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Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Schneider

Medicaid

February 12, 2008

Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

RE: Analysis of the impact of proposed CMS regulations

Dear Representative Waxman:

Enclosed are documents providing an analysis of the proposed CMS rules and the impact on Medicaid for the State of Indiana. I hope this information will assist you in your state-by-state impact analysis and will lead to more effective and efficient outcomes.

Sincerely,

Jeffrey M. Wells, MD
Director of Medicaid

Enclosures: 4





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Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

March 12, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2258-P (Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership)

Dear Ms. Norwalk:

On behalf of the State of Indiana, I am writing to express my concerns regarding the proposed rule CMS-2258-P (Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) published in the *Federal Register* on January 18, 2007. If implemented as proposed, the rules could reduce the availability of health care services to the uninsured and increase cost shifting to small business.

Indiana recognizes the importance of a strong state-federal partnership in the Medicaid program; however, we believe that the policies proposed in the rule represent fundamental policy changes that would limit the use of long-standing, legitimate state funding mechanisms. The proposed rule would impose a cost limit for public health care providers and alter the definition of a "unit of government." Both of these proposals would reduce funding options for states and are likely to substantially reduce services for Medicaid patients and the uninsured in Indiana.

Limiting public provider reimbursement to cost would reward inefficiencies and prevent states from bringing cost-effective market principles into their Medicaid programs. Cost limits would impede a state's ability to utilize prospective payment systems that create incentives for efficient, cost conscious care. Prospective payment systems, which are used in the Medicare program, pay



providers a predetermined fixed price that depends on patient resource needs but is independent of the amount of services actually provided. Since the payment is independent of service provision, providers are given an incentive to provide cost-effective care and are not rewarded for high costs. Inefficient provision of health care services drives up costs, both for the uninsured and for small business struggling to provide coverage to their employees.

The proposed rule also unfairly discriminates against one type of provider by applying the cost reimbursement limitation only to public providers. This proposal would allow states to pay private providers rates that the federal government deems excessive for public providers, even though the needs of public providers are often significantly greater. Public providers typically provide a disproportionate share of care to the uninsured and offer critical community-wide services such as trauma care and first response services. At the same time, public providers' payer mix is often markedly different from private providers, with higher uncompensated care costs and a greater reliance on Medicaid revenues to fund operations. Limiting Medicaid reimbursement to public providers has the potential to greatly reduce their primary source of funding.

We also believe that the proposed change in the definition of "unit of government" oversteps statutory authority by defining what subunits of state government may contribute to and what financing sources states may utilize in financing the non-federal share of Medicaid. This discretion has been left to state governments since Medicaid was created in 1965 and represents a fundamental right of states to determine which of its entities are governmental and which are not. The new definition undermines the efforts of states and local governments to deliver a core governmental function of ensuring access to health care in the most efficient and effective manner by preventing them from organizing themselves as they deem necessary.

An abrupt change in the definition of unit of government has the potential to disrupt the delivery of health care services by altering the existing financing structure for public agencies. A transition period to the new definition would enable the state to realign the flow of certain tax monies from public agencies to the state. As this process could take as long as three years, we believe it is important to give states time to properly implement the change.

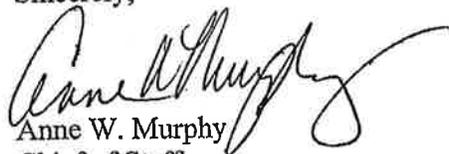
The requirements that intergovernmental transfers (IGTs) be derived only from tax revenues and that such funds be specifically appropriated ignores the much broader nature of public funding and budgeting. States, local governments and governmental providers derive their funding from a variety of sources, not just taxes, and such funds are no less public due to their source or specific category of appropriation. Limiting IGTs to tax revenues and dictating how states budget the non-federal share of their programs will deprive states of long-standing funding sources and leave them with significant budget gaps that are likely to lead to reductions in Medicaid services for vulnerable populations.

We find cause for further concern in the rule's prohibition on a state's use of taxes that support indigent care as a source of funding for the state share of Medicaid spending. As public providers often care for a disproportionate share of uninsured patients, many of whom share

characteristics of the Medicaid population, we believe that it is appropriate to use taxes that support indigent care toward the non-federal share of Medicaid. States should be left to their own discretion to determine which taxes may be used as the non-federal source for Medicaid match.

