February 4, 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:

We are writing to comment 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. These comments are being submitted on behalf of the Consortium for Citizens with Disabilities (CCD). The CCD is the leading coalition of national organizations working together to advocate for national public policy that ensures the self determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. CCD's membership consists of disability advocacy organizations, services providers, and other interested parties and covers the full spectrum of disabilities, including people with physical disabilities, people with mental illness, people with developmental disabilities, children receiving foster care, and other populations directly impacted by this proposed rule.

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.

CCD'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. Further, while the interim final rule references greater consumer choice of case managers—a laudable goal—we believe that the rule could actually decrease choice in some circumstances. In many communities where there are few case management providers, the rule could limit access because the rule would prohibit case managers from serving Medicaid beneficiaries if they also contract with child welfare, probation, or juvenile justice agencies. This new limitation on access to case management will be especially pronounced in rural areas and for individuals who have limited access to transportation.

Our specific comments and recommendations are as follows:

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 within 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.[1]

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 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. In many cases, there is also a sequencing of steps that must be followed, so that a delay at arranging just a single service could halt the transition process. It is not reasonable to restrict case management services to a 60-day period.

There has been an outcry from front-line service providers over this proposal. Our member organizations have received alarming reports of what this provision will mean for individuals attempting to transition to the community. For example:

- We have learned of one individual with a developmental disability whose transition to a waiver program has already taken several months and is not

[1] Olmstead Update No. 3 issued by Health Care Financing Administration (precursor to CMS) on July 25, 2000.

yet complete. This is complicated because the transition involves relocating to another state (to be near parents and other family members);

- We have learned of the challenges of transitioning persons who are dually diagnosed with mental illness and developmental disabilities. A big challenge has been for Medicaid to figure out which agency is responsible for which activities when a developmental disabilities services agency and a mental health services agency have been involved; and,
- We have learned how complicated a transition can be when the Medicaid agency successfully prepares individuals for discharge from an institution and identifies housing (often an enormous barrier), but then struggles to identify wrap-around community services, especially when providers are in short supply.

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 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. Further, we believe that this could exacerbate inequities among groups of people with disabilities if, for example, people with developmental disabilities were perceived to be less likely to complete a transition after 60 days. 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 integral component test (or intrinsic element 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 CMS 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 integral component 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 case management services.

We recommend:

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

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 part of a person-centered planning process that involves the individual, family members, and other relevant participants, it is determined that it is not appropriate to limit an individual to a single case manager due to the complex and diverse nature of their needs or the challenges of coordinating services across various public and private programs, as documented by their plan of care."

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 for people with serious mental illness that provides services 24 hours a day and 7 days a week. Paying for case management services on the basis of 15-minute increments will be a significant barrier for many state ACT programs.

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 CMS "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 all new restrictions that prohibit parole or probation officers or other employees or contractors of the justice system or court from providing Medicaid case management services.

As with the issues surrounding the interaction between child welfare agencies and Medicaid, we believe that the effective and efficient delivery of Medicaid and non-Medicaid services is enhanced when Medicaid seeks to coordinate its services with those of the criminal justice and juvenile justice systems. We are not advocating that Medicaid funds be used to pay for probation and parole. Nonetheless, the prohibition on states deciding to use probation and parole officers or other employees to provide Medicaid case management services for certain populations is potentially harmful and nonsensical. Additionally, contractors of the juvenile justice and criminal justice systems may have critical competencies in successfully

providing services to certain populations that will be lost if these entities are prohibited from also contracting with Medicaid programs. Given the disproportionate level of involvement of Medicaid beneficiaries with mental illness with the juvenile justice and criminal justice systems, and this in some cases may result from inadequate access to Medicaid services, we are especially concerned about the impact that this policy will have on individuals with mental illness.

We recommend:

- Withdraw the policy restrictions in the preamble that prevent parole and probation officers and other employees 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 (FAPE). 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.[2] (Regulations implementing Section 504 [34 CFR 104.33] require that public school systems must provide 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:

- Revise the interim final rule to permit medically necessary case management services to be provided in school and other appropriate

[2] 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

settings to all children, without regard to whether the services are part of an IEP or IFSP under IDEA.

If you have any questions, please contact the CCD Health Task Force Co-Chairs: Liz Savage, The Arc and United Cerebral Palsy Disability Policy Collaboration (202-783-2229- savage@thedpc.org), Kathy McGinley, National Disability Rights Network (202-408-9514, Kathy.McGinley@ndrn.org or Peter Thomas, ACCSES, (202-466-6550).

These comments are respectfully submitted by,

ACCSES
American Association of People with Disabilities
American Association on Intellectual and Developmental Disabilities
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Psychological Association
APSE: The Network on Employment
Association of University Centers on Disabilities
Autism Society of America
Autism Speaks
Bazelon Center for Mental Health Law
Brain Injury Association of America
Child Welfare League of America
Council for Exceptional Children
Council of State Administrators of Vocational Rehabilitation
Disability Rights Education and Defense Fund
Easter Seals
Epilepsy Foundation
IDEA Infant Toddler Coordinators Association
Independence Care System
Mental Health America
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Social Workers
National Association of State Head Injury Administrators
National Council for Community Behavioral Healthcare
National Disability Rights Network
National Down Syndrome Congress
National Multiple Sclerosis Society
National Rehabilitation Association
National Respite Coalition

National Spinal Cord Injury Association
The Arc of the United States
Title II Community AIDS National Network
United Cerebral Palsy
United Jewish Communities
United Spinal Association