendations, and legal arguments and proposed changes to the bill sent to you by Chris Koyanagi of the Bazelon Center for Mental Health Law and as such, I desire these changes and recommendations to be made. The proposed changes to the rehabilitation service category will restrict access to intensive community mental health services needed by adults and children with disabilities who rely on Medicaid for their healthcare. These rehabilitative services help people avoid institutionalization and live productive lives in community and society. Please take seriously Bazelon's letter and recommendations and rethink the changes to the rehabilitation service category.

Submitter : **Mrs. Celeste Stevenson** **Date: 09/20/2007**

Organization : **Mrs. Celeste Stevenson**

Category : **Individual**

Issue Areas/Comments

Background

Background

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by (insert your name, address and affiliation)

Non-covered services: 441.45(b)

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

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. ? 1396d(a). See 42 U.S.C. ?? 1396a(a)(10), 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:

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

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

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

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

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

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

The regulation denies payment for therapeutic foster care as a single program, requiring instead that each c

GENERAL

GENERAL

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Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by (insert your name, address and affiliation)

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

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. ? 1396d(a). See 42 U.S.C. ?? 1396a(a)(10), 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:

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

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

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

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

Submitter : **Date: 09/20/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-2261-P-118-Attach-1.DOC

#118

Sharon Perry
1403 Inyo #30
Crescent City, CA 95531

Re: File Code CMS-2261-P

I'm a fifty five year old disabled woman who lives in a small rural county in Northern California. Because of my bipolar mental disability, I'm on SSI and SDI. For the last twenty years, I've been a mental health patient at the county Mental Health Department where I live. In many respects, the support and treatment that I've received here has enriched my life and kept me from having to be hospitalized. Indeed, I believe it's safe to say that it probably has saved my life. The purpose of this letter is to express my opinion on the proposed changes by the Centers for Medicare and Medicaid (CMS) rehabilitation service category that could restrict access to intensive community mental health services. Children and adults with disabilities who rely on Medicaid for their healthcare depend on these services.

As the single most significant source of financing for the public mental health system, Medicaid provides needed access to community-based care through the rehabilitative services option to help children and adults avoid institutionalization. The new rules could also have a profound effect on Medicaid services needed by other vulnerable populations, including people with physical and developmental disabilities.

Listed below are comments and suggestions regarding the proposed changes.

Non-covered services: 441.45(b)

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

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

latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

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

Recommendation:

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

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

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

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

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

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

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

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

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

Recommendation:

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

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

Rehabilitative Services : 441.45(a)(2)-

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

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

Recommendation:

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

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

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

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

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

This definition also includes as appropriate rehabilitation services services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services is at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services. There is concern that states and providers will interpret the current proposed regulation as prohibiting coverage of services necessary for retention of improved functioning and for maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Recommendation:

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

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

Related Medicaid Rehabilitation Issues:

1) Payment and Accounting for Services

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

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

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

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

Recommendation:

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

2) EPSDT Mandate

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

Recommendation:

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

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

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

Submitter : **Ms. Doris mendlovitz** **Date: 09/21/2007**

Organization : **Self**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I think it is a mistake to take away services like medicaid becaues of users of the mental health rehabiltation or therapy.Why do you want these people to suffer. Its bad enough that they are shunned by society and suffer a tremendous amount of discrimination and are often subjected to all kinds of discriminatory actions of society by the very ignorance that you are preposing to enhance by taking away the very treatment that allows these same people to function in society in a normal fashion as others think of it.

Submitter : **Ms. Margaret Holt Baird** **Date: 09/21/2007**

Organization : **Ms. Margaret Holt Baird**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

Regulatory Impact Analysis

Regulatory Impact Analysis

CMS-2261-P-120-Attach-1.DOC

#120

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by Margaret Holt Baird

Non-covered services: 441.45(b)

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

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

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Recommendation:

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

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

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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.

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

Recommendation:

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

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

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

Recommendation:

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

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

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This definition also includes as appropriate rehabilitation services services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services is at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services. There is concern that states and providers will interpret the current proposed regulation as prohibiting coverage of services necessary for retention of improved functioning and for maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Recommendation:

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

Submitter : **Mrs. Dawn Lehr** **Date: 09/21/2007**

Organization : **Mrs. Dawn Lehr**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please protect day habilitation!!!
My adult daughter, Erica Keller is an employee of East Ark Enterprises, Shelter Workshop in West Memphis, Arkansas.
Since the age of 2 years old she has been treated for brain tumors, strokes, profound hearing loss, mental retardation, severe scoliosis with spinal fusion, short stature, along with other disabilities. But through all her trials she has been strong, determined and inspiration to many.
She has watched her brother and friends grow up and become independant. The shelter workshop has given her a purpose and independance. She is very proud of her work, and loves to tell everyone about it. She hates to miss a day of work.
The benefits of her working at the sheltered workshop are invaluable.
I know that she is in a safe environment each day.
The sheltered workshop allows both of us to work. Without the sheltered workshop we would not be able to work and would probably be on welfare.
I have worked at Le Bonheur Children's Hospital for 20 years.
I would not have been able to do that unless we had the safe haven of East Ark Enterprises.
Please protect day habilitation!!!

CMS-2261-P-122

Submitter : **Dr. Kathryn Ellerbeck** **Date: 09/21/2007**

Organization : **Center for Child Health and Development, KUMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a developmental-behavioral pediatrician and take care of a large number of children who have developmental disorders. These children CLEARLY benefit from behavioral managment of adaptive skills delays and disruptive behaviors. Although I also provide mediation management - good behavioral management is often more successful. It is unfair to restrict these supports to those who have previously had "normal functioning". Habilitation can be very successful for children and their families, and in thc end - the cost will be less than having these children placed in more restrictive environments because of aggressive behaviors and limited sclf-care skills.

Submitter : **Mrs. Lizabeth Taylor** **Date: 09/21/2007**

Organization : **Mrs. Lizabeth Taylor**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-123-Attach-1.TXT

#123

438.210(a)(4)(ii)(B)). An example of a child who was developmentally on track to perform a function, but did not because it was not yet age-appropriate would be helpful. Currently, the regulation only has an example of an adult.

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

Related Medicaid Rehabilitation Issues:

1) Payment and Accounting for Services

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

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

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

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

Recommendation:

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

2) EPSDT Mandate

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

Recommendation:

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

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

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

Lizabeth Taylor
1898 Highway 188 East
Mount Ida, AR 71957
lizabethtaylor@hotmail.com

September 20, 2007

Dear Senators/US Representatives:

I have been informed that Congress is trying to cut funding for ***Developmental Day Treatment Clinic Services*** **(DDTCS)**. I am in disbelief that the Congress would even consider cutting funding to some of the weakest among us. These programs offer hope to the families of adults and children with developmental disabilities. There are many other programs and areas where spending could be cut back including your own salaries...you should be ashamed. I am afraid many in Congress have allowed greed to take control rather than integrity, honesty, and common sense.

I have personally toured one of the MiChild Enrichment Centers and was very impressed with the level of caring and support that was offered there. Through kindness, patience, and encouragement these children strive to achieve their individualized learning objectives learning skills and life lessons along the way. Without this program…they may not have another opportunity like this.

Please reconsider pulling funding for this program.

Sincerely,

Lizabeth Taylor

Submitter : **Mr. David Johnson** **Date: 09/21/2007**

Organization : **Mr. David Johnson**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

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

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

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

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

Recommendation:

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

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

Collections of Information Requirements

Collections of Information Requirements

Related Medicaid Rehabilitation Issues:

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

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

GENERAL

GENERAL

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Rehabilitative Services : 441.45(a)(2)-

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

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Recommendation:

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

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

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by David E. Johnson, MSW, LICSW

Non-covered services: 441.45(b)

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

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

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

Recommendation:

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

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

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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.

Regulatory Impact Analysis

Regulatory Impact Analysis

If there is a need to contain costs, the appropriate method is to restrict means tested eligibility. This change targets the most vulnerable and disabled citizens who have no voice, few advocates, and no representation in our political process. It effectively shifts costs to the local level where taxpayers are unlikely authorize increases. The effect of these changes would abandon a whole class of disabled to inadequate services.

