

# New Mexico Human Services Department

Bill Richardson, Governor  
Pamela S. Hyde, J.D., Secretary

Medical Assistance Division  
PO Box 2348  
Santa Fe, NM 87504-2348  
Phone: (505) 827-3106

*Schneider*  
*Medicaid*

February 12, 2008

Henry A. Waxman, Chairman  
Congress of the United States  
House of Representatives  
Committee on Oversight and Government Reform  
2157 Rayburn House Office Building  
Washington, DC 20515-6143

RE: Analysis of Recent Centers for Medicare & Medicaid Services (CMS) Regulations

Dear Chairman Waxman:

The State of New Mexico Human Services Department Medical Assistance Division (HSD MAD) respectfully submits this analysis, per your request. This analysis addresses the following regulations:

1. cost limits for public providers (CMS 2258-FC)
2. payment for graduate medical education (CMS 2279-P)
3. payment for hospital outpatient services (CMS 2213-P)
4. provider taxes (CMS 2275-P)
5. coverage of rehabilitative services (CMS 2261-P)
6. payments for costs of school administrative and transportation services (CMS 2287-P)
7. targeted case management (CMS 2237-IFC)

## **1) Cost Limits for Public Providers (CMS 2258-FC)**

The following estimated five year projection was divided into dollar amounts for the Sole Community Provider Fund (SCPF) and Upper Payment Limit (UPL/Supplemental). The numbers for the Sole Community Provider piece were determined by using our calculation of prior year base plus UPL plus an estimated Market Basket Index of 4%.

The impact of this proposed rule would be a reduction in Medicaid applicants and beneficiaries as a result of a decrease in service providers.

The UPL amount was determined by taking the current amount and using a 10% estimated inflator for each year.

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<u>SCPF</u>		<u>State Share</u>	<u>Federal Share</u>
FY09	\$178.4 million	\$51.7 million	\$126.7 million
FY10	\$247.1 million	\$71.7 million	\$175.4 million
FY11	\$324.7 million	\$94.2 million	\$230.5 million
FY12	\$412.1 million	\$119.5 million	\$292.6 million
FY13	\$510.5 million	\$148.1 million	\$362.5 million
<u>UPL</u>			
FY09	\$59.2 million	\$17.2 million	\$42.0 million
FY10	\$65.1 million	\$18.9 million	\$46.2 million
FY11	\$71.6 million	\$20.8 million	\$50.8 million
FY12	\$78.8 million	\$22.8 million	\$55.9 million
FY13	\$86.6 million	\$25.1 million	\$61.5 million
<u>Total</u>			
FY09	\$237.6 million	\$68.9 million	\$168.7 million
FY10	\$312.2 million	\$90.5 million	\$221.7 million
FY11	\$396.3 million	\$114.9 million	\$281.4 million
FY12	\$490.9 million	\$142.4 million	\$348.5 million
FY13	\$597.2 million	\$173.2 million	\$424.0 million

1,444.3

**2) Payment for Graduate Medical Education (CMS 2279-P)**

This proposed rule, as published in the Federal Register in May of 2007, provides clarification that costs and payments associated with Graduate Medical Education (GME) are not expenditures for medical assistance that are federally reimbursable under the Medicaid program. This proposed rule also modifies the federal upper payment limit by disallowing GME payments from the Medicaid upper payment limit calculation. If the rule is enacted, the GME program would no longer be federally funded. States could continue to make GME payments, however no federal funds could be used for this purpose. Currently, there are seven facilities receiving GME payments in New Mexico. The University of New Mexico hospital receives approximately 98% of the total GME funds in New Mexico.

The impact of this proposed rule would be a reduction in Medicaid applicants and beneficiaries as a result of a decrease in service providers.

The estimated cost impact of this rule for the next five years would be \$7.5 million dollars (\$2.2 million state and \$5.3 million federal) per each fiscal year.

**3) Provider Taxes (CMS 2275-P)**

This proposed rule limits provider taxes to 5%. Currently, the premium tax is the only provider tax in New Mexico. The premium tax in New Mexico is 4%; therefore the total cost impact of this rule would be \$0.00 dollars.

