Children's Defense Fund

February 4, 2008

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-2237-IFC

To Whom It May Concern:

The Children's Defense Fund (CDF) is pleased to have the opportunity to comment on the Interim Final Rule for Medicaid Optional State Plan Case Management Services that was published in the *Federal Register* on December 4, 2007. (72 Fed.Reg. 68077-68093)

CDF's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start*, and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective voice for all the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, into trouble, drop out of school, or suffer family breakdown.

CDF has worked with others for more than three decades to ensure children access to affordable, seamless, comprehensive health and mental health coverage. One of our very first reports in 1977, *EPSDT: Does It Spell Healthcare for Poor Children?*, challenged state non-enforcement of Medicaid for poor children and recommended new regulations requiring states to improve treatment for poor children. Important steps have since been taken over the years to increase the number of children eligible for health coverage under Medicaid and to guarantee them all medically necessary services under the program.

It is thus with serious concerns that we submit comments on the Interim Final Rule for Medicaid Optional Case Management Services that chips away at the very protections and services that have been a lifeline for children with physical, emotional and developmental disabilities, and for those children who suffer a range of health problems as a result of abuse and neglect and other trauma. Over the years, important principles and practice improvements have emphasized the importance to these children of individualized treatment, comprehensive integrated services, and family engagement in the delivery of services. The President's New Freedom Commission on Mental Health, for example, has reinforced the need for systems of care and cross-system collaboration to address children's behavioral health needs. CDF worked closely with others to make all children in foster care eligible for Medicaid because of its importance in addressing the special health and mental health needs of these children and youth.

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While some parts of the Interim Final Rule directly and correctly implement the Deficit Reduction Act of 2005 ("DRA", P.L. 109-71), other parts, particularly when considered in tandem with the Provisions of the Interim Final Rule, seem to exceed the intent and statutory authority of the DRA. This is reinforced by the fact that the Accounting Statement at the end of the discussion preceding the Interim Final Rule (at 72 Fed. Reg. 68090-68091) estimates federal savings of $1.28 billion during the first five years the rule is implemented, significantly more than the $760 million projected by the Congressional Budget Office when it analyzed the targeted case management provisions in the DRA.

The interim final rule, especially when combined with other Medicaid regulations that have preceded it in the past five months, particularly those addressing Medicaid coverage of rehabilitative services and school-based services and transportation, ignores the importance of service directions advanced over the past several decades to get appropriate medical care to children with special health care needs. The Children's Defense Fund recommends that you withdraw this Interim Final Rule for Medicaid Optional State Plan Case Management Services and not implement it on March 3, 2008, as planned. Instead we recommend that you provide appropriate clarifying guidance to states, which is in line with the Deficit Reduction Act of 2005 and Congressional intent about what are appropriate targeted case management services and what are not. The guidance should conform to the Medicaid statute, as amended, and not unfairly and unnecessarily restrict services for children and other vulnerable populations.

In CDF's comments below on the Interim Final Rule for Medicaid Optional Case Management Services ("interim final rule" or "case management regulations"), we first raise general concerns about how the case management regulations will disadvantage low income children in need of special health and mental health care, and then focus more specific comments on the application of the new rules to children who are receiving child welfare and child protective services, including children in foster care.

The Interim Final Rule Threatens the Responsiveness of the Medicaid Program to Children and Youth With Complex Health and Mental Health Needs

Our overarching concern about this interim final rule and other Medicaid regulations issued recently by the Centers for Medicare and Medicaid Services (CMS) is that together they reconfigure the Medicaid program without sufficient statutory authority to do so, and will prevent children and youth, especially those with complex health and mental health needs, from getting the comprehensive integrated services they need.

We also have a number of other general concerns about the impact of the case management regulations and the Provisions of the Interim Final Rule. The regulations, together with the clarification in the Provisions:

- **Repeatedly suggest that case management services for certain Medicaid eligible children are optional. However, Medicaid law clearly establishes that case management services are a mandatory service for children. Under Medicaid's Early and Periodic, Screening, Diagnostic, and Treatment benefit, a child has a right to all medically necessary services including case management services.** The Interim Final

Rule severely restricts the circumstances in which the services could be offered to and received by children and youth, despite the fact that the Director of CMS, shortly after the DRA was passed, clarified for Congress that the EPSDT functions of state Medicaid programs were left untouched by the DRA.

