

January 31, 2008

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2237-IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: File Code CMS-2237-IFC**

To Whom It May Concern:

The National Council for Community Behavioral Healthcare is submitting the following comments on the interim final rule with comment period (interim final rule) with respect to Medicaid coverage of case management and targeted case management services that was published in the *Federal Register* on December 4, 2007.

The National Council for Community Behavioral Healthcare is a not-for-profit, 501(c)(3) association of 1,300 behavioral healthcare organizations. Our members offer medical, social, psychological, and rehabilitation services in community settings to help people with mental illnesses and addiction disorders recover and lead productive lives. Each year, members serve almost six million adults, children and families in communities across the country.

The National Council is a voice for safe, effective, appropriate, accessible, efficient, consumer-centered and timely behavioral healthcare services. Established in 1970, with roots in the community mental health center movement, we remain committed to the principle that those with mental illnesses or addiction disorders should have access to the full spectrum of services they need, in their own community.

The National Council's commitment to quality is evidenced by its efforts to provide state-of-the-art educational services to its membership on the recovery from mental illness, psychosocial rehabilitation and medical interventions, as well as training to ensure compliance with applicable state and federal laws and regulations governing the Medicaid program.

Case management services are a critical Medicaid benefit that help millions of low-income children and adults with disabilities gain access to needed medical, social, educational and other services. Forty-nine states plus the District of Columbia provide targeted case management services to some populations of adults with disabilities and all states, in compliance with the EPSDT mandate, provide medically necessary case management services to children.

The National Council's over-arching comment on the interim final rule is that it goes well beyond the policies established by the Congress in the Deficit Reduction Act of 2005 (DRA, PL 109-171). We recommend that the Centers for Medicare and Medicaid Services (CMS) review and revise the interim final rule so that it comports with the statutorily-enacted policies of the DRA. We urge you to remove the additional policy restrictions not specifically authorized by the Congress in the DRA. According to CMS's projections, the interim final rule would save \$1.28 billion over five years, an impact well above the \$760 million in savings projected by the Congressional Budget Office (CBO) when scoring the policy changes enacted by Congress in the DRA. This difference in the estimated impact on Medicaid spending itself is one indication that the rules go beyond what Congress intended.

Specifically, we recommend:

***Eliminate all provisions in the interim final rule that restrict the amount of time individuals can receive transition assistance and that impose new burdens on states and case management providers.***

Current Medicaid policy allows states to provide case management and targeted case management services to assist in a transition of a Medicaid beneficiary from an institution to the community. Federal reimbursement is available for case management provided for up to the last 180 days of the stay in the institution. This policy was issued in 2000 in response to the U.S. Supreme Court's *Olmstead* decision, which found that the Americans with Disabilities Act requires states to provide services in the most integrated community settings that are appropriate to beneficiaries' needs.<sup>1</sup>

**We are opposed to the new restrictions that limit transition case management services to a maximum of 60 days.** The interim final rule seriously undercuts a prominent Bush Administration program, the Money Follows the Person Initiative. Transitioning people into the community is a difficult and complex process. It is necessary to assess an individual's support needs, arrange for Medicaid services, identify and obtain safe, affordable, and accessible housing, and arrange for other non-Medicaid services and supports. It is not reasonable to restrict case management services to a 60-day period.

**We are opposed to the provision in the interim final rule that providers can only be paid for transition case management services once an individual has successfully transitioned into the community.** This policy limits the pool of providers who could shoulder the financial delay and risk in order to serve as case management providers. We are concerned that some case managers may be especially effective at providing case management services, and they may have unique capacities to work with

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<sup>1</sup> Olmstead Update No. 3 issued by Health Care Financing Administration (precursor to CMS) on July 25, 2000.

certain populations (such as people with specific types of disability, persons with limited English proficiency, or people who identify as racial/ethnic minorities), yet they will be unable to serve as case managers because they do not have the financial resources to bear the risk that they will not be paid for the services they provide.

Consider, for example, a scenario where an individual receives transition services and then cannot complete a transition because suitable housing is not available—or is not available within a 60-day period. Why shouldn't payment be made for Medicaid coverable services that were actually provided?

**We also believe that this payment restriction will limit opportunities for individuals seeking to transition from institutions to the community.** By creating a risk for states and providers that they will not be paid if an individual who starts the process of planning a transition is not actually able to complete a transition, it could create new barriers to prevent certain individuals from being given the opportunity to attempt a transition to the community. We are concerned, for example, that this will lead states and providers to restrict who is counseled about or offered case management services based on arbitrary perceptions of who is likely to successfully complete a transition. Recent research demonstrates that up to fifty percent of individuals transitioning out of inpatient psychiatric hospitalization never make it into community-based services – why would we make it even more difficult for this vulnerable population to transition into the community? We also worry that this could lead to new obstacles before an individual can even start the process of planning a transition. Does CMS intend to permit states or providers to impose restrictions on transition case management services such as providing transition services only after an individual has obtained their own community housing?

