



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: CMS-2237-IFC Medicaid Program; Optional State Plan Case Management Services

To Whom It May Concern:

The American Public Human Services Association and its affiliate, the National Association of Public Child Welfare Administrators, 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.

Please be assured that APHSA and NAPCWA share CMS' strong commitment to protecting the fiscal integrity of federally funded programs. However, APHSA and NAPCWA have concerns that this regulation goes far beyond the authority granted to CMS by Congress through the Deficit Reduction Act of 2005. The DRA included specific provisions clarifying how costs should be allocated when child welfare workers also administer Medicaid case management, and what foster care activities do not qualify as components of Medicaid case management services. However, the DRA did not authorize CMS to limit beneficiaries to one case manager, exclude child welfare workers as case management providers, or apply many of the other sweeping changes that are included in this regulation. APHSA asks that CMS remove all provisions from the final rule that are not expressly authorized by the DRA.

While CMS has allowed a comment period, we understand that the next iteration of this rule will be final, and that comments, although accepted, are purely advisory. This regulation does not stand as a mere clarification of the DRA's previous authorizations. We are deeply concerned that this rule was issued as an interim final rule given that its scope extends beyond the original intent of the DRA. 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 previous congressional action and CMS' expected savings from this rule of \$1.28 billion.

The sweeping changes made by this rule would have significant impact on both the programmatic and fiscal capacity of public child welfare agencies to effectively serve children and families. This regulation would diminish the ability of systems to work together effectively, and ultimately undermine coordinated and comprehensive case management for many of the most vulnerable children served by the child welfare system.

We appreciate the opportunity to provide you with the following specific comments.

Provisions of the Interim Final Rule

Legislative History, Section F, Changes made by the Deficit Reduction Act of 2005

The DRA excluded direct foster care services from the definition of activities eligible to be reimbursed as case management by Medicaid. However, this regulation would exclude foster care clients and any child welfare worker that may provide case management from Medicaid case management services. The restrictions imposed by the rule extend beyond congressional intent. In a recent letter to Health and Human Services Secretary Michael Leavitt, Senator Charles Grassley indicated that the DRA provided guidance to CMS but was not intended to exclude children in foster care, and that the CMS rules were a “direct contradiction to congressional intent.” In addition, Senator Grassley noted that Congress did not intend to restrict case management services regarding the coordination of needed services.

Limitations on Case Management Services §441.18

Section § 440.169 states that, “Case management services could be reimbursed on behalf of Medicaid-eligible individuals...in foster care...when the services are identified due to a medical condition targeted under the State’s Plan, and are not used in the administration of other non-medical programs.” This statement aligns with the provisions set forth in the DRA. In §441.18, case management activities that are not allowable Medicaid costs as direct child welfare services are stated again in alignment with previous DRA language. However, in §441.18, this statement is seemingly contradicted by the following:

“We believe that child protective services are the direct services of state child welfare programs and are not Medicaid case management. These activities of child welfare/child protective services are separate and apart from the Medicaid program. Thus, Medicaid case management services must not be used to fund the services of state child welfare/child protective services workers...However, children receiving child welfare/child protective services may still qualify to receive Medicaid targeted case management services when these services are provided according to the Medicaid State plan program by a qualified Medicaid provider who is not furnishing direct services of other programs.”

We understand CMS’ interest in ensuring that activities that do not fall within the congressional definition of activities are excluded from Medicaid case management services. However, states could implement other means of determining appropriate activities short of excluding all child welfare workers as Medicaid providers. For example, many states already employ accounting or time studies to identify allowable and unallowable activities.