- **Impose a number of new restrictions on the provision of case management services, without any statutory authority to do so.** For example, the interim final rule establishes an "integral component" test, which exceeds the authority in the Deficit Reduction Act and was rejected by Members of Congress when it was proposed by the Administration as the legislation was being drafted.

- **Elaborate on the new rules (in the Provisions of the Interim Final Rule) in a way that goes well beyond what is in the letter of the regulations, and in a number of cases such interpretations would restrict the use of case management without statutory authority to do so.** If these interpretations in the Provisions of the Interim Final Rule represent Centers for Medicare and Medicaid Services policy on Medicaid case management, we recommend that they be withdrawn or reconsidered.

- **Undercut efforts to promote service coordination and integration and responsiveness to the unique medical needs of individual children with complex health and mental health needs.** It was the increased recognition of the complex needs of children and adults and the need for increased coordination and integration that prompted the expanded use of case management and targeted case management services. It promoted better coordination between Medicaid providers and child welfare, special education and other child-serving agencies. These same directions are consistent with recommendations of the President's New Freedom Commission on Mental Health and many of the promising practices for children recognized in different ways by multiple agencies within the Executive Branch.

- **Include restrictions in early intervention services for infants and toddlers and special education that are likely to put more children with special needs at risk of coming to the attention of the child welfare system.** Child welfare intake is likely to grow as barriers are erected that prevent parents from getting the help their young children and school age children need through the Early Intervention Program and other special education programs.

- **Shift costs for critical health and mental health activities for children and other vulnerable populations from the federal government to already cash-strapped states in a significant way.** The anticipated costs of these rules alone are close to 70 percent higher than the cost anticipated in the Deficit Reduction Act, which these rules are supposed to be implementing. These additional costs come at the very time states are anticipating how to cope with significant additional costs being shifted to them as a result of other regulatory changes to the Medicaid program that CMS has recently proposed, are struggling with ways to help the State Children's Health Insurance Program reach more eligible children, and are trying to find ways to cope with increased demand for services from the current economic downturn.

- **Set in motion a series of events that will have an impact beyond Medicaid beneficiaries**. When states have to reach elsewhere for these specialized services, other children in need who are not Medicaid eligible may find themselves negatively impacted when already scarce services have to be stretched further.

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The Interim Final Rule, Particularly as Interpreted by the Provisions of the Interim Final Rule, Will Harm Children with Special Health and Mental Health Care Needs in the Child Welfare System, Including Children in Foster Care.

A number of the new case management regulations, especially if they are interpreted by CMS as described in the Provisions of the Interim Final Rule, will have a particularly harmful effect on children and youth who receive child protective and other child welfare services, including those in foster care, and these regulations are the focus of our comments below. It is also important to note, however, that many of the case management regulations and much of the additional language in the Provisions of the Interim Final Rule described below, will also have an equally harmful impact on children and youth in juvenile justice and probation systems and some children in special education programs.

- **The restrictions on "activities integral to" the administration of another program or "an integral component of" another Medicaid covered services in the case management regulations threaten to deny all Medicaid case management services to children with complex medical needs in foster care and a range of other programs (Sec. 441.18(c)(1)(4); 72 Fed. Reg. 68086-68087)**

The interim final rule specifies that Medicaid federal financial participation will not be available for Medicaid case management services that are: 1) an integral component of another Medicaid covered service (Sec. 441.18(c) (1), 2) integral to the administration of foster care (Sec. 441.18(c) (3), or 3) integral to the administration of a list of non-medical programs, including child welfare, child protective services, and guardianship. (Se. 441.18(c)(4). The term "integral" is not defined and is very vague. Rather than helping to clarify what is and is not a covered Medicaid case management service, the restriction on activities that are "integral to the administration of" foster care and other non-medical programs creates even more confusion. It is also particularly troubling that CMS is raising the specter of such a test, given that it was rejected by Members of Congress when it was proposed by the Administration as the Deficit Reduction Act was being drafted. Therefore it clearly is not authorized by the DRA.

