

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>10/10/07</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER 000191	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____	<input type="checkbox"/> FOIA DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Ms. Forkner</i>	<i>Not reviewed</i>	<input checked="" type="checkbox"/> Necessary Action	

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			.
4.			

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Gateway House, Inc.

RECEIVED

October 2, 2007

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Department of Health & Human Services
OFFICE OF THE DIRECTOR

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Centers for Medicare & Medicaid Services

Attention: CMS-2261-P

P.O. Box 8018

Baltimore, MD 21244-8018

Reference: File code CMS-2261-P

To Whom It May Concern:

Gateway House is submitting the following comments on the Proposed Rule to amend the definition of Medicaid Rehabilitative Services as published in the Federal Register, August 13, 2007 (Volume 72, Number 155).

Located in Greenville, South Carolina, Gateway House is a Day Rehabilitation Program based on the Clubhouse Model of Psychiatric Rehabilitation. Gateway House serves adults with severe and persistent mental illness, with 85% of our members (clients) having a diagnosis of Schizophrenia. We have been in business as a Non-Profit Organization for over 23 years, relying primarily on Medicaid and state funding to provide needed rehabilitation services to mentally ill citizens in our community. We currently have 145 active members, with an average daily attendance of 82.

It is clear from the published "Summary" of this proposed rule that the intent of CMS is to severely restrict rehabilitative services to Medicaid eligible individuals with long term mental illness through increased documentation requirements for already overburdened Providers and through extremely restrictive service definitions. CMS appears to want to cut funding for medically necessary services to the most vulnerable segment of this country's population- those with long term mental illness. Our members rely on Medicaid as their only health insurance and are alarmed by the degree to which their coverage could be reduced by the proposed rule change.

Medicaid has become the single largest funding source for mental health services in the United States. For CMS to proceed with their current strategy of a "Rule change" will result in precious funding being wasted on challenging the creative writing skills of mental health professionals to document needed services in a manner that will result in Medicaid reimbursement. Or, worse yet, the funds will be misused to provide specific, time limited, and ineffective interventions to adults with mental illness in a misguided effort to at least offer them something, rather than abandoning them to isolation in the community, only to decompensate. Much more intensive and expensive services will then be needed to stabilize the individual only to again be abandoned. In my 35 years of community mental health work, the most effective program to stop this revolving door,

the Clubhouse Model, is being directly threaten by the proposed Rule changes. We can not be effective under these proposed Rules as specified below.

PROVISIONS OF THE PROPOSED REGULATIONS

Section 440.130(d) (3)

The requirements outlined in this section focus on documentation. Taken individually, they all make sense from an accountability standpoint. However, the more vague requirements there are such as “recovery goals”, “intrinsic services” and “reasonable plans” that are open to interpretation, the more paybacks that can be imposed. There is too much room for interpretation from state to state.

With recent changes in documentation requirements in South Carolina, each staff person at Gateway House is now spending approximately 20 hours per week writing daily and weekly progress notes. This adds up to over 1,000 hours of staff time monthly. The annual cost to Gateway House is approximately \$300,000.00 compared to our total budget of \$1,200,000.00. Instead of spending valuable time providing needed services to our members, we are spending half of our time doing extraneous paperwork.

Recommendation: Develop a Rule change that would stop the “gotcha” game and truly benefit the clients served. Develop “fines” short of full paybacks and work to reduce the paper work demands on Providers so they can focus on service delivery to their clients. Surely there is a way to pursue unscrupulous Providers without overwhelming good Providers with paperwork. Some states require monthly progress notes while other states require daily documentation. There needs to be consistency with documentation requirements as well as what is interpreted as allowable billable services. Some states allow for “creative interventions” which include providing psychological support services to mentally ill individuals working on job placements in the community, while other states will not allow any billing for job related services. It is confusing to us that bingo, hangman, coloring in coloring books, and other similar games, if documented properly, can be considered billable services, while providing onsite psychological support to help people disabled by a mental illness be able to adjust to a real job in the community is not billable. If we are serious about focusing on recovery, CMS needs to allow Providers to bill for services that will in fact lead to recovery as well as more independence.

Section 440.130(d)(1)(vi)

This section and others has to do with the expectation that there will be a “measurable reduction of disability and restoration” and the exclusion of services to “maintain a level of functioning.” Severe and Persistent Mental Illness, such as schizophrenia, has a devastating effect on a person’s whole life. One can not chop that life up into specific measurable goals, prescribe a specific intervention in a predetermined amount and expect to impact that life. The proposed Rule goes even further in the wrong direction by disallowing most of the elements of that life as billable under Medicaid. In fact, I’m hard pressed to even think of an intervention that could not be interpreted as being vocational,

prevocational, educational, social or recreational. Even "Housing" is listed, which may be interpreted as any intervention to support a person in living more independently. Then there are "services that are intrinsic elements of programs other than Medicaid" which are also disallowed. How can this be considered "Person Centered?"

We understand that CMS provides an example of what might appear to be a "social activity" which may in fact be addressing the rehabilitation goal of social skills development as identified in the rehabilitation plan. CMS goes on to state that such an activity would need to be specifically related to an identified rehabilitative goal as documented in the rehabilitation plan with specific time-limited treatment goals and measurable outcomes. Furthermore, the social activity would need to be provided by a qualified provider, be documented in the case record and meet all requirements of this proposed regulation. How does anyone develop social skills? Do we really think that a person with mental illness is so different from anyone else? Why would a Provider even attempt such billing, knowing that the goal must be time limited and the individual would often have no place to use the social skills developed upon goal attainment?