Response to Comments

Response to Comments

If there is a need to contain costs, the appropriate method is to restrict means tested eligibility. This change targets the most vulnerable and disabled citizens who have no voice, few advocates, and no representation in our political process. It effectively shifts costs to the local level where taxpayers are unlikely authorize increases. The effect of these changes would abandon a whole class of disabled to inadequate services.

CMS-2261-P-125

Submitter : diane bauknight **Date:** 09/21/2007

Organization : diane bauknight

Category : Individual

Issue Areas/Comments

Background

Background

Mental health does not lend itself for a rehabilitative system. Serious and persistent mental illness is a life-long disorder that requires services and supports to keep people stable enough to live at home instead of being thrown to the streets or put in jails.

Submitter : Ms. susyn rasmussen **Date:** 09/21/2007

Organization : Ms. susyn rasmussen

Category : Individual

Issue Areas/Comments

Background

Background

I strongly encouage you to rewrite this rule so it is clear and understandable, and eliminates vague or contridictory terms. This is one of the worst rules I have seen written by CMS.

Collections of Information Requirements

Collections of Information Requirements

I rarely write in but I keep an eye on changes. I am a consumer of mental health services and it is important for me to understand what is allowed and what isn't because it is all too easy for providers to cover only what they want to v. what is actually needed. I have been pushed into programs previously where my only purpose there was to provide a warm body for a head count and their funding. I would like to avoid that.

GENERAL

GENERAL

Because this ruling has been so hard to understand on it's on - and I usually do get the jist of most that I have seen previously, I would like to refer to the comments made by the Bazelon Center for Mental Health Law. Their comments seem well thought out and balanced in content. Most of all, in this case I feel their comments are practical. I don't think you will find them costing more money or detracting from the purpose of this ruling.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

What I dislike most is that I can not read it. I have no idea what you are talking about particularly in referance to 441.45(b) concerning services covered by other agencies. It just makes no sense.

I also strongly oppose 440.130(4) that allows discrimnation. I am fully elegible for Medicaid for several reasons. I also have an 'unpopular' and 'uncommon' disorder that few providers are qualified or want to treat. This can apply to anyone and no one should be discriminated against based on their disorder or needs in federal policy. That is just not a good way to save money.

Regulatory Impact Analysis

Regulatory Impact Analysis

I obviously do not have experience in filling out this form. If anything, the fact that I have done so anyway should carry weight.

Because this ruling has been so hard to understand on it's on - and I usually do get the jist of most that I have seen previously, I would like to refer to the comments made by the Bazelon Center for Mental Health Law. Their comments seem well thought out and balanced in content. Most of all, in this case I feel their comments are practical. I don't think you will find them costing more money or detracting from the purpose of this ruling.

CMS-2261-P-126-Attach-1.PDF

Submitter : **Bob Bennett** **Date: 09/21/2007**

Organization : **Approach to Balance**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

Be Happy, Be Healthy, Be Peaceful, Life live with ease....these are the goals for recovery, although of course, individuals will have individual goals as well. As typical, however, these regulations, as well as probably 80% of all regulations in govenment today are aimed at enriching attorneys and bureaucrats while giving the least as possible to those in need. Would eliminating the bureacracy entirely allow individuals in need to receive care without perhaps 75% or more of every dollar allocated going to various bureacracies which care more for their own personal welfare and agendas than the well being of their clients? Remember, this is (was) a government of the people, by the people and for the people,not one which the duty of the people is to be subservient to a bureacracy.
Thank you,

#127

DATE

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Bazelon Center for Mental Health Law is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

OVERVIEW (PREAMBLE)

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

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. We applaud CMS for including requirements that are designed to ensure the individual=s participation in this process, but believe the wording could be improved. There is a real difference between an individual providing Ainput@ and an individual having Aactive participation.@ By including both terms in different places, the regulation confuses this issue. Further, by requiring the plan to be developed by the provider significantly diminishes the role of the individual. In mental health service delivery, it is a better and far more common practice to have a service planning team working with the active participation of the individual than to have a single provider develop the plan.

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

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

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

Recommendation:

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

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

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

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

When developing a rehabilitation plan with the individual, providers should inform the person of their right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated.

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. 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 Arehabilitation and other services@ to help individuals Aretain@ capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain an individual=s functional level.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it 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.

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

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person=s functional capacity B clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

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

Recommendation:

Add to section (vii) the word Aassessment@ before the word Adiagnosis@ and replace the word Acare@ with the word Arehabilitation.@

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 Arestorative@ after Amedical@ 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 Aservices 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

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, we do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed.

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.

Finally, there should be documentation that the provider has provided the individual with information on advance directives.

Recommendations:

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

C that this plan be written in plain English so that it is understandable to the individual.

C that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan.

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

C that the plan include intermediate rehabilitation goals;

C that, as indicated, the plan include provisions for crisis intervention;

C that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

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

C 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 encourage a single treatment and rehabilitation plan and 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 A/or@ after the word Aand@ 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 Aschools, 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 Aintrinsic elements@ of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

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

We can see only two situations in which Medicaid might have been paying for services that fall under this test. Either a provider bills Medicaid for a service which is not a Medicaid-covered service B in which case this is a fraud-abuse issue and does not warrant a change in rule for all providers and systems. Or, CMS is

concerned that non-medical programs are furnishing Medicaid covered services (and meeting all Medicaid requirements) but have other resources available to them for providing the service (even though these other resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 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)(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 Ain 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.

Recommendation:

Delete the phrase "in secure custody."

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

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

Recommendation

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

OTHER ISSUES

Payment and Accounting for Services

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

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

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

The requirements in this regulation regarding service planning and documentation are relevant here. These

new rules should negate the need for overly prescriptive micro-management of Medicaid providers.

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Sincerely,

Chris Koyanagi
Policy Director

CMS-2261-P-128

Submitter : Dr. A. W. Atkinson **Date:** 09/22/2007

Organization : Dr. A. W. Atkinson

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-128-Attach-1.RTF

#128.

September 22, 2007

TO: Centers for Medicare and Medicaid

FROM: A. W. Atkinson, MD, Board Certified in Developmental-Behavioral Pediatrics, Bluestem Center for Child and Family Development, 124 Elton Hills LN NW, Rochester, MN 55901
Contact: aatkinson@bluestemcenter.com; fax: 507-282-0932

RE: File code CMS-2261-P

I endorse the following Bazelon Center for Mental Health Law Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program.

Non-covered services: 441.45(b)

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

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

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

Recommendation:

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

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

The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any

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

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

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

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

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

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

Recommendation:

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

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

Rehabilitative Services : 441.45(a)(2)-

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

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

Recommendation:

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

retaining or maintaining functioning.

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

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

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

This definition also includes as appropriate rehabilitation services services designed to maintain current level of functioning but only when necessary to help an individual achieve a rehabilitation goal. While rehabilitation services should not be custodial, for people with serious mental or emotional disabilities, continuation of rehabilitative services is at times essential to retain their functional level. Failure to provide a supportive level of rehabilitation would result in deterioration, necessitating a reinstatement of intensive services. There is concern that states and providers will interpret the current proposed regulation as prohibiting coverage of services necessary for retention of improved functioning and for maintaining the highest possible functional level, leading individuals to deteriorate to the point where they will be eligible for services. This serves no one's interest.

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

Recommendation:

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

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

Related Medicaid Rehabilitation Issues:

1) Payment and Accounting for Services

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

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

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

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

Recommendation:

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

2) EPSDT Mandate

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

Recommendation:

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

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

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

CMS-2261-P-129

Submitter : **Susan Brokaw** **Date: 09/22/2007**

Organization : **Susan Brokaw Counseling Services**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Services to children should not be cut. Recommendation: Section 441.45(a), insert a new paragraph clearly stating that states must ensure that children receive all federally covered Medicaid rehabilitation services when medically necessary to correct or ameliorate a physical or mental illness or condition.

