Summary of CMS Interim Final Rule on Optional State Plan Case Management Services

The Centers for Medicare and Medicaid Services (CMS) has published interim final regulations to govern case management services under Medicaid (Federal Register, December 4, 2007, Vol. 72, No. 232, 68077-68093; 42 CFR Parts 431, 440 and 441). Under Medicaid, case management services are services that will assist individuals in gaining access to needed medical, social, educational or other services.

These regulations were promulgated to implement part of the Deficit Reduction Act of 2005 (DRA, Public Law, 109-171—see the Bazelon Center's March 2006 Mental Health Policy Reporter) and are CMS' interpretation of Section 6052, Reforms of Case Management and Targeted Case Management. The rule covers case management services and targeted case management services and seeks to clarify the situations in which payment will and will not be made by Medicaid.

The rules allow for a 60-day public comment period (ending at 5 p.m. on February 4, 2008). They become effective on March 3, 2008—90 days after their publication in the Federal Register. Although final on an interim basis, the rules can be modified prior to the effective date. Accordingly, advocates should submit comments to increase the likelihood of modifications (click here to find out how to submit comments).

Overview

The regulations include a lengthy definition of what constitutes case management under Medicaid. It is a restatement of previous federal policy. The major changes are:
Strict limitations on when child welfare agencies, juvenile justice and other agencies may bill for case management or targeted case management;
Limitations on when schools may bill for case management, which will deny reimbursement for case management for any child in school until the child has a special education program (IEP or IFSP) that includes case management as a necessary service.
Requirements that no individual have more than one case manager, even when the person has a combination of impairments (such as mental illness and HIV/AIDS, or mental retardation and a severe medical condition).

Restrictions on payment methodology and units of service for case management that require fee-for-service payment only and payment for 15-minute units of service.

No Federal Payment for Services that Are Integral to Another System

Consistent with Medicaid's third-party liability requirement, the background to the rules explains that Medicaid payment will only be available for the cost of case management or targeted case management services if no other third parties are liable to pay for those services.

CMS states that federal reimbursement will not be available for otherwise-covered case management services if those services are deemed to be an integral component of another covered Medicaid service. However, this duplication-of-payment rule does not preclude states from using Medicaid to pay for case management services that previously had been funded

solely with state or local dollars. It does prevent states from billing Medicaid for case management services that are furnished without charge to other users of the service.

Child Welfare, Juvenile Justice and Guardianship

In the DRA, Congress included a list of the types of activities considered integral to child welfare and therefore not covered as case management under Medicaid. These activities included investigating abuse and neglect, assessing adoption placements, recruiting foster parents, serving legal papers, home investigations, administering foster care subsidies and making placement arrangements. In the preamble to the new regulation, however, CMS appears to broaden this list, using language that could be interpreted to include activities to address the *mental health needs* of a child in foster care with a serious mental disorder. 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. The list of exclusions also includes foster care "case management." The regulations do not sufficiently make clear that such activities can be covered Medicaid services if they are to address the child's mental, emotional or behavioral issues stemming from a mental disorder.

At the same time, CMS makes clear that children receiving child welfare or child protective services or who are in the juvenile justice system can receive covered case management services. The preamble to the rules, however, states that child welfare workers, parole or probation officers or other employees or contractors of the child welfare or juvenile justice systems or the court cannot bill for case management services. Community mental health agencies furnishing case management services to children involved in child welfare or juvenile justice system are still authorized to bill Medicaid for those services. CMS also applies this rule to individuals in public guardianship, although Medicaid case managers may assist guardians and others. Case managers, however, may not be used to replace or fund the function of a guardian or conservator.

