February 4, 2008

Kerry Weems
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

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

Dear Mr. Weems:

The Association of Maternal and Child Health Programs is appreciative of the opportunity to comment on the proposed rule regarding targeted case management. AMCHP is the national organization representing state and territorial public health leaders whose mission is to improve the health and well-being of all women, children, and families, including children with special health care needs. We are opposed to the implementation of the proposed rule based on concerns that it will impede eligible beneficiaries from gaining access to needed medical, social, educational, and other services. We are also greatly concerned that the proposed regulatory changes are in direct conflict with the legislative requirements included in the Individuals with Disabilities Education Act (IDEA).

AMCHP members administer statewide programs such as newborn screening, home visiting, school-based health centers, and clinics for children with special health care needs, as well as many other vital health programs. State Title V Maternal and Child Health (MCH) programs coordinate closely with Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to assure the provision of all medically necessary services to children covered under Medicaid.

While we appreciate that the proposed regulation is promulgated with the intent of clarifying policy to states, our review finds that in many instances its provisions are confusing, contrary to other statues affecting case management services, and will cause unnecessary service disruptions among some of the most vulnerable low-income citizens who are eligible for Medicaid. For example, the regulation provides no explanation as to how this rule relates to the required Medicaid administrative activities under 1902(a)(11) (relating to the use of title V agencies to administer Medicaid) or provision of EPSDT supports under 1902(a)(43).

Title V of the Social Security Act requires that State programs operating under the Maternal and Child Health Services Block grant have interagency agreements with Medicaid, and the Medicaid statute contains a similar/reciprocal requirement in 1902(a)(11). Many of these interagency agreements include provisions under which Medicaid delegates informing, outreach, and similar administrative case management duties to Title V agencies. A majority of these activities are in support of the effective administration of child health services under the EPSDT program.

Since the regulation is intended to implement only 1915/1905, we understand that the proposed rule does not affect or modify the administrative activities performed by Title V Maternal and Child Health programs under 1902(a)(11) and 1902(a)(43). Clarification and verification on this point is needed. Additionally, the following concerns remain:

According to CMS's own analysis, the interim final rule on targeted case management would reduce federal Medicaid spending by $1.28 billion over five years, considerably more than the $760 million projected by the Congressional Budget Office (CBO) when it analyzed the Deficit Reduction Act (DRA). This difference is one indication that the rule goes beyond what Congress intended. The rule would either shift costs to states to compensate for the lost federal funds or force states to cut services for beneficiaries.

Furthermore, the rule would significantly limit state flexibility to provide case management in the most effective and efficient manner possible by:

§441.18(a)(2) Restricting Case Management for Children with Disabilities

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 in order to ensure that they receive an appropriate public education, as required by both the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. The interim final rule would allow case management for children with disabilities in schools only when it is designated as a required service in the child's Individualized Education Program (IEP) or an infant's or toddler's Individualized Family Service Plan (IFSP). The new rules specifically disallow the provision of case management when it is part of a child's plan under Section 504 even if a child's disability requires the coordination of multiple medical, social, and educational services in order for the child to participate in school programs. The children served by targeted case management who are affected by the rule change are primarily those who have a challenging and complex system of health and social services to navigate.

§441.18(c)(3)Forcing States to Fragment Services for Children in Foster Care

The interim final rule prohibits any federal funding for case management services that child welfare agencies (or qualified Medicaid providers that have contracts with these agencies) provide to children in foster care. Under the new rule, only a Medicaid provider operating outside the child welfare system could provide case management services to children in foster care. This would force states to fragment the services provided to children in foster care — a result directly contrary to the purpose of the case management benefit, which is to coordinate needed medical, social, and educational services. Furthermore, almost half of all children in foster care have a disability or a chronic medical problem, and up to 80 percent have serious emotional problems.

§440.169(c) Limiting Case Management for Beneficiaries Leaving Institutional Care

According to the proposed rule, federal matching funds would be available for case management provided only during the last 60 days of a stay in an institution if the stay is 180 days or more, and for only the last 14 days of a stay that lasts fewer than 180 days. This usually is not enough time to arrange housing and other services needed for a successful transition, especially for those individuals with complex mental health needs or developmental disabilities. These changes undermine the President's New Freedom Initiative to help people with disabilities participate more fully in community life.

§441.18(a)(8) and §441.18(a)(9) Limiting States' Flexibility to Manage Medicaid Efficiently

A central tenet of the federal-state partnership to operate Medicaid is that states must follow federal guidelines while retaining broad flexibility over payment rates and policies. The new rule disregards this tenet, arbitrarily restricting state flexibility in a way that could make Medicaid payments less efficient. The rule would prohibit states from making fee-for-service payments for case management services in increments that exceed 15 minutes of a given service. This would be a significant change for states, which often use case rates, per diem rates, or other methodologies to pay for case management when these approaches are more efficient.

§441.18(a)(5) Single Medicaid Case Manager

The rule 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 such individual. There are times when it may be necessary to have multiple case managers work together as a team on behalf of an individual.

Conclusion

CMS should withdraw these rules and provide more appropriate guidance to states that is in line with Congressional intent regarding case management services. We appreciate your consideration.

Sincerely,

Michael R. Fraser, Ph.D.
Chief Executive Officer

• AMCHP •
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