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

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

CMS-2261-P-130

Submitter : Carol Mollohan **Date:** 09/23/2007

Organization : Infant-Parent Relationships

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

It has been demonstrated by research that a dysfunctional infant-parent relationship often leads to mental and physical health problems later in life. It is cost effective to identify and intervene with these families as early as possible. Ideally during the birth to three years when they are eligible for the Birth to Three Early Intervenetion Program. This requires referral to an infant mental health professinoal.

Submitter : Mr. lance martin **Date:** 09/23/2007

Organization : Mr. lance martin

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: DHHS - CMS Service CMS-2261-P
42 CFR Parts 440 & 441
Medicaid Program - Coverage for Rehabilition Services

"PLEASE PROTECT DAY HABILITATION !!!!!!!!"
THERE IS PENDING LEGISLATION DUE TO VOTE ON TUESDAY 9/25/07
"THAT WILL CHANGE THE RULE OF REGARDING THE DEFINITION OF HABILITAION SERVICES"
CHANGING THIS RULE WILL HAVE A MAJOR AFFECT ON MY ADULT NIECE, ERICA KELLER TO RECIEVE SERVICES AT EAST ARK INTERPRIZES (SHELTERED WORKSHOP IN WEST MEMPHIS, AR)

PLEASE VOTE NO.....

THIS WORKSHOP AND PROGRAM, IS ONE REASON THAT ERICA CONTINUES TO FIGHT FOR HER LIFE....SHE WILL NEVER BE ABLE TO LEAD A NORMAL LIFE BUT HAS SURVIVED CANCER FOR OVER 25 YEARS. THIS PROGRAM HELPS HER TO FEEL NORMAL IN THIS WORLD AND ALLOWS HER PARENTS TO WORK AND PROVIDE THE SPECIAL ATTENTION THAT ERICA REQUIRES ON A DAY TO DAY BASIS. ERICA IS 27 YEARS OLD, BARELY STANDS 4 FOOT TALL (BECAUSE OF THE CHEMO & RADIATION TREATMENTS IN HER EARLY YEARS) SHE HAS A BIG HEART AND WOULD DO ANYTHING FOR ANYBODY AND IS A "FIGHTER"......PLEASE FIGHT FOR HER...AND VOTE NO.

Submitter : **George Tetreault** **Date: 09/24/2007**

Organization : **George Tetreault**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a clinical psychologist I am concerned that the proposed rule revision will eliminate mental health services provided to children at their school of attendance. I in no way profit from the delivery of these services at schools. It has been my experience that children who receive mental health services at school either through a day treatment model or CTSS model are able to remain in the community and not be placed out of their home.

These mental health programs are individualized and in some cases include services for the child's family. I believe that these mental health services can be very effective at decreasing truancy and students dropping out of school.

CMS-2261-P-133

Submitter : **Mr. Jeremy Christensen** **Date: 09/24/2007**

Organization : **Valley Mental Health**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-133-Attach-1.PDF

#133

September 24, 2007

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

To Whom It May Concern:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

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

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

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of functioning.' Because recovery from mental illness is often a long term process, this

definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

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

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

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

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

Sincerely,

Jeremy Christensen, LCSW
Valley Mental Health
Salt Lake City, Utah

CMS-2261-P-134

Submitter : **Mr. Fred Waddle** **Date: 09/24/2007**

Organization : **Easter Seals UCP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

See attached comments on rehab options We are very opposed to these changes. Therapeutic Foster Care is a best practice service. We served 618 children last year and are able to reunite most children with their natural families, families of relatives, or have them adopted by our Therapeutic Foster Families. These children can recover from seriou mental illness with the proper.interventions and well trained families and access to professionals. Paying for part of a service will not allow the service to be developed. Local Department of Social Services do not recruit and train these families, that is why private companies have taken on the task of providing extraordinary training and support to make these children successful living in natural setting.

GENERAL

GENERAL

See attached comments on rehab option proposed rules

CMS-2261-P-134-Attach-1.RTF

#134

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

OVERVIEW (PREAMBLE)

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

PROVISIONS OF THE PROPOSED RULE

Section 440.130: Diagnostic, screening, preventative and rehabilitative services

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

This section provides a general definition of the rehabilitation plan, including the role of the individual in the planning process. We applaud CMS for including requirements that are designed to ensure the individual=s participation in this process, but believe the wording could be improved. There is a real difference between an individual providing Ainput@ and an individual having Aactive participation.@ By including both terms in different places, the regulation confuses this issue. Further, by requiring the plan to be developed by the provider significantly diminishes the role of the individual. In mental health service delivery, it is a better and far more common practice to have a service planning team working with the active participation of the individual than to have a single provider develop the plan.

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

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

Rehabilitation providers should also be encouraged to inform individuals that they have the right to prepare an advance health care directive, or to appoint a

health care agent, enabling them to express in advance their wishes should they later become incapacitated. All Medicaid providers are required under federal law to inform individuals about advance directives, although state law governs how those directives are to be developed and implemented.

Recommendation:

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

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

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

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

When developing a rehabilitation plan with the individual, providers should inform the person of their right to prepare an advance health care directive, or to appoint a health care agent, enabling them to express in advance their wishes should they later become incapacitated.

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. 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 Arehabilitation

and other services@ to help individuals Aretain@ capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain an individual=s functional level.

Recommendation:

Further clarify that a child need not demonstrate that he or she was once capable of performing a specific task in the past if it 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.

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

The definition of medical services should explicitly make clear that functional assessment, as well as diagnosis, is a covered rehabilitation service. It is impossible to create an effective and meaningful plan of services without an assessment of the person=s functional capacity B clinical assessments focus on clinical signs and symptoms (such as hallucinations) and are insufficient for preparation of a rehabilitation plan and do not provide a good basis of measuring change.

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

Recommendation:

Add to section (vii) the word Aassessment@ before the word Adiagnosis@ and replace the word Acare@ with the word Arehabilitation.@

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 Arestorative@ after Amedical@ 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 Aservices 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

The inclusion of this section is to be commended, and generally we agree with the intention as well as the specific language. However, we do urge some amendments (see below). In addition, there are some issues where the regulation is unclear and issues are unaddressed.

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.

Finally, there should be documentation that the provider has provided the individual with information on advance directives.

Recommendations:

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

C that this plan be written in plain English so that it is

understandable to the individual.

- C that the plan include an indication of the level of participation of the individual as well as his or her concurrence with the plan.

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

- C that the plan include intermediate rehabilitation goals;

- C that, as indicated, the plan include provisions for crisis intervention;

- C that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

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

- C 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 encourage a single treatment and rehabilitation plan and 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 A/or@ after the word Aand@ 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 Aschools, 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 Aintrinsic elements@ of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

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

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

resources are generally targeted to non-Medicaid individuals). In the latter case, what is the legal basis for denying federal financial participation for the Medicaid-covered individual?

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), 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)(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 Ain 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.

Recommendation:

Delete the phrase "in secure custody."

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

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

Recommendation

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

OTHER ISSUES

Payment and Accounting for Services

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

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

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

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

Recommendation:

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

EPSDT Mandate

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

Recommendation:

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

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

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

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

Sincerely,

Fred Waddle

Submitter : Lisa Paulsen **Date:** 09/24/2007

Organization : Lisa Paulsen

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Offering full support regarding providers being able to provide services in any setting. There have been limitations, as to where services can be provided in the past.

Submitter : **Mr. Jackie Cordolo** **Date: 09/24/2007**

Organization : **Mr. Jackie Cordolo**

Category : **Individual**

Issue Areas/Comments

Background

Background

Habiliation vs. Rehabilitation

Collections of Information Requirements

Collections of Information Requirements

Psychological servics have been extremely costly and shown little effectivenes.The soluation however is not to terminate all habilatative services but to terminate all services in which no evidence exists to support their usuage. Like insurence companies government needs to state what treatments are acceptable for what problems. The American Psychological Associationcan not be trusted to do this.In 2006, the American Psychological Association abandoned committment to evidenced based practices.The president of the association published a report stating that psychologists should turn to evidenced based practices or whatever they feel like and that both are equivalent. See below:

Title Evidence-Based Practice in Psychology.