We recommend:

- Rescind in its entirety § 440.169(c);
- Revise § 441.18(a)(8)(viii)(A) to read, “Specify that the time period that case management may be provided in an institution must not exceed an individual’s length of stay.”; and,
- Rescind in its entirety § 441.18(a)(8)(viii)(E).

***Eliminate all provisions that would impose an intrinsic element or integral component test not authorized by statute.***

We are deeply troubled that CMS is imposing new restrictions that will limit access to medically necessary case management services to Medicaid-eligible individuals. We believe that these policies were not authorized by the Congress and will be extremely harmful to Medicaid beneficiaries.

Through a so-called “intrinsic element test”—or as this policy is described in this rule as an “integral component test”—Federal financial participation (FFP) is not available for Medicaid case management services when the activities deems that they “are integral to the administration of another non-medical program, such as a guardianship, child welfare/child protective services, parole, probation, or special education program except for case management that is included in an individualized education program or individualized family service plan”. We understand that the Administration proposed such a test in the legislative debate leading up to the enactment of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and this test was explicitly rejected by the Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others). We oppose an intrinsic element test because it goes beyond the third party liability requirements of the Medicaid law as established by the Congress; we believe it is vague and could be applied to restrict services that are appropriately covered; and, it is arbitrary and could restrict access to Medicaid services even if no other program is available to provide coverage for otherwise Medicaid coverable services to Medicaid beneficiaries. This test has the potential to cause great harm to Medicaid beneficiaries who need timely and reliable access to Medicaid rehabilitative services.

We recommend:

- Rescind in its entirety § 441.18(c)(1); and,
- Rescind in its entirety § 441.18(c)(4).

***We oppose limitations on transportation provided by case managers***

The background to the rule states that referral and related activities of case managers do not include providing transportation to the service or escorting the individual. We believe persons with mental illness are a special case in this regard, and urge you to revise this policy.

An indication of how problematic it is for persons with serious mental illness to manage transportation systems is the fact that training in the skill of using transportation is one of the most frequently cited skills training services under state Medicaid rehabilitation services rules. This difficulty will seriously impede many individuals with mental illness from accessing the services that are deemed necessary and are included in their treatment plan.

There are two issues here: whether a case manager should be able to bill for the time of helping the individual access a necessary service by transporting the person to that appointment, and whether case management services can be furnished during transportation. Since rehabilitation and case management services can be furnished in any setting, we believe there should be no question that case management services provided while a case manager accompanies a person on a journey should be reimbursable.

With respect to time spent accompanying a person, but not spent furnishing another specific case management service, we believe this time too should be coverable as part of the case manager's responsibility to ensure that the individual receives the services to which they have been referred. For many children and adults with mental illness, transportation by Medicaid transportation vendors is inadequate because these vendors are not trained to address their special needs. In some circumstances, these individuals would be unable to access services without transportation provided by case managers.

While the statement prohibiting these payments appears only in the background section, it is important that CMS policy allow for a case manager to transport an individual to the service at least in those cases where there is a clear possibility that, due to their disability, the person would otherwise not access the service.

***Promote the reduction in the number of Medicaid case managers serving each individual, but permit state flexibility to allow multiple case managers in certain circumstances.***

The rules would also limit state flexibility by prohibiting a state from providing a beneficiary with more than one case manager even when the complexity of the beneficiary's condition demands the expertise of more than one program. In most cases, having one case manager would be beneficial to avoid duplication. But, if a beneficiary has multiple conditions — for example HIV/AIDS, mental illness and an intellectual disability — no single case manager may be able to coordinate housing, health care, and social needs across multiple systems.

We recommend:

- Revise § 441.18(a)(5) to include an exception, as follows: “; except when, as determined by the State, it is not practical to limit an individual to a single case manager due to the complex and diverse nature of their needs, as documented by their plan of care.”
- Clarify that the one case manager standard refers to the agency to take into account the high turnover rate of individuals employed as case managers.

***Eliminate provisions that impose unworkable documentation requirements on providers and limit state flexibility to establish payment practices and procedures.***

A central tenet of the federal-state partnership to operate Medicaid is that states must follow federal guidelines but retain broad flexibility in establishing payment rates and determining payment policies. Disregarding this tenet, the rules arbitrarily restrict state flexibility to determine payment methodologies in a way that could make Medicaid payments less efficient.