There is no effect on Medicaid applicants and beneficiaries in New Mexico due to this rule.

#### **4) Payment for Hospital Outpatient Services (CMS 2213-P)**

This proposed rule, as published in the Federal Register in September of 2007, amends the regulatory definition of outpatient hospital services for the Medicaid program. The stated purpose of the change is to align the Medicaid definition more closely to the Medicare definition in order to improve the functionality of the applicable Upper Payment Limits (UPL).

Currently, New Mexico pays for outpatient services at a prospective rate of 77% of billed charges. These are then cost settled through the annual cost report which is the same as the outpatients' services that are traditionally paid for by Medicare.

With regard to the section of the proposed rule that deals with the Upper Payment Limit calculation, the rule indicates that two forms of UPL demonstrations for outpatient services will be accepted. One would be a cost to charge ratio based on the Medicare cost report. The other would be a payment to charge ratio (also based on data from the Medicare cost report). New Mexico will still have to meet the UPL for outpatient services. The fact that the hospitals are paid at cost based on the Medicare cost report with some reductions should by definition satisfy the UPL test.

The total cost impact of this rule in New Mexico would be \$0.00 dollars.

There is no effect on Medicaid applicants and beneficiaries in New Mexico due to this rule.

#### **5) Coverage of Rehabilitative Services (CMS 2261-P)**

The New Mexico Medicaid Program believes there are provisions in this regulation, as published in the Federal Register in August of 2007, that are unclear or misguided and may impede the ability of the Medicaid program to appropriately provide services to some individuals. While there has not yet been a financial impact, the regulations are unclear in aspects that may enable CMS to interpret the rules in the future in ways that would unfairly penalize a state. Therefore, it is not feasible to provide an estimate of the expected reduction in federal Medicaid funds to New Mexico over each of the next five years.

The issues can be categorized in three major areas: (1) unsound payment methodology; (2) denying coverage based on elements of other programs; and (3) an inadequate definition of rehabilitative services:

##### **Unsound Payment Methodology**

This rule reinforces recent poor interpretations of policy by CMS by specifically excluding the option of paying for therapeutic foster care or similar programs, such as Assertive Community Treatment (ACT), through a single daily rate, case rate, or similar payment to the provider. Instead, individuals in these programs can receive all covered rehabilitation services, but each service must be billed separately, requiring detailed accounting by all providers.

New Mexico understands the need for CMS to assure reimbursement is reasonable, but by failing to consider the nature and intent of some services, this blanket

restriction against a “bundled” rate for a multidisciplinary service will distort the nature of an evidenced-base service from being provided.

The recent proposed and interim rules published in the Federal Register in December of 2007 by CMS on Targeted Case Management (CMS 2237-IFC) make the same error by prohibiting the payment of case management to be at a monthly rate (§ 441.18(a)(8)(vi)). In certain limited cases, monthly case management rates can be shown to be a cost effective and function as an appropriate cap on case management expenditures. It is unclear why CMS would deny themselves the ability to approve a monthly rate when it can be shown to be appropriate and cost effective.

### **Non-covered services**

A second problematic part of the new rule (§ 441.45(b)) prohibits federal payment for services that CMS deems “intrinsic elements” of other programs. The list of programs included under this rule includes foster care, child welfare, education, child care, vocational and prevocational training programs, housing, parole and probation, juvenile justice and public guardianship. Individuals in these programs would remain eligible for Medicaid and covered rehabilitation services could be provided to them and reimbursed—but only if the services are not intrinsic elements of the other programs. “Intrinsic elements” is undefined. In 2004, Congress rejected a CMS proposal to include similar language in the Medicaid law. It is questionable whether it is permissible for the agency to take this action under regulation. This section introduces a whole new concept into Medicaid, one that conflicts with federal statutory requirements. It denies Medicaid coverage for covered services to covered individuals if such services are furnished through another program, including when they are considered intrinsic elements of that program. There are many mechanisms that states and localities use to fund mental health services for persons who are uninsured or underinsured. These programs frequently operate on capped appropriations distributed through grants to providers. This is a very different situation from when an individual has other insurance (where the insurer has a contracted legal liability to pay) or when an agency has already received a federal payment to meet a specific need of a particular person (such as through Title IV-E for certain case management services).