Education

In a departure from previous policy, CMS is also restricting when Medicaid may be billed for case management in schools. Medicaid case management must remain separate from administration of the IDEA. Medicaid will not pay for case management activities required by the IDEA but not needed to assist students in gaining access to needed services. Thus Medicaid case management *cannot* be billed for the work of developing, reviewing and implementing a child's special education program (IEP) For younger children, Medicaid case management *can* be billed for activities such as taking the infant or toddler's history, identifying service needs and gathering information from other sources to form a comprehensive assessment. For all schoolchildren, administrative functions such as scheduling IEP/IFSP team meetings and providing written notice are not considered Medicaid case management services. Section 1903(c) of the Medicaid statute authorizes Medicaid to pay for any service listed in a child's IEP, so once an IEP or IFSP is written, if case management is required, Medicaid may be billed.

Managed Care

In contrast to the restrictive rules regarding children in child welfare, juvenile justice or school programs, CMS is permitting separate, additional billing for case management

services for individuals who are enrolled in a capitated managed care plan. The rationale for this is that the managed care entity's payment rate only covers managing the medical services an individual needs, but not for helping the individual gain access to social, educational and other services.

Administrative Activities

Finally, CMS states that administrative activities of various other non-medical programs cannot be billed to Medicaid. These non-medical programs include special education, parole and probation, legal services, child welfare/child protective services and guardianship. This exclusion does not in any way, according to CMS, "compromise Medicaid recipients' eligibility for medically necessary services, including case management and targeted case management services that are not used to administer other programs."

Definition of Case Management

Case management services are defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation.

Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.)

The preamble to the regulation clarifies that case management cannot be furnished to an individual who is not yet determined eligible for Medicaid. However, Medicaid administrative costs can include assisting individuals in applying for or obtaining eligibility, re-determinations of eligibility, intake processing, preadmission screening for inpatient care, prior authorization and utilization review, and outreach. States may not claim costs for administrative activities if the activities are an integral part or extension of a direct medical service.

Elements of Case Management

The assistance provided under case management includes the following four elements:

A comprehensive assessment to determine the need for medical, educational, social or other services. This includes assessing the individual's strengths and preferences, taking client history, identifying needs and completing related documentation, and gathering information from other sources (such as family members, medical providers, etc).

The development of a specific plan of care based on information collected through the assessment. The plan must list the goals and actions to address the medical, social, educational and other services the individual needs. The person must be an active

participant and the case manager must work with the individual (or the person's authorized healthcare decision maker) and others when developing service goals and identifying a course of action to respond to assessed needs.

Referral and related activities to help individuals obtain needed services. This includes activities that help link individuals with medical, social or educational providers or other programs that are capable of providing needed services to address identified needs and achieve goals in the plan of care. This includes making referrals to providers for needed treatment and scheduling appointments for the individual. However, transporting and escorting an individual to a service is not covered as case management. Also not covered are the direct services, program or activity to which the individual is linked.

Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and is adequately addressing the person's needs. Follow-up may be with the individual's family members or service providers, or other entities or individuals. Monitoring may involve either face-to-face or telephone contact. The activities can be conducted as often as necessary (including at least one annual monitoring) to help determine whether:

- services are being furnished in accordance to the individual's plan;
- the services in the care plan are adequate; and
- there are changes in the eligible individual's needs or status. If so, necessary adjustments can be made in the care plan and service arrangements with providers.

Case management may include contacts with individuals who are not eligible for Medicaid when necessary to manage the care of the person who is receiving case management services (e.g., to help access services, identify needs and supports, and provide useful feedback to case managers). Contacts with an individual's family or others that are for the purpose of helping the Medicaid-eligible individual access services are covered. Family members may also be involved in all components of case management—for example, when they provide feedback or alert the case manager to changes in the individual's condition or needs.

CMS encourages a person-centered approach. This is defined as a process used to develop, implement and manage a care plan that attempts to fulfill the objectives and personal preferences of the individual or the legal representative of that individual. The process focuses on the person rather than the system. It directly involves the person (or legal representative) in the development of the plan and in all aspects of its implementation and management, and is tailored to meet individualized needs.

