



MAY 16 2006

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003 (A-01-04-00006)

Attached is an advance copy of our final report on targeted case management services rendered by the Massachusetts Department of Social Services (Social Services) during Federal fiscal years 2002 and 2003. We will issue this report to Massachusetts within 5 business days. We conducted this audit at the request of the Centers for Medicare & Medicaid Services (CMS).

Section 1905(a)(19) of the Social Security Act (the Act) authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) of the Act defines case management services as "services that will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services." A 2001 CMS letter to State Medicaid directors refers to case management services as targeted case management when the services are furnished to specific populations in a State. The letter provides that allowable targeted case management services for Medicaid-eligible beneficiaries include assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services. The letter specifies that allowable Medicaid case management services do not include direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

In Massachusetts, Social Services provides foster care, adoption, and other child protection services. These services include targeted case management services for Medicaid-eligible children who have been referred to Social Services as potentially abused or neglected or who are receiving services from Social Services after having been determined to be abused or neglected or at risk of being abused or neglected. The Federal programs enacted to assist States in paying the costs of direct foster care, adoption, and other child protection services include Titles IV-B, IV-E, and XX of the Act.

Our objective was to determine whether the Massachusetts Office of Medicaid (the State agency) claimed allowable Medicaid targeted case management services rendered by Social Services during Federal fiscal years 2002 and 2003.

The State agency claimed unallowable Medicaid targeted case management services rendered by Social Services. Contrary to Federal requirements, the Social Services monthly rates for targeted case management charged to Medicaid included social workers' salaries for providing direct social services, such as child protection and welfare services. Eliminating these unallowable costs from the calculation of the monthly rates, we determined that the State agency overstated its claims for targeted case management services by \$171,147,058 (\$86,645,347 Federal share). We attribute the overstatement to the State agency's lack of procedures for ensuring compliance with Medicaid requirements.

We were unable to express an opinion on the remaining \$26,571,177 (\$13,460,989 Federal share) claimed by the State agency. Although this amount related to services that may appear to be allowable as targeted case management, we found a significant risk that these services may have already been reimbursed under other Federal programs.

We recommend that the State agency:

- refund to the Federal Government \$86,645,347 in unallowable costs;
- work with CMS to determine the allowability of the \$26,571,177 (\$13,460,989 Federal share) on which we were unable to express an opinion;
- refund to the Federal Government any targeted case management costs that represent direct medical, educational, or social services claimed and reimbursed subsequent to our audit period; and
- establish procedures to ensure that targeted case management rates used to claim Medicaid reimbursement do not include payment for direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

In its comments on our draft report, the State agency disagreed with our findings and recommendations and presented several rationales to support its position that all of the services that it claimed as targeted case management were allowable. We maintain that our findings and recommendations are correct and need no modification.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689. Please refer to report number A-01-04-00006.

Attachment



MAY 19 2006

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Report Number: A-01-04-00006

Ms. Beth Waldman
Medicaid Director
Office of Medicaid
Executive Office of Health and Human Services
Commonwealth of Massachusetts
1 Ashburton Place, 11th Floor
Boston, Massachusetts 02108

Dear Ms. Waldman:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please contact me at (617) 565-2689 or through e-mail at Michael.Armstrong@oig.hhs.gov or Joseph Kwiatanowski of my staff at (617) 565-2701 or through e-mail at Joseph.Kwiatanowski@oig.hhs.gov. Please refer to report number A-01-04-00006 in all correspondence.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures

Page 2 – Ms. Beth Waldman

Direct Reply to HHS Action Official:

Charlotte S.Yeh, M.D.
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF TARGETED CASE
MANAGEMENT SERVICES
RENDERED BY THE
MASSACHUSETTS DEPARTMENT
OF SOCIAL SERVICES DURING
FEDERAL FISCAL YEARS 2002
AND 2003**



Daniel R. Levinson
Inspector General

May 2006
A-01-04-00006

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Section 1905(a)(19) of the Social Security Act (the Act) authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) of the Act defines case management services as “services that will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services.” A 2001 Centers for Medicare & Medicaid Services (CMS) letter to State Medicaid directors refers to case management services as targeted case management (TCM) when the services are furnished to specific populations in a State. The letter provides that allowable TCM services for Medicaid-eligible beneficiaries include assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services. The letter specifies that allowable Medicaid case management services do not include direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

In Massachusetts, the Department of Social Services (Social Services) provides foster care, adoption, and other child protection services. These services include TCM services for Medicaid-eligible children who have been referred to Social Services as potentially abused or neglected or who are receiving services from Social Services after having been determined to be abused or neglected or at risk of being abused or neglected. The Federal programs enacted to assist States in paying the costs of direct foster care, adoption, and other child protection services include Titles IV-B, IV-E, and XX of the Act.

For Federal fiscal years (FYs) 2002 and 2003, Social Services claimed Medicaid TCM reimbursement amounting to \$197,718,235 (\$100,106,336 Federal share) through the Massachusetts Office of Medicaid (the State agency).

OBJECTIVE

Our objective was to determine whether the State agency claimed allowable Medicaid TCM services rendered by Social Services during Federal FYs 2002 and 2003.

SUMMARY OF FINDINGS

The State agency claimed unallowable Medicaid TCM services rendered by Social Services. Contrary to Federal requirements, the Social Services TCM monthly rates charged to Medicaid included social workers’ salary costs related to direct social services, such as child protection and welfare services. Eliminating these unallowable costs from the calculation of the monthly rates, we determined that the costs of TCM services claimed through the State agency were overstated by \$171,147,058 (\$86,645,347 Federal share). We attribute the overstatement to the State agency’s lack of procedures for ensuring compliance with Medicaid requirements.

We were unable to express an opinion on the remaining \$26,571,177 (\$13,460,989 Federal share) claimed by the State agency. This amount related to the assessment of beneficiaries' service needs, development of a specific care plan, referral to needed services, and monitoring and followup. Although these services may appear to constitute allowable TCM services under existing policy, our audit work identified a significant risk that the services may have already been reimbursed under other Federal programs. Specifically, the services were inherent in, and inseparable from, the direct services that Social Services provides pursuant to Federal and State laws and regulations. In recent years, CMS has denied State plan amendments submitted by Maryland, Montana, and Rhode Island for similar reasons.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$86,645,347 in unallowable costs;
- work with CMS to determine the allowability of the \$26,571,177 (\$13,460,989 Federal share) on which we were unable to express an opinion;
- refund to the Federal Government any TCM costs that represent direct medical, educational, or social services claimed and reimbursed subsequent to our audit period; and
- establish procedures to ensure that TCM rates used to claim Medicaid reimbursement do not include payment for direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

STATE AGENCY'S COMMENTS

In its comments on our draft report, the State agency disagreed with our findings and recommendations. The State agency presented several rationales to support its position that all of the services that it claimed as TCM were allowable. The State agency's comments are included as Appendix D.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We maintain that our findings and recommendations are correct and need no modification.

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INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income and disabled individuals. The Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program for the Federal Government. Each State Medicaid program is administered by the State in accordance with a CMS-approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Targeted Case Management Services

Section 1905(a)(19) of the Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g) of the Act defines Medicaid case management as “services that will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services.” CMS’s State Medicaid directors letter 01-013, issued January 19, 2001, refers to case management services as targeted case management (TCM) when the services are furnished to specific populations in a State. Activities commonly understood to be allowable TCM for Medicaid-eligible beneficiaries include assessment to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of allowable services.

The Massachusetts Office of Medicaid

The Massachusetts Office of Medicaid (the State agency) administers the Medicaid program through its subsidiary office, MassHealth Operations. The responsibilities of the State agency include processing claims and monitoring provider operations. On a quarterly basis, the State agency submits Form CMS-64 to summarize, by category of service, Medicaid expenditures for Federal reimbursement.

The Massachusetts Department of Social Services

The Massachusetts Department of Social Services (Social Services) provides services focused on child abuse and neglect, foster care, adoption, and domestic violence. Massachusetts law requires Social Services to provide and administer a comprehensive social service program, including services such as casework or counseling, protective services, legal services, and referral and informational services. The Federal programs enacted to assist States in paying for direct foster care, adoption, and other child protection services include Titles IV-B, IV-E, and XX of the Act.

Social Services activities include TCM services for Medicaid-eligible children who have been referred to Social Services as potentially abused or neglected or who are receiving services from Social Services after having been determined to be abused or neglected or at risk of being abused or neglected. Most referrals to Social Services come from professionals in law enforcement,

education, and health care. Social Services uses monthly rates to claim Medicaid reimbursement for TCM services through the State agency.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed allowable Medicaid TCM services rendered by Social Services during Federal fiscal years (FYs) 2002 and 2003.

Scope

We reviewed TCM services rendered by Social Services from October 1, 2001, through September 30, 2003. Social Services claimed TCM services totaling \$197,718,235 (\$100,106,336 Federal share) for 654,930 beneficiary months during this period.¹

We limited consideration of the Social Services internal control structure to those controls concerning claims processing because the objective of our review did not require an understanding or assessment of the complete internal control structure. Further, we concluded that our review of the State agency's internal control structure could be conducted more efficiently by substantive testing.

We performed our fieldwork from January through June 2004 at the Social Services and State agency offices in Boston, Massachusetts.

Methodology

To accomplish our audit objective, we:

- reviewed Federal laws, regulations, and other requirements regarding Medicaid reimbursement for TCM services;
- interviewed State officials;
- reviewed the Social Services contract with the Public Consulting Group, Inc., for the administrative handling of TCM claims;
- compiled a file of Social Services TCM services rendered from October 1, 2001, through September 30, 2003, from the CMS Medicaid Statistical Information System;
- reconciled the file of Social Services TCM services to the Forms CMS-64 that the State agency submitted for the audit period; and
- reviewed Social Services's calculations of monthly rates charged for TCM.

¹A beneficiary month represents all TCM services provided to a beneficiary during a given month.

To verify the results of our review of the TCM rate development, we also reviewed the documentation for a statistical sample of 100 beneficiary months containing a total of 575 TCM services that the State agency billed to Medicaid.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency claimed unallowable TCM services rendered by Social Services during Federal FYs 2002 and 2003. Contrary to Federal requirements, the Social Services TCM monthly rates included social workers' salary costs related to direct social services, such as child protection and welfare services. Eliminating these costs from the calculation of the monthly rates, we determined that \$171,147,058 (\$86,645,347 Federal share) of the total \$197,718,235 (\$100,106,336 Federal share) claimed was unallowable. We attribute these unallowable costs to the State agency's lack of procedures for ensuring compliance with Medicaid requirements.

We were unable to express an opinion on the remaining \$26,571,177 (\$13,460,989 Federal share) claimed by the State agency. This amount related to the assessment of beneficiaries' service needs, development of a specific care plan, referral for needed services, and monitoring and followup. Although these services may appear to constitute allowable TCM services under existing policy, our audit work identified a significant risk that the services may have already been reimbursed under other Federal programs. Specifically, the services were inherent in, and inseparable from, the direct services that Social Services provides pursuant to Federal and State laws and regulations. In recent years, CMS has denied State plan amendments submitted by Maryland, Montana, and Rhode Island for similar reasons.

PROGRAM REQUIREMENTS

TCM program requirements are contained in Federal law, a CMS program manual, a CMS policy letter to State Medicaid directors, State law, and the State plan.

Federal Law

Section 1905(a)(19) of the Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. Section 1915(g)(2) defines Medicaid case management as services that assist beneficiaries in gaining access to needed medical, social, educational, and other services.

Program Manual

The CMS "State Medicaid Program Manual," section 4302.2(G)(1), states:

Although FFP [Federal financial participation] may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received,

FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred.

