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January 11, 2008

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

Dear Mr. Smith:

The following comments are submitted by the Bazelon Center for Mental Health Law on the Interim Final Rule for Medicaid Optional State Plan Case Management Services, published in the Federal Register on December 4, 2007.

The Bazelon Center is a legal and policy advocacy organization, based in Washington, D.C. and dedicated to upholding the rights of adults and children with mental illness.

Case management is essential for ensuring that individuals who need a range of services and supports can live successfully in the community despite a serious mental disorder. If these rules are not amended, many individuals who require this assistance will suffer undue harm.

In the preamble background to the rule itself, CMS goes well beyond the law and the recently enacted Deficit Reduction Act to unduly restrict the use of this service. If these statements represent CMS policy on case management, they should be reconsidered.

On the other hand, the rules could be improved if several other provisions in the background section were included in the rule itself. Several provisions in the rule are not as clearly stated as they could be, but are more detailed in the explanatory language. We urge that certain wording within the background section (as detailed below) be moved into the official regulation, as referenced in our comments below.

Reimbursement of Case Management for Certain Individuals (§441.18(c)(3))

The regulations emphasize that Medicaid will not pay for case management services deemed “integral” to the administration of another program, including

guardianship, child welfare/child protective services, parole, probation or special education (except when case management is a service identified in the child's IEP or IFSP). There is little explanation in the regulation of what "integral to" means. Given that Medicaid case management is intended to relate to the services and supports that are required as a result of an individual's medical condition, it is hard to see how such medical services are an integral responsibility of any of these other systems. The issue of concern, therefore, appears to be distinguishing case management that is needed as a result of the individual's health, and case management that would be needed even if the individual did not have a serious health condition.

The background to the rule includes the following statement on this question. "Case management services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home or other community placement...when services are identified due to a medical condition." This statement does not appear anywhere in the rule itself, despite the fact that this is the key issue with respect to Medicaid coverage for case management services to persons with disabilities and serious health conditions.

For a person with a serious mental illness, accessing any needed services and supports is problematic. Case management is essential for both health and mental health services and for other basic supports.

CMS should not only include in the rule the sentence from the background, cited above, but provide further clarification that Medicaid will cover case management services for persons with serious health conditions, regardless of whether there are other systems that coordinate basic services for all persons under their charge (such as child welfare, or probation, etc.).

It should be noted that the rule also includes a provision (§441.18(a)(4)) requiring states to ensure that case management services "will not duplicate payments made to public agencies or private entities under the state plan and other program authorities." This language is a more appropriate approach to ensuring that Medicaid is last payer and should be retained. The statement in the background that this provision does not preclude states "from using Medicaid to pay for case management services that previously had been funded solely with state and/or local dollars" is also helpful, because it clarifies that just because one agency could pay for case management, Medicaid may still be billed if the service is covered under the state plan and provided to a Medicaid-eligible individual (and other Medicaid requirements are met).

Child Welfare Activities That Are Excluded (§441.18(c)(3)(i))

In the background to the rule, but not in the rule itself, CMS has expanded the list of non-covered child welfare activities beyond those detailed in the Deficit Reduction Act of 2005. This language could be interpreted to include activities that address the mental health needs of a child in foster care. For example, "provision of services to children and families in their own homes, identification of risk factors, referral to services and evaluation (or monitoring) of interventions" appear to be unallowable activities when furnished by child welfare workers. However, CMS fails to recognize in this paragraph that all of these activities would be covered case management services if they related

directly to the child's serious medical condition. For example, if identification of risk factors relates

to risk of a mental health crisis and is therefore related to treatment planning. This needs to be clarified.

Providers of Case Management

In the background to the rule, CMS states that Medicaid case management services cannot be used to pay for services of state child welfare/child protective services workers, or child welfare contractors.