There is little clarity in the regulation on how this provision would be applied as the regulation provides no guidance on how to determine whether a service is an intrinsic element of another program.

Furthermore, few of the other cited programs have a clear legal obligation to provide these services or have the resources to do so. Without revision, this new rule would conflict with the federal statutory mandate to provide all medically necessary services covered by the state Medicaid plan, and for children, all medically necessary services covered by 42 U.S.C. § 1396d(a). See 42 U.S.C. §§ 1396a(a)(10), (1396d(r)). The net result of this new rule will be that Medicaid-eligible individuals will be denied services, both by Medicaid and by the other cited program (due to lack of resources in the other program). Thus, the rule effectively denies medically necessary Medicaid

services, in direct contradiction of the statute. This entire section conflicts with the Medicaid statute.

#### **Definition of Restorative Services**

While the new definition of restorative services (§ 440.130(d)(1)(vi)) includes a statement that the recipient does not have to have actually performed a function in the past to meet the definition of “restorative services”, this issue still needs further clarification. It is a complex issue that CMS in the past has sometimes interpreted to restrict continuation of rehabilitative services essential for a recipient to retain his/her functional level, confusing this aspect of rehabilitation with custodial care.

To assure recipients can receive necessary services, CMS should specifically state that restorative services include services to enable a child to achieve age-appropriate growth and development and that it is not necessary that the child actually performed the activity in the past. Secondly, CMS should specify that services may be furnished when necessary with a goal of retaining a functional level for recipients who can be expected to otherwise deteriorate. Section 1901 of the statute specifically authorizes funds for “rehabilitation and other services” to help individuals retain capability for independence and self-care. This provides authority for CMS to allow states to furnish services that will maintain a recipient’s functional level. However, the CMS regulation falls short of specifying that coverage. Medicare regulations are explicit in their coverage of maintenance of current functioning as an acceptable goal and the same should be available under Medicaid.

#### **6) Payments for Costs of School Administrative and Transportation Services (CMS 2287-P)**

This final rule was issued in December of 2007. The Medicaid School Based Services (MSBS) administrative claiming program and billing for transportation services from home to school will cease at the end of June 2008. This will significantly impact all children who attend publicly funded schools in New Mexico. The annual loss of \$3.8 million reimbursed to school districts will result in the loss of school nurses, health aides, behavioral health providers, therapists and other health-related positions that schools in New Mexico fund with MSBS reimbursements. New Mexico has 81 School Based Health Centers whose funding is also jeopardized by this rule. In New Mexico, schools are required to spend their Medicaid funds on health and health-related services for all students. Therefore, all children who attend publicly funded schools in New Mexico will be impacted by this significant loss of funding for health-related services in the school setting.

In addition, schools play a key role in enrolling and re-enrolling children in the Medicaid program. MSBS reimbursements to schools in New Mexico fund the school-based Presumptive Eligibility (PE)/ Medicaid On-Site Application Assistance (MOSAA) program positions, some of which will be unfunded under this new rule. PE/MOSAA workers in schools are vital for enrolling children in Medicaid and maintaining enrollment. The loss of this funding will hinder the enrollment process for this fragile population.

Total cost impact for Medicaid School Based Services over the next five years would be \$3.8 million dollars (\$1.1 million state and \$2.7 million federal) per year. The total cost impact for

transportation services over the next five years would be \$219,000 (\$155,490 federal and \$63,510 state) per year.

New Mexico's communication document detailing the impact of this rule is attached to this analysis for your review.