Letter to State Medicaid Directors

CMS's State Medicaid directors letter 01-013, issued January 19, 2001, refers to case management services as TCM when the services are furnished to specific populations in a State. The letter provides that activities commonly understood to be allowable TCM services for Medicaid-eligible beneficiaries include assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services. The letter further states:

Medicaid case management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred. For example, if a child has been referred to a state foster care program, any activities performed by the foster care worker that relate directly to the provision of foster care services cannot be covered as case management. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as case management. In the case of foster care programs, we view the following activities as part of the direct delivery of foster care services and therefore may not be billed to Medicaid as a case management activity.

The letter then provides examples of direct services that may not be claimed as Medicaid case management, including gathering research and completing documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, conducting home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

State Law

Massachusetts General Law, part I, Title II, Chapter 18B, section 2, requires Social Services to provide and administer a comprehensive social service program including, but not limited to:

- casework or counseling, including social services to families, foster families, and individuals;
- protective services for children, unmarried mothers, the aging, and other adults; and
- legal services for families, children, and other individuals as they relate to social problems.

State Plan

State plan amendment 94-017, dated July 1, 1994, which covers TCM services provided by Social Services, states that case management will include collection of assessment data, development of an individualized plan of care, coordination of needed services and providers, home visits and collateral contracts as needed, maintenance of case records, and monitoring and evaluation of client progress and service effectiveness.

UNALLOWABLE AND POTENTIALLY UNALLOWABLE TARGETED CASE MANAGEMENT COSTS

The monthly rates that Social Services charged for TCM services included cost components for services that were unallowable or potentially unallowable for Medicaid reimbursement.

Cost Data Used in Rate Development

Each year, Social Services calculated a monthly charge for TCM services based on 100 percent of the salaries of the social workers it employed. On the basis of a random moment timestudy, Social Services allocated those salary costs to various cost centers representing the categories of services that social workers provided. Social Services used the dollar value of the cost centers to calculate the monthly charge to Medicaid for TCM and then split the charge into two rates, one for services provided when abuse was substantiated and another for services provided in determining that an allegation of abuse was unsubstantiated and closing the case.²

The cost centers included in the TCM monthly rates are listed below and described in Appendix A:

- referral to services,
- protective intake,
- preparation for and participation in legal proceedings,
- referrals to the district attorney,
- case management,³
- development of service plans,
- case reviews,
- child placement activities,
- investigative efforts,
- services for children with special needs, and
- all other permanency planning efforts.

²Social Services referred to these rates as the TCM general rate and the unopened protective intake rate, respectively.

³This cost center should be distinguished from Medicaid “TCM” as used in this report. “Case management,” as used by Social Services, largely includes services that represent the day-to-day provision of services by social workers, such as “initial case assignment, subsequent case assignment, and on-going casework activities.” These direct services should be distinguished from TCM services, which focus on assessment, referral, and monitoring and include “assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services.”

Many of these services were direct services, rather than services to assist the beneficiary in gaining further access to medical, educational, or social services, which is the purpose of TCM. In addition, all of the cost centers included services that were required to be provided pursuant to Massachusetts State law. Furthermore, many of these services were authorized under other Federal programs to assist children and families, including Titles IV-B (Child and Family Services), IV-E (Federal Payments for Foster Care and Adoption Assistance), and XX (Block Grants to States for Social Services) of the Act. Although Social Services allocated the costs of services to Title IV-E before allocating any costs to Medicaid, it did not allocate any services to Title IV-B or Title XX, both of which provide Federal funding to State child protection programs. Accordingly, our computation of unallowable costs excluded the costs allocated to Title IV-E.

Unallowable Costs Claimed

The costs of direct services included in the TCM rates totaled \$409,361,460 (\$130,890,742 for State FY 2002, \$135,040,643 for State FY 2003, and \$143,430,075 for the first quarter of State FY 2004), as shown in Appendix B. After removing these costs, we used the State agency's methodology to recalculate the monthly TCM rates. (See Appendix C.) Applying the recalculated rates to the respective beneficiary months claimed, we recomputed the claimable amounts. As shown in the following table, we determined that Social Services overstated TCM costs by \$171,147,058 (\$86,645,347 Federal share). These overstated costs represented 86 percent of the total \$197,718,235 (\$100,106,336 Federal share) claimed for Federal FYs 2002 and 2003.

TCM Rates by Year and Category

	State FY 2002		State FY 2003		First Quarter of State FY 2004 ⁴	
	Substantiated Abuse	Unsubstantiated Abuse	Substantiated Abuse	Unsubstantiated Abuse	Substantiated Abuse	Unsubstantiated Abuse
Claimed rate	\$286	\$83	\$326	\$112	\$263	\$98
Less auditors' recalculated rate	\$49	\$11	\$31	\$10	\$54	\$12
Difference questioned	\$237	\$72	\$295	\$102	\$209	\$86
Months claimed	267,902	2,577	316,626	1,195	66,398	232
Amount overstated ⁵	\$63,492,774	\$185,544	\$93,404,670	\$121,890	\$13,877,182	\$19,952
Total overstatement	\$171,147,058					
Total Federal overstatement	\$86,645,347					

⁴The State FY is July 1 through June 30, whereas the Federal FY is October 1 through September 30. Accordingly, our calculation for Federal FYs 2002 and 2003 included the first quarter of State FY 2004.

⁵The "amount overstated" row does not total \$171,147,058 because an immaterial number of claims used amounts other than the State-approved claimed rate for the given year.

Our review of 575 services provided by social workers in 100 randomly selected beneficiary months corroborated the results of our review of the rate development. Of the 575 services, 480 (84 percent) clearly did not meet the definition of TCM. Instead, the services were “direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred” and for which Federal reimbursement is specifically precluded.

Following are examples of these direct services, as indicated in the case notes for 1 sampled beneficiary month. The case notes were submitted as support for a \$163 Federal Medicaid claim.

- On March 4, 2003, the social worker received a call from a foster parent, called the child’s probation officer, and attended court with the child.
- On March 11, 2003, the social worker made a home visit accompanied by another social worker who stated that they were working on budgeting, parenting, and the child’s setting.
- On March 26, 2003, the social worker left a phone message for the child’s principal requesting that the child be allowed to return to school.

We believe that all of these services were direct social services that would be precluded from Federal Medicaid reimbursement because they did not focus on assessment, referral, or monitoring. Further, the record for the child contained a service referral form for foster care, rather than for medical, educational, or social services.

The State agency believed that the direct services rendered by Social Services were allowable Medicaid TCM services under the approved State plan amendment dated July 1, 1994. As a result, the State agency did not establish procedures to ensure compliance with Medicaid requirements as stated in CMS’s January 19, 2001, letter.

Potentially Unallowable Costs Claimed

The cost centers used in the TCM rate development also contained the costs of services related to TCM-type activities that were included in the State’s social service program. These services, which accounted for about 14 percent of the total claimed amount of \$197,718,235, included activities to help the beneficiary gain further access to needed medical, educational, or social services. However, these services were inherent in, and inseparable from, the direct services that Social Services provides pursuant to Federal and State laws and regulations.

Our review of the 575 services provided by social workers again corroborated the results of our review of the rate development. Specifically, 95 services (16 percent) related to TCM-type activities that were included in the State’s social service program. For example, a case note for 1 sampled beneficiary month, which was part of the support for another \$163 Federal Medicaid claim, stated that the social worker called the child’s therapist. The therapist discussed the child’s psychological and emotional well-being, the information that the child provided during sessions, and the need for more consistent and intensive therapy. This service exemplifies an

activity that is inherent in the services provided by the social service program, even though it assists the beneficiary in gaining further access to needed medical, educational, or social services.

In recent years, CMS has based its denials of State plan amendments submitted by Maryland, Montana, and Rhode Island on the inseparability of these types of services from the direct services that State social service agencies provide pursuant to Federal and State laws and regulations. Nevertheless, in its 2001 letter to State Medicaid directors, CMS did not explicitly prohibit coverage of TCM services that are included in the direct services provided by a social service agency. Accordingly, we were unable to express an opinion on the remaining \$26,571,177 (\$13,460,989 Federal share) claimed by the State agency.

EFFECT OF OVERSTATED COSTS FOR TARGETED CASE MANAGEMENT SERVICES

The costs of TCM services claimed through the State agency were overstated by \$171,147,058 (\$86,645,347 Federal share) because Social Services did not limit its TCM services claimed for Federal reimbursement to assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services. Instead, Social Services claimed costs related to direct social services, such as child protection and welfare services.

The remaining \$26,571,177 (\$13,460,989 Federal share) claimed by the State agency was for assessment of the beneficiary's service needs, development of a specific care plan, referral to needed services, and monitoring and followup. Although these services may appear to constitute allowable TCM services under existing policy, we identified a significant risk that the services may have already been reimbursed under other Federal programs because they were inherent in, and inseparable from, the direct services that Social Services provided pursuant to Federal and State laws and regulations.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$86,645,347 in unallowable costs;
- work with CMS to determine the allowability of the \$26,571,177 (\$13,460,989 Federal share) on which we were unable to express an opinion;
- refund to the Federal Government any TCM costs that represent direct medical, educational, or social services claimed and reimbursed subsequent to our audit period; and
- establish procedures to ensure that TCM rates used to claim Medicaid reimbursement do not include payment for direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its comments on our draft report, the State agency disagreed with our findings and recommendations. The State agency's comments, excluding 9 exhibits totaling 100 pages, are presented in Appendix D. We have forwarded the exhibits in their entirety to CMS. A summary of the State agency's comments follows, along with our response.

Development and Implementation of Targeted Case Management Rates

State Agency's Comments (Section II)

The State agency noted that our recommended disallowance stemmed from its TCM rate methodology. Thus, it began by explaining how it calculates TCM rates. The State agency said that the rate calculation was based on time allocation percentages for Social Services social workers and total costs for social workers' salaries. The State agency maintained that the rate calculation excluded costs claimed under other Federal programs to ensure that Federal reimbursement was not duplicated. According to the State agency, Social Services claimed all instances of TCM services provided to MassHealth (Medicaid) enrollees within a given month under the monthly rate, regardless of the actual number of occurrences of services for a child within that month, provided that at least one TCM service was documented as occurring for a child within that month.

The State agency pointed out that the Region I CMS Regional Administrator had approved its State plan for TCM services more than 10 years ago and that the State agency had at all times relied on the Regional Administrator's delegated authority to determine that all claiming under the State plan was in accordance with all applicable Federal rules and requirements. The State agency also asserted that applicable Federal laws and regulations had not changed since the State plan was approved.

The State agency said that it had worked closely with CMS Region I staff to develop its TCM rate methodology. The State agency noted that in 1998, the CMS Region I Administrator had reviewed the Social Services TCM rate petition in detail and had requested a change, which Social Services made. The State agency added that in 2001, the Regional Administrator had suggested that Social Services expand its TCM claiming to capture additional cost centers. Thus, the State agency concluded that we had no basis for recommending that the State agency refund any portion of its TCM reimbursement.

Office of Inspector General's Response

We maintain that our original conclusions as stated in the draft report are correct and need no modification. The State must comply with all Federal requirements. These requirements include CMS's January 19, 2001, State Medicaid directors letter and section 4302(a)(1) of the "State Medicaid Program Manual." Both state that Federal financial participation is not available for direct services. Approval of the State plan does not mean that all claiming under the State plan was in accordance with these requirements. Federal regulations (42 CFR § 430.35(c)) state: "A

question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.”

When the State agency received CMS's 2001 letter, it did not seek any guidance from CMS on claiming reimbursement for direct social services. The exchange of letters regarding the development of the TCM rates, included in Exhibit 3 of the State agency's comments, does not indicate that CMS specifically approved the State agency's practice of including the questioned direct costs in its TCM rate calculation. The letters also do not clarify how the State agency is to treat potentially allowable TCM services that are inseparable from direct services. The letters address only whether certain costs should be claimed as separate administrative costs or whether such administrative costs should be incorporated into the TCM rates.

