

June 1, 2009

Ms. Charlene Frizzera
Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Room 445-G
Washington, D.C. 20201

RE: RIN 0938-AP75 – Rescinding Optional State Plan Case Management Rule
File Code: CMS 2275-P2

Dear Acting Administrator Frizzera:

The undersigned organizations are writing to express our strong support for a proposed rule, published on May 6, 2009 by the Department of Health and Human Services (HHS) that partially rescinds the Case Management Services interim final rule.

The Senate Finance Committee and the Energy & Commerce Committee took leading roles in imposing congressional moratoria on this regulation because the costly administrative burdens it imposed on state Medicaid agencies, school districts, child welfare agencies, and front line community-based providers serving persons with developmental disabilities and mental illnesses had little or no basis in Medicaid law. In pursuing a final rule making process under the state Case Management Services Option – also known as the Targeted Case Management Option – we encourage the Center for Medicare and Medicaid Services (CMS) not only to affirm the current statutory definition, but also address ongoing policy and financing issues under this critically important optional program.

Background

The December 4, 2007 interim final rule – CMS 2237-IFC entitled, “Optional State Plan Case Management Services” was intended to implement a new statutory definition for case management and targeted case management services contained in Section 6052 of the Deficit Reduction Act (DRA), which was enacted in 2005. The DRA statutory definition is fully reflected in Section 441.18(c) of the most recent proposed rule. CMS 2287-P2 specifically authorizes a set of services that will assist Medicaid eligible beneficiaries in gaining needed medical, social, and educational services. The authorized services under the new rule encompass assessment, development of specific care plans, referral and related activities, and monitoring and follow up services; the regulation is equally clear regarding services and activities which cannot be reimbursed for in this

state optional program. In turn, these same policies were unambiguously addressed in a CMS State Medicaid Directors letter issued in 2001.

The HHS Case Management/Targeted Case Management Rule Should Be Partially Rescinded Because It Has No Basis in Title XIX, And Imposes Costly Administrative Burdens

By contrast, the December 4, 2007 case management regulation went well beyond the black letter law of the DRA case management definition. Indeed, the administrative requirements and financing prohibitions were so sweeping that the true objective of the rule – to impose \$1.3 billion in back-door-budget-cuts on the program without appropriate congressional input – seemed readily apparent. What follows are some of the most striking examples:

Child Welfare Agencies -- Barred From TCM/Case Management

The 2007 interim final rule put significant restrictions on case management services for the 500,000 low income infants and children in America's foster care system. CMS 2237-IFC stipulates that case management services are available to children in foster care only if they are furnished by a Medicaid provider operating outside the child welfare system. These regulations also prohibit payment for case management services provided by child welfare agency workers or by any other provider that contracts with a state's child welfare agency. By contrast, the DRA TCM provisions relative to child welfare are highly specific and bear no reasonable resemblance to these overboard payment prohibition. In turn, these provisions in the interim final rule raised concerns about whether public child welfare authorities could provide children with serious mental and emotional disturbances access to therapeutic foster care, which is an intensive intervention designed to keep youngsters in out-of-home placement out of residential treatment centers.

Narrowed Transitional Case Management – Threw DD Medicaid Waivers Into Chaos

CMS 2237-IFC shortened the *Olmstead* standard for transitional case management (services provided to persons with disabilities transitioning from institutional placements to community settings) to 60 days and shifted the financial risk to community-based providers serving persons with disabilities if the transitional case management was not successful. More generally, the payment prohibitions in the rule were so sweeping that they jeopardized dozens of Medicaid community-based waiver programs serving persons with developmental disabilities in many, many states.

Children With Disabilities In School Systems

The TCM regulations would restrict case management services provided to children with disabilities in school settings. The rule contains a new parallel third party liability

standard – the “integral component” test – that casts doubts on federal financial participation for case management services required as part of a

child’s Individual Education Plan Program (IEP) and early intervention Individualized Family Services Plan (IFSP) authorized under the Individuals with Disabilities Education Act (IDEA). Furthermore, CMS 2237-IFC specifically disallows the provision of case management services when it is part of a child’s plan under Section 504 of the Rehabilitation Act. These provisions seem to directly contradict current Medicaid statute.