**7) Targeted Case Management (CMS 2237-IFC)**

The effect of this rule on Medicaid applicants and beneficiaries in New Mexico is significant. Recipients with the greatest health issues would experience more confusion related to accessing services and delayed access to care as a result of this rule. The recipients impacted directly will be children and adults on the home and community based services waivers (the medically fragile and developmentally disabled waivers), children in the Families Infant Toddlers program, some high risk pregnant women, and children under state guardianship or under the jurisdiction of the juvenile justice agencies.

Since juvenile justice case management is essential to refer children for appropriate medical care rather than incarceration, and case management for children under state guardianship must be done by state workers who are the responsible authorities for these children, the State will need to continue to fund these services with no federal match even though they really meet the definition and serve the purpose of case management.

The estimated cost impact of this rule for each of the next five years for high risk children under state guardianship would be as follows:

		<u>State Share</u>	<u>Federal Share</u>
FY09	\$7,620,833	\$2,210,043	\$5,410,79
FY10	\$7,773,250	\$2,254,244	\$5,519,00
FY11	\$7,928,715	\$2,299,329	\$5,629,38
FY12	\$8,087,289	\$2,372,315	\$5,714,97
FY13	\$8,249,034	\$2,392,221	\$5,856,81

\$5.410  
364  
455  
185  

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\$6.4 1709

The estimated cost impact of this rule for each of the next New Mexico is as follows:

		<u>State Share</u>	<u>Federal Share</u>
FY09	\$513,192	\$148,826	\$364,366
FY10	\$528,588	\$153,291	\$375,297
FY11	\$544,446	\$157,890	\$386,556
FY12	\$560,779	\$162,626	\$398,153
FY13	\$577,603	\$167,505	\$410,098

28,131  
1,933  
1,369  
2,971  
Five years  
= \$33.4

The estimated cost impact of this rule for each of the next five years on the Developmentally Disabled Waiver program due to removing the ability to pay at a monthly case management rate would be:

		<u>State Share</u>	<u>Federal Share</u>
FY09	\$641,324	\$ 185,984	\$455,340
FY10	\$654,150	\$ 189,704	\$464,446
FY11	\$667,233	\$ 193,498	\$473,735
FY12	\$680,578	\$ 197,368	\$483,210
FY13	\$694,189	\$ 201,315	\$492,874

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2,369,000  
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The estimated cost impact of this rule for each of the next five years on the Medically Fragile Waiver program in New Mexico due to removing the ability to pay at a monthly case management rate is as follows:

		<u>State Share</u>	<u>Federal Share</u>
FY09	\$261,120	\$ 75,725	\$185,395
FY10	\$266,342	\$ 77,239	\$189,103
FY11	\$271,669	\$ 78,784	\$198,885
FY12	\$277,102	\$ 80,360	\$196,742
FY13	\$282,645	\$ 81,967	\$200,678

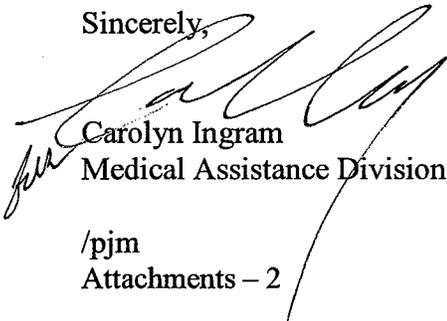
971,000

New Mexico's response to the request for comments on this rule is attached to this analysis for your review.

Thank you for this opportunity to provide this analysis to you and the Committee on Oversight and Government Reform. The total page count for this production is 14. Feel free to contact me or Paula McGee at (505)827-6234 with any questions related to this analysis. As always, thank you for your efforts.

I hereby certify that (1) a diligent search has been completed of all documents in my possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Committee or identified in a privilege log provided to the Committee.