With respect to the potentially unallowable costs that we identified, we recognize that the State agency consulted CMS while it was developing the TCM rates and that such consultations may have included the allowability of TCM services that are inseparable from, or an inherent part of, direct social services. As a result, we have expressed no opinion on these potentially unallowable costs and have instead referred the issue to CMS for resolution.

Inclusion of Cost Centers

State Agency's Comments (Section III)

The State agency asserted that it had included all of the cost centers in its TCM rates in accordance with applicable Federal law. It further maintained that the TCM statute was broad and must be read to include as a Medicaid TCM service any activity that assists individuals in gaining access to services. The State agency acknowledged that CMS had issued additional guidance regarding State plan case management and Title IV-E foster care programs in the form of the 2001 letter. However, the State agency maintained that CMS officials had conceded in a Government Accountability Office report that the letter contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid State agencies were involved. The State agency thus concluded that we could not properly base any recommendation that the State agency refund Federal TCM reimbursements on this flawed letter.

The State agency asserted that we must use the analytical framework established by the United States Court of Appeals for the First Circuit in Commonwealth of Massachusetts v. Bowen, 816 F.3d 796 (1st Cir. 1987), to determine whether TCM services provided by Social Services social workers were Medicaid reimbursable. The State agency said that this case stood for the proposition that a medical service could not be denied Federal reimbursement solely because the service was provided under a nonmedical assistance program. According to the State agency, the court ruled that the nature of the service, rather than what the service is called or what agency administers it, determines whether the service qualifies as medical assistance.

The State agency argued that the analytical framework established by Bowen supported its contention that the cost centers included in the TCM rates were within the statutory meaning of TCM and the approved Medicaid State plan amendment. The State agency explained why each

service type that we recommended for disallowance was a TCM service to assist the beneficiary in gaining access to needed direct services.

Office of Inspector General's Response

Bowen does not address the question of whether a particular service is a legitimate case management service that assists the beneficiary in gaining access to needed direct services or a direct service (or an integral part of a direct service) that may be unallowable as TCM or that may have been reimbursed under other Federal programs.

CMS's 2001 letter remains its most thorough issuance on TCM matters and represents a valid interpretation of the statute. It is deserving of great deference so long as the interpretation does not contravene the statute. Although the State agency claimed that CMS officials had retreated from the substance of the letter, Congress recently enacted an amendment to section 1915(g) of the Act that incorporates much of the letter's substance (Deficit Reduction Act of 2005, Public Law 109-171, section 6052 (2005)). The State agency's response failed to address the applicability of the requirement in the letter that "Medicaid case management services do not include payments for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred." Moreover, our findings are based not only on the letter but also on the "State Medicaid Program Manual," which prohibits reimbursement for direct services. The State agency did not address these requirements.

We do not agree with the State agency that some of the cost centers represent legitimate TCM activities. For example, although the State agency maintained that its definition of "case management" met the CMS definition of TCM, we found that its definition was so broad that any service provided by, or cost incurred by, Social Services could be interpreted as falling under this definition. Our review of the case notes prepared by Social Services social workers showed that the services (and related costs) that the State agency claimed as "case management" were direct social services, such as child welfare home visits, that social workers routinely provided. By expanding the definition of TCM activities, the State agency included the costs of direct social services under the umbrella of TCM.

According to statute, TCM is a service that assists beneficiaries in gaining access to needed services. For the 100 beneficiary months that we sampled, the State agency claimed an average of 12 months of TCM at an average cost of about \$3,000 per beneficiary during our 24-month audit period. We question whether the State required this much time and money to assist a beneficiary in gaining access to needed services without actually providing direct services. A complicating factor is the State agency's practice of allowing only social workers employed by Social Services to provide TCM for neglected and abused children. Because the State agency does not provide matching funds for TCM services rendered by Social Services (or other State departments), it has little incentive to monitor their Medicaid TCM utilization and costs.

Due Process

State Agency's Comments (Section IV)

The State agency maintained that we had denied it due process by basing the disallowance of entire categories of activities identified in the random moment timestudy on specific claims that were not provided to the State agency and not directly tied to the TCM rates. The State agency also said that it was fundamentally unfair for us to assert that an activity was not a reimbursable TCM service without creating a record of the alleged improper activities and providing the State agency with an opportunity to respond.

Office of Inspector General's Response

We strongly disagree that our review was unfair or denied the State agency the opportunity to respond. Our disallowance was based on the cost centers used to develop the TCM rates, not the narrative in the case notes for particular services. We provided the State agency with details of the rate review on January 20, 2005, and with details of the service review on January 21, 2005. The State agency also maintained a copy of all case notes that it provided for our review. Should CMS concur with any of the recommendations in this report, the State will be accorded due process and a right to appeal as provided for in Federal regulations.

Adjustment of Targeted Case Management Rates

State Agency's Comments (Section V)

The State agency claimed that the amount that we determined to be unallowable was overstated by almost \$22 million because we did not adjust the TCM rates properly. The State agency said that it used a "fixed with carry forward" process to set current rates based on actual expenses from 2 years earlier and that we failed to account for this practice when we adjusted the TCM rates.

Office of Inspector General's Response

Our review accounted for the State agency's use of a "fixed with carry forward" process to set current rates. We used the actual monthly rates that the State agency used to claim TCM reimbursement on the quarterly Forms CMS-64. We applied our recalculated TCM rates to each claim (net of adjustments) submitted through the CMS Medicaid Statistical Information System. The State agency should provide CMS with details of any adjustments that it made to these rates after our audit, including the specific claims adjusted. It should be noted that the provisional rates in each year reviewed were significantly higher than the respective adjusted final rates. Until adjustments are made, these paid claims also remain in an overpayment status.

Services Provided Pursuant to Federal and State Laws

State Agency's Comments (Section VI)

The State agency asserted that we had no lawful basis for concluding that any TCM service claims were unallowable or potentially unallowable because the services were required to be provided pursuant to State or Federal law. According to the State agency, there is no evidence that Congress intended Title IV-B or Title XX funds to substitute for the Federal reimbursement guaranteed to the States under the Medicaid program. The State agency concluded that we “should not publish an audit report suggesting that the State agency’s TCM claims are not allowable based on a CMS policy that is inconsistent with applicable Federal law.”

Office of Inspector General's Response

The audit report does not suggest that costs are potentially unallowable solely because the costs were meant to be reimbursed under Titles IV-B and XX. Instead, these costs are potentially unallowable because the case management services were integral to, and inseparable from, unallowable direct services. As such, reimbursement for these services may essentially be reimbursement for direct services already funded under Titles IV-B and XX. We therefore referred this issue for CMS’s consideration.

Nevertheless, we note that CMS has determined that the limited nature of Titles IV-B and XX appropriations is not relevant to which program bears the costs of the provision of direct services. CMS has long indicated that such costs should be borne by Titles IV-B and XX. In the context of whether Title IV-E should share in such costs, CMS states the following (47 Federal Register 30922, 30923 (July 15, 1982)):

We agree that treatment-oriented services, such as helping families be reunited, . . . are vital to the goals of Pub. L. 96-272 [the law creating Title IV-E]. However, concurrently with the enactment of Title IV-E, Congress enacted a revised Title IV-B (Child Welfare Services Program), which provides for the delivery of these social services. In addition, Title XX of the Act, now the Social Services Block Grant, provides funds to States for services. Because other sources of Federal funds are available for the provision of these services, the Department has prohibited reimbursement from Title IV-E funds for treatment-oriented services as inconsistent with the statutory concept of maintenance expenditures. Funds for those purposes are the major focus of the service programs. Therefore, the final regulation continues the NPRM [Notice of Proposed Rule Making] requirement by prohibiting FFP under Title IV-E for treatment-oriented services.

These principles appear equally applicable to the Medicaid TCM context because the statute has defined TCM to include only assistance in gaining access to direct services and not direct services themselves.

Our disallowances were not based on whether TCM services were required to be provided under State law or another Federal program. Instead, we used examples to illustrate that services provided by Social Services and characterized by the State as TCM services were included as direct social services under other programs. Further, we intended to raise the possibility that these direct services may have already been funded by the Federal Government under Titles IV-B and XX.

We stand by our recommendations that the State agency refund to the Federal Government \$86,645,347 in unallowable costs; work with CMS to determine the allowability of the \$26,571,177 (\$13,460,989 Federal share) on which we were unable to express an opinion; refund to the Federal Government any TCM costs that represent direct medical, educational, or social services claimed and reimbursed subsequent to our audit period; and establish procedures to ensure that TCM rates used to claim Medicaid reimbursement do not include payment for direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

APPENDIXES

**DESCRIPTION OF COST CENTERS USED TO CALCULATE
MONTHLY RATES**

Referral to services includes those services specifically designed to prevent or eliminate the need for the removal of a child from his or her home. These services include referrals to comprehensive developmental activities, parent training, and obtaining medical records.

Protective intake includes investigative efforts to prevent or eliminate the removal of a child from his or her home. These efforts include receipt and screening of reports of abuse and investigations to determine whether there is reasonable cause to believe that a child has been or may be abused or neglected.

Preparation for and participation in legal proceedings includes judicial determinations, court proceedings, and voluntary placement agreements.

Referrals to the district attorney include notification and provision of information to the appropriate district attorney and local law enforcement authority if certain specific conditions have resulted from abuse or neglect.

Case management, as referred to by the Massachusetts Department of Social Services (Social Services), includes services that represent the day-to-day provision of services by social workers, such as initial case assignment, subsequent case assignment, and ongoing casework activities.

Development of service plans includes assessment and service planning.

Case reviews include case review meetings, renewal of the services plan, and supervisory reviews of the case reviews.

Child placement includes administrative duties, such as opening cases, meetings with the child and parents to discuss the case, documenting decisions regarding detailed care and custody issues, and family resource evaluation.

Investigative efforts include activities to make it possible for the child to return to his or her home. These efforts include receipt and screening of reports of suspected abuse or neglect by a caretaker.

Services for children with special needs include the arrangement for and entry into adoption assistance agreements with adoptive parents.

All other permanency planning activities include activities not associated with the arrangement for and entry into adoption assistance agreements with adoptive parents.