Payment Prohibitions – Administrative Burdens

The payment prohibitions included in CMS 2237-IFC contain provisions that have a disproportionate impact on Community Mental Health Centers (CMHCs) and other community providers serving people living with serious mental illnesses. For example, no bundling of any kind is allowed for case management services in fee-for-service state. In addition, case management must be billed in increments of 15 minutes, or less. As previously noted, this administrative requirement appears nowhere in the Medicaid statute or prior regulations. Finally, Medicaid beneficiaries receiving case management under the 2007 rule can have only one plan and one case manager. The combined impact of these brand new requirements is to impose enormous paperwork burdens and further fragment services delivery.

Rescinding CMS 2237-IFC Is Critically Important, But Further Action Is Needed In The Final Rulemaking.

Because of the tremendous uncertainty created by the combined impact of the over-reaching regulatory requirements described above, rescinding these provisions in CMS 2287 P2 is an essential step toward bringing needed clarity at the state level to financing of case management and targeted case management services for vulnerable Medicaid beneficiary populations. Further, the undersigned organizations strongly support the definition contained in the new case management regulation.

The undersigned organizations also believe that CMS should use the rule making process concerning this key state optional program to clarify closely related policy and financing questions. In particular, the final regulation should authorize state Medicaid agencies to engage in reimbursement for case management and targeted case management through the establishment of reasonable and efficient payment methodologies including fee-for-service payments, case rates, daily rates, and other forms of capitated payment. In the current congressional deliberation on health care reform, there appears to be a developing consensus that so-called bundled rates should be applied more widely in the context of Medicare payments. Exactly the same policy arguments apply to Medicaid – particularly in the context of the case management/targeted case management option.

In conclusion, CMS 2237 IFC is an overboard regulation primarily designed to achieve Medicaid spending cuts that could not be attained through the legislative process. By contrast, CMS

2287-P2 accurately reflects congressional intent and provides clear guidance to states on how to reimburse for case management and targeted case management services.

Sincerely,

ACCSES

Alliance for Children and Families

American Academy of Pediatrics

American Association of People with Disabilities

American Association on Intellectual & Developmental Disabilities

American Dental Education Association

American Humane Association

American Music Therapy Association

American Network of Community Options and Resources

American Occupational Therapy Association

American Physical Therapy Association

APSE

Association of Assistive Technology Act Programs

Association of University Centers on Disabilities

Autism Society of America

Bazelon Center for Mental Health Law

Black Administrators in Child Welfare, Inc.

Brain Injury Association of America

Children's Defense Fund

Children's Health Fund

Child Welfare League of America

Council for Learning Disabilities

Division for Early Children of the Council for Exceptional Children

Easter Seals

Epilepsy Foundation

Family Violence Prevention Fund

Family Voices, Inc.

First Focus

Foster Family-Based Treatment Association

Generations United

IDEA Infant Toddler Coordinators Association

Institute for the Advancement of Social Work Research

Lutheran Services in America

March of Dimes

Medicaid Health Plans of America

Mental Health America
National African American Drug Policy Coalition, Inc.
National Alliance on Mental Illness
National Alliance to Advance Adolescent Health
National Assembly on School-Based Health Care
National Association of Councils on Developmental Disabilities
National Association for the Education of Homeless Children and Youth
National Association for Children's Behavioral Health
National Association of County Human Services Administrators
National Association of Social Workers
National Association of State Directors of Developmental Disabilities Services
National Association of State Directors of Special Education
National Association of State Head Injury Administrators
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Disability Rights Network
National Down Syndrome Congress
National Down Syndrome Society
National Federation of Families for Children's Mental Health
National Foster Care Coalition
National Multiple Sclerosis Society
National Health Law Program (NHeLP)
National Indian Child Welfare Association
National Rehabilitation Association
North American Council on Adoptable Children
Nurse-Family Partnership
Orphan Foundation of America
Prevent Child Abuse America
The Arc of the United States
The Rebecca Project for Human Rights
United Cerebral Palsy
United Neighborhood Centers of America
United Spinal Association
Voices For America's Children
Youth Law Center