Sincerely,



Carolyn Ingram  
Medical Assistance Division Director

/pjm  
Attachments - 2

- C: Pamela S. Hyde, JD, Cabinet Secretary  
Katie Falls, Deputy Secretary  
Tony Martinez, Office of the Governor  
Michelle Welby, Office of the Governor  
Senator Jeff Bingaman  
Senator Pete Domenici  
Representative Heather Wilson  
Representative Tom Udall  
Representative Stevan Pearce  
Paula McGee, Healthcare Operations Manager, MAD



# STATE OF NEW MEXICO Medicaid School-Based Services

## *Proposed Federal Cuts Have Significant Impact – Immediate and Future*

### **NEW MEXICO MEDICAID SCHOOL-BASED SERVICES (MSBS)**

Healthy children and youth have a better chance of achieving academic, social and personal success than children and youth who are singled-out by a health concern or disability that impacts their ability to participate in school. Because of their position in the daily lives of children, youth and their families, New Mexico schools are poised to offer unique advantages and opportunities that can help families access health information, medical and behavioral health services, and facts about Medicaid enrollment. Under the auspices of the MSBS program, New Mexico schools offer key health and health-related services that are designed to integrate and maintain active learning for Medicaid-eligible children and youth with special education and health care needs.

In 1988, Congress recognized the fiscal burden that delivering health care imposed on schools and passed a law to make Medicaid funds available to schools for certain health-related services for children and youth with disabilities. In 1994, New Mexico's Medicaid program began offering public school districts the opportunity to receive Medicaid reimbursement for a portion of their special education and related costs when students require services as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) and are eligible for Medicaid/SCHIP. Nearly all of New Mexico's 89 school districts, in addition to several charter schools and state-funded schools, currently participate in this important program.

There are two ways that schools are reimbursed by the MSBS program:

- **Direct Care Services:** Schools receive partial payment for health care provided to children and youth with disabilities who receive those services as part of an IEP/IFSP. Reimbursable services include nursing services; physical, occupational and speech therapies; social services; nutritional assessments and counseling; behavioral health services; and specialized transportation.
- **Administrative Outreach Services:** Schools also receive Medicaid reimbursement for services that directly support efforts to provide health-related services to Medicaid-eligible children and youth. These administrative activities include providing information about Medicaid programs and how to access them; facilitating the eligibility determination process; assisting recipients in obtaining transportation and translation services when necessary to receive health care services; making referrals for Medicaid-reimbursable services; and coordinating and monitoring medical services that are covered by Medicaid.

In New Mexico, school districts are required to spend all of the money that they receive from Medicaid under the MSBS program on additional health and health-related services to benefit *all* their students, not just those who are eligible for Medicaid or special education. In participating school districts, this means money for more school nurses, health education programs, physical education programs, school-based health centers, and other health services that would otherwise be unfunded.

### **MSBS REIMBURSEMENT IN NEW MEXICO – FISCAL YEAR 2007**

In state fiscal year 2007 (July 1, 2006 to June 30, 2007), New Mexico school districts received a total of approximately **\$14.1 million and served nearly 17,000 children and youth with disabilities** under the MSBS program.

<b>MSBS Services Delivered by New Mexico Schools</b>	<b>MSBS Reimbursement in FY07</b>
Direct Care Services	\$11.1 million*
Specialized Transportation Services	\$219,000*
Administrative Outreach Services	\$3 million
<b>Total MSBS Reimbursement in FY07</b>	<b>\$14.1 million</b>

\*New Mexico school districts that participate in the MSBS program pay the state's share (28.85% in federal fiscal year 2006 and 28.07% in federal fiscal year 2007) on direct service reimbursements. School districts are also required to pay 5% of the total of their direct and administrative service reimbursements back to the Human Services Department (HSD) for the staffing and administration of the program within HSD.



# STATE OF NEW MEXICO Medicaid School-Based Services

## *Proposed Federal Cuts Have Significant Impact – Immediate and Future*

### **CMS PROPOSED RULE**

On August 31, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would eliminate reimbursement for school-based administrative activities and for certain transportation services provided to children in the school setting. The elimination of these components of the MSBS program would mean the immediate loss of approximately \$4 million to New Mexico school districts; and an anticipated future loss of as much as \$10 million every year. While CMS contends that the program should be discontinued due to improper billing by school districts, New Mexico has made concerted efforts to eliminate potential fraud, waste and abuse in the program and to collaborate with schools to ensure program integrity, quality and accountability.