Abstract The evidence-based practice movement has become an important feature of health care systems and health care policy. Within this context, the APA 2005 Presidential Task Force on Evidence-Based Practice defines and discusses evidence-based practice in psychology (EBPP). In an integration of science and practice, the Task Force's report describes psychology's fundamental commitment to sophisticated EBPP and takes into account the full range of evidence psychologists and policymakers must consider. Research, clinical expertise, and patient characteristics are all supported as relevant to good outcomes. EBPP promotes effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. The report provides a rationale for and expanded discussion of the EBPP policy statement that was developed by the Task Force and adopted as association policy by the APA Council of Representatives in August 2005. (PsycINFO Database Record (c) 2007 APA, all rights reserved)

Authors APA Presidential Task Force on Evidence-Based Practice, US

Source American Psychologist. 2006 May-Jun Vol 61(4) 271-285

Thus 20 researcharticles supporting the efficacy of technique A is considered equivalent to the psychologists feelings about using technique B. This is just poor professional values.

Often such reports turn to the Smith Glass and Miller study for support butthis meta-analysis was seriously flawed, indeedeven rigged to get results- see:

Prioleau, L., Murdock, M., & Brody, N. (1983). An analysis of psychotherapy versus placebo studies. The Bchavioral and Brain Sciences, 6, 275-282.

In short people should not be denied access that could improve there functioning. However, there should be clear research to support that these services can improve their condition. Indeed,psychological interventions with no empirical support should be replaced with supportive services.In the end this will save the government far more money and substantially reduce waste

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Prioleau, L., Murdock, M., & Brody, N. (1983). An analysis of psychotherapy versus placebo studies. The Behavioral and Brain Sciences, 6, 275-282.

Submitter : **JAMES KELLER** **Date: 09/24/2007**

Organization : **JAMES KELLER**

Category : **Individual**

Issue Areas/Comments

Background

Background

42 CFR PARTS 440 AND 441. DAY HABILITATION.

GENERAL

GENERAL

MY DAUGHTER AS A CHILD HAD A BRAIN TUMOR AND HAS A LEARNING DISABILITY THAT KEEPS HER FROM A JOB ON THE "OPEN" MARKET.
SINCE SHE HAS WORKED FOR SHELTERED WORKSHOP,ALMOST 10 YEARS, SHE HAS LEARNED SO MUCH. SELF-RESPECT AND WORKING WITH OTHERS TO NAME A FEW. SHE ALSO FEELS THAT SHE HAS A PLACE IN THE REAL WORLD.
IF THIS LAW IS CHANGED IT WILL BE DEVASTATING TO HER. PLEASE DO NOT CHANGE THIS. THANK YOU.

Submitter : **Ms. Gina Arlen** **Date: 09/24/2007**

Organization : **Ms. Gina Arlen**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As the mother of a child with an autistic spectrum disorder, I am dismayed that CMS-2261P could eliminate funding for BHR services for my son, because such services will be mislabeled as habilitative.

Young children with autism and related disorders almost always display some type of developmental delay in social skills in infancy. When these skills fail to develop at an age-appropriate rate, these children need REhabilitation services to RESUME development of these latent skills.

Unfortunately, not all administrators of State Medicaid plans will appreciate this distinction, and will use the revised rules to cut funding for services to developmentally disabled children.

With an autism epidemic sweeping the nation, it is unconscionable to withdraw help from children with autistic spectrum disorders especially considering that such help has been proven to be successful. For a documented 10-year research study specific to the state of Pennsylvania, please go to www.ibc-pa.org/research1.htm.

The other aspects of CMS-2261P related to improving the quality of professional supervision and oversight of BHR services such as improving treatment outcome measurement, improving documentation of service delivery will all increase the quality of service rendered to children. It is not necessary to utterly DENY Medicaid funding for services to children with developmental delays in order to save some money.

Submitter : **Mrs. Markeeta Richardson** **Date: 09/24/2007**

Organization : **Mrs. Markeeta Richardson**

Category : **Individual**

Issue Areas/Comments

Background

Background

Habilitation vs. Rehabilitation

Collections of Information Requirements

Collections of Information Requirements

I have a child with autism who benefited greatly from behavioral health services that provided habilatation to his communication skills. It seems to me that the Federal government could do better then cutting services to children. I believe that they can use budget cuts toimprove progams rather then remove critical program for children. One idea that comes immediately to mind would be to require all psychiatrists to get approval in writing from patients or patient guardians for off lable use of medications.They should be required to let people know that the FDA has not approved this drug for this condition, so in effect this person or child is an experiment. I,personally,know three children who are perscribed medication that is not approved for children.

Submitter : Mr. rodger ferdinand **Date:** 09/25/2007

Organization : Timberlands Regional Support Network

Category : Health Care Provider/Association

Issue Areas/Comments

Background

Background

42 CFR Parts 440 and 441
[CMS 2261-P]
RIN 0938-A081
Medicaid Program; Coverage for Rehabilitative Services

GENERAL

GENERAL

Your proposed changes will only hurt those in need of help.

CMS-2261-P-141

Submitter : Mr. Steven Kossor **Date:** 09/25/2007

Organization : The Institute for Behavior Change

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

It is not necessary to exclude children with developmental delays from those covered under an EPSDT program in order to stop abuses of Medicaid. The provisions of CMS-2261P that increase supervision by professionals, improve documentation requirement, and mandate better record-keeping should 'solve the problem' in a big way. Incompetent providers will not be able to meet these standards, and the people who have been depending on them for help will be able to go to other (competent) providers of service. Keep the 'standards' language, but delete the 'redefinition' of Rehabilitation services, and you've done a world of good for Medicaid and the children who seek help from providers of Medicaid services. I have attached a description of the model of 'Behavioral Health Rehabilitation Service' delivery that I use and is fully compatible with the CMS-2261P revisions, so you will see that it is clearly not necessary to re-define 'Rehabilitation' services.

CMS-2261-P-141-Attach-1.TXT

#141

The Network for Behavior Change, pc

Steven A. Kossor, Director Federal EIN: 23-2967070 phone or fax
848 West King's Highway Coatesville, PA 19320-1714 (610) 383-1432

There are no obstacles, only hurdles of varying heights. None is so great that it cannot be overcome, gotten around or gone under. Even mountains disintegrate with time.

Behavioral Health Rehabilitation (BHR) Services Summary

The Network for Behavior Change provides BHR Services to children (anyone under the age of 21) in their homes, schools and community under the supervision of licensed psychologists. These services include psychological testing, behavior treatment programs, psychological counseling and consultations with parents, medical doctors, teachers and others in the child's interest. We are allowed to deliver these services only if at least one parent (or guardian) is *actively* involved in the planning and delivery of the treatment program. If a parent is not actively participating in the treatment program, services must be stopped. Here is how we plan and deliver services. If you have any questions about this process, please call 610-383-1432 anytime. We will return your call as quickly as possible but certainly within 24 hours, or on Monday following a weekend. You can leave an emergency message and receive an *immediate* response by leaving your message at extension #40.

The written Treatment Plan that describes and governs a child's treatment program is always developed with input from the child, parent(s), teacher(s) and other adults who have roles in the child's life. The child's strengths, weaknesses, and treatment needs will be reviewed on an ongoing basis by a **Behavior Specialist** who will consult with parents (and others, if necessary) at least once weekly to gather data about the child's progress. A **Therapeutic Staff Support** (TSS) provider may be assigned to work directly with the child to implement the child's treatment plan on an intensive, one-to-one basis for several hours each week. A **Mobile Therapist** may meet with the child at home, in school, or elsewhere in the community to provide psychological counseling on one or more occasions each week. The Mobile Therapist and Behavior Specialist may also meet with the child's teachers, extended family members, or other adults who interact with the child, so that all adults in the child's life can "be on the same page" regarding the child's strengths, weaknesses and treatment needs. A licensed psychologist assumes full and complete responsibility for all services provided.

