CLASP

CENTER FOR LAW AND SOCIAL POLICY

February 4, 2008

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: CMS-2257-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-2237-IFC
Interim Final Rule: Medicaid Program; Optional State Plan Case Management Services, 72 Fed. Reg. 68077 (December 4, 2007),

To Whom It May Concern:

I am writing on behalf of the Center for Law and Social Policy (CLASP) to comment on the interim final rule regarding Medicaid case management and targeted case management services, which was published in the Federal Register on December 4, 2007: Medicaid Program; Optional State Plan Case Management Services, 72 Fed. Reg. 68077.

CLASP seeks to advance the economic security, educational and workforce opportunities and family stability of low-income children, youth and families. One component of this work involves advocacy on behalf of children who are involved with or at risk of becoming involved with the child welfare system. As such, we are particularly concerned about the detrimental effects the interim rule will have on children being served by child welfare programs, including child protective services and foster care programs.

In the preamble, the Centers for Medicare and Medicaid Services (CMS) contends that the rule implements Section 6052 of the Deficit Reduction Act of 2005 (DRA) and clarifies when Medicaid will pay for case management and targeted case management services.[1] While the DRA required CMS to publish regulations to implement Section

[1] Targeted case management services are case management services that are provided without regard to the requirements of 42 U.S.C. § 1396a(a)(1) (statewide requirement) or § 1396a(a)(10)(b) (comparability requirement). Regular case management services are reimbursed as administrative expenditures while targeted case management services are reimbursed as services at the federal medical assistance percentage (FMAP) rate. The provisions of the rule focus on the definition of case management which impacts both regular case management services and targeted case management services. Thus, these comments will reference the impact of both.

6052, the rule issued by CMS exceeds the statutory authority, contradicts Congressional intent and will likely deny numerous individuals access to critical services. Although the rule will have a negative impact on many Medicaid beneficiaries, our comments focus on the negative impact to children involved with the child welfare system.

Overarching Concern About the Interim Final Rule:

The overall approach set forth by CMS in the rule fundamentally misunderstands the nature of the child welfare system – including both child protective services and foster care. CMS creates a false dichotomy between the objective of the Medicaid program – providing eligible individuals access to needed health care – and the objective of the child welfare system – defined by CMS as "protecting vulnerable children and moving them toward a safe and stable living situation." CMS goes further by declaring that the activities geared toward achieving safety and stability "are separate and apart from the Medicaid program." 72 Fed. Reg. 68086.

In reality, the activities necessary to achieve safety and stability overlap with the activities needed to promote physical and mental health. The concept of Medicaid case management recognizes that individuals often need a range of services – medical, social, educational and other – in order to maximize their health. Since individuals often need assistance accessing these services, Congress long ago determined, and reiterated in the DRA, that Medicaid will pay for such assistance. By the same token, a child may need a range of services to find safety and stability. This range of services undoubtedly includes medical services that help a child heal, cope with trauma, function in a foster home and prepare to return safely home or move to another loving family. A case manager assisting with access to services to promote either goal may identify and help obtain many of the same services. The potential overlap is particularly great since case management must be offered to child beneficiaries that need it under the Early and Periodic Screening, Diagnostic and Treatment component of Medicaid.[2]

The Health Care Financing Administration (HCFA) acknowledged this overlap and sought to clarify "HHS [Department of Health and Human Services] policy on targeted case management services under the Medicaid program as it relates to an individual's participation in other social, educational, or other programs." A State Medicaid Director Letter issued January 19, 2001, explained that:

> Foster care programs employ their own case workers who, in addition to facilitating the delivery of foster care benefits and services, help individuals access and coordinate the delivery of other services. When foster case workers are also enrolled in Medicaid as providers of case management services, States must undertake a careful review to ensure the activities to be claimed under Medicaid

[2] 42 U.S.C. § § 1396a(10), 1396d(a)(4)(B) and 1396d(r). The rule speaks of case management only as an optional service, ignoring the provisions of EPSDT which make it mandatory for children who need it. CLASP recommends CMS revise its discussion of the rule accordingly.

> meet the definition of case management and are not directly connected to the delivery of foster care benefits and services. [3]

While HCFA cautioned states to distinguish between case management services and direct foster care services, it recognized the potential overlap and clarified that:

> When consistent with Medicaid requirements discussed below, Medicaid can be used to supplement [case management] activities for Medicaid eligible individuals when they are embedded in another social or other program.