OFFICE OF INSPECTOR GENERAL ANALYSIS OF COSTS CLAIMED UNDER TARGETED CASE MANAGEMENT

Cost Center	State Fiscal Year (FY) 2002 Actual			State FY 2003 Actual			State FY 2004 Provisional		
	TCM Cost Basis ¹	Unallowed	No Opinion	TCM Cost Basis	Unallowed	No Opinion	TCM Cost Basis	Unallowed	No Opinion
Intact family/preplacement activities									
Referral to services	\$5,865,578	\$0	\$5,865,578	\$6,095,700	\$0	\$6,095,700	\$6,427,500	\$0	\$6,427,500
Protective intake	33,346,731	33,346,731	0	28,134,092	28,134,092	0	36,541,348	36,541,348	0
Preparation/participation in legal proceedings	7,230,880	7,230,880	0	4,142,585	4,142,585	0	7,923,598	7,923,598	0
Referrals to district attorney	935,718	935,718	0	1,032,300	1,032,300	0	1,025,360	1,025,360	0
Case management	49,506,938	49,506,938	0	61,307,887	61,307,887	0	54,249,703	54,249,703	0
Development of service plans	17,132,492	0	17,132,492	7,497,672	0	7,497,672	18,773,785	0	18,773,785
Case reviews	3,609,293	0	3,609,293	3,851,942	0	3,851,942	3,955,063	0	3,955,063
Postplacement activities (nonvoluntary)									
Child placement	8,746,746	8,746,746	0	7,741,342	7,741,342	0	9,584,684	9,584,684	0
Referral to services	3,608,400	0	3,608,400	2,716,726	0	2,716,726	3,954,085	0	3,954,085
Investigative efforts	489,687	489,687	0	633,545	633,545	0	536,599	536,599	0
Preparation/participation in legal proceedings	4,454,061	4,454,061	0	4,520,677	4,520,677	0	4,880,760	4,880,760	0
Referrals to district attorney	315,237	315,237	0	723,817	723,817	0	345,437	345,437	0
Case management	17,947,771	17,947,771	0	20,656,563	20,656,563	0	19,667,167	19,667,167	0
Development of service plans	4,458,974	0	4,458,974	2,228,025	0	2,228,025	4,886,144	0	4,886,144
Case reviews	5,498,877	0	5,498,877	2,502,974	0	2,502,974	6,025,669	0	6,025,669
Postplacement activities (voluntary)									
Child placement	639,910	639,910	0				701,213	701,213	0
Referral to services	169,412	0	169,412				185,642	0	185,642
Investigative efforts	149,844	149,844	0				164,199	164,199	0
Preparation/participation in legal proceedings	254,129	254,129	0				278,475	278,475	0
Referrals to district attorney	45,255	45,255	0				49,590	49,590	0
Case management	1,177,622	1,177,622	0				1,290,438	1,290,438	0
Development of service plans	309,271	0	309,271				338,899	0	338,899
Case reviews	501,974	0	501,974				550,063	0	550,063
Permanency planning activities									
Services for children with special needs	1,640,579	1,640,579	0	1,735,091	1,735,091	0	1,797,746	1,797,746	0
All other permanency planning activities	4,009,634	4,009,634	0	4,412,744	4,412,744	0	4,393,757	4,393,757	0
Total	\$172,045,013	\$130,890,742	\$41,154,271	\$159,933,682	\$135,040,643	\$24,893,039	\$188,526,925	\$143,430,075	\$45,096,850

¹TCM is targeted case management.

Cost Center	State FY 2002 Actual			State FY 2003 Actual			State FY 2004 Provisional		
	Title IV-E Cost Basis	Unallowed	No Opinion	Title IV-E Cost Basis	Unallowed	No Opinion	Title IV-E Cost Basis	Unallowed	No Opinion
Intact family/preplacement activities									
Referral to services	\$2,629,474	\$0	\$2,629,474	\$2,715,916	\$0	\$2,715,916	\$2,881,378	\$0	\$2,881,378
Protective intake	0	0	0	0	0	0	0	0	0
Preparation/participation in legal proceedings	3,244,290	3,244,290	0	1,842,151	1,842,151	0	3,555,093	3,555,093	0
Referrals to district attorney	0	0	0	0	0	0	0	0	0
Case management	22,210,520	22,210,520	0	27,466,522	27,466,522	0	24,338,288	24,338,288	0
Development of service plans	7,678,948	0	7,678,948	3,215,454	0	3,215,454	8,414,591	0	8,414,591
Case reviews	1,626,697	0	1,626,697	1,712,699	0	1,712,699	1,782,535	0	1,782,535
Postplacement activities (nonvoluntary)									
Child placement	5,047,684	5,047,684	0	3,465,607	465,607	0	5,531,252	5,531,252	0
Referral to services	1,999,321	0	1,999,321	1,222,393	0	1,222,393	2,190,856	0	2,190,856
Investigative efforts	254,322	254,322	0	0	0	0	278,686	278,686	0
Preparation/participation in legal proceedings	2,468,308	2,468,308	0	2,011,208	2,011,208	0	2,704,772	2,704,772	0
Referrals to district attorney	0	0	0	0	0	0	0	0	0
Case management	10,155,022	10,155,022	0	9,248,211	9,248,211	0	11,127,873	11,127,873	0
Development of service plans	2,495,986	0	2,495,986	981,054	0	981,054	2,735,101	0	2,735,101
Case reviews	3,039,799	0	3,039,799	1,120,149	0	1,120,149	3,331,012	0	3,331,012
Postplacement activities (voluntary)									
Child placement	290,626	290,626	0				318,468	318,468	0
Referral to services	77,232	0	77,232				84,631	0	84,631
Investigative efforts	67,687	67,687	0				74,171	74,171	0
Preparation/participation in legal proceedings	115,611	115,611	0				126,687	126,687	0
Referrals to district attorney	0	0	0				0	0	0
Case management	534,671	534,671	0				585,892	585,892	0
Development of service plans	141,143	0	141,143				154,664	0	154,664
Case reviews	228,062	0	228,062				249,910	0	249,910
Permanency planning activities									
Services for children with special needs	1,640,579	1,640,579	0	1,735,091	1,735,091	0	1,797,746	1,797,746	0
All other permanency planning activities	1,823,243	1,823,243	0	2,225,618	2,225,618	0	1,997,910	1,997,910	0
Total	\$67,769,225	\$47,852,563	\$19,916,662	\$58,962,073	\$47,994,408	\$10,967,665	\$74,261,516	\$52,436,838	\$21,824,678

**OFFICE OF INSPECTOR GENERAL TARGETED CASE MANAGEMENT
MONTHLY RATE RECALCULATION**

STEP 1

Segment and total the expenses from the State FY that (1) potentially could be claimed for reimbursement under TCM and (2) were already claimed for reimbursement under Title IV-E.

	State FY 2002		State FY 2003		State FY 2004	
	Total	Title IV-E	Total	Title IV-E	Total	Title IV-E
Cost basis	\$41,154,271	\$19,916,662	\$24,893,039	\$10,967,665	\$45,096,850	\$21,824,678

Note: The overall percentage of costs determined unallowable in the rate (79 percent) differs from the percentage of questioned costs to the total claim (86 percent) because of differences in the consumer counts and Federal reimbursement rates between years.

STEP 2

Separate the total TCM and Title IV-E costs into their general and unopened protective intake (UPI) segments. The TCM general expenses are equal to the total expenses less the UPI expenses. The UPI expenses are equal to total UPI qualifying expenses times the UPI percentage. Social Services determined the UPI percentage by dividing the number of UPI consumers by the total number of consumers.

The qualifying UPI expenses are those expenses from the “referral to services” (replacement and nonvoluntary) expenditure line items on the cost allocation plan. These expenditure line items qualify as UPI expenditures because they are associated with providing TCM-related services to both UPI consumers and the general consumer population. All other expenditure line items are associated with providing TCM-related services only to the general consumer population.

	State FY 2002		State FY 2003		State FY 2004	
	Total	Title IV-E	Total	Title IV-E	Total	Title IV-E
General amount	\$40,339,509	\$19,518,586	\$24,136,933	\$10,629,758	\$44,204,034	\$21,388,466
UPI amount	814,762	398,076	756,106	337,907	892,816	436,212

STEP 3

Calculate the State FY actual general and UPI rates. We calculated the monthly rates by taking the total TCM claimable expenditures, total Title IV-E claimed expenditures, and total other

Federal claimed expenditures and dividing by 12 months and then dividing by the number of consumers served (as stated in the Social Services rate calculation). We calculated each final TCM rate by subtracting the Title IV-E credit rate (based on the total Title IV-E claimed expenditures) from the preliminary TCM rate (based on the total TCM claimable expenditures).

	State FY 2002 Rate			State FY 2003 Rate			State FY 2004 Rate		
	Total	Title IV-E	Final Rate	Total	Title IV-E	Final Rate	Total	Title IV-E	Final Rate
General	\$95	\$46	\$49	\$55	\$24	\$31	\$105	\$51	\$54
UPI	21	10	11	18	8	10	23	11	12



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

MassHealth

MITT ROMNEY
Governor

KERRY HEALEY
Lieutenant Governor

TIMOTHY MURPHY
Secretary

BETH WALDMAN
Medicaid Director

December 20, 2005

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region I
John F. Kennedy Building
Boston, MA 02203

Re: Review of Targeted Case Management Services Rendered by the Massachusetts
Department of Social Services During Federal Fiscal Years 2002 and 2003. (Report
Number A-01-04-00006)

Dear Mr. Armstrong:

Thank you for the opportunity to respond to the above referenced draft report of the Office of the Inspector General ("OIG"). As you know, in 1994 CMS (then HCFA, but referred to throughout as CMS for the sake of convenience) approved Massachusetts' State Plan for targeted case management services ("TCM") provided to children served by the Department of Social Services ("DSS"). For more than 10 years Massachusetts has received federal financial participation under this approved State Plan to match its state expenditures on TCM services. TCM services have helped MassHealth-eligible children who are also children served by DSS to access needed social, medical, educational, and other services. TCM services are critical for these vulnerable children, and they are services that such children are entitled to receive, in accordance with 42 USC 1396a(a)(10), 1396d(a)(4)(B), 1396d(a)(19), 1396d(r)(5), and 1396n(g).

The OIG maintains that the majority of the Commonwealth's claims for TCM are unallowable because DSS's TCM monthly rates included social workers' salary costs related to "direct social services such as child protection and welfare services." Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003 (hereinafter, the "Draft Audit Report"). In addition, the OIG maintains that DSS's entire TCM claim for the audit period is "unallowable or potentially unallowable" because all of the services were required to be provided pursuant to Massachusetts state law and because many of the services were authorized under other federal programs to assist children and families, including Titles IV-B (Child and Family Services), IV-E (Federal Payments for Foster Care and Adoption Assistance) and XX (Block Grants to States for Social Services).

As more particularly described in the detailed response enclosed as Attachment A to this letter, the Commonwealth believes that the OIG audit is seriously flawed and erroneous. We believe that DSS's TCM claiming has been at all times consistent with our approved State Plan, and with applicable federal and state laws and regulations. As a result, the Commonwealth emphatically disputes the following recommendations of the OIG: (1) to refund \$86,645,347 in unallowable

costs; (2) to work with CMS to determine the allowability of the \$26,571,177 (\$13,460,989 federal share) on which the OIG did not express an opinion; and (3) to refund to the federal government any TCM costs claimed and reimbursed subsequent to the audit period that represent direct medical, educational, or social services. Finally, although we agree that we must have procedures to ensure that TCM rates used to claim Medicaid reimbursement do not include payment for direct medical, educational, or social services to which the Medicaid-eligible individual has been referred, we believe that we currently have such controls in place.

In particular, the Draft Audit Report reaches its recommendations on the appropriateness of DSS's TCM claiming by ignoring applicable federal law, and denies the Commonwealth due process by failing to identify the specific activities that the OIG asserts were incorrectly identified as TCM.

We hope that upon review of our comments, the OIG will withdraw these findings. If the report is substantially revised from the Draft Audit Report, we request the opportunity to review and comment on any such revised draft before a final version is published.

Again, thank you for the opportunity to comment on the Draft Audit Report. If you would like to discuss further, please feel free to contact me.

Sincerely,



Beth Waldman
Medicaid Director

Cc: Timothy Murphy
Harry Spence

Attachments

Attachment A

The Commonwealth's Response to the Draft Audit Report

I. Introduction

In the Draft Audit Report, the OIG maintains that the majority of the Commonwealth's claims for TCM are unallowable because DSS's monthly rates include workers' salary costs related to "direct social services such as child protection and welfare services."¹ In addition, the OIG maintains that DSS's entire TCM claim for the audit period is "unallowable or potentially unallowable" because all of the services were required to be provided pursuant to Massachusetts state law and because many of the services were authorized under other federal programs to assist children and families, including Titles IV-B (Child and Family Services), IV-E (Federal Payments for Foster Care and Adoption Assistance) and XX (Block Grants to States for Social Services).²

The Commonwealth disagrees with the OIG's conclusions and addresses each in turn below.