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

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

Another concern relates to discharging patients once they reach a certain level of functioning. Clients have reported being in time limited programs where they hid improvement for fear of being discharged from the very service that helped them improve. They report having no where to go upon discharge, nothing meaningful to do and no one with whom to share any goal they may have attained. They also fear the return of depressive and psychotic symptoms that they know may recur despite compliance with medications. The words "Recovery goals" appear to have been inserted into the proposed regulation, with no understanding of what it means. It appears to be just another documentation requirement. People rarely recover from severe mental

illness. It is a biological illness with no known cure. The word "Recovery" as it applies to mental illness refers to the often life-long struggle of an individual to recover their lives to the greatest extent possible despite their illness. To set recovery goals means to provide supports and services specifically listed as not covered under the proposed Medicaid rule. The exclusion of services that are "prevocational" is particularly troublesome, as many interventions and supports necessary for "recovery" fall within this realm.

CMS can not simply make a Rule and abandon the Medicaid eligible people with mental illness. We have discharged these people from institutions with promises of providing community based services that were, at the time of discharge, essentially nonexistent or grossly under funded. Now, the single largest funding source used to develop these services in the community is threatening to make a rule change. We contend that it would be inhumane and unethical to implement these Rule changes without first of all identifying and developing adequate and alternative funding sources.

CMS has allowed states to utilize Medicaid funding to sustain and maintain the highest possible functional level for adults with severe mental illness for years. This *MUST* remain as an acceptable goal under Medicaid for delivering services to individuals living with a serious and persistent mental illness..

Section 440.130(vii)(3)

In South Carolina, we know how the South Carolina Department of Health and Human Services and the South Carolina Department of Mental Health expect Providers to document progress towards goals in the rehabilitation or personal care plan. They expect a progress note for every daily activity, which is typically hourly, the focus of the activity, the start and end time for each hourly activity, the client's level of participation and response for each hourly activity, the number of minutes the client participated in the activity, and in addition to the above, a weekly summary of staff interventions provided, the client's general progress as well as their response to the interventions, a plan for the following week, a list of measurable objectives, identifying which ones were addressed during that week, and a list of objectives that will be worked on the following week. In South Carolina, DHHS and the DMH have allowed a weekly summary for over 23 years, but decided to implement the above documentation requirements several months ago due to audit exceptions. It has been stated that CMS is "cracking down" on all states and daily documentation has always been a CMS requirement. If this is true, why is there such a variation from state to state in terms of documentation requirements? Why can't CMS come up with a standardized progress note form and require each state to comply with it? Why can't CMS develop a reasonable documentation procedure that covers the requirements but does not "cripple" the Providers who are delivering the services?

We can not state this strong enough. A progress note requirement for every encounter is an unnecessary and major burden, especially for services like PSR that are delivered to groups. This requirement has rendered our service record useless. The record can no longer be used to track the course of services being provided or for any clinical purpose

due to the sheer volume of notes. Instead of producing about 120 one-page progress notes per week, the professional staff at Gateway House must now document approximately 10,000 activities (2,200 pages) on a monthly basis at a cost of nearly \$300,000.00 annually.

WE STRONGLY RECOMMEND that on a national level, progress notes be required on a monthly basis.

The mission of Gateway House is to improve the quality of life for persons living with a serious and persistent mental illness. Unfortunately, it is becoming more and more difficult to respond to the many needs of our members and to fulfill our mission because of the paperwork and bureaucratic requirements and barriers. The varied interpretation and often misinterpretation of the Medicaid regulations; the fear of paybacks; being told to document one way one month and then to document another way the next month; and the subjectivity of an auditor's findings and recommendations leave Providers in a very vulnerable and defenseless situation.

We urge CMS to strongly reconsider the Proposed Rule changes and to further develop and refine a Medicaid system that recognizes the ongoing needs of persons living with a serious and persistent mental illness. A certified Clubhouse Model Program provides evidenced based rehabilitation services that help the mentally ill return to work, and/or to school. A member's involvement in a Clubhouse Model Program naturally decreases over time, especially after securing an independent job in the community or when returning to school. However, continued support services are often necessary in order for them to maintain their job or to remain in an educational setting in the community. For some, the severity of their mental illness will prevent them from being employed or pursuing a career. Therefore; ongoing services to sustain their level of functioning will be required in order to prevent and/or reduce psychiatric hospitalization; prevent homelessness; as well as prevent frequent visits to hospital emergency rooms and jails.

Sincerely,



Phil Emory
Executive Director

cc:

Mike Leavitt, United States Secretary of the Department of Human Services
Mark Sanford, South Carolina Governor
United States Senator Jim DeMint
United States Senator Lindsey Graham
United States Representative J. Gresham Barrett
United States Representative Henry Brown
United States Representative James E. Clyburn
United States Representative Bob Inglis

United States Representative John Spratt
United States Representative Joe Wilson
South Carolina Senator Thomas C. Alexander
South Carolina Senator Ralph Anderson
South Carolina Senator Kevin L. Bryant
South Carolina Senator Michael L. Fair
South Carolina Senator Jim Ritchie, Jr.
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