When Congress addressed case management services in Section 6052 of the DRA, it appears to have been codifying the guidance in the 2001 State Medicaid Director Letter. First, Congress clarified that case management includes the four types of activities described in the 2001 letter: (1) assessment of an individual's service needs; (2) development of a specific care plan based on the assessment; (3) referral and related activities to help the individual obtain needed services; and (4) monitoring and follow-up activities to ensure the care plan is effective. Next, the legislation, like the State Medicaid Director Letter, clarified that case management does not include "the direct delivery of an underlying medical, educational, social or other service." In providing statutory examples of activities that constitute the direct delivery of foster care services, Congress adopted the list set forth in the 2001 letter.[4] Congress also recognized the potential for activities in various programs to overlap with activities constituting Medicaid case management services and required allocation of the costs of any case management services that are reimbursable under multiple federally funded programs according to OMB Circular A-87.

On April 5, 2006, Senator Charles Grassley (R-Iowa), then chair of the Senate Finance Committee, wrote to Department of Health and Human Services Secretary Michael Leavitt to guide CMS in implementing the case management and targeted case management provisions of the DRA. Specifically, Senator Grassley stated: "[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 further clarified that "disallowance of reimbursement under Medicaid for services specified in the DRA for TCM [targeted case management] for children in foster care . . . is in direct contradiction to Congressional intent."

In crafting the interim final rule on case management services, CMS appears to have ignored this Congressional intent and the plain meaning of the statutory language. Rather than further clarifying, the rule adds further confusion and inappropriately denies access to critical case management services.

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[3] State Medicaid Directors Letter (SMDL 01-013) (January 19, 2001) available at: http://www.cms.hhs.gov/smdl/downloads/smd011901c.pdf

[4] Compare SMDL 01-013 at page 3 with Section 6052 where it amends 42 U.S.C. § 1396n(g)(2) to add subparagraph (A)(iii).

Our comments on specific provisions are as follows:

Specific Provisions of the Interim Final Rule:

The Convoluted Definition of Case Management Will Deny Critical Services to Many Abused and Neglected Children

§ 441.18(c)(2) Direct delivery of underlying services

In this section of the rule, CMS restates the DRA provision which excludes from the definition of case management activities that constitute the direct delivery of underlying services to which an eligible individual has been referred. However, CMS goes further by adding a list of programs to which individuals might be referred, including "child welfare/child protective services and foster care programs." This addition offers no guidance in sorting out what is an underlying service of those other program and what is a case management service under Medicaid.

§ 441.18(c)(3) & (4) Activities integral to the administration of other programs

In these sections of the rule, CMS excludes from the definition of case management activities that are "integral to the administration of" foster care and other programs. The phrase "integral to the administration of" offers little guidance about what activities are and are not covered.

In the preamble, CMS provides examples that suggest how the agency is likely to interpret these sections. For example, the preamble states that:

> "Medicaid case management services must not be used to fund the services of State child welfare/child protective workers. Further, Medicaid may not pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they would otherwise be qualified Medicaid providers, because they are furnishing direct services of the programs of that agency. " 72 Fed. Reg. 68086

> "Medicaid case management must not be used to fund the services of foster care workers. . . Furthermore, case management activities included under therapeutic foster care programs will be subject to this payment exclusion since these activities are inherent to the foster care program." 72 Fed. Reg. 68087

Each of these exclusions is justified on the grounds that the services are either direct services of or integral to the administration of child welfare programs. This analysis ignores the fact that case management activities are integral to multiple programs and that

the very same activities can be necessary to achieve the objectives of multiple programs. In essence, CMS seems to argue that if an activity promotes the objectives of the child welfare system, it could not possibly promote the objectives of Medicaid. CMS appears to believe that activities performed by child welfare workers or contractors (child protective services workers, foster care workers, or therapeutic foster care workers) by definition cannot be Medicaid case management services, even if the child welfare workers are qualified Medicaid providers whose actions help the individual access medical services.

This reasoning is absurd. If the activities promote the objectives of both child welfare programs and Medicaid, they are integral to both. The effective and efficient administration of both child welfare and Medicaid require case management services. Of course, not all case management activities benefit both programs, but many do. The key to figuring out whether Medicaid or child welfare should pay for a particular activity is to determine whether the activity constitutes Medicaid case management, child welfare case management or both? If the activity constitutes only Medicaid case management, Medicaid should pay. If the activity constitutes only child welfare case management, child welfare should pay. If the activity constitutes both Medicaid and child welfare case management, costs should be properly allocated to avoid duplicative federal reimbursement. That is precisely what Congress called for when it required cost allocation pursuant to OMB Circular A-87.

The approach set forth by CMS is convoluted and likely to result in the denial of critical case management and targeted case management services to many vulnerable children. CMS should withdraw section 441.18(c) and replace it with language that provides clearer guidance in distinguishing whether a particular activity constitutes the direct delivery of underlying medical, educational, social or other programs. The list of excluded foster care activities provided by Congress is the appropriate starting place, although it could use further explication. In addition, if CMS believes there are other specific activities that benefit only child welfare programs, it should specify those in the regulatory language. CMS should also strike all language in the preamble that suggests that any services provided by child welfare workers or contractors are not reimbursable under Medicaid. The test should not turn on who provides the services,[5] but rather on the nature of the services.

