



February 4, 2008

Mr. Kerry N. Weems
Acting Administrator
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: CMS-2237-IFC Medicaid Program; Optional State Plan Case Management Services

Dear Mr. Weems:

The American Public Human Services Association and its affiliate the National Association of State Medicaid Directors, respectfully submit this comment letter regarding the Interim Final Rule with Comment Period on the *Optional State Plan Case Management Services*, published in the December 4, 2007, *Federal Register* (72 FR 68077) for the Centers for Medicare and Medicaid Services (CMS).

APHSA and NASMD recognize that CMS has the responsibility to implement important provision of the Deficit Reduction Act of 2005 (DRA) to clarify the design and delivery of Targeted Case Management services. However, APHSA and NASMD are concerned that this regulation goes far beyond the original language and intent of the DRA, mandating significant and harmful changes to long-established, CMS-approved case management programs, including Targeted Case Management, administrative case management, and even home and community based waiver programs. It will require restructuring of programs in nearly ever state, causing major disruptions and significant additional costs. More importantly, these changes may result in the loss or diminished quality of services to vulnerable Americans, including a reduction in the ability of states to assist the elderly and people with disabilities in successfully transitioning from institutional to community-based service settings.

National Association of State Medicaid Directors
810 First Street, N.E., Suite 500
Washington, DC 20001
202-682-0100
www.nasmd.org

For example, the DRA included specific provisions to spell out how costs should be allocated when child welfare workers also oversee Medicaid case management. The regulations go beyond this Congressional solution, limiting beneficiaries to one case manager and mandating that case management be billed in 15-minute increments, thereby disrupting established case management relationships for consumers and restricting the ability of states to develop the most effective reimbursement strategies for assuring on-call case management availability. In addition, the regulation eliminates the use of administrative case management, an important tool used in many states to provide targeted support services to Medicaid consumers, and dramatically restricts the timeframe in which case management services can be used to assist institutionalized populations in arranging transitions to community settings. Extending any willing provider requirements to waiver case management, and eliminating the ability of states to have case managers authorize access to services, raises considerable concern over the ability of states to be able to control the quality and appropriateness of services provided to this most vulnerable group of enrollees and disrupts the ability of states to implement effective long term care system reforms designed to improve consumer access to community options.

The overreach of this regulation is underscored by the discrepancy in cost savings between the Congressional Budget Office's initial projection of \$760 million over five years based on the DRA and CMS's expectation of savings of \$1.28 billion from this rule. The authorization that CMS received to implement the Targeted Case Management regulations through an interim final rule should only extend to the provisions that Congress spelled out in the DRA; the remainder of the changes included in the regulation should be given the full consideration through the formal rule making process. APHSA and NASMD ask that CMS remove all provisions from the interim final rule that are not expressly authorized by the DRA. In addition, APHSA and NASMD urge CMS reconsider some of the provisions regarding Targeted Case Management. Specific comments follow.

APHSA and NASMD are willing to work with CMS to reconsider the development of case management guidelines that more accurately reflect the needs of the Medicaid population.

Overall Concerns and Questions

Interim Final Rule goes beyond the scope of the DRA

States have been told informally that CMS considers this regulation to go beyond Targeted Case Management as required in a state plan, and could be applied to all forms of Medicaid case management, whether or not the care is provided under the "state plan" category for case management and targeted case management. Therefore, CMS considers the requirements of the regulation to apply to case management under the various Home and Community-Based Services waiver programs, as well as any other form of case management covered by Medicaid. This far exceeds the authorization

provided in the DRA to make reforms to some cost allocation methods within the TCM programs.

The Effective Date Does not Give Adequate Transition Time

Given the substantial changes to state practices, numerous new requirements, and the fact that this is a final rule, the implementation date of March 3 for the rule is impossibly short. States cannot come into compliance with this rule in the time provided, potentially putting federal funds in jeopardy. In fact, CMS has already recognized this difficulty and recommended that states work with their regional offices to begin implementation. However, when CMS issues a regulation with an effective date, states become obligated by law to comply by that date. States are concerned, because in the past, auditors have found overpayments from the effective date of a regulation forward, regardless of any informal flexibility suggested by CMS.