Transition to the Community

CMS has authorized, as a separately covered case management service, services to transition an individual from an institution to community services. For such individuals, case management may be furnished during the last 60 consecutive days (or a shorter period specified by the state) of a Medicaid-covered long-term institutional stay of 180 consecutive days or longer and during the last 14 days prior to discharge from an institutional stay of less than 180 consecutive days. However, many people with mental

illnesses will not benefit from this rule. The rule prohibits payment for case management or targeted case management services provided to individuals under age 65 who reside in an IMD or to inmates in a public institution, including a residential treatment center for children under age 21 (but not including foster care, group home or other community placement)). Payment for case management or targeted case management services for these individuals is not available until the individual has transitioned to the community.

This is a departure from prior policy, where community case manager services were available during the last 180 days of all institutional stays. It is likely to stifle successful transition to the community in furtherance of the Supreme Court's *Olmstead* decision regarding provision of services in the most integrated community setting.

Single Case Manager Required

When an individual falls within more than one state target group (e.g. mental retardation and mental illness), CMS requires that only one case manager bill Medicaid. That case manager must coordinate all necessary services and link with providers in both systems to ensure the individual's needs are met. CMS justifies this rule on the basis that the individual must have a single plan of care and therefore needs a single case manager to manage all necessary services. In recognition that this will require a major shift in state operations, CMS has given states a transition period before this provision will be enforced. States have the lesser of two years or one year after the close of the first regular session of the legislature (that begins after this regulation becomes final) before CMS will enforce the rule.

Payment Methodology

States must specify the methodology they will use to reimburse for case management services. Payment must be fee-for-service and rates must also be calculated employing a unit of service not exceeding 15 minutes.

Consumer Protections

States must allow individuals free choice of any qualified Medicaid provider within the geographic area identified in the plan. However, a state may limit providers for some groups, including those with "chronic mental illness" or developmental disabilities, in order to ensure that the case manager can provide access to services required by the individual. For example, if the case manager is employed by the community mental health agency that will furnish other services, this facilitates full implementation of the person's plan. If the state does limits providers in this manner, it must identify those limits in the state plan and specify how they will guarantee that providers are able to ensure that individuals in the target groups have access to the services they need.

States must also meet certain other requirements regarding case management services:
Not use case management services to restrict an individual's access to other services under the plan.
Not condition the receipt of case management services on the receipt of other Medicaid services (and vice versa) or compel an individual to receive case management services.

Not allow case managers to act as gatekeepers to other services under the plan by exercising authority to deny or authorize care.

Case Records: Documentation

States must require case management providers to maintain case records that include:

- the name of the individual and the date of service;
- the name of the provider agency (if relevant) and the person providing services;
- documentation of whether the individual declined services in the care plan;
- documentation of services received (including nature, content and units) and whether specified goals where achieved;
- documentation of need for (and occurrences of) coordination with other case managers;
- a timeline for obtaining needed services; and
- a timeline for reevaluation of the plan.

State Plan Amendment Requirements

A separate state plan amendment is required for each target group of Medicaid beneficiaries receiving case management services. Each separate plan amendment must describe (if there are any differences among the subgroups) the:

- case management services to be furnished;
- qualifications of the case managers; or
- methodology under which case management providers will be paid.

The state must also:

- define the group (and any subgroups) eligible to receive services;
- identify the geographic area to be served;
- describe the services furnished (including the types of monitoring);
- specify the frequency of assessments and monitoring and provide a justification for those frequencies;
- specify the qualifications of the service providers that are reasonably related to the population being served and services furnished;
- specify whether transition case management services are to be provided to Medicaid-eligible individuals in institutions (except individuals ages 22-64 in IMD's or inmates of public institutions);
- if so, specify whether the services are for individuals with institutional stays of 180 consecutive days or longer or to those with stays of less than 180 consecutive days. Additionally, states must:
    - o specify the time period (which must not exceed the length of stay in the institution)or other conditions for services;
    - o include an assurance that the amount, duration and scope of activities will be documented in a plan of care that includes case management activities prior to and post-discharge;
    - o specify that case management is only provided by and reimbursed to community case management providers;

- specify that federal financial participation (FFP) can only be claimed until discharge from the institution and enrollment of the individual in community service; and
- describe the system and process to monitor providers compliance with the provisions.