Last year, 300 members of the House and 55 Senators wrote to the Bush Administration to express their concern about the impact of this proposed regulation and to urge the President not to move ahead with it. Despite these objections, the proposed rule is slated to take effect on September 1, 2007. On behalf of the State of Indiana, I urge you to consider the devastating impact that this rule will have on the safety net in our state and work with Congress to strengthen, rather than deplete, the resources of the Medicaid program.

Sincerely,



Anne W. Murphy
Chief of Staff

Indiana Family and Social Services Administration



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Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
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June 21, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2279-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-2279-P (Medicaid Program; Graduate Medical Education)

Dear Ms. Norwalk:

On behalf of the State of Indiana, I am writing to express concerns regarding the proposed rule CMS-2279-P (Medicaid Program; Graduate Medical Education) published in the *Federal Register* on May 23, 2007. The Centers for Medicare and Medicaid Services proposes to eliminate federal financial participation for direct graduate medical education costs incurred by teaching hospitals. This change will result in a significant decrease in reimbursement for teaching hospitals overall, and raises serious public health concerns regarding the future of graduate medical education programs with the proposed elimination of Medicaid as a funding source.

The commentary of the proposed rule distinguishes two types of costs unique to teaching hospitals – direct graduate medical education and indirect medical education. Direct graduate medical education is defined in the rule as compensation for “the direct costs of their educational activities, as measured by the number of residents being trained and the historic cost of training residents.” In the context of the Medicare cost report, it is unclear whether the direct GME costs to be disallowed are direct costs of salaries and benefits for interns and residents from Worksheet B Part I or the Medicare allowed direct GME cost calculated on Worksheet E-3 Part IV. It is also not clear whether other hospital overhead costs allocated to the education program cost centers would constitute indirect medical education costs or would be included as direct medical education costs and therefore considered to be non-allowable costs.

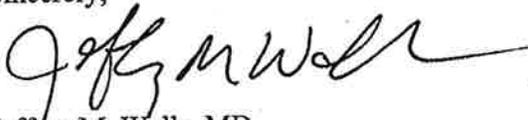
www.IN.gov/fssa
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The proposed addition at §447.201(c) does not make the distinction between direct and indirect GME and states "the plan must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system". However, within the CMS commentary it is stated that States "are able to recognize, as part of the inpatient hospital rate structure, the additional Medicaid covered service costs that teaching hospitals incur when delivering Medicaid covered services". Clarification is requested as to whether the proposed addition to §447.201(c) refers only to direct graduate medical education costs.

The exclusion of direct graduate medical education costs from direct reimbursement to teaching hospitals and from the estimate of Medicare payments used in the calculation of upper payment limits essentially forces either the State or the hospitals to absorb these higher costs. The reduction in overall reimbursement that teaching hospitals could experience as a result of this rule may have the unintended consequence of creating a disincentive for hospitals to continue to provide graduate medical education programs. This could lead to a future shortage of medical professionals, especially those providing services to low-income or indigent patients, and bring about the same situation which payments for graduate medical education were originally intended to remedy.

Sincerely,



Jeffrey M. Wells, MD
Director of Medicaid



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Office of Medicaid Policy and Planning
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October 12, 2007

Herb Kuhn
Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-2261-P, Comments to Proposed rule: Medicaid Program; Coverage for Rehabilitative Services

The State of Indiana appreciates the opportunity to provide comments to the proposed rule published in the Federal Register on August 13, 2007 at Vol. 72, No. 155, amending Medicaid regulations for the coverage of rehabilitative services.

Since 2005, Indiana has been working to transform the State's behavioral health system. The end goal of the transformation is to create a consumer centric system of planning, delivering, and evaluating effective care. To achieve this goal the State is focusing on aligning systems, services, funding and technology as well as measuring results to inform ongoing quality improvement efforts.

While overall, the objectives of the Medicaid Rehabilitation Option (MRO) proposed rule are aligned with the direction Indiana's behavioral health system is heading the State has two major concerns it would like to see addressed by the Centers for Medicare and Medicaid Services (CMS).

1. Timing for State Compliance

The proposed rule will require significant changes to Indiana's State Plan, Administrative Code, and the State's MRO Provider Manual. The process of amending the administrative code includes: conducting a fiscal analysis, providing an opportunity for public notice and comment, and receiving administrative approval from several offices within the agency, all of which may take up to a year to complete.

