

BEFORE THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES

---

In the Matter of )  
 )  
 )  
RESCISSION OF SCHOOL-BASED )  
SERVICES FINAL RULE, OUTPATIENT )  
SERVICES DEFINITION FINAL RULE, )  
AND PARTIAL RESCISSION OF CASE )  
MANAGEMENT SERVICES INTERIM )  
FINAL RULE )  
 )  
CMS-2287-P2; CMS-2213-P2' CMS 2237-P )  
 )  
 )

---

**JOINT COMMENTS OF SIXTEEN STATE MEDICAID AGENCIES  
IN SUPPORT OF PROPOSED RESCISSIONS**

These comments are submitted on behalf of the agencies and officials responsible for administering the Medicaid program in the States of Alaska, California, Connecticut, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, New York, Ohio, Oklahoma, South Dakota, Tennessee, Vermont and Washington (the “Commenting States”), which fully support the proposed rescissions of the previously-adopted final rules on school-based administrative and transportation costs and on the definition of outpatient hospital services, and the partial rescission of the interim final rules on case management services. The proposed rescissions, set forth in the May 6, 2009, of the Federal Register (74 Fed. Reg. 21232) are dictated by sound program policy considerations and are fully consistent with the actions of Congress in delaying implementation of these rules.

School-Based Administration and Transportation Costs

Fewer goals are more central to the Medicaid program and to federal policy generally than securing the health of this nation's children. The EPSDT component of Medicaid sets forth particular requirements for achieving this goal, but federal policies for decades have focused on identifying and treating health issues of children, as a means of encouraging their development and avoiding serious health problems in later life.

For many children, particularly those raised in less prosperous circumstances, schools have become a primary source for health care services, and dealing with the health issues of children has become a significant component of the jobs of many school officials. Providing Medicaid funding for this aspect of school officials' activities is critical to assuring the continued performance of this vital function, especially so in these times when school districts and the governmental bodies that support them are facing such severe fiscal pressures.

For many years CMS and its predecessor agencies recognized the important role played by schools in assuring proper health care for children. The regulation in question, issued in December 2007, thus represented not only a sharp break with past policies but a blow to the effective delivery of vital services to millions of children for whom the alternative sources of care are slim at best.

The regulation rested on two improper premises. The first is that the administrative activities associated with health care in the schools are educational in nature and should therefore be paid for solely from education-related sources. That position has been rejected in the past by Congress and by the courts, and represents an unrealistic and uninformed view of the role of public schools in today's society. The second improper premise is that past perceived abuses in the claiming of administrative costs justifies elimination of federal support

for this activity altogether. This premise rests on outdated information, and ignores the substantial steps taken by CMS over the past decade to define more clearly what school administrative activities may appropriately be covered by Medicaid.

Inconsistencies in CMS policy and its application in this area continue to be experienced, and we urge CMS to continue its efforts to develop nationally-applicable school administrative claiming standards that are consistent with federal grant program policies and relevant national accounting and statistical standards. This, rather than eliminating all federal support for school-based administrative activities, should be CMS' goal.

Cutting back support for the health care component of school activities is the wrong approach at the wrong time, and promises to cause great harm to state Medicaid programs and the children that they serve. The Commenting States strongly endorse the proposal to rescind this misguided regulation.

The same is true of the proposal to eliminate all federal support for transportation of disabled children between home and school, where those children receive most if not all of their health care services. There is no warrant for singling out this one group of Medicaid-eligibles, while continuing to allow coverage of transportation of all other Medicaid-eligibles to their medical providers. The rationale offered for this regulation was the same as that offered for eliminating all school-based administration, and is just as invalid in the transportation context as in the administration context. The Commenting States therefore support strongly the proposed rescission of changes in the regulations relating to transportation.

#### Definition of Outpatient Hospital Services

The Commenting States also strongly support the rescission of the rule modifying the definition of outpatient hospital services, adopted in November 2008 but which is subject to a

congressional moratorium through June 30, 2009. This regulation, if it became effective, would cause great disruption to state program administration, and would impair access to federal funds at precisely the time when those funds are sorely needed to help maintain Medicaid services in the face of an economic recession.

The disruption arises from the changes in claiming methodologies that would have to be implemented to continue to receive federal support for services provided in outpatient hospital/clinic settings. To the extent that the services would remain reimbursable under other categories of Medicaid service, the disruption serves no real purpose, but instead causes work for its own sake.

But the regulation has other, more serious impacts. By forcing traditional components of outpatient hospital services to be separately claimed, the regulation would reduce the federal support for these services, both by limiting the ability to spread overhead costs of the hospitals and by restricting their access to disproportionate share payments. There are existing limits on these sources of federal funds (the Upper Payment limit and the individual state DSH allotments). There is no justification for a regulation that imposes additional limits on the ability to access federal funds for legitimate Medicaid services.

The outpatient hospital definition regulation was a solution addressed to a non-existent problem. It serves no useful purpose and should be rescinded.

#### Optional State Plan Case Management Services

The Commenting States also support the partial rescinding of the December 4, 2007 interim final rule regarding optional state plan case management services. CMS is correct that provisions of the interim final rule would unduly restrict beneficiary access to needed

covered case management services and limit State flexibility in determining efficient and effective delivery systems for case management services.