II. Overview of Massachusetts TCM Rates

a. The TCM Rate Development Process

Since the basis of the OIG's recommended disallowance is the TCM rate methodology, it is important to understand how the Commonwealth calculates TCM rates. DSS utilizes two main sources of data to develop its TCM claiming rates: DSS's Cost Allocation Plan (CAP), which allocates time for all DSS social worker activities; and DSS's Quarterly Reports, which provide statistics on consumers in the care of DSS.

The CAP uses a Random Moment Time Study (RMTS) to determine time allocation percentages for DSS social worker activities.³ The RMTS isolates specific categories of social worker activities and is utilized to determine the time social workers spend performing activities in each category. The rate calculation, based on these time allocations and total DSS costs for social worker salaries, is a multi-step process that generates a monthly rate. An interim monthly rate is reconciled against actual costs on an annual basis to obtain the final TCM monthly rate. The rate calculation excludes the costs that are claimed under other federal programs, such as Title IV-E, in order to ensure non-duplication of federal reimbursement.⁴ DSS claims all instances of TCM services provided to MassHealth enrollees within a given month under the monthly rate, regardless of the actual number of occurrences of services for a child within that month, provided that at least one TCM service is documented as occurring for the child within that month.⁵

¹ Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003 (hereinafter, the "Draft Audit Report") at p. 3.

² Draft Audit Report at p. 5.

³ A copy of the Commonwealth of Massachusetts Department of Social Services Random Moment Time Study Instructions (RTMS) is attached hereto as Exhibit 1.

⁴ SFY04 Targeted Case Management Rates Revision at p. 3.

⁵ Id.

During the RMTS, social workers' time is allocated through cost centers shown in the chart below:

Cost Center	Included in TCM Rate Calculation	Excluded from TCM Rate Calculation
Pre-Placement Activities: Services to Children and Intact Families		
Referral to services	X	
Protective intake – receipt, screening, investigation of potential cases	X	
Preparation/participation in judicial proceedings or voluntary placement agreements in family courts	X	
Referrals to district attorney	X	
Participation in other court proceedings		X
Case management	X	
Development of case service plans	X	
Case reviews	X	
Fair hearings and appeals		X
Direct counseling or treatment to ameliorate or remedy personal problems, behaviors or home activities		X
Post-Placement Activities: Services to Children in Out-of-Home Placements		
Child placement	X	
Referral to services	X	
Investigative efforts	X	
Preparation/participation in judicial proceedings or voluntary placement agreements in family courts	X	
Referrals to district attorney	X	
Participation in other court proceedings		X
Case management	X	
Development of case service plans	X	
Case reviews	X	
Fair hearings and appeals		X
Direct counseling or treatment to ameliorate or remedy personal problems, behaviors or home activities		X
Procurement of health care services for children in placement		X
Permanency Planning Activities		
Services for children with special needs	X	
All other permanency planning	X	

Training Activities		
All training activities		X
Eligibility Determination and Re-determination Activities		
All determination and re-determination activities for Title XIX, Title IV-E and SSI disability benefits		X

b. The Approved State Plan

CMS approved the Commonwealth's State Plan for TCM services for children served by the Department of Social Services on December 22, 1994 – more than 10 years ago.⁶ Authority to approve a State Plan is delegated to the CMA Regional Administrator.⁷ All such approvals must be made on the basis of policy statements and precedents previously approved by the Administrator.⁸ The Regional Administrator for Region I approved the Commonwealth's TCM State Plan and the Commonwealth has at all times relied on the Regional Administrator's delegated authority to determine that the State Plan was properly approved and that all claiming under the State Plan was in accordance with all applicable federal rules and requirements. Since the State Plan was approved there has been no change in applicable federal laws or regulations.

c. CMS Region I Reviewed the State's TCM Rate Method at Its Inception and Thereafter – Directing the State to Make Changes It Determined Necessary

CMS Region I staff have worked closely with the Commonwealth to develop its TCM rate method and the costs that are included in that rate. Although Massachusetts' State Plan was approved by CMS in 1994, DSS did not submit its first TCM claim until almost two years later. During the two years from 1994 through 1996, CMS Region I participated in numerous meetings and phone calls and exchanged numerous letters with DSS and Commonwealth TCM rate development consultants. In 1995, the Commonwealth's TCM rate consultant spent three days meeting policy and financial specialists from CMS Region I, reviewing DSS social

⁶ The approved definition of definition of TCM services is described as follows:

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social, and other services. State Plan Amendment at paragraph H.

Case management will include:

1. collection of assessment data;
2. development of an individualized plan of care;
3. coordination of needed services and providers;
4. home visits and collateral cont[r]acts [sic] as needed;
5. maintenance of case records; and
6. monitoring and evaluation of client. progress and service effectiveness.

State Plan Amendment at paragraph H.2.

⁷ 42 CFR 430.15(b).

⁸ Id.

worker case notes, to familiarize CMS with the activities that social workers engage in and to demonstrate that those activities are reimbursable as TCM. In 1996, additional discussions and letters were exchanged concerning DSS's rates and the costs that would be included in those rates, including but not limited to addressing specific questions that CMS Region I had about incorporating into the TCM rate social worker costs for protective intake – a category of costs that the OIG now says in the Draft Audit Report is not a TCM activity.

In 1998, after DSS began TCM claiming, the CMS Regional Administrator for Region I requested a copy of DSS's rate petition, which provided CMS with an opportunity to reconsider and review the Commonwealth's rate setting in more detail. Following this review, CMS Region I asked DSS to split its rates into two: a rate for TCM provided to children when DSS never opens a case file; and a different rate for TCM provided to children when DSS does open a case file. The Commonwealth made the rate change as CMS directed. As recently as January 18, 2001, the CMS Region I Administrator wrote to the Commonwealth effectively advising that the DSS TCM rate is under-inclusive and should be revised to capture additional cost centers related to "provider overhead", such as Medicaid rate development and claims preparation and Early, Periodic Screening, Diagnosis and Treatment (EPSDT) outreach services provided by DSS.⁹

The Commonwealth at all times properly relied on the Regional Administrator's delegated authority to determine that DSS's TCM rate was in conformance with all applicable federal rules and requirements. There is no basis for the OIG to recommend that the Commonwealth refund any portion of its TCM reimbursement, where CMS Region I agreed that the DSS TCM cost centers are appropriate and, if anything, has most recently suggested that DSS expand its TCM claiming.

III. All of the Cost Centers in the TCM Rate Are Properly Included in Accordance with Applicable Federal Law.

In all audits, including this one, the OIG is required to determine whether funds are properly expended for the purposes for which they were appropriated under federal and state law and regulations.¹⁰ For that reason, the Commonwealth's response includes a discussion of the applicable federal law, some of which is ignored in the OIG's Draft Audit Report.

a. The Targeted Case Management Statute Is Broad and Must Be Read to Include as Medical Assistance Any Activity that Assists Individuals in Gaining Access to Services

In 1985, the Medicaid Act was amended to add Targeted Case Management services. The statute is broad in scope and without limitations. In relevant part, it provides:

⁹ A copy of the January 18, 2001, letter from CMS Region I is attached as Exhibit 3A. A copy of the Commonwealth's April 9, 2001, letter to the Division of Cost Allocation is also attached as Exhibit 3B. The Commonwealth's letter more clearly describes the activities that DSS proposed to include in the Department of Social Services Administrative Cost Allocation Plan (the "CAP"). In the April Letter, the Commonwealth explains why it maintains that certain activities that CMS said should be included in DSS TCM rate could be included in the CAP. Attached as Exhibit 3C is CMS's May 3, 2001, response rejecting the Commonwealth's explanation and insisting that the activities described in the April 9 Letter are reimbursable TCM activities.

¹⁰ 42 CFR 430.33(a)(2).

... the term "case management services" means services which will assist individuals under the plan in gaining access to needed medical, social, educational and other services. 42 USC 1396n(g)(2).

The following year, the Medicaid Act was further amended to add Targeted Case Management to the list of services included as covered services under the Medicaid Act. TCM services now appear as an optional Medicaid service at 42 USC 1395d(a)(19). In accordance with federal EPSDT requirements, medically necessary TCM is a required service for all eligible beneficiaries under age 21. 42 USC 1396a(a)(10), 1396d(r)(5), 1396d(a)(4)(B). All of the children in the DSS target group are eligible for EPSDT services and are entitled to receive medically necessary TCM.

CMS has never promulgated regulations interpreting 42 USC 1396n(g), although it has promised to do so as recently as January 19, 2001.¹¹ CMS has included guidance interpreting the TCM statute in the State Medicaid Manual since at least December 1991. The State Medicaid Manual provides examples of non-Medicaid-reimbursable services that a targeted case manager may assist a beneficiary in accessing, including assistance in obtaining food stamps, energy assistance, emergency housing or legal services.¹² It provides no guidance on the activities that fit within the broad scope of the phrase "assist ... individuals in gaining access" except to say that "case management services are furnished to assist an individual in gaining or coordinating access to needed services."¹³ The guidance does make clear that while assisting "individuals in gaining access to services" is a Medicaid-reimbursable activity, the services that the targeted case manager assists the enrollee in accessing are not necessarily Medicaid-reimbursable simply because a targeted case manager is coordinating the enrollee's services.¹⁴

In January 2001, CMS issued additional guidance in Dear State Medicaid Director Letter #01-013 (the "SMDL") That SMDL states that its purpose is to "clarify existing HHS policy regarding State Plan case management and Title IV-E foster care programs."¹⁵ Even CMS

¹¹ SMDL #01-013, January 19, 2001, p. 1

¹² SMM at 4302.2.G.1.

¹³ Id.

¹⁴ Id.

¹⁵ In the letter CMS acknowledges that it has never defined case management services in regulations but provides a description of the following activities, which it states are case management activities:

Assessment: This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the Medicaid eligible individual.

Care Planning: This component builds on the information collected through assessment phase and includes activities such as ensuring the active participation of the Medicaid-eligible individual and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid-eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medicaid-eligible individual.

Referral and Linkage: This component includes activities that help link Medicaid-eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

officials concede that the SMDL “contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid state agencies were involved.”¹⁶ The OIG cannot properly base any recommendation that the state refund federal TCM reimbursements on this flawed SMDL. This is particularly so where the Commonwealth received guidance from CMS Region I about its TCM rate after the SMDL had been issued and CMS Region I did not even refer to the SMDL. If anything, CMS suggested that the Commonwealth’s TCM claiming could be expanded.¹⁷

b. The OIG Must Use the Analytical Framework Established by the First Circuit to Determine Whether Services Provided by DSS Social Workers Are Medicaid-Reimbursable TCM

The Commonwealth’s compliance with all applicable federal statutes, regulations and guidelines must be determined using the analytical framework established by the First Circuit in Commonwealth of Massachusetts v. Secretary of Health and Human Services 816 F.2d 796 (1st Circuit, 1987) *affd.*, (without discussion of the substance of the holding below), Bowen, Secretary of Health and Human Services et al v. Massachusetts 487 U.S. 879 (U.S. S.Ct. 1988) (hereinafter, “Bowen”).¹⁸ Bowen is controlling law in the First Circuit.

The facts in Bowen are strikingly similar to the facts relating to this audit. In the Draft Report, the OIG maintains that DSS’s entire TCM claim for the audit period is “unallowable or potentially unallowable” because all of the services were required to be provided pursuant to Massachusetts state law and because many of the services were authorized under other federal programs to assist children and families, including Titles IV-B (Child and Family Services), IV-E (Federal Payments for Foster Care and Adoption Assistance) and XX (Block Grants to States for Social Services).¹⁹ Likewise, in Bowen, CMS performed an audit of Medicaid claims submitted for rehabilitation services provided to individuals with mental retardation in intermediate care facilities (ICF/MRs). Certain of these rehabilitation services were provided jointly by the Department of Mental Health and the Department of Education. Following the audit, CMS disallowed all of the ICF/MR services provided jointly by DMH and DOE personnel and contractors. CMS took the position that the services provided by DOE personnel and contractors were “per se educational” and excluded from Medicaid coverage solely because they were provided by DOE personnel and contractors pursuant to the state’s special education law (Ch. 766) and because the Education for All Handicapped Children Act (EHCA) that established a federal funding mechanism for states provided special education services.