In addition, to properly implement the new requirements the State would need to provide extensive training to MRO providers. Training would ensure providers have processes in place



to document, in the written rehabilitation plan, the need for rehabilitative services and progress towards rehabilitative goals. As previously stated, this type of provider training is aligned with Indiana's stated goal of transforming the behavioral health system; however it will require significant time and resources to administer in a way that complies with the proposed rule.

The State asks CMS to consider delaying implementation to provide sufficient time to complete the tasks necessary to comply with the final rule. A 12 month delay would be recommended for these reasons. Any additional information that CMS can provide to the states in the interim regarding the timing and expectations for compliance would be critical to the State's ability to meet future deadlines.

2. "Intrinsic Element" Test

The proposed rule provides limited guidance regarding the "intrinsic element" test and what services will be categorized as "elements of other programs" such that they will not be paid under Medicaid. In light of the emphasis in behavioral health services on best practices and collaboration between entities serving people with mental illness or serious emotional disturbance the test creates a significant concern for Indiana.

In order to effectively administer the Medicaid program and continue to consistently provide much needed MRO services to its members, the State contends that this test should be eliminated from the final rule. States must be free to determine the needs of their members and structure their programs (within federal statutory requirements) to best meet these needs. A rehabilitative service covered under the state plan, which is provided to a Medicaid member by a qualified Medicaid provider, should be paid for by Medicaid if it fulfills all other the requirements of the regulation.

In the very least, further clarification as to how CMS expects this test to be applied is necessary. Specifically, the State requests guidance on the following scenario:

If a child has been placed in a residential setting by Child Protective Services, and this setting is not a psychiatric residential treatment facility, can a community mental health provider be reimbursed for MRO services provided either in a clinic setting or on-site at the facility, assuming that behavioral health services are not included in the per diem for the facility?

Other Clarifications

In addition to the above stated concerns, there are a number of clarifications that would assist the State in educating providers and drafting a State Plan Amendment.

440.130(d)(1)(iv) Under the direction of

This section of the proposed rule defines "under the direction of" as it pertains to providers of physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders. The final sentence of the definition states that "this language is not meant to

exclude appropriate supervision arrangements for other rehabilitative services.” The State requests clarification of the “not meant to exclude” language. If the intent is that the “under the direction of” definition does not apply to providers of any other rehabilitative services the State recommends that the language read “this language does not exclude appropriate supervision arrangements for other rehabilitative services.”

440.130(d)(1)(v) Rehabilitation plan

Indiana currently requires MRO providers maintain a treatment plan consisting of an individualized plan of care for each patient. The State asks that CMS include in the definition whether the rehabilitation plan is to be maintained as a stand-alone document or can be contained within a treatment plan.

440.130(d)(1)(vi) Restorative services

“Rehabilitation goals are often contingent on the individual’s maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan.”

The State needs clarification on this definition. It appears the intent of the rule is to prohibit the use of the rehabilitative option for services which provide for maintenance of functioning rather than recovery. However, the State contends that there may be situations where maintenance of function is not only a critical component of a patient’s recovery, but also is necessary to keep the individual from deteriorating and requiring more rehabilitative services. An example of such a service would be medication management; without this service it is possible that a patient may not remain compliant with their medication and suffer a relapse thereby requiring additional rehabilitative services resulting in an unnecessary cost to the Medicaid program. Please clarify CMS’s position with regard to these types of services.

Is the intent of CMS to ensure that these “maintenance” goals are reviewed at least annually? Is the expectation that services be tapered off over time? These issues need to be clarified in order for the State to effectively amend its SPA and administrative code as well as train providers.

440.130(d)(3) Written rehabilitation plan

Indiana currently requires MRO providers maintain a treatment plan consisting of an individualized plan of care for each patient. The State asks that CMS clarify in the rule whether the rehabilitation plan should be maintained as a stand-alone document or can be included as part of the treatment plan documentation.

441.45(a)(4)(iv) “[R]equire that providers maintain case records that include the following: ... the nature, content, and units of the rehabilitative services.”

The State requests clarification as to CMS's definition of "units" of rehabilitative services. Is it the intention of CMS to require providers to document units of time or units of service in the rehabilitation plan? It is necessary that the State receives this clarification in order to properly amend the State Plan and administrative code as well as ensure providers are accurately trained.