A new authorization for BHR Services must be re-approved every four months. Prior to each re-authorization request meeting, the parent/guardian (and teacher, if services are rendered in a school) will be asked to *carefully* review the psychological evaluation, treatment plan and plan of care -- to make sure that all of these documents contain accurate, up-to-date, and complete information about the child. Accurate and complete information makes it possible to obtain re-authorization of services from Managed Care Organizations (MCO) as efficiently as possible. Without an MCO authorization to continue delivering services, it is not possible to continue providing services.

BHR Service providers are required by law to make prompt reports of suspected child abuse or neglect to state authorities. If a child is suspected of being the victim of abuse or neglect, the BHR Service provider must make a report of this suspicion to state authorities. If this becomes necessary, the child's parent or guardian will be notified promptly that a report has been filed. Parents or guardians are invited to contact the Director of the Network for Behavior Change, Steven Kossor, at 610-383-1432 to discuss questions about this or any other aspect of the BHR Service treatment delivery process. BHR Services are delivered without charge to the children and families who receive them. Because public funds are used to provide these services, it is important that careful records are kept to document the dates, times and types of services rendered. Parents must take care to sign documentation for services only if those services *were actually delivered as written.* Our goal is to create two things in children and the adults who care for them: **hope** and **courage**. Hope that the future can be better, and the courage to do what is necessary to make it better. We will apply our resources conscientiously toward those two goals, and look forward to working together to accomplish them.

Behavior Specialist Name: ______________________ **Call 610-383-1432 anytime & ext. #** ______

Submitter : Mr. Ken Scarbrough **Date:** 09/25/2007

Organization : Cloquet Public School District # 094

Category : Local Government

Issue Areas/Comments

Background

Background

As the single most significant source of financing for the public mental health system, Medicaid provides needed access to community-based care through the rehabilitative services option to help children and adults avoid institutionalization. The new rules could also have a profound effect on Medicaid services needed by other vulnerable populations, including people with physical and developmental disabilities.

As school district responsibilities continuc to grow in dealing with "at risk" populations, we rely on Medicaid funding to get needed services to the students we are mandated to serve. We have a local collaborative made up of school districts and county agencies which work hard to meet the medical and mental health needs of our young people. The proposed rule change will make this much more difficult.

Thank you.

Submitter : **Dr. Tomora Thomas** **Date: 09/25/2007**

Organization : **Hinds Behavioral Health Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE AND MEDICAID SERIVICES
FICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

ea... note: We did not receive the attachment that was cited in is comment. We are not able to receive attachments that have been epared in excel or zip files. Also, the commenter must click the llow "Attach File" button to forward the attachment.

ease direct your questions or comments to 1 800 743-3951.

CMS-2261-P-144

Submitter : Courtney Lester **Date:** 09/25/2007

Organization : Idaho Federation of Families for Children's Mental

Category : Consumer Group

Issue Areas/Comments

Background

Background

Changes to the existing rehabilitation policy would prove detrimental to families in our state. Community based services are most reliant on this benefit. While we understand the discrepancy in existing policy language to make paying for this benefit difficult, it must be considered that the services that this policy currently funds would literally disappear from children who need them. If community based psychosocial rehabilitation is limited under this category, it will have negative effects on children who are coming so far with the help of their provider. These services are essential and worthy of payment under this policy by Medicaid.

Collections of Information Requirements

Collections of Information Requirements

Statewide, family run organization. We are a peer to peer organization providing support and advocacy for families with children with mental health needs. We serve hundreds of families in our state.

Submitter : **Floyd Smith** **Date: 09/26/2007**

Organization : **AuSable Valley CMH**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-145-Attach-1.PDF

#145

AuSable Valley
Community Mental Health Services

1199 W. Harris Avenue
P.O. Box 310
TAWAS CITY, MICHIGAN 48764

(989) 362-8636
FAX (989) 362-7800

William Williams, D.O. Chairman
Floyd R. Smith, Ph.D., Director

September 26, 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

AuSable Valley Community Mental Health Services 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.

We serve about 6000 people per year in the rural counties of Iosco, Ogemaw, and Oscoda. This is about 10% of the total population of those counties. People served bring severe mental illness, severe developmental disabilities, family problems, developmental issues, and substance abuse disorders. We provide a range of services, including inpatient, outpatient, support services coordination, residential services, supported living, supported employment, and school based prevention services. We have been in operation for the past 31 years, operating as an Authority of the three counties which we serve

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas 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 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 and have 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(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 especially problematic in rural areas of the country, such as ours. In most cases, we are the primary provider of such services in our three counties. The provision of alternate service providers is likely to require that consumers go out of area in order to secure such providers—truly a disservice to the people we serve.

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

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

Recommendations:

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

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

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

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 is the element of the regulation with which we are most heavily concerned. 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.

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

implementation period from the time of approval of the State Plan Amendment by the Agency.

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

Sincerely,

Floyd R. Smith, Ph.D.
Executive Director

CC: Hon. Carl Levin
Hon. Debbie Stabenow
Hon. Bart Stupak
Hon. Jennifer Granholm
National Council of Community Behavioral Health
Michigan Association of Community Mental Health Boards
David Beck Ed.D.
Lee Mertz

CMS-2261-P-146

Submitter : **Ms. Arnold Dunbar** **Date: 09/26/2007**

Organization : **Adult and Child Mental Health Center, Inc.**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-146-Attach-1.DOC

#146

DATE: 9-26-07

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

Adult and Child Mental Health Center, Inc. is submitting the following comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, as published in the Federal Register, August 13, 2007.

Adult and Child Mental Health Center is a Indiana state certified Joint Commission on Accreditation of Healthcare Organizations accredited community mental health center primarily serving seriously emotionally disturbed children and seriously mentally ill adults residing in Indianapolis, Indiana and Johnson County Indiana. Our organization provides recovery oriented behavioral health services to approximately four thousand three hundred (4300) registered clients each year. Our services include "evidence based treatments" such as Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Supported Employment and Illness Management and Recovery. Our continuum of services include access to inpatient psychiatric care, residential treatment, therapeutic foster care, partial hospitalization, intensive outpatient therapy, home based counseling, and case management. Because our organization primarily serves a low income disabled population, Medicaid Rehab Option funding is our primary funding source supplemented by Division of Mental Health and Addiction funding, and Indiana Department of Child Services funding.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas 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 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 not 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.

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(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? The guiding factor should be that the service record includes information that is necessary for clinical purposes and that this information is presented in a way that meaningfully demonstrates the nature and course of services being provided.

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

multiple service plans do not facilitate coordination or accountability. The regulation does not prohibit a single plan of service, but it would be extremely helpful to the field if CMS could clarify that this is indeed preferable.

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

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

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

Recommendations:

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

X that this plan be written in plain English so that it is understandable to the individual.

X 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.

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

X that the plan include intermediate rehabilitation goals;

X that, as indicated, the plan include provisions for crisis intervention;

X that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

X 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.

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.

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

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

Sincerely,

A.Robert Dunbar
Executive Director

CC: Members of the IndianaState Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

DRAFT

Submitter : Mrs. Becky Kuhn-Sykes **Date:** 09/26/2007

Organization : Mrs. Becky Kuhn-Sykes

Category : Individual

Issue Areas/Comments

Collections of Information Requirements

Collections of Information Requirements

I am the mother of an 8 year old son born with Down Syndrome and dx with Autism. Sammy stands over 50 inches tall, weights 95lbs. and wheres size 14 husky clothing. Not to mention has the strength of 2 warriors. When we raise the bar for him in learning more self help skills & including him in community functions. His behaviors have escaladed to the point I cannot manage him alone with out obtaining injuries. This would put Sammy at risk for being placed into a more restricted setting. Denying him the right to live in his family home and participate in community activities.

GENERAL

GENERAL

With the new language of the proposed regulations. I fear many children with mental retardation &/or Autism will be discriminated againist for the sole purpose of their disability. Children with Developmental Disabilities need to be taught appropriate behavior management skills. New behavioral issues will rise with these children when you raise the bar of expectations and force them to step out of their comfort level. We are no longer living in the 60's & 70's when our expectations of this population were thinking they were unteachable. Children with developmental disabilites are proving this ancient philophosy wrong everyday! Children with Developmental Disabilites can benefit from rehabiliatve TBA services. Appropriate behaviors can be restored for them to continue to live in their family homes and participate in their community's activities. If you look at denying this population these necessary services based on the fact, you are defining the service as "habilative" verses "rehabiliative" is discrimating againist their rights! If you denying them their rights we may as well look at opening institutions back up. For these children and their families would be prisoners in their own homes!