Specifically, the Commenting States support the removal of §§ 440.169(c) and 441.18(a)(8)(viii) regarding the time limitation for the provision of case management services to individuals transitioning to a community setting. The new limitations were a substantial change from previous CMS policy and imposed arbitrary and unrealistic deadlines on the amount of time needed to assist individuals transitioning to the community after long-term institutionalization.

The Commenting States agree with the proposal to remove §§ 441.18(a)(5) and (a)(6), which require that case management be provided on a comprehensive basis through a single case manager and prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan. These are service delivery questions that are best left to the States. While it may make sense to require a single case manager in some cases, many States believe that the varied and complex needs of certain Medicaid populations may require separate case managers who are familiar with the needs presented by specific diagnoses and with the providers available to serve those needs. Similarly, it should be left to the States as to whether to delegate the agency's authority to authorize or deny certain services to a case manager who is most familiar with the individual's needs. Among other things, these provisions, if not rescinded, threaten to hinder States in their obligation to assure the health and welfare of waiver participants under section 1915(c)(1) of the Act and the regulations promulgated by CMS at 42 C.F.R. § 441.302(a).

The Commenting States also support the rescission of 42 C.F.R. § 441.18(a)(8)(vi), which requires that the unit of service for case management services not exceed 15 minutes. The appropriate unit of service is a decision that should be left to the States and may

vary depending on the type of case management service and the population being served. Many States use a daily, weekly or monthly rate that is typically based on the anticipated amount of services to be provided. Such a rate structure creates a predictable expense for States and reliable income for case management providers, and does not provide an incentive to case managers to inflate their hours. In addition, requiring case managers to record, and States to pay for, services in 15-minute increments would create a tremendous administrative burden for both parties.

The Commenting States support the revisions to 42 C.F.R. § 441.18(c). The language that is proposed to be rescinded (or modified) puts in place a definition of case management that is significantly more constrained than the statutory definition adopted by Congress in the Deficit Reduction Act and the interpretive policies in force prior to the issuance of the interim final rule. These aspects of the interim final rule would deny Medicaid reimbursement for all case management services provided to some of a State's most vulnerable populations, including foster care children, simply because they were receiving assistance or support through other state programs. This would have led to an unnecessary fragmentation of care and a reduction in critically needed federal funding. The attempt to deny Medicaid reimbursement for these case management services was misguided and should be rescinded.

While the Commenting States support the proposed partial rescission of the interim final rule, there are other aspects of the interim final rule that also will affect access to services and that negatively affect States' ability to effectively administer their Medicaid programs and that should also be rescinded. In particular, CMS should reconsider 42 C.F.R. § 441.18(a)(3) -- which provides that a State may "not compel an individual to receive case management services, condition receipt of case management (or targeted case management)

services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services” -- at least as it applies to Section 1915(c) home- and community-based waiver programs. Many States have found that requiring case management as a condition of participation in HCBS waiver programs is the only effective way to ensure that participants do in fact have access to services under the plan. Participants in these plans are vulnerable individuals who, under the express terms of the statute, would otherwise require institutionalization; thus, they require a high degree of supervision and care, and their health and welfare cannot be assured as required by statute and regulation unless a robust case management system is in place.

In addition, CMS should clarify and rectify the discussion of 42 C.F.R. § 440.169(d), which defines “referral and related activities” that may be claimed as case management services. A discussion in the preamble to the interim final rule indicates that CMS would interpret this provision as not including the activities of a case manager who accompanies an individual to needed services. See 72 Fed. Reg. 68082 (“Referral and related activities do not include . . . escorting the individual to the service. . . The case management referral activity is completed once the referral and linkage has been made.”) On occasion, depending on the special needs of the individual, it is necessary for a case manager to escort an individual in order to help link that individual with a provider or other program or service. This is particularly true, for example, for individuals with mental illness or with developmental disabilities, and some States include such activities in their definition of case management. The Commenting States believe that such activities are covered by the interpretative policies in force prior to the issuance of the interim final rule, and urge CMS to clarify that the discussion in the preamble of the interim final rule is without force and effect.

Finally, in its proposal, CMS states that it will “retain the remaining provisions of the interim final rule with comment period, and finalize those provisions in a future rulemaking.” It appears that, in light of the congressional moratorium, CMS is treating the “interim final rule with comment” as a proposed rulemaking and that the provisions of the interim final rule that CMS proposes to retain are not yet finalized, despite their publication as “interim final” rules. The Commenting States request that CMS confirm or explain the status of the retained “interim final” provisions.

Respectfully submitted,

Charles A. Miller  
Caroline M. Brown  
Covington & Burling LLP  
1201 Pennsylvania Avenue, N.W.  
Washington, D.C. 20004

On behalf of the Medicaid Agencies of the  
States of Alaska, California, Connecticut,  
Hawaii, Illinois, Kansas, Kentucky,  
Louisiana, Maine, New York, Ohio,  
Oklahoma, South Dakota, Tennessee,  
Vermont and Washington

June 1, 2009