



January 29, 2008

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
P.O Box 8018
Baltimore, MD 21244-8018

To Whom It May Concern:

Reference: File code CMS-2237-IFC

The Coalition of Behavioral Health Agencies, Inc. is submitting the following comments on the interim final rule for Medicaid Optional State Plan Case Management Services, published in the Federal Register on December 4, 2007.

The Coalition of Behavioral Health Agencies, Inc. is the umbrella trade association and public policy advocacy organization of New York's behavioral health community, representing over 100 non-profit behavioral health agencies. Taken together, these agencies serve more than 350,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of a diverse New York City and its environs.

The Coalition's member organizations sustain some of New York's most vulnerable citizens: persons with HIV, struggling families, the fragile elderly, people living with co-morbid health conditions, people discharged from psychiatric hospitals and detoxification units, prison discharges and troubled children. They provide a full continuum of behavioral health services including: ACT, AOT, case management, clinic treatment programs, community residential programs, continuing day treatment programs, crisis outreach and intervention services, drop-in centers, family support services, home and community based services, homeless outreach, mobile crisis intervention programs, on-site rehabilitation, psychosocial clubs, school based programs, supportive housing, transitional employment placement, transitional management services, vocational and social rehabilitation and vocational services for adolescents.

Case management services are a critical Medicaid benefit that helps millions of low-income children and adults with disabilities gain access to needed medical, social, educational and other services. The interim final rule makes changes that go well beyond the policies established by Congress in the Deficit Reduction Act of 2005 (DRA, PL 109-171). Implementation of the rule would have a detrimental impact on Medicaid beneficiaries, particularly children in foster care and individuals with physical or mental disabilities or other chronic health conditions.

We urge CMS to revise the interim final rule so that it complies with the statutorily-enacted provisions of the DRA. In particular, we urge CMS to remove the additional policy restrictions not specifically authorized by Congress.

Below, please note the Coalition’s specific recommendations and comments as they pertain to the interim final rule.

Comments re: PROVISIONS OF THE INTERIM FINAL RULE

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

The final rule should not require providers to bill for services separately that are part of a “package of services”.

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

This new shift in rate setting methodology is inconsistent with evidence-based mental health practices that are based on delivering services together in a flexible and coordinated way. The shift in documentation and billing procedures significantly increases the amount of time that clinicians must spend completing paperwork, thus reducing the amount of time available to spend with clients.

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.

Recommendation

We strongly urge CMS to remove this entire section because it conflicts with the payment methodology of evidence-based practices. Furthermore, we urge CMS to work with other Federal agencies, the states and the field to devise payment methodologies that support best practices and the most successful outcomes for children and adults with mental disorders.

Provision of Services to Institutionalized Individuals (Section 441.18(a)(8)(vii)-(viii))
The final rule should not reduce the number of days case management services are reimbursable during the transition period out of institutional settings.

The interim final rule applies a new and tighter standard to case management services provided to individuals who are transitioning from institutional care to the community. Under previous regulations, federal reimbursement was available for transitional case management services for up to 180 days prior to the person's discharge (issued by the Health Care Financing Administration (precursor to CMS) on July 25, 2000). 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.

Furthermore, the interim final rule seriously undermines the "Money Follows the Person" demonstration, a centerpiece of the President's New Freedom Initiative to help people with disabilities participate more fully in community life. Under the "Money Follows the Person" demonstration, which is intended to support efforts to move Medicaid beneficiaries from institutions to the community, some states are receiving federal financial participation (FFP) for case management services provided up to 180 days prior to discharge (all of the state plan amendments were recently approved by CMS).

The interim final rule reduces the time frame that case management services are reimbursable to only 60 days in a stay that lasts 180 days or more and for only the last 14 days of a stay that lasts less than 180 days, with no explanation as to why this is necessary, and without citing any examples of abuse of the previous regulation.

Transitioning long-stay individuals to the community requires significant work, including finding housing and linking an individual with support services. The proposed time periods will be insufficient for many people, especially those with complex health care needs (i.e. mental illness, substance abuse disorder), to complete a successful transition to the community.