Monitoring/Follow-up: This component includes activities and contracts that are necessary to ensure the care plan is effectively implemented and adequately addresses the needs of the Medicaid-eligible individual, family members, providers or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid-eligible individual’s care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid-eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

¹⁶ Medicaid Financing State’s Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight, GAO-05-748 (June 2005) at footnote 43.

¹⁷ See footnote 9, *supra*.

¹⁸ A copy of Bowen is attached as Exhibit 4 for the OIG’s convenience.

¹⁹ Draft Audit Report at p. 5.

The First Circuit in Bowen rejected CMS's argument in its entirety, providing the broad principles for analyzing the availability of federal financial participation under the Medicaid Act where a service could be described as both "medical assistance" and something else, such as, in this case, "child protection and welfare services."

The analytical framework adopted in Bowen is set forth as follows:

1. The Social Security Act (of which the Medicaid Act is a part) must be broadly construed, so as to carry out Congress's intent to provide medical expense coverage for all qualifying individuals. Bowen at 816 F.2d, 801, citing Mayburg v. Secretary of Health and Human Services, 740 F.2d 100, 103 (1st Cir. 1984). The Medicaid Act is mandatory, not discretionary, and does not authorize the Secretary to avoid reimbursing states for a percentage of their expenditures for medical assistance, required under the Act.²⁰ Indeed, the Act states: "From the sums appropriated therefor, the Secretary ...*shall* pay to the state... an amount equal to the federal medical assistance percentage... of the total amount expended as medical assistance" [emphasis added].²¹
2. Further, when the Secretary is interpreting the Medicaid Act, his interpretation is entitled to "some weight," but it is not entitled to the same deference as the Secretary's interpretation of his own regulations. There is no deference to the Secretary's interpretation of his agency's regulations if he interprets his regulations in contravention of the statute.²²
3. In construing the federal law, the question to be answered regarding whether the state is entitled to federal financial participation is whether the state is providing "medical assistance." The test for determining whether a service is "medical assistance" relies on the *nature of the services*, not what those services are called or who provides them.²³ In Bowen, the court recognized that some of the services at issue could be both "special education" and "medical assistance" services. The court held that CMS lacked administrative discretion to establish a blanket exclusion of Medicaid reimbursement for "special education services" because the blanket exclusion denied reimbursement for [rehabilitation] services, and rehabilitation services are "medical assistance" that the Medicaid Act requires the Secretary to reimburse.
4. Indeed, Bowen holds that there must be clear evidence of legislative intent to substitute federal funding from another federal title for the federal funding available under the federal Medicaid Act. The First Circuit rejected CMS's claim that the federal funding mechanism provided through EHCA for state-provided special education and related services indicated that Congress did not intend to fund any special education services under the "more general terms" of the Medicaid Act. The Bowen court found nothing in the legislative history of the EHCA indicating that the federal funding available under the EHCA was intended to substitute for federal reimbursement under the Medicaid Act.²⁴ The court noted that, as a factual matter, the state did not receive reimbursement through the EHCA for any of the claimed Medicaid services.

²⁰ Bowen at 801.

²¹ Id. citing 42 USC 1396b(a).

²² Id. at 816 F.2d, 800-801 (citations omitted).

²³ Id. at 804. [emphasis in the original].

²⁴ Id. at 803.

c. Using the Analytical Framework Bowen Requires, the Cost Centers Included in the TCM Rate Are within the Statutory Meaning of TCM and Massachusetts' Approved Medicaid State Plan Amendment

Regardless of what the services are called and who performs them, each of the activities in the RMTS that the OIG has determined are not TCM activities are among the "set[s] of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency."²⁵ Each of these activities is a component of Targeted Case Management, and together, the purpose of each of these activities is to assist individuals in gaining access to needed medical, social, and other services.

The activities that the OIG agrees do assist enrollees with gaining access to needed medical, social and other services are related to activities that are included in categories OIG claims are not TCM activities, as shown in the chart below:

Cost Center	Included in TCM Rate Calculation	Labeled "Child Protection and Welfare Service" by OIG
Pre-Placement Activities: Services to Children and Intact Families		
Referral to services	X	
Protective intake	X	
Preparation/participation in legal proceedings	X	
Case management	X	
Referrals to district attorney	X	
Development of service plans	X	
Case reviews	X	
Post Placement Activities: Services to Children in Out-of-Home Placements		
Child placement	X	
Referral to services	X	
Investigative efforts	X	
Preparation/participation in legal proceedings	X	
Referrals to district attorney	X	
Case management	X	
Development of service plans	X	
Case reviews	X	
Permanency Planning Activities		
Services for children with special needs	X	
All other permanency planning	X	

²⁵ See Massachusetts State Plan Amendment at paragraph H.2.

Each of the activities at issue, and its relationship to the activities that the OIG agrees are TCM activities, is described in more detail below.

A. Pre-Placement Activities: Services to Children and Intact Families

As an overarching set of activities, “pre-placement” refers to activities and services to children and intact families where a removal of a child from his/her home has not occurred. Social workers engage in these activities when: the potential exists for a child to be placed outside the home but the services are being delivered to an intact family, whether or not a decision has been made to remove the child from the home; or the services are related to preparation for a placement. In the case of a potential placement, social workers document pre-placement services in a defined case plan. All of the pre-placement activities described below contribute to the social worker’s best efforts “to assess the individual child and family situation regarding the appropriateness and accessibility (within limits of available resources) of preventative services and to offer the family and assist (as appropriate) in providing such services to the family whenever possible.”²⁶

The RMTS classifies the social worker’s pre-placement activities in 10 discrete functions. Seven of these pre-placement functions are included as a cost center in the Commonwealth’s TCM rates. How each of the seven categories currently included in the TCM rate is a TCM service is detailed below.

1. **Referral to services:** In this activity, the social worker provides information and referral to parent(s) about medical, dental or mental health services, referral to parent health education and assistance, referral to services other than foster care – such as housing assistance or subsidized day care. The OIG agrees that referral to services is a TCM service.
2. **Protective intake – receipt, screening investigation of potential cases²⁷:** Protective intake has two components: (1) screening and (2) investigation. Screening is a key part of the process of reporting, identifying, accessing and providing treatment for families and children.²⁸ Investigation identifies children who may have been abused or neglected (or may be at risk of abuse or neglect) and determines the nature of the DSS’s involvement with the family.

For the new case, protective intake represents the social worker’s initial step to determine the services that are necessary to prevent or eliminate the need for out-of-home placement. Preliminary assessment of service needs is essential to determining whether the child can safely remain in the home, and if so, with what supports. This activity includes the social worker’s gathering of information to assess whether the child needs substitute care (commonly, foster care, group foster care, or residential educational placement) provided by DSS.

²⁶ DSS Policy #90-004(R), Placement Prevention and Placement Policy, attached as Exhibit 5.

²⁷ Protective intake is generally described in the RMTS and more completely described in additional supporting documents, some of which are referenced in the RMTS, including DSS Policy #86-015, Protective Intake, which is attached here as Exhibit 6.

²⁸ DSS Policy #86-015, Protective Intake.

For the ongoing case, in which a new investigation takes place, gathering of information may result in a reassessment of service needs, including whether the child needs substitute care and/or a new or revised service plan.

Protective intake is a TCM service that helps enrollees gain access to needed medical, social and other services (including, social services provided by DSS, such as substitute care, if necessary) and specifically may include collection of assessment data, home visits and collateral contacts as needed, in accordance with activities described in the state's approved TCM State Plan. Protective intake is the first step in the process of development of case service plans, an activity that the OIG agrees is a TCM service.

3. **Preparation for and participation in, judicial determinations or voluntary placement agreements in family courts²⁹**: This activity is described in the RMTS as the social worker's preparation for and participation in judicial determinations, court proceedings or voluntary placement agreements in family court. The social worker's participation helps the enrollee gain access to needed social services, i.e., substitute care, by providing assessment data needed to support a court order to place the child out of the home. This activity is a critical component of the set of interrelated services designed to locate and coordinate needed services.
4. **Referrals to the district attorney³⁰**: DSS makes referrals to the district attorney whenever DSS has reasonable cause to believe the child is a crime victim.³¹ Whenever DSS makes a referral to the district attorney, it establishes a multi-disciplinary service team to review the provision of services to children and their families who are the subjects of the referral.³² The team discusses the status of the child and the family, determines whether different or additional services should be added to the child's service plan, and discusses the effects of prosecution on the child and family and whether diversionary programs would be possible.³³ Among other things, the social worker's role is to document the date, participants, content and outcome of the team meeting. The social worker activities related to the multi-disciplinary service team that fall within the category of "referrals to the district attorney" include collection of assessment data, development of an individualized plan of care, coordination of needed services and providers, maintenance of case records and monitoring and evaluation of client progress and service effectiveness. The social worker works directly with the multi-disciplinary team to identify the need for changes to case service plans. As such, the activity described as referrals to the district attorney is an integral component of the development of case service plans, a service that the OIG agrees is a TCM service.
5. **Case management**: This activity includes "assisting clients on an ongoing basis, in identifying and obtaining available services to meet assessed needs. Activities

²⁹ RMTS at p. 4.

³⁰ This activity is described generally in the RMTS and more completely in DSS Policy 85-012(R), Policy and Procedures for Referrals to the District Attorney, which is incorporated by reference in the RMTS and attached here as Exhibit 7.

³¹ DSS Policy 85-012(R).

³² Id.

³³ Id. at p. 186.

include specifying services to be provided in the family's service plan, determining what services are appropriate and available, providing assistance to the client in obtaining supervision, supporting ongoing casework through discussion of family dynamics, treatment planning, service delivery, agency mandate and case load priorities..."³⁴ This activity also includes opening and assigning a case to the social worker, maintaining contact with the family and collaterals identified in the case service plan, the social worker's time obtaining supervision on the case, documenting case management activities, and meeting with and assisting clients in identifying and obtaining available services.³⁵ As described in the RMTS, the purpose of case management is to help enrollees access needed medical, educational, social and other services. Case management activities include all of the five specific TCM service activities described in the approved State Plan: collection of assessment data, development of an individualized plan of care, coordination of needed services and providers, home visits and collateral contacts as needed, maintenance of case records and monitoring and evaluation of client progress and service effectiveness.

6. **Development of case service plans:** The OIG agrees that this activity assists enrollees in accessing needed medical, educational, social or other services and is, therefore, a TCM service.
7. **Case reviews:** The OIG agrees that this activity assists enrollees in accessing needed medical, educational, social or other services and is, therefore, a TCM service.³⁶

B. Post-Placement Activities: Services to Children in Out-of Home Placements

Post-placement activities are social worker activities related to children where the decision has been made to remove a child from his home and placement arrangements have been initiated. The categories of post-placement activities are largely the same as the categories of pre-placement activities. Both pre- and post-placement include referral to services, preparation for and participation in judicial determinations or voluntary placement agreements in family courts, participation in other court proceedings, referrals to the district attorney, case management, development of case service plans, and fair

³⁴ RMTS at p. 6

³⁵ Id. at pp. 5 and 6

³⁶ The following pre-placement activities were excluded from the TCM rate for the reasons specified herein:

Participation in other court proceedings: This activity describes the social worker's participation in activities related to judicial proceedings in courts other than family court. RMTS at p. 5. Although in some instances the social worker's participation in these other court proceedings does assist children in accessing needed services, out of an abundance of caution, the Commonwealth does not include any time spent on these services in its TCM rate.