Submitter : **Mrs. Earnestine Barton** **Date: 09/26/2007**

Organization : **Parent & Guardian**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

Reference: File code CMS-2261-P

Comments on the Proposed Rule for Coverage for Rehabilitative Services under the Medicaid program, submitted by Earnestine Barton, 4716 Strickland Road, Flowery Branch, Georgia 30542

Non-covered services: 441.45(b)

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

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

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

Recommendation:

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

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

The preamble states that Medicaid-eligible individuals in programs run by other agencies are entitled to any rehabilitative service that would have been provided to individuals outside of those other programs. The preamble also makes clear that Medicaid rehabilitative

services must be coordinated with services furnished by other programs. The regulation should include this language.

It is especially important that mental health providers be able to work with children and adults with serious mental disorders in all

Submitter : Ms. Diane DeRue **Date:** 09/26/2007

Organization : The Counseling Center of Wayne and Holmes Counties

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#149

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE AND MEDICAID SERIVICES
FICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

ea... note: We did not receive the attachment that was cited in
is comment. We are not able to receive attachments that have been
epared in excel or zip files. Also, the commenter must click the
llow "Attach File" button to forward the attachment.

ease direct your questions or comments to 1 800 743-3951..

CMS-2261-P-150

Submitter : Mrs. Kelvin Hundley

Date: 09/26/2007

Organization : Mrs. Kelvin Hundley

Category : Other

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

I am Writing in conserns of the Proposed rule changes to Medicaid spending to wich I am opposed. I would like for Adventure House to stay open so I can countinue to work in the work Unit. Working and medication has helped me maintain a regular sechedule. That helps me stay out of the Hospital. Ive been a member of Adventure House since august of 2000 and hav'nt been in the hospital since. Adventure House needs to stay open and be a model for others needing rehabilitation. Medicaid put to good use has been very helpful. Thank you for your time ,Kelvin Hundley

CMS-2261-P-151

Submitter : Ms. Patricia Mack **Date:** 09/26/2007

Organization : Hinds Behavior Health Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-151-Attach-1.DOC

#151

September 28, 2007

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

To Whom It May Concern:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

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

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

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

Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse

Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

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

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

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

Sincerely,

Patricia Mack, BS, LSW, CCM
Case Management Supervisor
Hinds Behavioral Health Services
3450 Highway 80 West
Jackson, MS 39209
601-982-2885 or 601-951-3228
E-mail- pmack@hbhs9.com

CMS-2261-P-152

Submitter : Mr. Paul Wood **Date:** 09/26/2007

Organization : Gateway House

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

If the new regulations are approved many mentally ill citizens more than likely become homeless without the support of programs like Gateway House in Greenville, SC. I am a member with mental illness that will continue to need the services of Gateway House indefinately in orfder to remain productive in the community. The daily progress notes that staff are being required to write are taking them away from the members who need their support in order to stay out of the hospital. Programs like Gateway House should be able to bill for the support services they are providing to members who are interested in working on real jobs. Unfortunately, the more jobs we have for the members, the less funding we receive. If there were more programs klike Gateway House there would be less mentally ill people living on the streets, in jail or in the hospital. Thanks you for reading my comments.

CMS-2261-P-153

Submitter : Linda Kaufmann **Date:** 09/26/2007

Organization : Community Mental Health for Central Michigan

Category : Other Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

153

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE AND MEDICAID SERIVICES
FICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

ea... note: We did not receive the attachment that was cited in
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llow "Attach File" button to forward the attachment.

ease direct your questions or comments to 1 800 743-3951..

CMS-2261-P-154

Submitter : **Linda Kaufmann** **Date: 09/26/2007**

Organization : **Community Mental Health for Central Michigan**

Category : **Other Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2261-P-154-Attach-1.DOC

#154

September 26, 2007

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

Reference: File Code CMS-2261-P

To Whom It May Concern:

Community Mental Health for Central Michigan (CMHCM) 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.

CMHCM provides a wide range of mental health services in a six county area – Clare, Gladwin, Isabella, Mecosta, Midland, and Osceola – to over 5,600 consumers. We are dedicated to help the members of our communities with a developmental disability or mental illness gain control over their lives, achieve dignity and respect, and realize their full potential. Some of the services we provide are: 24-hour emergency services; outpatient therapy; community supported living; residential services; partial day services; inpatient hospitalization; networking with other community agencies; prevention activities; and public education.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following areas 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 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 Arehabilitation and other services@ to help individuals Aretain@ 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.

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.

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

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

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

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

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

Sincerely,

Linda Kaufmann, LMSW, ACSW
Executive Director

C: Dave Camp, U. S. Congress

CMS-2261-P-155

Submitter : C. Marsha Martino **Date:** 09/26/2007

Organization : Goodwill Industries of Northern New England

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

1. The proposed rule states that services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. 440.130(d)(1)(vi). Rehabilitation should be defined to include "maintenance of a state that would otherwise deteriorate in the absence of the service".

2. Rates should not be unbundled. Provisions for bundled rates should remain for defined populations.

Submitter : **Mr. Michael Spennato** **Date: 09/26/2007**

Organization : **Mr. Michael Spennato**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-156-Attach-1.DOC

CMS-2261-P-156-Attach-2.DOC

#156

I am testifying on behalf of those consumer members who utilize ICCD Certified Clubhouses with regards to the proposed rule **file code CMS-2261-P. "PROVISIONS OF THE PROPOSED REGULATIONS" Qualified providers of rehabilitative services**

My name is Michael G Spennato I am a recipient of mental health services since 1989, have been an advocate since 1997, have been a member of Sky Light Center an ICCD (International center for Clubhouse Development) Certified Clubhouse since 2002 preside as the Vice-President of the New York Clubhouse Coalition and sit on the Board of Directors for Sky Light Center since 2003and on the faculty of the ICCD since 2004.

The Clubhouse model is very different than the Medical Model of mental health services and does not fit into the focus of medical necessity as such. While I am in agreement that we need to have a licensed provider to request or refer a patient for services, I also believe that the medical model of treatment in mental health rehabilitation centers is not the only answer for consumers who are suffering with mental health issues. As no two people are alike, not one method of mental health rehabilitation will work for all.

An ICCD Certified Clubhouse provides recipients of mental health services with opportunities in Education and Employment that no other Medical Modeled Mental Health services provide. This is done by allowing its members to take ownership in their treatment through participation in the clubhouse and its community thus increasing the chances for long term recovery and fewer, repetitive, hospitalizations and providing the consumer with a place to return to in the event of destabilization. This participation is not a teaching device, but an experiential tool that allows the members/consumers to develop and increased the level of hope, self-esteem and functioning that is encouraged by positive reinforcement in an effort well done regardless of the productivity.

If the funding stream is relegated to a Medical Model approach, it may jeopardize the integrity the ICCD Certified Clubhouse Model and could be insufficient to sustain the current level of service that an ICCD Certified Clubhouse provide, I am not speaking about those clubhouses which are truly Drop-In Centers and do not follow a set of standards that have been Internationally accepted. In addition if Medicaid is the primary source of income for rehabilitation services then there is a much greater chance for antiselection thus excluding members who have limited incomes but who have incomes too high to be Medicaid eligible. The current members that I speak of are those who receive Social Security Disability Income (not SSI) and are on Medicare and Veterans. These two groups may not be eligible for any form of Medicaid, such as the Medicaid Spend Down and Buy in Programs

I CCD Certified Clubhouses have a uniquely integrated program that encourages its members to return to their communities in a productive manner. An example is this approach is the Transitional Employment Program that is exclusive to Certified Clubhouses. In this program a member /consumer is allowed the opportunity to attempt a part-time work experience for a time limited period of 6-9 months where the employer is

guaranteed that there will be coverage. The member is able to try the experience in the hope of finding a position, either in a Supported or Independent Employment in the future which will possibly allow the consumer to return to a more stable work situation. A program such as this does not teach or train but aids the member/consumers attempt at work thus providing hope, increased self-esteem and in addition provides the community with a new potential self-sufficient member of society who in turn pays taxes, becomes less dependent on the community mental health services programs and may, possibly, return to a full-time employment that provides an income and insurance coverage that would allow the consumer of mental health services the ability to sustain their independence from the benefits system while at the same time continuing in their ongoing treatment. A program such as this does not teach or train but helps to. We in the clubhouse community know that it is in keeping with best practices that the program works and that while it many not seem to be medically necessary it is as the results of ICCD Clubhouse Programs have provided its members with lower relapse rates and grated employment and educational outcomes.