There are two significant ways to fight these proposed cuts to the MSBS program:

- **Submit Comments to CMS on Proposed Rule CMS 2287-P**  
A public comment period on the proposed rule has been opened through November 6, 2007. Implementation of the rule would occur on October 1, 2008. It is important to let CMS know how important MSBS funding is to New Mexico schools, and to emphasize the role of schools in facilitating enrollment into the Medicaid program and in helping children and families access the services they need. Studies have shown that parents are much more likely to enroll their children in Medicaid if they can do so at a convenient location, such as their child's school. Comments can be submitted electronically at <http://www.cms.hhs.gov/eRulemaking> by clicking on the link titled "Submit electronic comments on CMS regulations with an open comment period".
- **Pass the *Protecting Children's Health in Schools Act of 2007* Bills**  
In February 2007, two bills were introduced in Congress that would establish in law the right of schools to bill Medicaid under the MSBS program. The House bill (H.R. 1017) was introduced by Representative John Dingell (D-Michigan) and the Senate version (S. 578) was introduced by Senator Ted Kennedy (D-Massachusetts). This legislation would amend Title IX of the Social Security Act to establish safeguards that will protect the integrity of the MSBS program while ensuring Medicaid reimbursement for direct care and administrative outreach services provided in schools to children with disabilities.

### **WHAT CAN YOU DO?**

You can help ensure that Medicaid funding to school systems under the MSBS program be retained. School districts need to continue providing the highest quality of health services to children and youth, and credible and reliable health information and outreach to families. Because of their position in the daily lives of students and families, schools are vitally important to ensuring that New Mexico's children and youth are healthy and successful.

- Submit comments to CMS on proposed rule CMS 2287-P. Full text of the rule can be downloaded at [www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2287P.pdf](http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2287P.pdf).
- Support the *Protecting Children's Health in Schools Act of 2007* bills, which firmly establish the MSBS program in law.
- Ensure that any federal policy changes that are developed or implemented maintain at least the current level of funding for the MSBS program.
- Write to New Mexico's Congressional Leadership: Senator Jeff Bingaman (D), Senator Pete Domenici (R), Representative Tom Udall (D), Representative Heather Wilson (R), and Representative Steve Pearce (R).
- Write to the U.S. Department of Health & Human Services Secretary, Michael Leavitt, urging continued reimbursement for MSBS direct care and administrative outreach services.
- Understand that these program cuts would make it more difficult to provide health services to children and low-income families in New Mexico schools.

***Our community must understand the importance of this issue to all New Mexico schools!***

For more information about the MSBS program in New Mexico, contact:  
N.M. Human Services Department  
Medical Assistance Division, School Health Office  
(505) 827-6233 or [www.state.nm.us/hsd/mad/schoolhealth.html](http://www.state.nm.us/hsd/mad/schoolhealth.html)



# New Mexico Human Services Department

Medical Assistance Division  
PO Box 2348  
Santa Fe, NM 87504-2348  
Phone: (505) 827-3106

Bill Richardson, Governor  
Pamela S. Hyde, J.D., Secretary

February 11, 2008

Mr. Kerry N. Weems, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-2237-IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

RE: File Code: CMS-2237-IFC

Dear Mr. Weems:

The following comments are submitted by the State of New Mexico Human Services Department Medical Assistance Division on the Interim Final Rule for Medicaid Optional State Plan Case Management Services, published in the Federal Register on December 4, 2007. This response was prepared in collaboration with the following New Mexico state organizations: Aging and Long-Term Services Department, Department of Health, and Public Education Department.

Case management is critical for enabling individuals with Developmental Disabilities, as well as populations of the Disabled and Elderly, HIV/AIDS, Medically Fragile, High Risk Pregnancy, Brain Injured, and At Risk Children to live successfully in communities even though they may need a range of services. Not amending these rules could result in the undue harm and suffering of many New Mexico residents.