Technical Concerns

Case Management Services §440.169

Transition Planning Period §440.169(c)

On July 25, 2005, CMS published Olmstead Update No. 3 that provides guidelines to assist in the transitioning of individuals out of institutional programs and into community settings. The guidelines provide for the payment for transition case management for up to 180 days. Olmstead Letter No. 3 states that, “We [CMS] are revising our guidelines to indicate that Optional State Plan Case Management may be furnished during the last 180 consecutive days of a Medicaid eligible person’s institutional stay, if provided for the purpose of community transition.” This reduction rolls back the guidance that this Administration issued by the *Olmstead* decision.

Under the new regulations “individuals who have been institutionalized for 180 consecutive days or longer” are eligible to receive case management for a period of up to 60 days, while individuals institutionalized for a period shorter than 180 days may only receive Optional State Plan Case Management “during the last 14 days before discharge.” While CMS claims that these restrictions will be put in place to ensure that the transitional case manager is not duplicating the work of the institution’s case manager, CMS also recognizes the importance of a transitional case manager by stating that individuals with complex medical needs require “case management that is beyond the scope of work of institutional discharge planners.” However, the new regulations do not recognize the real world timeframe and complexities involved in making a transition into the community.

For individuals who have been institutionalized for a significant period of time, defined by CMS as being greater than 180 days, discharge planning is more than just orchestrating a return to the individual’s previous life and home. Many of these individuals no longer have a home to return to, and transitional case managers are tasked

with the responsibility for organizing an entire new life for an individual. Housing alone is a major barrier to transition for individuals, and it often takes longer to secure appropriate housing than is afforded by this regulation.

One program that will be impacted is Money Follows the Person, which relies heavily on the transitional case management services. CMS has approved many MFP grants that require significant amounts of transitional case management services as the cornerstone for moving individuals from institutional to community settings. HCBS programs are required to provide person-centered, individualized planning, which requires taking a measured, thoughtful and intensive approach to planning a new life in the community. The new guidelines fail to account for the realities of setting up complex individualized services.

The requirement for only 14 days of coverage for stays shorter than 180 days also presents problems because it gives case managers inadequate time to complete a comprehensive assessment of a beneficiary's needs, and obtain timely appointments for the individual. Initial appointments with psychiatrists and mental health providers can take several weeks. Individuals receiving this level of care are in need of a comprehensive assessment to determine appropriate aftercare services. TCM providers need to have adequate time to find community resources to meet these needs and set appointments which coincide with the discharge date.

We are concerned that these provisions could cause a return to the generic solutions of the past. This would in turn cause an increase in the length of institutional stays for individuals who could otherwise be reintegrated into the community, leading to a significant increase in cost to the federal government.

Delayed Billing

APHSA and NASMD are also concerned with the provision that restricts providers from billing for their services until after the beneficiary has been discharged and is enrolled in community services. States are concerned that providers may not be willing to provide services if they are at risk of not getting paid, severely limiting the already short list of case management providers. Secondly, the role of TCM services is to provide a complete assessment and the links and referrals to necessary services. CMS reaffirms in this regulation that recipients have the freedom to decline participation in any services. Providers and states should not be penalized for ensuring all aspects of clients' rights are upheld if clients ultimately decide to not follow recommendations.

Definition of Comprehensive Case Management § 440.169(d)

While the concept of a comprehensive case manager is good for the Targeted Case Management service, case management provided in waivers or non-comprehensive administrative case management serves a vital function in many state programs. The regulation runs the risk of disqualifying case managers with expertise in particular areas and relationships with established programs. In addition, this restriction would limit the

pool of providers to those who have expertise in all medical, behavioral health, developmental disability, and social support areas. APHSA and NASMD are willing to work with CMS look into ways to make this requirement more inclusive since the expertise and quality of many workers will be bypassed based on the requirements of this rule

Limitations on Case Management Services §441.18

Right of Refusal §441.18(a) (3)

This regulation includes a requirement that states cannot “compel an individual to receive case management services, condition the receipt of case management (or targeted case management) services on the receipt of other services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.” This requirement calls into question how state Medicaid programs will be able to coordinate state plan services and develop a care plan. Further, the interaction of this right of refusal with the required assurances under the HCBS waiver poses a substantial issue for states. Many of the necessary and effective activities required by CMS to operate HCBS waivers have been funded and delivered through case management. Therefore, this provision could present serious barriers to effective state compliance with waiver assurances and may reduce the quality and cost-effectiveness of waiver services. It is unclear how states can design a system that provides all the necessary service coordination if an individual refuses case management services. Case managers play a pivotal role in assisting individuals and families to locate appropriate services and provide individuals the information needed to gain access to these services. Thus, states will face significant challenges around this right of refusal and its interaction with affording access to appropriate and cost-effective services.