Indeed if the true intent of such a provision is to ensure that Medicaid is last payer and that duplicate payments are not being made, the requirement at Sec. 441.18(a)(4) is a better way to do that. It states specifically that states must ensure that case management services "will not duplicate payments made to public agencies or private entities under the state plan and other program authorities."

Recommendation: Delete Sec. 441.18(c)(1)(4), which sweeps in under the "integral to" test child welfare/child protective services, parole, probation, guardianship and special

education services, and the Provisions of the Interim Final Rule at pages 68086-68087 that elaborate upon all of these.

- **The Provisions of the Interim Final Rule specifically prohibit Medicaid funding for case management services delivered by state child welfare or child protective services workers, or child welfare contractors, as well as foster care staff. (72 Fed. Reg. 68086-68087)**

There is nothing in the Deficit Reduction Act to justify the interpretation in the Provisions of the Interim Final Rule that Medicaid case management funds cannot be used to pay for the services of any state child welfare or child protective services workers or child welfare contractors. We accept that there were certain illustrative administrative foster care activities cited in the DRA that would not be allowable as Medicaid case management services (Sec. 441.18 (c)(3)), and even accept the longer list in the interim final rule, given that the DRA indicated that its list was not meant to be inclusive. However, the general prohibition in the Provisions of the Interim Final Rule goes far beyond the DRA and would violate current Medicaid law. The Provisions of the Interim Final Rule states:

> Thus, Medicaid case management services must not be used to fund the services of State child welfare/child protective services workers. Further, Medicaid may not pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they would otherwise be qualified Medicaid providers, because they are furnishing direct services to the programs of that agency. (page 68086)

At page 68087, the Provisions of the Interim Final Rule goes on to say that in addition to the foster care administrative activities excluded from case management in the DRA: "Medicaid case management services must not be used to fund the services of foster care workers."

Congress in the DRA did not prohibit Medicaid coverage of case management services provided by child protective and child welfare services workers, or child welfare contractors (or by probation and parole officers and juvenile justice system employees and contractors who are also noted in the Provisions of the Interim Final Rule at page 68086). Nor did Congress prohibit Medicaid funding for all case management services provided by foster care workers.

The DRA was intended to codify the federal policy on targeted case management set out in a January 19, 2001 State Medicaid Directors Letter (SMDL 01-013). That letter specifically permitted Medicaid case management services to be performed by foster care workers, recognizing that Title IV-E is not liable for the assessment, care planning and monitoring of medical needs. However, the letter cautioned that the case management activities of the foster care workers that were claimed under Medicaid needed to be distinguished from activities of the workers directly connected to the delivery of foster care benefits and services. (page 1) And the DRA helped to make that distinction. In fact, an April 5, 2006 letter from then-Chairman of the Senate Finance Committee, Senator Charles Grassley, to Secretary Leavitt clarified that the DRA did not intend to disallow reimbursement for case management services under Medicaid for children in foster care.

It also makes no sense from a clinical or therapeutic perspective to prevent staff directly serving a child (who are most knowledgeable about their needs), from being involved in the assessment, case planning, referral, monitoring and follow up related to their getting the health and mental health services under Medicaid that they need. Almost half of the children and youth in foster care have a disability or chronic medical problems, and up to 80 percent have serious emotional problems. Timely access to health and mental health services is key to their receiving quality care. Yet under the new rules, only a Medicaid provider operating outside the child welfare system, and not contracting with any one within the system, could provide case management services to children in the system. To ensure quality care for the child, the focus should remain on clearly defining what Medicaid case management services are, which it does at Sec. 440.169 of the case management regulations, rather than restricting which qualified professionals can deliver these services.

> **Recommendation:** Eliminate Sections 441.18(c)(1), (4) of the case management regulations and the language in the Provisions of the Interim Final Rule at pages 68086-68087 that prohibit child welfare/child protective services and foster care workers from delivering the services.