Fair hearings and appeals: This activity describes the social worker's participation in activities related to fair hearings and appeals of decisions made by DSS to support a report of abuse or neglect. RMTS at p. 8. Although in some instances, the social worker's participation in these proceedings does help children to access needed services, out of an abundance of caution, the Commonwealth does not include any time spent on these services in its TCM rate.

Direct counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions: The Commonwealth does not include any time spent on these services in its TCM rate. RMTS at p. 9.

hearings and appeals, and direct counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions. The activities contained in each of these categories and whether those activities are TCM services are discussed above and are not repeated here. Post-placement activities included at cost centers and not described above are child placement and investigative efforts. How each of these additional categories of services functions as a TCM service is detailed below.

1. **Child Placement:** This category includes a variety of activities, such as arranging for or monitoring a voluntary intake, assisting the family with completion of an application for assistance from DSS, setting up case records, and initiating a process to assess the needs of the child or family for services. It also includes making reasonable efforts to avoid placement by locating and authorizing available services, assisting the child in accessing qualified family placements if an out-of-home placement is necessary or in accessing community placement, including group homes and residential schools. The social worker's activities in this category include identifying service needs and authorizing the provision of those services including, for example, clothing.

These activities are TCM services in that they assist individuals in gaining access to needed social services, such as foster care and educational services, including residential school placements, as well as other services that may even eliminate the need for substitute care. Child placement activities include at least the following specific TMC service activities described in the approved State Plan: collection of assessment data, development of an individualized plan of care, coordination of needed services and providers, home visits and collateral contacts as needed, and maintenance of case records.³⁷

2. **Investigative Efforts:** The activities in this category occur once a child is removed from the home, and are equivalent to protective intake.³⁸ Investigative efforts are a TCM activity for the same reasons that protective intake is a TCM activity. That analysis is not repeated here for the sake of brevity.³⁹

C. Permanency Planning Activities

Two categories of TCM services are related to children who are adopted rather than returned to their home of origin. These are: services for children with special needs, and all other permanency planning activities.

³⁷ RMTS at pp. 12-13.

³⁸ RMTS at p. 13.

³⁹ The following post-placement activity was excluded from the TCM rate for the reason specified:

This activity consists of the case manager's participation in coordinating medically necessary EPSDT treatment, a CMS mandated case management activity. It includes coordination of needed services and providers as specified in the approved State Plan. It is described in the RMTS as "...caseworker participation in procuring Project Good Health [i.e., EPSDT] services for children in cases where a removal from his or her home has occurred..." This activity is generally equivalent to health services to children in placement activity as described in the Case Policy and Procedures Manual. DSS Policy #85-003. This TCM activity was not included in the calculation of the TCM rate because the Commonwealth was considering the development of an EPSDT administration claim at that time and wanted to avoid any possibility of duplicate claiming.

1. **Services for children with special needs:** These activities are related to the arrangement for and entry into adoption assistance agreements or alternative placements. When DSS identifies a goal of adoption for a special needs child in its custody, the case manager develops a permanency plan for the child, which reflects the goal of adoption. The social worker meets with the pre-adoptive parent(s) to discuss the financial and health insurance supports they may need to bring the child into their home on a permanent basis and arranges for DSS and pre-adoptive parent to enter into an adoption assistance agreement reflecting those supports. When DSS identifies an alternative permanent plan other than adoption, the case manager develops a service plan that addresses the child's special needs and specific tasks related to achieving the child's permanency planning goal. In all cases, the case manager participates in the development of individualized plans of care, coordinates needed services and providers, performs home visits and makes collateral contacts and maintains case records, in accordance with the approved State Plan.⁴⁰
2. **All other permanency planning activities:** These activities are related to permanency planning other than the arrangement of special needs adoption agreements. This activity is a TCM service that helps the enrollee gain access to needed social services, i.e., permanent family placement. This category includes the same TCM service activities as those described for in the category for services for children with special needs.⁴¹ For example, the social worker will develop a permanency plan with a goal of guardianship and arrange a guardianship subsidy agreement to facilitate successful placement into a permanent home.

In Appendix A to the Draft Audit Report, the OIG provides an incomplete, and therefore misleading, description of the activities that are recognized in each cost center. As demonstrated by more complete descriptions of the social worker's activities in each cost center, all of the activities included in the cost centers that make up the TCM rate are TCM reimbursable activities.

IV. The OIG Denies the Commonwealth Due Process by Claiming to Support the Disallowance of Entire Categories of Activities Identified in the RMTS Based on Specific Claims that Have Not Been (1) Provided to the Commonwealth, and (2) Are Not Directly Tied to the TCM Rate in Any Case

The OIG states that it has "verified" its conclusions about the TCM rate by reviewing a statistical sample of 100 beneficiary months containing a total of 575 TCM services, which the State Agency billed to Medicaid.⁴² The OIG contends that "of the 575 services, 480 (84%) clearly did not meet the definition of TCM."⁴³ The OIG has not identified which of the activities it reviewed are not TCM services. As a result, the Commonwealth is unable to respond to the OIG's findings for each case. It is fundamentally unfair for the OIG to assert that an activity is not a reimbursable TCM service without creating a record of the alleged improper activities and providing the Commonwealth an opportunity to respond.

⁴⁰ DSS Policy 87-001, Policy and Procedures for Permanency Planning, attached as Exhibit 8.

⁴¹ Id.

⁴² Draft Audit Report at p. i.

⁴³ Id. at p. 6.

Further, the OIG statement that all of the 575 services were "billed" to Medicaid is in error and misleading. In accordance with the OIG's request, the Commonwealth supplied specifics on all of the 575 events (activities) that were provided during the months associated with the 100 sample claims. The rate method Massachusetts utilizes selects only one activity per member (enrollee) per month to support the TCM claim, no matter how many TCM services the member received in that month. DSS utilizes a claim validation protocol to ensure that only activities that meet all requirements for claiming are utilized. Of the 575 services the OIG reviewed, only those that were used to support a claim were subjected to the validation protocol. Again, since OIG has not identified which of the 575 events are not TCM activities, the Commonwealth is unable to determine which, if any, of the events the OIG finds unallowable were "billed" to Medicaid.

In fact, the Draft Audit Report only identifies four events that it concludes are not TCM activities. Only one of these events was used to support a TCM claim. In any case, the Commonwealth disagrees with the OIG's conclusions with respect to all of the examples for the reasons set forth below:

Example #1 (Draft Audit Report, p. 7)

On March 4, 2003, the social worker received a call from a foster parent, called the child's probation officer, and attended court with the child.

This activity is a TCM service in which the social worker assesses the child's need for services by talking to the child's foster parent and probation officer, identifies whether there are any changes to the child's placement that would have an impact on the child's service plan and, depending on the social worker's assessment of needed services, provides recommendations and referrals for the services that would be best for the child.

Example #2 (Draft Audit Report, p. 7)

On March 11, 2003 the social worker made a home visit accompanied by another social worker who stated that they were working on budgeting, parenting, and the child's setting.

The OIG's description of this event creates the impression that the DSS social worker is providing a direct service of assisting the parent with parenting skills and budget management. The OIG's description is inaccurate and misleading. The social worker's case notes in this case read as follows: "Worker attended home visit. Lipton Center Family Support Worker Joanne was also in attendance for UR. Joanne stated that they [the family and the Lipton Center] were working on budgeting, parenting and setting limits." The social worker's notes make clear that the person providing the direct social service was the Lipton Center Worker. The event is a TCM service in that the DSS social worker assessed and recorded what direct services were being provided by the (non-DSS) Lipton Center worker.

Example #3 (Draft Audit Report, p. 7)

On March 26, 2003, the social worker left a phone message for the child's principal requesting that the child be allowed to return to school.

This is example documents a TCM service in that the social worker is assisting the child in gaining access to needed educational services by contacting the child's school to arrange for the child's return to school.

Example #4 (Draft Audit Report, p. 7)

For example, a case note for 1 sampled month, which was part of the support for a \$163 Federal Medicaid claim, stated that the social worker called the child's therapist. The therapist discussed the child's psychological and emotional well-being, the information that the child provided during sessions, and the need for more consistent and intensive therapy.

This example documents a TCM service because the DSS social worker is assessing the child's need for therapy and assessing whether additional or different services should be added to the child's case plan.

In any event, the OIG performed a rate development audit and not a claims audit. The TCM rate was developed based on the RMTS, and not on the claims or activities that the OIG reviewed. The OIG's use of the 575 events to bolster its conclusions about the TCM rate is misleading because these events are not directly related to rate development.

V. The OIG Did Not Properly Adjust the TCM Rate and, as a Result, the Amount the OIG Determines is Unallowable is Overstated by Almost \$22 Million

As described in the TCM rate petition provided to the OIG and attached to this response as Exhibit 2, the Commonwealth's TCM rates include a cost settlement for setting current rates based on costs from two years back, referred to as a "fixed with carry forward" process. The OIG failed to consider the fixed with carry forward process when it adjusted the TCM rate. This OIG error results in an overstatement of almost \$22 million.

The fixed with carry forward process is a reconciliation tool that must be used to accurately recalculate the TCM rate. Although a fiscal year's expenses are not known in advance, TCM claims are submitted throughout the year. Therefore, in order to submit claims for a current year, a trended rate based on past expenses must be developed. The Commonwealth's process is to take actual expenses from two years back to determine the trended rate for the current year. (For the purpose of clarity, we will call the current year "Year X") In addition, an adjustment is made to this figure to reflect the difference between the rate that was used for claiming during Year X minus 2 and the rate calculated for use during Year X.

The OIG only considered actual costs for its rate calculations and failed to consider adjustments for the fixed with carry forward process. Because costs for TCM services were trended upward, the adjustments for past periods have tended to be positive. Without the fixed with carry forward adjustments, the TCM rates based only on actual costs for each year follow:

Actual TCM Cost Rates Per State Fiscal Year

	Substantiated Abuse	Unsubstantiated Abuse
SFY'02	\$240	\$83
SFY'03	\$224	\$70
SFY'04	\$258	\$79

Using the OIG's recalculated rates, which were based on actual costs, and comparing them to the Commonwealth's actual costs, the OIG's recommended disallowance would be reduced by \$22,746,059, as demonstrated by the chart below:

Miscalculation of Disallowance from Comparing Current Expenditures to Claiming Rates Based on Expenditures 2 Years Back

	Q2-Q4 SFY 2002		SFY 2003		Q1 SFY 2004	
	Substantiated Abuse	Unsubstantiated Abuse	Substantiated Abuse	Unsubstantiated Abuse	Substantiated Abuse	Unsubstantiated Abuse
State Actual Cost Rate	\$240	\$83	\$224	\$70	\$258	\$79
Auditor's Recalculated Rate	\$49	\$11	\$31	\$10	\$54	\$12
Difference Unallowed	\$191	\$72	\$193	\$60	\$204	\$67
Months Claimed	267,902	2,577	316,626	1,195	66,398	232
Amount Overstated	\$51,169,282	\$185,544	\$61,108,818	\$71,700	\$13,545,192	\$15,544
Total Overstatement	\$126,096,080					
Federal Amount Overstated ¹	\$25,584,641	\$92,772	\$31,005,087	\$36,379	\$7,172,179	\$8,231
Total Federal Overstatement	\$63,899,288					
Auditor's Federal Overstatement	\$86,645,347					
Amount Difference	(\$22,746,059)					

¹ Federal share calculated as 50% FMAP for SFY02 Q2 - Q4, 50% FMAP SFY03 Q1 - Q3, 52.95% FMAP SFY03 Q4, and 52.95% FMAP for SFY04 Q1

In addition, the Commonwealth's review of Appendix B to the Draft Audit Report indicates that the OIG utilized provisional costs and caseloads to recalculate the TCM rate for state fiscal year 2004. If the OIG used actual costs and caseloads for state fiscal year 2004, this would cause the OIG's calculated disallowance amount for the period to increase by \$843,663.