441.45(a)(5) State plan requirements

The State asks that CMS provide clarification regarding expectations for individual state plans. Is each state required to submit a SPA reflecting the changes proposed by the rule or does this requirement only apply to new SPAs? Will CMS be providing a new preprint for the MRO section of the State plan? If so, will when will the preprint be available to the states? These questions address the concern that Indiana has regarding the time the State will need to modify the administrative rules, train providers, and update systems to reflect the proposed rule.

441.45(b)(3) Recreational or social activities

Many of the services in this list (particularly prevocational services and certain recreational or social activities) may be an important step in promoting an individual's recovery and independence. The Preamble to the proposed rule indicates that some of these activities under certain circumstances may be provided under the rehabilitation option. The State requests that CMS clarify the language of the rule to provide more detail about those recreational or social services which may be provided under the rehabilitation option.

In addition, it is crucial that the State and its providers receive clarification of this section of the rule so that they can effectively train providers to maintain case records which document when such recreational or social activities are necessary to an individual achieving his/her rehabilitative goal.

Thank you for the opportunity to provide comments to the Medicaid Rehabilitation Option proposed rule. The Indiana Office of Medicaid Policy and Planning looks forward to continuing to work with you and your staff on this and all other issues related to the Medicaid Rehabilitation Option.

Sincerely,



Dr. Jeffrey M. Wells
Director, Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration



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Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration

402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob Jr., Secretary

February 4, 2008

Kerry N. Weems
Acting Administrator
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, Comments on Interim Final Rule: Medicaid Program; Optional State Plan Case Management Services

The State of Indiana appreciates the opportunity to provide comments on the interim final rule (IFR) published in the Federal Register on December 4, 2007 at Vol. 72, No. 232, amending Medicaid regulations for the coverage of case management services.

The Indiana Family and Social Services Administration (FSSA) is made up of multiple Divisions whose charge it is to oversee the many programs that assist Indiana's Medicaid population in gaining access to needed medical, social, and educational services. Members who receive case management services through these programs are some of the most vulnerable individuals in the State.

The FSSA recognizes the Centers for Medicare and Medicaid Services' efforts to improve case management services; however the IFR includes sweeping changes which would fundamentally restructure the current policy around case management services. States in the past have been granted significant flexibility to structure their case management programs to best address the needs of their target populations. The limitations imposed by the IFR would inhibit the State's ability to make good public policy and put those Medicaid members who rely on the assistance of case managers at risk.

The State finds the IFR lacks the specification necessary for making the complex and comprehensive changes necessary to comply. In order for the State to fully understand the requirements of the IFR, CMS must provide greater detail and clarity for a number of the provisions. In addition, the IFR fails to provide sufficient time for the State to come into compliance with the regulation. The State will require substantial time to adapt its State Plan, Administrative Rules, and System Infrastructure to meet these restrictions. Most importantly it is imperative that the State be given sufficient time to ensure that the infrastructure changes



instituted meet the needs of the population being served and maintain sufficient support and oversight to preserve the health and safety of every member. An effective date of March 3, 2008 is not appropriate for such a comprehensive system restructuring; similar efforts by the State to transform systems of care have taken 1-2 years to plan and between 2-3 years to implement.

The State has compiled the following comments to address its requests for clarification, but first directs its remarks to those issues that will most significantly impact the policy under which the State's case management programs currently operate.

STATE'S PROJECTED FISCAL IMPACT

Indiana expects substantial negative fiscal impact associated with implementing the provisions of the TCM IFR. Given the timeline for evaluating the IFR and the lack of specificity in key areas, the State is unable to fully calculate those costs at this time. Preliminary discussions have led the State to conclude that Indiana would, at a minimum, be required to:

- Rescind or amend existing contracts for case management services with its vendors Indiana Professional Management Group (IPMG) and the Area Agencies on Aging (AAA).
- Hire a significant number of new staff and case managers to assume responsibility for a number of administrative activities which are currently under contract.
- Complete IT Systems and infrastructure changes associated with the provision of case management services that would have operational costs which the State is unable to measure at this time.

The State is aware that CMS expects the consolidation of case management services under a single provider to result in a cost savings to both the State and Federal Medicaid programs. However, the lack of clarity and specificity provided by CMS inhibit the State's ability to understand the true implications of this rule and make it difficult to assess the fiscal impact the IFR will have on the Indiana Medicaid program.