The preamble background to the actual rule includes language that exceeds the law and the recently enacted Deficit Reduction Act to unjustifiably restrict the use of this service. The statements should be reconsidered, presuming they represent the Centers for Medicare and Medicaid Services (CMS) policy on case management.

There are numerous items in the background section that were not included in the actual rule. Moving certain wording from the background section to the official regulation, as referenced in the comments below, could provide clarity.

#### Limitations on Case Management Services (§441.18 (a)(3))

While these interim rules make sense for targeted case management programs, numerous problems are created when CMS applies these same provisions to HCBS 1915(c) waivers due to

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direct conflict with HCBS 1915(c) waiver requirements. The most problematic of these provisions is the requirement that case management services be optional, even for participants in Waiver programs. Currently in New Mexico, all of the 1915(c) Waivers require participation in case management in order to participate in those Waivers.

CMS requires states to make the following assurances for HCBS Waivers:

- Facilitate eligibility determination including an assurance that the participant meets institutional level of care criteria.
- Develop an individualized service plan, including referral to non-Waiver services, and identification of risk factors.
- Active continuous monitoring of the implementation of the Waiver service plan to assure that services are furnished in accordance with the service plan and meet the participants' needs.
- Assure the health and welfare of participants, including oversight of risk factors identified in the individualized service plan, and reporting of any incidents of abuse, neglect and exploitation.
- Educate participants regarding rights, responsibilities, grievance procedures, incident management and right to confidentiality.

New Mexico meets these required assurances by delegating these functions to HCBS Waiver case managers, as approved by CMS. In the case of the self-directed Waiver these functions are delegated to the contractors for “consultant services” and “third party assessor”. This delegation is appropriate because case managers are local, qualified providers who can interact with recipients on a regular basis.

If a Waiver participant decided to decline case management services, New Mexico would have no way to comply with these assurances for the following reasons:

- The interim rules prohibit state agencies from claiming administrative match for activities listed in the definition of case management, so state employees could not step in to undertake these duties.
- Delegating these functions to providers of other Waiver services is inappropriate due to the inherent conflict of interest providers have with regard to level of care determination, service plan development and monitoring both service delivery and health and welfare.
- Eligibility determination is too complex for recipients to undertake independently, not to mention that participants also have a conflict of interest in this regard.

Another provision that New Mexico finds problematic in section F of these interim rules is the prohibition of using case managers in a gatekeeper or prior authorization fashion. Several of our Waivers, (approved by CMS) authorize case managers to approve service plans and budgets within certain parameters, so that state employees and the Utilization Review contractor are only reviewing and approving/denying service plans that require a higher level of clinical review. New Mexico finds delegation of this authority to be efficient given the budgeting methodology currently in place – which uses an annual resource allotment or “capped” structure. Removing this authority from case managers will require New Mexico to increase administrative costs in order to review all service plans and budgets rather than just those that fall outside established parameters.

Payment Methodology (§441.18(a)(8)(vi))

Because there are circumstances under which a monthly case management rate can be cost effective, New Mexico believes CMS is making a significant mistake in not allowing case management to be paid at a monthly rate in instances where it can be shown to be cost effective.

The New Mexico Medicaid Program has used monthly rates for case management in very few instances, primarily in Home and Community Based Services waiver programs where there are specific budgets and financial caps in place. The monthly case management rates are based on the average recipient need for case management.

The implementation of a monthly rate based on average utilization need has proven very effective in removing the incentive for a case management agency to provide the maximum amount of case management allowed to every recipient when each 15-minute unit is reimbursed separately. The New Mexico Medicaid Program can provide further historical and financial information to CMS supporting the cost effectiveness in these limited circumstances.

New Mexico urges CMS to continue to allow itself the option of approving a monthly case management reimbursement methodology when the case for economy and appropriate utilization control can be made by a state.