Requiring a Single Case Manager Will Lead to Fragmented Services

§ 441.18(a)(5) Requirement for single case manager

In this section, CMS requires that case management services be delivered through a single case manager. There is nothing in the DRA that authorizes CMS to limit case management services in this way. CMS contends that this requirement will promote

[5] CLASP agrees it is appropriate that those who provide Medicaid services be qualified Medicaid providers. However, CMS goes far beyond that requirement and prohibits even qualified Medicaid providers from being reimbursed for providing Medicaid case management services if these providers are also child welfare workers or contractors.

efficient, coordinated service delivery, but in fact it will often do just the opposite. As other commentators have noted, individuals needing case management often have complex medical needs. A child in foster care, for example, may have developmental delays, chronic physical health problems such as asthma or HIV and chronic mental health problems such as post-traumatic stress disorder, depression, or attention deficit disorder. It is highly unlikely that a single individual will be knowledgeable enough to assess the service needs for each of these challenges, develop an appropriate care plan and implement and monitor that plan. This is particularly true since, as noted in the previous section, CMS appears not to allow the person most familiar with the child's overall needs, a child welfare worker or contactor, to provide the case management services. Instead, CMS would require that a single Medicaid provider, seemingly one who has no relationship with a child welfare program, provide case management services that address all of a child's needs. Rather than permit case workers who are knowledgeable about the child's particular medical conditions and the how the child's experience of abuse and neglect interacts with those conditions to work closely together to develop a comprehensive care plan, the approach called for by CMS would lead to further fragmentation of services. This development is all the more troubling since child welfare agencies across the country have recognized the multi-faceted needs of the children they serve and are starting to provide coordinated, comprehensive services to address those complex needs.

CMS should amend § 441.18(a)(5) by striking the phrase "through one case manager" from the end of the sentence. CMS should also revise the language in the preamble that discusses the requirement for a single case manager. The language about providing "a unified care planning process" based on "a comprehensive assessment" is critical and should remain. There are times when having a single case manager will help promote the goals of greater coordination, however, states should be able to pay for case management services provided by multiple individuals when necessary to provide comprehensive services. CMS may want to require that the different providers work closely together to assure that the care planning is coordinated, but it should not prohibit reimbursement for multiple providers who, working together, provide a comprehensive case management services.

Bureaucratic Billing Mechanisms Will Limit Access to Critical Services

§ 441.18(a)(8)(vi) Methodologies for calculating payment rates

In this section, CMS requires states to reimburse case management service providers according to units of service that do not exceed 15 minutes. In the preamble, CMS states that case management services should be reimbursed based on units of time, rather than on a capitated basis – where a single payment is provided to address all of an individual's health needs instead of paying separately for each service provided to the individual. The preamble language also suggests that CMS would prohibit the bundling of services – that is combining reimbursement for several services into a single payment. 72 Fed. Reg. 68085. Nothing in the DRA authorizes CMS to impose these bureaucratic billing mechanisms. CMS argues they are appropriate because case management services can

include contacts of brief duration. That is precisely why it is more economical and efficient to bill these services through a bundled, capitated rate. With such billing mechanisms, service providers can focus on actually providing needed services rather than documenting each tiny increment of service provided. CLASP agrees that the bundled, capitated rates should not be arbitrary and unrelated to actual service provision. However, there are recognized rate setting methodologies that accurately capture costs within a capitated, bundled rate. So long as the methodologies used are approved by CMS, there is no reason to require tedious fee for service billing in increments of 15 minutes or less. CMS should strike § 441.18(a)(8)(vi) and the preamble language discussing billing methodologies.

Conclusion:

The provisions of the interim final rule and the discussion in the preamble to the rule go beyond the authority provided in the DRA. They ignore Congressional intent and offer confusion rather than clarity. CLASP urges CMS to withdraw the interim final rule and to suspend implementation of these provisions until a revised rule can be drafted. CLASP calls upon CMS to issue regulations that are consistent with Section 6052 of the DRA and that provide helpful guidance about how to determine when an activity constitutes Medicaid case management or targeted case management and when it does not.

CLASP appreciates your consideration of our comments and would be happy to discuss further any of our concerns and recommendations. We hope that as CMS reviews these and other comments, a revised rule will be developed that clarifies the use of case management and targeted case management services without unnecessarily limiting access to these services, which are often critical to securing health care for children and other vulnerable groups.

Sincerely,

Rutledge Q. Hutson
Director of Child Welfare Policy