PROGRAMMATIC COMMENTS

440.169(c) Institution to community transition period

The provision limiting case management to only 14 or 60 consecutive days before discharge, depending on length of stay, to a HCBS waiver would be devastating to Indiana's ability to transition individuals out of a nursing facility and into community based services. In the past year, Indiana transitioned 206 individuals out of a nursing facility into a community setting, 75% of those 206 transitions took longer than the proposed allowable timeline. The time limits would also severely limit our ability to fully realize the goals set out in our CMS Money Follows the Person (MFP) Demonstration Program. We respect the ideal of timely transitions; however, our past experience shows that additional transition time is necessary to make all proper arrangements to assure the health and welfare of each individual. The proposed limitation does not recognize the complexity of finding vulnerable individuals appropriate and safe housing, transportation, medical and support services. Even simple transitions activities, such as building an entry ramp or modifying a bathroom in a person's existing residence can not be accomplished

within this timeframe.

The limited transition period will also have an adverse fiscal impact on individual members. A recent meeting with the Social Security Administration revealed that issues related to rerouting benefits and changing authorized payees can arise when individuals transition. Not having access to Social Security benefits at the time of their transition can be of serious consequence.

The State has made significant efforts to comply with the Supreme Court decision that arose from *Olmstead v. L.C. and E.W.* Since January 1, 1999, the state has transitioned 2,013 individuals with developmental disabilities to community-based services. Decreasing the reimbursement available for transitions creates a disincentive for case management providers to transition individuals with complicated needs back into the community.

The IFR also states that a case manager may only be reimbursed for a transition after a member has been enrolled in community services. This presents problems in the Aging community when case management services were legitimately provided, but the individual ultimately did not transition due to a change in health status or death. In the past year, 515 individuals were provided TCM for transition out of a nursing facility, only 60% (206) of those were successfully transitioned. Allowing no reimbursement for any TCM provided to those individuals would strongly discourage providers from working to transition complex individuals.

441.18(a)(3) *Right to refuse case management services*

Indiana appreciates and endorses self direction and personal autonomy of waiver participants. We believe that IFR's requirement to allow refusal of case management services is well intentioned, but misguided. The current 1915(c) waiver process fully supports self direction for waiver participants, and provides for whatever level of case management the participant requests. The health care system provides significant barriers and challenges for healthy and savvy health care consumers. Persons with significant physical or intellectual challenges, who may not have the advantage of family or other informal supports, would face greater problems, as well as susceptibility to exploitation. Case management does not have to equate to unneeded interference. Properly provided, it affords the levels of support appropriate to the individual participant, while preserving self direction to the level comfortable for the participant. The IFR exceeds what is necessary to support self direction while preserving quality of services.

Case management services are an inherent component of the infrastructure by which the State provides, reviews, and monitors services. Case managers in Indiana and other states, are by design accountable as the first line of quality, health and welfare monitors. This limitation would significantly impact the state's ability to provide services and would jeopardize the health and safety of the individual.

In all areas of long term care, including self-directed care, the state has worked to achieve a process that encompasses the entire spectrum of needs. The Federal Aging and Disability Resource Center model and the expansion of Options counseling services work to ensure that all aspects of a person's needs are addressed, including those that the individual may not be able to immediately identify. Case managers and Options counselors are trained to discuss with a client

all areas of life so as to discover all possible needs and they are trained to be able to identify all possible services available to their customers.

441.18(a)(5) *Single case manager*

The single case manager limitation is one of the State's most significant concerns. While the agency recognizes the value of providing more holistic services, the end result of this limitation is not in the best interest of all Medicaid members.

A member may currently be receiving case management services from multiple case managers (e.g., developmental disabilities case management services and case management for the chronically mentally ill). While some of the case management services provided may appear to be duplicative, it is important to recognize that each case manager is skilled in accessing services and linking members to providers which are specific to these very different needs. This new provision presumes a predominance of one need over the other and that is not always the case. The value these case managers hold is their in-depth knowledge and understanding of the system in which the member must access services. These systems are often disparate such that one case manager may not have all the experience and knowledge to offer the necessary support to a member.

While it is the intention of the State that systems of care become more integrated, it is imperative that the State be given the opportunity to address the conflicts and understand the concerns that have arise as a result of the IFR. The State has taken steps towards transforming the systems of care associated with other Medicaid programs which serve the populations receiving case management.