- **Provisions of the Interim Final Rule also prohibit case managements services under therapeutic foster care programs from being reimbursable as Medicaid case management services. (72 Fed. Reg. 68087)**

In addition to prohibiting any Medicaid case management funds from being used to fund foster care workers, the Provisions of the Interim Final Rule go on to say that "case management activities included under therapeutic foster care programs will be subject to this payment exclusion since these activities are inherent to foster care." (page 68087) While they then go on to clarify that federal financial participation for medical services to a Medicaid eligible child with medical needs in such a therapeutic foster care program will still be available provided all Medicaid requirements are met, that is not the issue here. Here we are talking about case management services to help ensure that the child gets connected to the services. There is no statutory authority for the exclusion of Medicaid case management activities in therapeutic foster care. In addition, such an exclusion ignores three important points. First, there are many children in therapeutic foster care who are not benefiting from the Title IV-E Foster Care Program, and therefore the exclusions that apply to the IV-E program should not include foster care programs that are not eligible for IV-E funds. Second, children in therapeutic foster care are there because of their need for therapeutic services. They need help in getting necessary medical services for their complex medical needs. They are often in these specialized family care settings because they have complex needs that require the coordination of multiple service providers to connect the child with the correct combination of services and treatments. And third, there are provisions already in the regulations and in Medicaid law that will help protect against inappropriate claims for Medicaid case management services for children in therapeutic foster care, if that is the concern that needs to be addressed.

> **Recommendation:** Delete the paragraph at page 68087 in the Provisions of the Interim Final Rule that excludes from Medicaid the reimbursement of case management services for children in therapeutic foster care.

- **New restrictions are placed on the use of Medicaid case management services to help children and youth in residential placements return to the community. (Sec. 441.18 (a)(8)(vii)-(viii)**

There are provisions in federal child welfare law that require the placement of children in the last restrictive most family-like placement within close proximity to the child's home and community. In order to meet this requirement, it is essential, particularly for children with special health care needs, that substantial efforts be made to ease their transition to community-based services from institutional or other residential care. Although the number of children in institutional care is substantially less than in other settings, the children in these placements often have particularly serious disabilities and may require significant assistance over a period of time as they prepare to return to less restrictive settings. They need help preparing to move to new surroundings, but they also need help putting in place and connecting with the range of specialized treatment and services they will need while living in the community.

The interim final rule, however, would significantly restrict the use of case management services to assist with such transitions in two ways. First it would limit the period of time to 60 days for children who had been institutionalized for more than six months and to 14 days for those institutionalized for less than that. Second, it would only reimburse after the child was returned to a community-based setting and, if the transition did not occur, the state would not be reimbursed for the funds expended for case management services.

There is a certain irony in this provision. While many of the provisions of the interim final rule seem directed as reducing Medicaid costs, this provision may in fact result in increased costs as children, and particularly adults in nursing homes and other institutional settings, are forced to remain there because of the lack of appropriate help in transitioning to less costly community settings. It also operates contrary to the intent of recommendations of the President's New Freedom Commission on Mental Health, which highlight the importance of maintaining children and adults in community-based placements.

. **Recommendation:** Retain Medicaid regulations currently in effect, which provide for federal matching funds for case management services to prepare an individual to transition to a community-based setting from an institution for 180 days prior to the person's discharge from an institution.

- **The new interim final rule on the administration of case management services ignores the complex nature the special health care needs of the children being served.**

The interim final rule for Medicaid case management services imposes several restrictions on the administration of the services that seem to ignore the needs of the children and youth that such services were intended to help. These new rules also ignore a central tenet of the federal-state partnership to operate Medicaid, which is that states must follow federal guidelines while retaining broad flexibility over payment rates and policies.

Single Case Manager (Sec. 441.18(a)(5))

The interim final rule makes clear that any state that provides for Medicaid case management services, including targeted case management services, must "provide comprehensive case management services on a one-to-one basis, to an individual through one case manager (441.18(a)(5). However, there seems to be no statutory basis for such a requirement. Even assuming that this restriction applies only to Medicaid case managers (which is not clear as the regulation is currently written), it ignores the nature of the special needs of the populations receiving Medicaid case management services. Recognizing that the stated goal of case management services is, as CMS elaborates upon in the Provisions of the Interim Final Rule, to "assist the individual in gaining access to needed medical, social, educational and needed services" (pages 68081-68083), it should be obvious that case managers with different expertise and experience will be needed to link children and youth with complex medical needs to the services they require. A single case manager may not have the training and expertise to manage treatment of diverse conditions. An abused child with a physical disability, who is HIV positive and has developed an emotional overlay, for example, could benefit from more than one case manager to get help for his multiple needs. In such cases, it would be more helpful to the children involved to require that where possible there be a single case manager, but, when the complex needs of a child require more than one Medicaid case manager, that there be evidence of coordination and collaboration among the case managers. The goal should be unified case planning rather than a singe case manager.