Single Case Worker Requirement §441.18(a) (5)

APHSA and NASMD supports the overarching goal of a coordinated case management approach across systems, but we have concerns about the requirement that case management services must be provided by a single Medicaid case manager. CMS states that Medicaid beneficiaries with co-morbid conditions should choose one case manager that has one area of expertise, or find a generalist case manager. APHSA and NASMD are concerned that this requirement could reduce the effectiveness of the case management service because the individual will no longer be served by experts of the systems that they inhabit. This could result in missed opportunities for the beneficiary to receive targeted care that the generalist case manager may not be aware of. In addition, it may conflict with case management programs which cover only medical, such as through EPSDT.

Currently in many states, when an individual qualifies for more than one target group, one of the case managers is identified as the “lead” and is therefore responsible for coordinating services to ensure that they are not duplicative. There should be flexibility in terms of case management for populations with specific care needs that can not be met

fully through a generalist approach. Given the complexity of each different service system, and the expertise needed to effectively direct an individual through each system, the most effective service is more likely to be provided by access to a case manager that is experienced in that one specialty.

Finally, CMS should provide states guidance on how to implement the single case manager provision. Implementing this requirement will impose great costs and additional complexities in services provision to states. Case workers must be retrained, information technology systems will require reprogramming, and new state policies must be enacted and implemented. Not only has CMS not provided for additional funding, guidance, or time to accomplish these and other alterations required by the rule; CMS will also be cutting over a billion dollars from the TCM program.

15-minute increments §441.18(a) (8) (vi)

The regulation also requires that case managers bill their services in units of time not to exceed 15-minutes. We do not understand the assertion that case management will be a more efficient and effective service if billed in 15-minute units. Case management is not a direct service provided in discrete units of time. Case management services must be available “on demand” and provide a variety of critical activities that go far beyond face-to-face meetings. The case manager must be available whenever the individual is in need of supports, not just for routine, scheduled meetings as with a doctor or other direct services provider. Requiring case management to be delivered in 15-minute increments is not appropriate for this kind of care because it does not provide the stable “platform” of availability or recognize the distinction of case management from other direct services.

Most states currently use negotiated daily, weekly, or monthly rates to bill for these services since the case manager is required to be on-call 24 hours a day. CMS is trying to abolish these practices with the explanation that these rates are bundled and therefore inefficient. However, it is not clear how CMS has come to the conclusion that this is bundling since it defines bundling in the HCBS waiver Technical Guide as a “service that encompasses two or more discrete services that are not closely related.” The methods currently used by states do not rise to this definition of bundling since the negotiated rates do not include unrelated services, but encompass the range of distinct and similar services that work toward the goal of appropriate management of an individual’s care plan.

Additionally, the transition to 15-minute unit billing will require significant administrative and technological overhaul in most states. The variety of activities done by case managers are not easily characterized into discrete units, which adds to the administrative burden of tracking activity in this way on an on-going basis.

Case Worker Restriction from Authorization §441.18 (a) (6)

The restriction that case managers can not authorize Medicaid services or act as a “gatekeeper” for such services is particularly troubling for the states that have been streamlining their long-term care systems to create one entry point for the Medicaid

population. This regulation would prevent such a streamlined approach. Instead, when individuals are referred to Medicaid programs or service providers, they may be required to complete separate assessments to determine level of care or medical necessity, develop a care plan, and receive a service authorization. Further, the comprehensive assessment instrument may not be compatible with the instrument used to carry out program specific activities.

With this restriction in place, the case manager will not be able to control implementation of the care plan since he or she cannot approve or authorize services. The care plan might describe general activities such as a referral for personal care services, but the specific number of hours of service and the tasks that may be needed could be beyond the influence of the case manager. This runs counter to the goal having a unified approach of one case manager, since parts of the current responsibilities of the case manager will now have to be delegated to other providers, who may not be as familiar with the specific needs of the beneficiary.