Auditor's Recalculated Rate Using Finalized SFY 2004 Expenditure and Census Data

	DSS Consumer Type		
	UP	General	Total
Annual Consumers in Placement			10,074
Annual Consumers Not in Placement			29,576
Annual Consumers	3,480	36,170	39,650
TCM Claimable	\$ 846,424	\$ 20,565,635	\$ 21,412,059
Annual Consumers	3,480	36,170	39,650
TCM Claimable Per Consumer	\$ 243	\$ 569	\$ 540
Preliminary Monthly TCM Rate	\$ 20	\$ 47	\$ 45
Title IV-E Claimed	\$ 313,940	\$ 7,618,325	\$ 7,932,265
Annual Consumers	3,480	36,170	39,650
Title IV-E Claimed Per Consumer	\$ 90	\$ 211	\$ 200
Monthly Title IV-E Credit	\$ 8	\$ 18	\$ 17
Preliminary Monthly TCM Rate	\$ 20	\$ 47	\$ 45
Monthly Title IV-E Credit	\$ (8)	\$ (18)	\$ (17)
Monthly Other Federal Credit	\$ -	\$ -	\$ -
Monthly Net TCM Rate	\$ 13	\$ 30	\$ 28

Miscalculation of Disallowance from Not Using Final SFY 2004 Expenditure and Census Data

	Q1 SFY 2004	
	Substantiated Abuse	Unsubstantiated Abuse
State Actual Cost Rate	\$258	\$79
Auditor's Recalculated Rate (using final expenditure and census data vs. provisional)	\$30	\$13
Difference Unallowed	\$228	\$66
Months Claimed	66,398	232
Amount Overstated	\$15,138,744	\$15,312
Total Overstatement	\$15,154,056	
Total Federal Overstatement ¹	\$8,024,073	
Auditor's Federal Overstatement	\$7,180,410	
Amount Difference	\$843,663	

¹ Federal share calculated as 50% FMAP for SFY02 Q2 - Q4, 50% FMAP SFY03 Q1 - Q3, 52.95% FMAP SFY03 Q4, and 52.95% FMAP for SFY04 Q1

As demonstrated by the chart below, after correcting both of the OIG's calculation errors, the OIG's recommended disallowance should be reduced by \$22,746,059.

Total Miscalculation of Disallowance

	Q2-Q4 SFY 2002		SFY 2003		Q1 SFY 2004	
	Substantiated Abuse	Unsubstantiated Abuse	Substantiated Abuse	Unsubstantiated Abuse	Substantiated Abuse	Unsubstantiated Abuse
State Actual Cost Rate	\$240	\$83	\$224	\$70	\$258	\$79
Auditor's Recalculated Rate	\$49	\$11	\$31	\$10	\$30	\$13
Difference Unallowed	\$191	\$72	\$193	\$60	\$228	\$66
Months Claimed	287,902	2,577	316,626	1,195	66,398	232
Amount Overstated	\$51,169,282	\$185,544	\$61,108,818	\$71,700	\$15,138,744	\$15,312
Total Overstatement	\$127,689,400					
Total Federal Overstatement¹	\$64,742,951					

Auditor's Federal Overstatement	\$86,645,347
Amount Difference	(\$21,902,396)

¹ Federal share calculated as 50% FMAP for SFY02 Q2 - Q4, 50% FMAP SFY03 Q1 - Q3, 52.95% FMAP SFY03 Q4, and 52.95% FMAP for SFY04 Q1

VI. There is No Lawful Basis for the OIG to Conclude that Any TCM Service Claims Are "Unallowable or Potentially Unallowable" Because the Services Were Required to Be Provided Pursuant to Massachusetts State or Federal Law

a. Services Provided Pursuant to Massachusetts State Law

The fact that the Department of Social Services provides TCM services pursuant to Massachusetts state law alone is irrelevant to the allowability of the Commonwealth's TCM claims. For close to 20 years, CMS has been expressly prohibited from using that as a basis to refuse to provide federal reimbursement for TCM. Specifically, in 1988, Congress enacted Section 8435 of Public Law 100-647, which reads as follows:

[CMS] may not fail or refuse to approve an amendment to a state plan... that provides for coverage of case-management services described in section 1915(g)(2)... or deny payment to a state for such services ... on the basis that the state had paid or is paying for such services from non-federal funds."

b. Services Are Authorized under Other Federal Programs to Assist Children and Families, Including Titles IV-B (Child and Family Services), IV-E (Federal Payments for Foster Care and Adoption Assistance), and XX (Block Grants to States for Social Services)

Since it issued the SMDL, without promulgating the promised regulations, CMS has inconsistently (and inappropriately) begun to utilize the State Plan approval process to articulate a new policy that results in the denial of federal financial participation under the Medicaid Act for TCM expenditures for any child in the care or custody of a state social services agency.⁴⁴ The theory CMS articulates now is that TCM services provided to

⁴⁴ CMS has denied approval of TCM State Plan Amendments from Rhode Island and Maryland but has approved Montana's TCM State Plan Amendment. A copy of Montana's approved State Plan Amendment is attached hereto as Exhibit 9.

children in the care or custody of social services agencies are not reimbursable because such services duplicate coverage of services “that are inherent in and inseparable to fulfillment of a state’s responsibilities under Title IV of the Act.”⁴⁵ CMS states that “even though the activities in question may not always have been explicitly labeled as case management when performed under the State’s Title IV responsibilities, the State has provided no evidence that the activities are not the same.”⁴⁶

Any CMS policy of denying Medicaid reimbursement for TCM services for all children in the care and custody of a state social services agency is plainly inconsistent with the intent of Congress when it enacted the TCM provisions of the Medicaid Act and the First Circuit’s holding in Bowen, supra.

In relevant part, the legislative history of the TCM statute provides:

The intent is to allow case management to be provided as an additional service. It is not the Committee’s intent that the State’s use case management solely to reduce program costs. It is the committee’s intent that the State’s may target any Medicaid group, including the non-elderly, under this provision. United States Code and Administrative News, 99th Congress - Second Session 1986 Volume 3 at 280. [emphasis added]

The Conference report goes on to add:

The conferees expect that the Secretary will assure that payments made for case management services under this section do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Conference Report, Consolidated Omnibus Budget Reconciliation Act of 1985 at 546. [emphasis added]

Furthermore, after amending the Medicaid Act to include Targeted Case Management generally, Congress further amended the Act to include TCM as a listed medical assistance service, making TCM a service all Medicaid beneficiaries eligible for EPSDT services are entitled to receive. 42 USC 1396a(10), 1396d(a)(19), 1396(n)(g), 1396d(r)(5), and 396d(a)(4)(B).

All of the children in the DSS target group are eligible for EPSDT services. The legislative history of the TCM statute demonstrates that Congress: (1) intended for TCM to be available to all Medicaid groups (and not to exclude children in the care or custody of a state social services agency); and (2) expected states to receive federal Medicaid reimbursement for TCM services that are provided under other non-Medicaid programs, provided that the Medicaid reimbursement does not duplicate other payments made to the state.

As demonstrated below, there is no evidence that Congress intended Title IV-B or XX funds to substitute for the federal reimbursement guaranteed to the states under 42 USC 1396b of the Medicaid Act. Indeed, it is evident from the text of the statutes that Congress intended to provide the federal government with discretion about whether to make funds available and states with flexibility about spending whatever funds the federal government decides from year to year to provide.

⁴⁵ Federal Register Vol 68, No. 225/ Friday, November 21, 2003. Notice of Hearing: Reconsideration of Disapproval of Rhode Island State Plan Amendment 02-009.

⁴⁶ Id.

For example, Title IV-B Subpart 1 gives states broad discretion to provide a wide array of services that the state determines will protect and promote the welfare of all children.⁴⁷

Unlike the automatic federal reimbursement guaranteed under the Medicaid Act, the total amount of the Title IV-B Subpart 1 grant is subject to annual appropriation.⁴⁸ The funding available during the audit years under Title IV-B Subpart 1 was de minimus compared to the State's expenditures for TCM services. In audit year 2002, DSS received \$4,591,700 in federal funds through Title IV-B Subpart 1. In audit year 2003, DSS received \$4,561,406.

On its face, Title IV-B Subpart 1 is designed to provide a small amount of funding for a wide variety of purposes, as determined by the state. In fact, the United States Department of Health and Human Services (HHS) recently told the General Accounting Office that it does not review how states use Title IV-B Subpart 1 funds because there are so few restrictions on how states can use them.⁴⁹

Subpart 2 of Title IV-B is intended to provide states with a small amount of funding for services other than activities that would be reimbursable TCM activities provided by state social workers.⁵⁰ Again, unlike the Medicaid Act, payment to the state is not automatic – the total amount of the Title IV-B Subpart 2 grant is subject to annual appropriation.⁵¹ The funding available during the audit years under Title IV-B Subpart 2 was de minimus compared to the state's expenditures for TCM services, particularly where only 10% of the funding from Title IV-B Subpart 2 could be used to pay for TCM services provided by social workers. In 2002 the state received \$5,593,489 million. In 2003 the state received \$6,037,548.

Finally, Title XX, the "Social Services Block Grant," provides funding to states to help achieve a wide range of social policy goals, which include preventing child abuse, increasing the availability of child care, and providing community-based care for the elderly and disabled.⁵² Again, unlike the Medicaid Act, payment is not automatic – Title XX is subject to federal appropriation. In accordance with the discretion provided by Title XX, the Commonwealth apportions its allotment among various state agencies. In the audit years in question, and currently, the Commonwealth apportions its allotment between DSS and the Massachusetts Commission for the Blind. There is no evidence that Congress intended to require states to utilize Title XX for TCM services to children in the custody of social services agencies; indeed, it is obvious from the statutory language and the fundamental concept of a "block grant" that Congress intended states to select how to use available funding from a wide variety of permissible choices.

The effect of CMS's policy would be to require Massachusetts to use all of the Title XX and Title IV-B funding available on federally mandated Medicaid TCM services, even though the plain language of Title XX and Title IV-B does not require the Commonwealth to utilize any of these funding sources for such services. CMS's policy is demonstrably inconsistent with the intent of Congress and with Bowen. The OIG should not publish a final audit report

⁴⁷ 42 USC 620, 42 USC 625.

⁴⁸ 42 USC 621

⁴⁹ Child Welfare Enhanced Federal Oversight of Title IV-B Could Provide States Additional Information to Improve Services (GAO-03-956) at p. 3.

⁵⁰ See. 42 USC 629b(a)(4)

⁵¹ 42 USC 629c

⁵² 2000 House Ways and Means Green Book, at Table 10.3

suggesting that the Commonwealth's TCM claims are not allowable based on a CMS policy that is inconsistent with applicable federal law.

Finally, DSS does not utilize the funds it receives from Title IV-E, Title IV-B or Title XX for activities that are Medicaid-reimbursable TCM.⁵³ The Commonwealth would be pleased to demonstrate to the OIG that it has not used Title IV-B or XX funds to pay for social worker salaries, and expects that the OIG will give it the opportunity to do so before finalizing the audit report.

VII. Conclusion

For all of the reasons stated above, the Commonwealth strongly disagrees with the Draft Audit Report and disputes each of its findings.

⁵³The OIG agrees that the Commonwealth allocates costs to Title IV-E to the extent permissible and does not include such costs in its TCM rate. Draft Audit Report at pp. 54. Since receiving the Draft Audit Report, DSS has discovered that \$34,000 in IV-B funds was erroneously applied to social worker salaries during the audit period – however, the amount of DSS social worker salaries that is unreimbursed from any federal title is well in excess of \$34,000.