There are two problems here. First, child welfare agencies may contract with a mental health agency to provide mental health services to a child. Federal law explicitly allows Medicaid payment for health care services to foster children and federal Title IV rules also do not allow the use of Title IV-E funds for medical services. Thus, services from a mental health provider to a child in the child welfare system should be covered under Medicaid. Yet this language appears to prohibit that if the service is through a contract with child welfare, even as other language in the background section states that “children receiving child welfare/child protective services may still qualify to receive Medicaid targeted case management services.”

Secondly, even when a child welfare worker furnishes case management of medical services or other support services that are needed by a child because of that child’s health condition, these services should be billable to Medicaid. The issue should not be the provider, but the service that is provided.

Child welfare workers are not generally health care workers, but if specially trained to manage a child’s mental health and related services, there is no reason they cannot be a qualified Medicaid provider of case management.

Although it may be less rare for probation or parole officers to be qualified to provide medical case management, there should also not be a blanket exclusion of these individuals as providers under Medicaid, if they can so qualify under state rules. Again, the issue should be the service provided, not the individual who provides it.

Payment for Services Provided without Charge

This provision is based on the legislative history of the law authorizing targeted case management in 1985. Unless interpreted sensibly, such a rule could undermine Medicaid’s role as an insurance program. Many mental health services are provided free of charge by various state and local agencies, all of which bill third party payers where the individual has insurance. Provision of care to uninsured persons should not preclude Medicaid reimbursement for Medicaid-covered individuals. If applied across the board to all Medicaid services, such a broad interpretation of this rule would result in almost no Medicaid reimbursement for any health care service, as most states have at least limited programs providing care to the uninsured.

CMS should adopt a policy that ensures that only when there is a clear obligation on the part of another payer will Medicaid reimbursement be denied on the basis that Medicaid should be last payer. Failing to pay for a service because limited state, local or other funds allow some uninsured persons to receive the service will undercut the role of Medicaid as a safety net program for our lowest income citizens.

Payment Methodology (§441.18(a)(8)(vi))

The rule requires case management services to be billed in units of service that must not exceed 15 minutes. In the background, CMS explicitly prohibits bundled rates for case management, requiring that case management be reimbursed fee-for-service based on units of time.

However, there are critical, evidence-based mental health services that are furnished as a comprehensive package and difficult (not to mention administratively expensive) to tease apart. For adults, assertive community treatment is one example of such a service, and for children multi-systemic therapy is such a service.

States should have the flexibility to pay for Medicaid services in the most cost-efficient manner. An over-reliance on detailed administrative reporting is not conducive to high quality and cost-effective care, as has been demonstrated in health care on the private sector side. Micro-management is rarely effective, and never efficient. States should be permitted to submit cost-reimbursement approaches to CMS for approval, and such approaches should allow various forms of payment including daily rates, case rates, per diem rates, etc. provided the methodology for the rate setting is sound and does not result in unnecessary costs to the Medicaid program.

Special Education, Section 504 and Medicaid (§441.19(b)(4))

CMS has interpreted the Medicaid provision that authorizes payment for special education services in too narrow a manner. Children who are placed in special education require an assessment and treatment planning (Medicaid covered case management services). While the development and review of an IEP plan may not, in its entirety, deal with medical issues, it is common for a mental health assessment and mental health treatment planning to be incorporated into that process. Often the child's community-based mental health case manager participates in these IEP discussions, ensuring the child's services have a single focus and set of goals. For Medicaid-covered children who have an IEP or IFSP, the initial assessment and treatment planning activities should be reimbursable.

In the background section, CMS states that FFP would also not be available for case management services furnished to children in school when those services are needed in order to ensure equal access to education under section 504 of the Rehabilitation Act. Schools, however, traditionally bill third party payers for any health care service furnished to a covered child in school. It is unclear why Medicaid, which CMS frequently states is an insurance program, should be exempt in this manner. The legislative language on third party payments specifically cites only health plans, insurers and similar entities. It does not state that public agencies must always be first payer, and as CMS has stated in this rule and background, states may bill Medicaid for services previously funded with state or local dollars provided all Medicaid requirements are met.