Benefit Restrictions §441.18(c)

Administrative Case Management §441.18(c) (5)

The regulations state that administrative functions must be performed by the single state agency staff, which may be meant to preclude agencies such as Area Agencies on Aging or local health departments from performing such functions. If this is the case, it will add a significant administrative burden to Medicaid personnel without an improvement in system performance. Further, the regulation states that activities that meet the definition of case management services cannot be claimed as administrative activities. The regulation attempts to distinguish between case management activities as a state plan service and tasks that may also be considered case management that are necessary for the proper and efficient administration of the state plan and that may therefore be covered as an administrative expense. It is not clear which, if any, individual components of case management can be claimed as administrative functions and whether important functions, for example, helping to link recipients to services through recipient hotlines, will continue to be reimbursable.

Some states, in order to provide comprehensive and unified services, combine both functions within a case management program. It is not clear whether a case manager could function in two roles with some costs allocated as a case management service and others as an administrative activity. Assigning these tasks to different organizations may mean that some states will fragment access to services, such as those provided under the HCBS program. It is unclear how this furthers the regulation's stated goal of creating a unified and comprehensive program.

Medicaid Administrative Match Contracts

The TCM regulation proposes to eliminate Code 9.b. Referral, Coordination, and Monitoring of Medicaid Services from the CMS Medicaid School-Based Administrative

Claiming Guide, dated May 2003. Many States have developed Cost Allocation plans (CAP) that have been approved by CMS which allow them to contract with County Health Departments and Districts, federally recognized Tribes, and other qualified governmental entities. These contracts allow these governmental entities to be reimbursed a portion of their expenses for performing administrative activities that clearly support the goals and objectives of the Medicaid State Plan. Allowable activities include Medicaid outreach, assisting Medicaid eligibles in applying for Medicaid covered services, and “referring potential eligibles to Medicaid services (Code 9)”.

While the proposed TCM rule would allow these governmental entities to continue receiving federal reimbursement for performing outreach activities, it prevents them from receiving reimbursement for referring these same clients to Medicaid health services. The activities described in Code 9 of the CMS Medicaid School-Based Administrative Claiming Guide clearly do not all meet the definition of Targeted Case Management, should not be reimbursed as a direct service. Hence, Code 9 should not be completely eliminated from the Guide without careful consideration and exceptions to the TCM rule. The elimination of Code 9 would seriously impact these governmental entities ability to assist States in meeting the goals of the Medicaid State Plan, and by receiving significantly less reimbursement for performing these activities, governmental entities would essentially be asked to perform these activities at their own cost, thus losing their motivation to assist States in meeting their Medicaid goals and negatively impacting all Medicaid clients.

Integral Component §441.18(c) (1)

The regulation excludes from the definition of case management services those services that are “integral components” of activities that constitute the “direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.” The regulation specifically refers to guardianship, child welfare, child protection, parole, probation, and special education (not included in an IEP) as an “underlying program.” This requirement is conspicuously analogous to the “intrinsic element” test that the HHS proposed in August 2005, which Congress soundly rejected and did not include in the DRA. In fact, the DRA imposes a much narrower standard that outlines specific services that case managers can not charge to the Medicaid program.

In going beyond Congress’s DRA provisions, CMS’ regulation appears to disallow state TCM claims within these service systems at any time, no matter how strong the underlying documentation, and regardless of whether there is a legal liability for another program to make a payment.

Conclusion

Medicaid is the nation’s health care safety net, and it is important for CMS to reexamine the effects that all these proposed restrictions will have on states and the already at-risk clients they serve. Case management is a vital service for Medicaid consumers. This sweeping interim final rule would restrict the ability for Medicaid funds to be used to

ensure that the most vulnerable citizens receive timely and appropriate access to care. It will also require tremendous administrative action to restructure programs throughout the country, without assuring a clear outcome of program improvement.

APHSA and NASMD are concerned with a number of the provisions included in this interim final rule and encourage HHS to withdraw the rule. Especially, we ask that HHS remove all provisions from the interim final rule that are not expressly authorized by the DRA. Thank you for the opportunity to comment on the proposed rule. If you have any additional questions, please contact Barbara Coulter Edwards, NASMD Interim Director, at (202) 682-0100.

Sincerely,



Jerry W. Friedman
Executive Director
American Public Human Services Association



David Parrella
Chair, Executive Committee
National Association of State Medicaid Directors