As you may have noticed I am sincerely concerned for the programs that are ICCD Certified as they are held to a higher standards, 36 to be exact, than any other clubhouse programs. These programs were formed in New York City in 1948 with the founding of WANA {We Are Not Alone) currently known as Fountain House. Have been developed over the years and are now in over 40 Countries throughout the world. It seems odd to me that a model that has worked for so long and has been part of our communities should now be in jeopardy of not being able to sustain itself in a country where we do believe in giving every member of our society a chance to succeed. Yes I know that there will be some clubhouses that may succeed in a new climate but for many, this new environment may be disastrous. It is with the consumers of mental health services in mind that I implore you to consider measures to provide for the clubhouse community, especially those that have been or will be ICCD certified.

September 28, 2007

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

To Whom It May Concern:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

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

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

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of

functioning.' Because recovery from mental illness is often a long term process, this definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

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

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

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

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

Sincerely,

Michael G Spennato

Submitter : **Mr. Mark Rosenberg** **Date: 09/26/2007**

Organization : **Mental Health America in Maine**

Category : **Consumer Group**

Issue Areas/Comments

Background

Background

n/a

Collections of Information Requirements

Collections of Information Requirements

n/a

GENERAL

GENERAL

Rehabilitation services must not be removed from the current Community Mental Health System. In fact it must be improved if the ultimate goal is to get people off of Medicare and Medicaid. I for one am grateful for the services in the area of rehabilitation I have received. We need to do a better job of targeting services to those who would best benefit from the services. I expect to graduate from under graduate school soon. If not for the services I received I don't know where I might have been. Please don't take this very unique and valuable service away.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

n/a

Provisions of the Proposed Rule

Provisions of the Proposed Rule

n/a

Regulatory Impact Analysis

Regulatory Impact Analysis

n/a

Response to Comments

Response to Comments

n/a

Submitter : **Mr. Mathew Johnson** **Date: 09/26/2007**

Organization : **Mr. Mathew Johnson**

Category : **Individual**

Issue Areas/Comments

Background

Background

Habilation vs. Rehabilitation

Collections of Information Requirements

Collections of Information Requirements

This regulation seems to be an invitation for game playing. In one section the government is saying it will not pay for habilation but then gives an example of anger management being paid for to restore relationships. This is political double speak and will just encourage providers to play elaborate games with the honest ones being hurt.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

One of the biggest problems with the regulation is on the one hand the government is saying it wants to support state D&A intitatives then it releases this regulation that kills off programs like communication training programs which are the hallmark of behavioral couples therapy-an empirically established technique for increasing abstenence. Other D&A interventions to be cut include relapse prevention skills and craving reduction skill programs....

Response to Comments

Response to Comments

The whole savings of this scheme is less then the cost of one day in Iraq. As a society, we can do better.

Submitter : Mr. James Turner

Date: 09/27/2007

Organization : Highlands Community Services

Category : Health Care Provider/Association

Issue Areas/Comments

Background

Background

We must keep Medicaid payments the same. All of our community services are billed to medicaid

Submitter : **Miss. L Roseboro** **Date: 09/27/2007**

Organization : **Miss. L Roseboro**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

CMS 2261-P

September 27, 2007

Submitter: L. Roseboro

Category: Provisions of the Proposed Regulations

This comment is in regards to the proposed rule in Sec. 441.45(b)(3).
I feel that the consumers that we are currently involved with who suffer from chronic mental illness would definitely suffer from this proposed rule. All of our consumers who are involved in the PSR program attend this program because for most of them this is the only way that they can be involved in a social/recreational, educational, or vocational activity outside of the home. Our consumers look forward to coming to our program everyday, and participating in work ordered day activities and goal planning activities. Our consumers enjoy being around the staff and peers, and have developed strong relationships with most of them. They enjoy being able to interact with the staff and peers in their assigned unit. The consumers who have transitional employment placements, which offer the consumer employment outside in the community, which otherwise they might not be able to get, also enjoy being a part of the work force. If the consumers didn t have this program to attend, they would be isolated at home were their MH symptoms would become worse, which would be cause for hospitalization, or even worse, jail. Currently, there is a problem with getting beds in the psychiatric units of most of our area hospitals, so most consumers that need help are not getting it right away, and are being put on a waiting list to get a bed in the psychiatric unit.

I think this proposed regulation will cause many consumers who are currently involved in this type of program that are diagnosed with a MH illness to end up being hospitalized, in jail, or maybe even worse. Not being able to participate in this program will cause the consumer to feel worthless.

If the purpose of the PSR program is to help restore the individual to a better functioning level, what will happen if the program is taken away from the consumer? They will definitely never be restored to a better functioning level, in my opinion the functioning level will only worsen.

Submitter : Mr. Henry Byther **Date:** 09/27/2007

Organization : Hinds Behavioral Health Services

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-161-Attach-1.DOC

#161

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:

In response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services I am submitting the following opinion.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

Although these rule changes may be appropriate for people with physical rehabilitative needs, according to a recent NAMI publication, 73% of people receiving Medicaid rehabilitative services have mental health needs. People with long term mental illness have a very distinct set of long term needs, for a wide array of supports; these are quite different from the needs of others requiring rehabilitative services, and must be funded differently. The dramatic shift of mental health funding to Medicaid has diminished the flexibility for states to provide the needed community services to people with mental illness.

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

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

One example of the inappropriateness of these changes in funding programs for people with mental illness is the emphasis on returning a person to 'previous levels of functioning.' Because recovery from mental illness is often a long term process, this

definition will likely reduce or eliminate many necessary psychosocial rehabilitation type services and supports.

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

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

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Sincerely,

Henry Byther, MS, CMHT
Supervisor of Clubhouse
Hinds Behavioral Health Services
3450 Highway 80 West
Jackson, MS 39209
601-969-7505 or 601- 500-1645
E-mail- hbyther@hbhs9.com

Submitter : **Mrs. Kimberly Brand** **Date: 09/27/2007**

Organization : **Adult and Child Mental Health Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

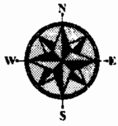
GENERAL

GENERAL

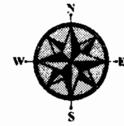
See Attachment

CMS-2261-P-162-Attach-1.DOC

#162



PATHWAYS CLUBHOUSE
A Part of: ADULT&child



September 28, 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 am submitting the following opinion in response to the recent request for comments on the Proposed New CMS Rules on Medicaid Rehabilitation Services.

The recent changes in practice by CMS and the associated proposed rule changes published on August 13, 2007 are having a dramatically negative effect at the local level in many states and threaten to do the same throughout the country. The effect of the rule changes may be well intentioned but in practice they will create a situation where medically necessary services and supports will be eliminated for some of this country's most vulnerable citizens – those with severe and persistent mental illness.

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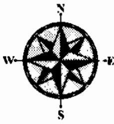
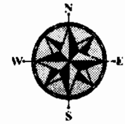
Although I wholeheartedly support the idea of "person centered" services and rehabilitation plans, it would be ineffective and eventually very expensive to have this kind of plan without a consistent

Beech Grove / 3841 S. Emerson Avenue / Suite C
Indianapolis, IN 46203: 317-882-3699 / Fax: 317-784-3068
www.geocities.com/pathways_clubhouse / Email: pathways_clubhouse@yahoo.com





funding stream for the other necessary recovery focused services such as education, employment, housing and pre-vocational services. Clubhouses affiliated with the International Center for Clubhouse Development (ICCD) have a long and rich history of providing a cost effective array of services such as these in a community based environment. ICCD Clubhouses more than any other program have strong partnerships with the local business, educational institutions and other social service providers.