We recommend that CMS clarify that it is a covered Medicaid service when a community mental health case manager participates in the IEP process in order to develop an appropriate plan of care for the child, and to ensure that the IEP and the mental health treatment plan are consistent. In addition, children requiring case management should be eligible to receive those services, regardless of whether the school has a 504 obligation.

Definition of Case Management (§440.169)

In general, the definition of the specific activities that are included under the Medicaid terms “case management” and “targeted case management” services restates current federal policy (including the definition in the Deficit Reduction Act and in most state plans) and is appropriate for persons with mental illness.

We therefore support the language in the rule regarding assessments, but believe it could be significantly strengthened if some of the statements now in the background section were included in the rule. These include: requirements that the assessment be based on the individual’s strengths and preferences and consider the individual’s physical and social environment; that there be regular face-to-face reassessments, at least annually.

We also support the provision that the individual may decline the service and may have free choice of qualified provider (although this choice may be limited for persons with mental illness in order to ensure access to the necessary services, see comment below).

Finally, this provision should refer to the need for the specific care plan to be recovery-focused (a requirement referenced in the recently released draft rules on rehabilitation services, but notably absent in these rules).

Transition Case Management (441.18(a)(8)(vii)-(viii))

These regulations apply a new and tighter standard to case management services provided for individuals who are transitioning from a residential placement to the community. Under previous rules, states could cover transitional case management for 180 days prior to the person’s discharge. These rules reduce that time frame to only 60 days, with no explanation as to why this is necessary, and without citing any examples of abuse of the previous rule.

Persons who have made a long stay in an institution, including many individuals with mental illness who have resided in a nursing home or who are over 64 and have resided in a Medicaid-covered psychiatric hospital will be adversely impacted by this change. Transitioning long-stay individuals to the community requires significant work, including application for and access to benefits, finding housing and lining up support services. This frequently can take more than 60 days.

Given that there is no statutory change to authorize this shift in policy, we strongly urge CMS to amend its policy and restore the 180 day limit.

Transporting Individuals to Services

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.

Single Case Manager (§441.18(a)(5))

The rule requires that Medicaid case management services be furnished by only one case manager for each individual, regardless of the complexities of the individual's case.

This is a wholly unrealistic shift in policy that will seriously harm Medicaid-covered individuals. It is not reasonable to expect that a mental health case manager, for example, will have the expertise and knowledge to assist an individual with HIV, for example, to conduct a full assessment of that person's needs, develop a treatment plan and monitor progress.

This change will cause states considerable problems and significantly increase training costs while depleting the pool of individuals who potentially have the capacity to be Medicaid case managers. It is also unclear why CMS believes this rule change will either improve quality of care or save resources.

Instead of such an arbitrary and unworkable rule, CMS should instead require close collaboration among case managers from different systems for those individuals who have dual diagnoses, each of which is a serious health condition.

Provisions That Should be Maintained

There are several sections of the new rules which are important, and which we endorse. Those provisions are as follows.

Limiting Providers (§441.18(b))

We strongly support the provision that allows states to limit providers of case management for persons with serious mental illness to those whose position ensures that they can effectively link their clients to mental health services. While the rule does not preclude independent case managers, there are situations where independent case managers will be unlikely to be able to assist persons dependent upon public mental health services. This provision in the law and these regulations allows states to provide efficient and effective case management in those situations.

Contact with Non-Eligible Individuals (§440.169(c))

Effective case management requires that case managers be able to work with non-eligible individuals, particularly family members of covered individuals in order to ensure high quality care. The explanation of this provision in the background section is appropriate, CMS is to be applauded for recognizing this need.

Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in cursive script that reads "Chris Koyanagi".

Chris Koyanagi
Policy Director