Moreover, the interim final rule prohibits 1) payment until the date that an individual leaves the institution, 2) is enrolled with the community case management provider, and 3) receives medically necessary services in a community setting. Although providers will be able to bill for services retroactively, a number of providers may not be able to work with hospitalized clients because of cash flow problems. This provision could create new barriers for vulnerable individuals thereby impeding the successful transition into the community and enrollment in necessary services.

Recommendation

We strongly urge CMS to amend this provision by doing the following:

- Rescind in its entirety § 440.169(c);
- Rescind in its entirety § 441.18(a)(8)(viii)(E).

Single Case Manager (§441.18(a)(5))

The final rule should not require Medicaid case management services be furnished by only one case manager for each individual.

The interim final 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. 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 a cognitive disability, this policy will seriously harm their health, quality of life and success of their treatment. No single case manager may have the expertise and knowledge to assist an individual with multiple conditions, be able to conduct a full assessment of that person's needs, develop a plan of care, coordinate services across multiple systems 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. The interim final rule does not explain how this change will improve quality of care or save resources.

Recommendation

We strongly urge CMS to revise § 441.18(a)(5) to include the following exception, "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". Furthermore, we urge CMS to require close collaboration among case managers from different systems for those individuals who have dual diagnoses, each of which is a serious health condition.

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

The final rule should not deny Medicaid coverage for case management services provided to Medicaid-covered individuals if such services are furnished through another program.

The interim final rule emphasizes that Federal financial participation (FFP) will not be available for Medicaid case management services when they are deemed to be "an integral [component] to the administration of another non-medical program, such as guardianship, child welfare/child protective services, parole, probation or special education except for case management that is included in [the child's] individualized education program (IEP) or individualized family service plan (IFSP)". There is little clarity on how to determine whether a service is an "integral" component of another program or how it would be applied. Furthermore, this policy was explicitly rejected by Congress (See July 7, 2006 letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others).

Moreover, this provision is contrary to the broad scope of case management that CMS endorses, and, indeed, appears to demand. The preamble and the regulations require a comprehensive plan for services which then guides the activities of the case manager. Yet, here, CMS contradicts this and places limits on case management activity that will fragment the provision of services

and leave states and providers guessing as to how these two opposing positions will come out in a Federal audit.

Without revision, this new rule would conflict with the current 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). As a result of this provision, Medicaid-eligible individuals may be denied services that are appropriately covered by Medicaid and/or by the other programs. Thus, the rule effectively denies individual's medically necessary Medicaid services, in direct contradiction of current federal statute.

Recommendation

We strongly urge CMS to remove this entire section, because it conflicts with 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 provided to a Medicaid-covered individual.

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

The final rule should not restrict federal financial participation for case management services that address the mental health needs of a child in foster care.

The Deficit Reduction Act of 2005 includes a list of activities that may not be included in case management under Medicaid, and for which FFP is not available, because they are services that are part of foster care services delivered by child welfare agencies. The interim final rule expands the list of non-covered activities beyond those detailed in the DRA of 2005 and would prohibit federal Medicaid funds for *all* case management services provided by child welfare and child protective agencies and any other provider that contracts with those agencies. Therefore, case management services would be available to children in foster care only if a Medicaid provider operating outside the child welfare system provided them. By restricting case management services in this way, the rule would force states to fragment services to children in foster care, which is inconsistent with the purpose of case management – to coordinate needed medical, social and educational services.

The child service sector is especially complex particularly for those in foster care. Effective case management is essential for children and families who are receiving services from it.

In recognition of this, 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. 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.” Senator Grassley's letter makes it clear that Congress did not intend to restrict case management services necessary to coordinate a child's medical, social, and educational services when

coordination of these services is necessary to address a child’s physical or mental health condition.

Recommendation

We strongly urge CMS to withdraw the policy restrictions in the preamble that prevent child welfare workers and contractors from serving as Medicaid case managers. We also urge CMS to rescind in its entirety 441.18(c)(1); and § 441.18(c)(4).

Special Education, Section 504 and Medicaid (§441.18)

The final rule should not narrow the scope of Medicaid-eligible children who can receive case management services in school settings.