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Sincerely,

Submitter : **Mr. James Cook** **Date: 09/27/2007**

Organization : **Client of Adventure House**

Category : **Other**

Issue Areas/Comments

GENERAL

GENERAL

Adventure House helps me get my medication and with transportation. I dont know what I would do without Adventure House and them helping me when I go into the hospital to keep my apartment and get around ,to get back into dthe flow of things after hospitalization. Im living in an Adventure House apartment and I couldnt survive without it . If it hadnt been for them I would be on the street. We dont need the proposed changes in Medicaid that take away payment for important services. thank you James Cook

Submitter : **Dr. Eric Crouse** **Date: 09/27/2007**

Organization : **Community Health Network d/b/a Gallahue MHS**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2261-P-164-Attach-1.RTF

#764

Gallahue Mental Health Services
Administration
6950 Hillsdale Court
Indianapolis, IN 46250-2040
317-621-7600 (tel)
317-621-7609 (fax)
eCommunity.com

September 27, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Community Health Network d/b/a Gallahue Mental Health Services 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.

Gallahue Mental Health Services is one of four hospital based Community Mental Health Centers in the State of Indiana. We are the largest provider of behavioral health services in the metropolitan Indianapolis area. We have served the Indianapolis metropolitan area and surrounding counties for over 35 years. We operate a 123 bed inpatient facility and a full range of outpatient behavioral health services. We serve over 4,500 patients on our inpatient services and over 18,000 patients in our outpatient programs in any given year. In addition to 8 outpatient facilities, 3 group homes, 1 semi-independent living apartment complex he have clinical staff in over 50 schools in the metropolitan Indianapolis area. The funding streams covering our $40+ million dollar budget are varied, including both private sector commercial payers, Medicare and Medicaid, and State of Indiana funds. A large number of our consumers are Medicaid eligible and receive a variety of Medicaid Rehabilitation Option (MRO) services particularly many of the children who we serve from the neediest schools in the area and the thousands of serious and persistently mental ill adults who we serve.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas of the proposed rule:

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. 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 Arehabilitation and other services@ to help individuals Aretain@ 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(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:

X that this plan be written in plain English so that it is understandable to the individual.

X 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.

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

X that the plan include intermediate rehabilitation goals;

X that, as indicated, the plan include provisions for crisis intervention;

X that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

X 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.

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

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

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

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

Recommendation:

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

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

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

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

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

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

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

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

Sincerely,

Eric C. Crouse, Ph.D.
CEO, Gallahue Mental Health Services
Vice President
Behavioral Health Services
Community Health Network
Indianapolis, Indiana

CC: Members of the Indiana State Congressional Caucus
The Honorable Mitch Daniels, Governor of the state of Indiana

CMS-2261-P-165

Submitter : Mr. John Markley

Date: 09/27/2007

Organization : Franklin-Williamson Human Services, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

'ARTMENT OF HEALTH AND HUMAN SERVICES
TERS FOR MEDICARE AND MEDICAID SERIVICES
'ICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

a... note: We did not receive the attachment that was cited in
s comment. We are not able to receive attachments that have been
pared in excel or zip files. Also, the commenter must click the
low "Attach File" button to forward the attachment.

ase direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Jessica Wilkins** **Date: 09/27/2007**

Organization : **Alcott Center for Mental Health Services**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2261-P-166-Attach-1.DOC

CMS-2261-P-166-Attach-2.DOC

#166

THE ALCOTT CENTER FOR MENTAL HEALTH SERVICES

September 27, 2007

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

To Whom It May Concern:

Reference: File code CMS-2261-P

The Alcott Center for Mental Health Services, a non-profit, county contracted community mental health center 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 Alcott Center for Mental Health Services offers mental health, residential, crisis and other services to hundreds of adults with severe and persistent mental illness. Our agency has provided services since the late 1970s and our main funding stream at this time is Medi-Cal and county general funds.

We have significant concerns with the proposed regulations, as they will create barriers to the recovery process for the children and adults that our agency serves. We would like to comment on the following four areas of the proposed rule:

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

This definition stipulates that restorative services are those that enable an individual to perform a function, and that the individual does not have to have actually performed the function in the past. This language is critical, as loss of function may have occurred long before restorative services are provided. This would be particularly true for children, as some functions may not have been possible (or age-appropriate) at an earlier date. 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 Arehabilitation and other services@ to help individuals Aretain@ 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(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.

Recommendations:

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

X that this plan be written in plain English so that it is understandable to the individual.

X 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.

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

X that the plan include intermediate rehabilitation goals;

X that, as indicated, the plan include provisions for crisis intervention;

X that the plan include individualized anticipated review dates relevant to the anticipated achievement of long-range and intermediate rehabilitation goals;

X 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.

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

There is little clarity in the regulation on how this provision would be applied as the regulation

provides no guidance on how to determine whether a service is an Aintrinsic element@ of another program.

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

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

Recommendation:

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

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

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

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

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

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

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

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

DRAFT

Sincerely,

Jessica Wilkins, MFT
Clinical Director
Alcott Center for Mental Health Services
310-785-2121
jwilkins@alcottcenter.org

Submitter : **Mr. Tim Collins** **Date: 09/28/2007**

Organization : **Mr. Tim Collins**

Category : **Individual**

Issue Areas/Comments

Background

Background

CMS-2261-P - Rehabilitation Services: State Plan Option - Habilation vs. Rehabiliation

Collections of Information Requirements

Collections of Information Requirements

The issue of habilation is not the core issue driving up costs. Cost containment needs to focus on greater accountability to providers. Many of these "behavioral health care services" seem to be little more then scams to get money to third world immigrants-many of whom do not even speak English and barely understand social customs of this country- yet are expected to train children in social skills. It is the culturally inept trying to help the mentally ill- sort of the blind leading the blind.

GENERAL

GENERAL

Finding alternative methods to treatment requires more provider accountability, greater focus on the use of evidenced based practices and the removal of 'community based' services- which are not a medical necessity but a cloaked form of funding more social services and back-dooring education. It is often lamented by one of my professors at St. Joseph's University that these services are little more then 'free babysitting for the poor' and that the 'only behavior specialized in by most so called 'behavior specialists' is defrauding the government.' Time for change

Provisions of the Proposed Rule

Provisions of the Proposed Rule

It seems that the current regulation change does not get at the heart of the problem. The costs of medicare and medicaid are driven up by community based services,which are poorly organized (often used as a back door to fund social service nonprofits who can not seem to balance a budget), use staff that lack training and skill (Pa requires only that MH clinicians have four course in MH- andthey define core course very vaguely), and driven by over perscription of services due to vague psychiartic diagnostic criteria. In short, community based programs such as "wrap around" or "behavioral health rehabilation services" have proven unworkable and should be eliminated. Vague criterion for diagnosis have lead to over diagnosis of "ADHD" and "autism" and now people speak to an "epidemic" Truth is that language delays are common for children(20% of the population),if every kid with a language delay gets and "autism" diagnosis- "autism" will be one in five. As to ADHD, people don't naturally take to difficult task- this requires discipline. Society seems to have abandoned teaching children discipline in favor of medicating them and providing them with extensive and costly behavioral health services.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Most providers in Pa are social service providers more interested in providing "services" then if the services are treatment. Disappointingly, most "services" have very little medical benifit to the people served.

Regulatory Impact Analysis

Regulatory Impact Analysis

The whole system of community based services should be eliminated. Short of that- the system would do much better with greater standardization of requirements to be given a service. Greater standardization of staff through the requirements of licensure. Greater oversight of personal.Greater evaluation of outcomes through standardized measures.

Response to Comments

Response to Comments

The fcderal government needs to look at thc licensing process for "therapeutic foster" homes for it seems that they have little therapeuticness to offer children.