- The Division of Mental Health and Addictions and Office of Medicaid Policy and Planning are working together to transform the behavioral health system to ensure the "right services are provided to the right person at the right time".
- The Division of Disability and Rehabilitative Services has been working towards a similar goal with the OASIS program; through the use of objective assessments the developmentally disabled population will be provided the funding to self-direct their care.

Both Divisions have been planning and researching these policy issues to properly transformation the way care is provided for approximately 2 years and have scheduled the implementation of these projects to occur incrementally over a span of 2-3 years. The State believes that a well-conceived and staged process is imperative when making such significant changes. It is the contention of the State that while the continued evaluation and modification of systems is necessary to ensure that case management is provided in an efficient and effective manner, such a wide-scale restructuring as called for by the IFR requires a great deal of thoughtful planning and careful implementation because the risk of doing it wrong puts the health and safety of a human being on the line.

In addition, the FSSA anticipates that this provision will create administrative problems for both the State and individual providers of case management services. The State has already entered into discussions to determine how to effectively serve members who are eligible for case management services under multiple programs; however, additional guidance and clarification is

needed from CMS in order for the State to put policy and process in place to implement the provision. Specific clarification is needed with regard to the following: Under the direction of CMS, Indiana has structured its MFP Demonstration transition teams to consist of a nurse and transition specialist. The transition team will work together to identify and secure all support networks, resources, medical care, housing, transportation, etc. within the community to which the participant seeks to transition. The existence of a team is important to the success of the participant's transition, and will provide a more robust, person-centered qualitative care plan.

The State has partnered with CMS to implement this \$21 million program. The requirements of the IFR are in direct conflict with the previous requirements and recommendations provided by CMS to Indiana and other states participating in the demonstration. As a result of the IFR limitations, the MFP program will not be successful in transitioning as many people out of institutions as was planned. This not only compromises the intentions of the MFP program, but also contradicts the national long term care policy of ensuring people are being served in the least restrictive setting available.

441.18(a)(1) Freedom of provider

The State believes that the IFR as written does not contain sufficient clarity to determine fully CMS's expectations regarding these provisions. How CMS interprets the definition of provider is critical to the State's ability to properly implement the IFR.

For the Aging and Disabled (A&D) and Traumatic Brain Injury (TBI) waivers, approved waiver providers are included on a pick-list; a waiver member may choose their case manager from this list. Each AAA creates a pick list to include providers who offer services to individuals in the respective geographical. The same pick list is provided to those on the Developmentally Disabled waivers.

The State's waiver programs provide members with access to and choice of providers of case management in different ways. Those on the A&D and TBI waivers select a case manager via a pick list individualized to the AAA's area, just as with the selection of other waiver service providers. Indiana's Developmental Disabilities (DD) waiver members are given the choice of a case manager; however, all of the case managers work under a single contract the State has with IPMG. The State notes significant benefits of this latter system, which constitute the original rationale for development of the contract for case management services. Increased consistency and ability to oversee quality service provision results in an assurance to CMS of better quality and safer HCBS for the individuals served through the DD waivers. Without the authority to contract for these services, all eligible Medicaid providers would be permitted to serve as a case management provider. This would create a system of fragmentation while decreasing the monitoring of needs, oversight of programming, and quality supports for all recipients.

441.18(a)(8)(vi) Reimbursement in units of time, bundling services not permitted

DD waiver case management services are reimbursed at a per month rate. This was done in order to control costs as well as ensure quality. The IFR states that "a bundle payment methodology exists when a state pays a single rate for more than one service furnished to an

eligible individual during a fixed period of time." Case management is a single defined service with specific activities in 440.169; therefore it should not be considered a bundled service.

Requiring a change to billable units will result in a system where the provider of case management is spending more time documenting the service rendered than actually spending time or supporting the individual in need. This returns the State back to system of managing "paper" and not people. Returning to a system of 15 minute billable units leads to uncontrollable costs. As the individual's needs change, to ensure access to all services the billable units will also need to change to reflect the consumer's needs. Most often these changes result in an increase in billable units. Such a system makes cost containment next to impossible. This provision does not promote flexibility within the system.

Going beyond financial implications, the matter of meeting consumer needs merits consideration. Unlike positions where attendance is a primary requisite for conducting important aspects of the job (e.g. cashier, manufacturing machine tending, etc.) case management performance centers on team coordination and service delivery to obtain an objective. Case management by contrast is a "mission critical" profession. Positions of this nature require the appropriate skills, delivered and the required time, to the degree necessary to accomplish defined and changing objectives. Assignments of this nature are traditionally salary-exempt by definition.