Requiring one case manager under §441.18(a) (5) also appears to go beyond the intent of the DRA’s guidance for case management activities and coordination of services. The assumption regarding children in foster care is that other state agencies will provide the services according to the beneficiaries specific needs and that that program would be best suited to coordinate their services by assuming case management responsibilities. Children involved in the child welfare system may present complex needs and challenges that require a case manager with expertise in knowing what services are available. This case manager would also need to be able to effectively evaluate or monitor such services as directed under the individual’s care plan. Under this regulation, beneficiaries in the child welfare system may receive lower quality care if restricted to one case manager because a single case manager may not have not have the necessary knowledge and expertise of all the services needed by clients with multiple conditions and needs. While requiring that only one case manager oversees the care plan for an individual

seems plausible in theory, in reality, it will only eliminate needed care to individuals. This requirement also undermines the widely recognized best practice of a holistic or unified case management model for children in the child welfare system. States have worked to establish systems that are comprehensive; it appears this rule would create two systems where states currently have one, a development which would make little sense from a fiscal or policy standpoint.

Moreover, having one case manager to ensure accountability and coordination of services for all components of care is an unrealistic and burdensome requirement for states. States would assume additional administrative burdens associated with monitoring this requirement.

Requiring units of service to be in 15-minute increments as defined under §441.18(a) (8) (vi) also seems to be an excessive administrative burden on states. State systems, already stretched thin, would need to absorb the costs to modify billing systems, establish new rates, adjust rules and manuals, and conduct provider training. This regulation would significantly impact state flexibility to efficiently manage the Medicaid program in coordination with other service systems; further, CMS has provided no guidance to states on how to operationalize a single case manager model across eligible populations.

§441.18(c) (1) stipulates that federal financial participation “is not available for activities that are an integral component of another covered Medicaid service.” This formulation is strikingly similar to the “intrinsic element” test that HHS proposed in August 2005, which Congress explicitly rejected and did not include in Sec. 6052 of the DRA. In fact, the DRA imposes a much narrower standard: whether other federal, state, or county programs are legally liable to pay for services that might be covered under the Medicaid case management option. By contrast, the interim rule substitutes an ill-defined, watered-down test that essentially would permit CMS to disallow state Medicaid case management claims at any time, for any reason, no matter how strong the underlying documentation. The regulation excludes from the definition of case management services those services that are “integral components” of another Medicaid service and 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 child welfare as an “underlying program.”

This section of the rule appears to imply that states are billing Medicaid for allowable Title IV-E administrative case management activities. As previously noted, many states already employ accounting and time studies to ensure that they are separating allowable costs. CMS should consider requiring states to provide assurances that clearly identify case management services within federal funding streams.

Restricting Medicaid case management access by child welfare agencies means that critical services to abused and neglected children will not be available. Arranging for medical services for children in foster care is not an allowable Title IV-E or IV-B activity. Medicaid case management provided within the context of therapeutic foster care should not be considered an intrinsic element of IV-E federally funded foster care and is not billable under Title IV-E, as stated by the Code of Federal Regulations, Title 45, Chapter XIII, Part 1355.20: “Title IV-E foster care is to cover the cost of food, clothing, shelter, daily supervision, school supplies, a child’s personal incidentals, liability insurance with respect to a child, and reasonable travel for a child’s visitation with family or other caretakers.”

States also question the application of this regulation to Home- and Community-Based Waivers, particularly in cases where these programs serve children involved in the child welfare system.

Finally, we are concerned that the regulation becomes effective March 3, 2008. Given the substantial changes to state practices, the multiple new requirements, and the fact that this is an interim final rule, this implementation date is impossibly short. States cannot come into compliance with this rule in the time provided, potentially putting federal funds in jeopardy.

The proposed restrictions on allowable case management services supported to date by Medicaid's case management option will effectively exclude a vulnerable population of children from needed mental health and health services. States have consistently conducted time studies and cost reports that extrapolate rehabilitative costs from Title IV-E billable services. If CMS removes the Medicaid case management option by enacting this rule, costs for these services will pass to constrained state budgets, seriously limiting services that would be provided to children in foster care.

APHSA is concerned by the reach of this rule beyond the congressional intent of the DRA and encourages HHS to withdraw the rule. Thank you for the opportunity to comment on this regulation. If you have any additional questions, please contact Anita Light, NAPCWA Director, at (202) 682-0100.

Sincerely,

A handwritten signature in black ink that reads "Jerry W. Friedman". The signature is written in a cursive style with a large, looping initial "J".

Jerry W. Friedman
Executive Director