The interim final rule 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. 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.

Recommendation

We strongly urge CMS to 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 Section 504 of the Rehabilitation Act. We also urge CMS to clarify that the participation of a community mental health case manager in the development, implementation and review of a child’s IEP is a Medicaid reimbursable service.

OTHER ISSUES

Transporting Individuals to Services

The final rule should include transporting an individual to services as a reimbursable activity under Medicaid’s case management option.

In the background section of the rule, CMS states that providing transportation or escorting an individual to a service is not a reimbursable “related activity” under Medicaid’s case management option. For people with serious mental or emotional disabilities, the skill of using transportation is one of the most frequently cited skills training services under the state Medicaid rehabilitation services rule. Difficulty using public transportation can impede many individuals with mental illness from accessing the services that are deemed necessary and are included in their plan of care.

Since rehabilitation and case management services can be furnished in any setting, we believe case management services provided while a case manager accompanies a person to a service should be reimbursable. Often times, while a case manager is transporting an individual to a

service they will engage the individual, plan additional services and most importantly link the client to a service. All of these services are reimbursable case management services. Furthermore, by transporting or escorting an individual to a service the case manager is able to ensure that the individual receives the services to which they have been referred.

Recommendation

We strongly urge CMS to reimburse 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.

Conflicts of Interest with Case Managers Also Providing Services

The final rule should clarify the meaning and circumstances in which “conflicts of interest” might occur.

In the preamble, it states that the State plan amendment for case management must ensure, if the case manager is also providing services, “that a conflict of interest does not exist that will result in the case manager making self-referrals” (FR 68083). The rule does not provide any additional information or clarification on this provision.

Recommendation

We strongly urge CMS to clarify the meaning and circumstances in which “conflicts of interest” might occur.

Effective Date

The final rule should clarify when all of the provisions of the interim final rule go into effect.

Within the interim final rule, it states that the regulations go into effect on March 3, 2008. However, in the preamble (FR 68082), CMS states that the requirement that an individual have a single case manager will have a delayed compliance date. Although this is the only provision for which enforcement is delayed beyond the effective date, many of the provisions of the interim final rule are contained within a section that spells out the requirements of a requested state plan amendment for case management, including, most notably, the rate methodology requirement. Do the new rate methodology requirements apply only to new state plan amendments submitted to CMS or all currently approved state plan amendments? Furthermore, when will CMS send a letter providing guidance on the implementation of the interim final rule to all State Medicaid Directors?

Recommendation

We strongly urge CMS to clarify when all of the provisions of the interim final rule go into effect.

CONCLUSION

We would like to thank CMS for the opportunity to submit comments on the interim final rule for Medicaid Optional State Plan Case Management Services.

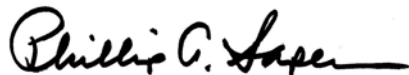
We are deeply concerned that the proposed rule will harm vulnerable beneficiaries with severe mental illness and substance abuse disorders. A reduction in federal support for case management services would force States to make a choice between continuing service provision at the same level at a greater cost in state/local dollars; decreasing the amount and quality of essential services individuals receive; reducing eligibility, benefits, or payments to providers; cutting back on other state programs and using those funds to replace federal Medicaid dollars lost; or a combination of all of the above. The interim final rule would also significantly limit state flexibility to provide case management in the most effective and efficient manner possible.

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 rule goes beyond what Congress intended. **We urge CMS to withdraw the interim final rule and provide appropriate guidance to states that is in line with Congressional intent and policies of the DRA regarding case management services.**

To the extent that any of these provisions become final, CMS must work with States to develop implementation timelines that allow for adequate time for administrative and programmatic changes to be made at both the state and provider level. States will need to modify their state plan, reimbursement methodology, data collecting systems, etc. At a minimum, States should be granted a one-year planning and implementation period from the time of approval of their State Plan Amendment.

If you have any questions, please contact Heather R. Mermel, Policy Associate, at (212) 742-1600 ext. 109.

Sincerely,



Phillip A. Saperia
Executive Director

cc: Members of the New York State Congressional Caucus
The Honorable Spitzer, Governor of the State of New York