The rules would prohibit states from making fee-for-service payments for case management services in any way other than paying for units of service that do not exceed 15 minutes. States often use case rates, per diem rates, or other payment methodologies to pay for case management. The highly prescriptive approach in the rules will make it difficult or impossible for states to provide case management as part of assertive community treatment (ACT), a comprehensive, evidence-based treatment program promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) for people with serious mental illness programs that provides services 24 hours a day and 7 days a week. Paying for case management services on the basis of 15-minute increments would not work for programs like ACT where case managers must be on-call and ready to respond at all times.

We recommend:

- Rescind in its entirety § 441.18(a)(8)(vi).

***Eliminate all new restrictions that prohibit child welfare agencies and contractors from providing Medicaid case management services to children receiving foster care.***

The DRA includes a list of activities that may not be included in case management under Medicaid, because they are services that are part of the foster care services delivered by child welfare agencies. We accept that this is the policy established by the Congress. The interim final rule, however, goes substantially farther and would prohibit federal Medicaid funds for *all* case management services provided by child welfare and child protective services agencies and contractors of these agencies, regardless of whether the contractors are qualified Medicaid providers.

On April 5, 2006, Senator Charles Grassley (R-Iowa), then chair of the Senate Finance Committee, wrote a letter to Mike Leavitt, Secretary of the U.S. Department of Health and Human Services, to explain what Congress intended in the DRA in order to provide guidance to CMS on implementation of the case management provision. He wrote: “[Case management] services, which the Congress intended would be appropriately considered a Medicaid expense, are particularly important to children in foster care. These are children who have multiple social, educational, nutritional, medical and other needs.” The letter cautions the Secretary that the “disallowance of reimbursement under Medicaid for services specified in the DRA for TCM for children in foster care. . . is in direct contradiction to Congressional intent.”

According to the preamble to the interim final rules, case management services would be available to children in foster care only if a Medicaid provider operating outside the child welfare system provided them. As noted, the rule prohibits payment for case management services by child welfare agency workers or by any other provider that

contracts with a state's child welfare agency. By restricting case management services in this way, the rules would force states to fragment services to children in foster care, a result directly contrary to the purpose of the case management benefit, which is to coordinate the medical, social and educational services that children in foster care need.

We recommend:

- Withdraw the policy restrictions in the preamble that prevent child welfare workers and contractors from serving as Medicaid case managers;
- Rescind in its entirety § 441.18(c)(1); and,
- Rescind in its entirety § 441.18(c)(4).

***Eliminate new restrictions that narrow the scope of Medicaid-eligible children who can receive case management services in school settings.***

All children in Medicaid are eligible for case management services when the services are medically necessary. Some states provide medically necessary case management services to children with disabilities in school settings to ensure that they can receive a free and appropriate public education. The interim final rules would allow the provision of case management for children with disabilities in schools only when case management is designated as a required service in the child's Individualized Education Program (IEP) or an infant or toddler's Individualized Family Service Plan (IFSP). The rule specifically disallows the provision of case management when it is part of a child's plan under Section 504 of the Rehabilitation Act.<sup>2</sup> (Regulations implementing Section 504 [34 CFR 104.33] require that public school systems must provide a free appropriate public education (FAPE) to each qualified person with a disability, regardless of the nature or severity of the person's disability. For purposes of the regulation, the provision of an appropriate education is the provision of regular or special education and related aids and services. Implementation of an IEP developed under IDEA is one means (but not necessarily the only means) of meeting the FAPE standard under Section 504.) Case management services are often needed by children with disabilities covered by Section 504, and school settings are an appropriate and effective environment for ensuring that children receive the services they need.

We recommend:

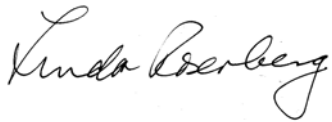
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<sup>2</sup> This appears to be a change from current policy. The Colorado state Medicaid plan includes case management for children with a Section 504 plan who have a disability and are medically at risk. <http://www.chcpf.state.co.us/HCPF/State%20Plan/State%20Plan%20Files/Sup%201A%20to%203%201-A%20TN95003.pdf>

- Revise the interim final rule to permit medically necessary case management services to be provided in school settings to all children, without regard to whether the services are part of an IEP or IFSP under IDEA.

Thank you for the opportunity to comment on the interim final rule.

Sincerely,

A handwritten signature in black ink that reads "Linda Rosenberg". The signature is written in a cursive style with a large initial "L" and "R".

Linda Rosenberg, MSW, CSW  
President and CEO