Assuming monthly caps apply for each consumer; we are yet unclear as to how to resolve situations where the needs of the consumer require service beyond the allocation for a given month. While there is little question that the expectation will be to ignore the monthly cap and accomplish the objective regardless of hours billed, NLRB regulations require hourly non-exempt compensation at 1.5 times the standard rate for service beyond a standard 40-hour work week. Further, the situation is likely to arise during times when consumers are most vulnerable, specifically during transitional periods and times of crisis.

441.18(a)(2) Case management not to restrict other services

Over the past two years, Indiana moved from a fragmented, non-responsive inconsistent case management system of over 1000 case management providers serving less than 6000 Medicaid waiver participants, to a statewide contract that manages 10,000 waiver participants with consistent orientation and training, practice standards, and immediate and appropriate response to identified issues. Indiana understands and endorses personal choice of waiver participants and assures that each waiver participant has ability to interview and choose a case manager from the roster of all case managers with openings on their member panels. We believe that the flexibility to manage the system in this manner is critical to our ability to support current waiver participants in the community and to continue to expand services to other eligible individuals. The provisions of the IFR constitute a barrier to the continuation of this system, and abased on prior experience, we believe will have a negative impact on the quality and quantity of services provided.

441.18(a)(6) Case manager not gatekeeper

Since the implementation of the waiver program, most states have designed their programs to include a gate-keeping function as part of case management. The inability to continue this design requires a complete overhaul of existing waivers, including the significant burden on both federal and state staff to deal with the administrative process required to alter waiver programs. Case managers, properly monitored by state staff, have proven to be excellent and fair single points of entry for services.

441.18(a)(8)(viii)(E) Community case managers

The IFR is not specific enough for the State to fully understand how CMS defines “community” case managers. State experience has shown that clearly developed higher standards for case management result in more appropriate, participant-driven, quality service provision. The highly competent case manager is able to allow and assist the individual to develop a plan of care to meet his/her needs, and the waiver program is available in a more consistent manner throughout the program. The loss of the ability to require standards of case management service provision would result in fragmented, inadequate care, putting those being served by the waiver programs at significant risk. Also, allowing the provider community or any interested party, to act as a case manager may lead to a conflict of interest, and a subtle but real limitation in client choice, especially if the same entity could render case management and serve as the provider of HCBS.

441.18(c)(5) Case management services may not be claimed as administrative

The proposed dichotomy of case management services and administrative activities is problematic for the State. Indiana has embraced the Federal ADRC Initiative which strives to streamline access to long term care services. The State has worked to meet this Federal goal by transitioning all 16 AAAs to the ADRC model. This has included increasing the role and responsibilities of the case managers to make access to long term care as simple and cohesive as possible. Many of the activities that the Federal ADRC initiative encourages case managers to engage in are now excluded from the definition of case management by these new provisions. By removing the administrative functions from the definition of case management, the State will be required to unbundle services and dismantle much of the ADRC process. As a result, the long term care system will be further fragmented which will lead to decreased efficiencies and ultimately reduced access for our most vulnerable Medicaid members.

The IFR is unclear as to whether a case manager could function in two roles with some activities claimed as a case management service and others as an administrative activity cost which would require allocating costs between types of coverage. Unbundling tasks and assigning them to different organizations would create a fragmented system. Efficient operation of a case management system is required to allow beneficiaries to access services in the most streamlined manner possible. The purpose of case management services is to enhance access to services not hinder access.

CONCLUSION

While Indiana recognizes CMS' intention to create a more holistic system for providing case management services, the State's ability to oversee the health and welfare of the vulnerable members receiving case management services is imperative to the wellbeing of Medicaid members and the overall stability of Indiana's Medicaid program. As written, the regulations restructure the current policy for providing case management services; this will inhibit the State's capacity to effectively serve the needs of the population. Without proper clarification and technical support the State can not timely comply with the requirements of the IFR. The State appreciates the opportunity to provide comments to the Medicaid case management services interim final rule and respectfully requests that CMS delay the interim final rule pending clarification and modification in accordance with the comments set forth here.

Sincerely,

E. Mitchell Roob Jr., Secretary
Indiana Family and Social Services Administration