Transition Case Management (§441.18(a)(8)(vii)-(viii))

New Mexico is proposing to create a new, capitated managed long-term services program entitled *Coordinated Long-Term Services* (CLTS) that will provide primary, acute, and long-term services to consumers/participants in one seamless, coordinated, and integrated program. The cornerstone of this program will be service coordination or case management. Through this program, home and community-based services will be promoted as an alternative to institutional placement. In order for the program to be successful, New Mexico urges CMS to reinstate the time reduction from 60 days back to 180 days to cover transitional case management to ensure that the transfer of individuals from institutional long-term care to receiving care in the community is as smooth and as safe as possible for Medicaid members receiving long-term care services.

Decreasing the allowable time for individuals transitioning from institutional to community settings would promote re-institutionalization resulting from inadequate transition planning and implementation.

Reimbursement of Case Management for Certain Individuals (§441.18(c)(3))

While the regulations stress that Medicaid will not pay for case management services deemed “integral” to the administration of another program, including parole, probation, child welfare/child protective services, guardianship, or special education (except when case management is a service identified in the child’s IEP or IFSP), it is not clear what is meant by “integral” in the regulation. The concern seems to be distinguishing between necessary case management due to an individual’s health and case management that would be needed regardless of an individual’s serious health condition.

Duplicate Payments to Public Agencies (§441.18(a)(4)) requires states to ensure that case management services “will not duplicate payments made to public agencies or private entities under the State plan and other program authorities”.

Title V of the Social Security Act relates to services for children and pregnant women. OBRA '89 specifically funded state health departments “to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services; [and] ...to reduce infant mortality and incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatments services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children.” 42 U.S.S. §701(a)(1)(A)&(B)

New Mexico believes that case management has been an effective tool for health departments to successfully implement some of these tasks. The interim rule does not allow sufficient flexibility in the regulation for health department programs to operate in their most effective manner.

Single Case Manager (§441.18(a)(5)) requires that Medicaid case management services be furnished by only one case manager for each individual, regardless of individual cases.

The New Mexico Medicaid believes this is reasonable in general but fails to allow for some essential variation in limited circumstances.

New Mexico has covered separately in this document the fact that some case management may need to be performed by a state health department acting under Title V of the Social Security Act. While New Mexico accepts that ultimately a child will have a single case manager, there is still a role for a case manager from the health department to initially identify and coordinate the care with any other case manager.

The same is true in providing targeted case management for pregnant women or for children at risk as in the Family Infant Toddlers (FIT) program. New Mexico believes that some programs have a role in assuring a recipient is appropriately accessing services. The recipient may qualify for two, possibly three, different targeted case management programs. New Mexico believes it is necessary to essentially coordinate the turning over of all case management responsibilities to a single case manager. While on-going case management could perhaps be provided by a single case manager, New Mexico believes that up to two months of over-lapping case management should be allowed when the recipient qualifies for more than approved targeted case management services. This would allow for the appropriate coordination and turn-over and would be in the recipient's best medical interest.

The most significant problem created by this provision relates to self-directed waivers for which the recipient is able to select consultant services from a “participant-delegate goods and service” category called “resource facilitation”. Some of these consultant services may meet the definition of case management-like services. This rule would preclude such services as well as

potentially requiring participants to purchase such services from the consultant agency that does not currently offer the expertise for this type of support.

The role of the consultant is pivotal to a participant's successful experience with self-direction. The consultant assists the participant to understand the program, develop his/her Service and Support Plan (SSP) and budget, and implement his/her SSP and budget. The consultant also serves an important quality assurance role, monitoring the progress of the participant and helping the State to ensure the participant's health and safety. Resource Facilitation and Intensive Case Management are two services in the self-directed waiver that would be negatively impacted by the interim rule. The interim rule appears to preclude offering these services to participants, and would eliminate a participants' right to purchase case management like activities due to the single provider provision.

New Mexico urges CMS to clarify the definition of case-management-like services to exclude this type of service under self-directed waiver from being considered equivalent to case management.

Thank you for this opportunity to comment. Feel free to contact me or Paula McGee at (505)827-6234 with any questions related to this commentary. As always, thank you for your efforts.

Sincerely,  
/s/

Carolyn Ingram  
Medical Assistance Division Director

/pjm

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