> **Recommendation:** Rather than requiring a single Medicaid case manager, the interim final rule at Sec. 441.18(a)(5) should specify that in the instances where multiple Medicaid case managers are used for a child or adult, because of dual diagnoses or other circumstances, that there be documentation of steps taken to ensure cooperation among them.

Unit of Time Rather Than Unit of Service Billing (Sec. 441.18 (a)(8)(vi)

This is another area where what the regulations say is different than what is said in the Provisions of the Interim Final Rule. The regulation requires states to establish rates on a unit of service that does not exceed 15 minutes, although the Provisions of the Interim Final Rule suggests that this might just apply to case management services reimbursed on a fee for service basis. Regardless, CMS includes no justification for requiring unit of time billing, which is significantly more cumbersome and time consuming than unit of service claiming, which is used for other Medicaid services. Case managers charged with meeting the complex medical needs of children should not be required to engage in unnecessary detailed time keeping when they can be held accountable with a more efficient claiming process.

> **Recommendation:** Amend Sec. 441.18(a)(8)(vi) of the interim final rule to require only that the plan specify the methodology used for calculating payment rates for case management providers without requiring a specific method for computing the rates.

Restrictions on Bundling of Services (72 Fed.Reg. 68085)

In the Provisions of the Interim Final Rule, CMS explicitly prohibits bundled rates for case management. However, there are important evidence-based mental health and other services that are

furnished as a comprehensive package over an established period of time and would be difficult to tease apart. As discussed above, states should have the flexibility to pay for Medicaid case management services in the most efficient manner appropriate to high quality care. At the same time, when states use bundled rates, such as in programs like multisystemic therapy or functional family therapy, they must, upon inquiry, be able to identify the appropriate cost basis for the Medicaid case management services included in the bundled services.

> **Recommendation:** Delete the discussion of restrictions on bundling rates for case management that is now at page 68085 of the Provisions of the Interim Final Rule.

- **The definition of case management services in the interim final rule should be modified slightly. (Sec. 440.169(d)(1); 72 Fed.Reg. 68080-68083)**

The Provisions of the Interim Final Rule elaborate on the definition of case management services in ways that the rule itself does not and raise several points that are relevant for case management services for children and youth with complex health and mental health needs who are in the child welfare system, but not in foster care. While we accept the exclusion of direct services from the definition of case management services and generally agree with the outline of what constitute case management services, we have several recommendations.

Transportation (72 Fed. Reg. 68082)

The Provisions of the Interim Final Rule state that case management services, which include referral and related activities to help an individual obtain needed services, do not include providing transportation to the service or escorting the individual to the service. While we accept that case management services do not include the direct services to which the individual is linked, the exclusion of transportation, and, where necessary, the provision of an escort, may prevent a child or youth from ever accessing needed services. The DRA listed transportation as one of the Title IV-E services that could not be a Medicaid case management services, and we are not contesting that. However, for children or youth who are in state funded foster care or who remain at home under protective supervision by the child welfare agency and are eligible for Medicaid and are in need of medical services for their complex medical needs, transportation and also an escort are often critical to ensure that the child will receive the medical or other services related to his medical condition. The child may be too young or too emotionally fragile to travel alone. To deny the inclusion of transportation in these cases as a Medicaid case management expense, will likely mean the child will never actually connect to the service being sought. Physically transporting the child to the service is essential as is the work done with the child and youth during the time he or she is being transported in familiarizing the child with the medical service he is about to receive.

> **Recommendation:** The bulleted paragraph at page 68082 in the Provisions section that describes the exclusion of transportation should be modified to make clear that referral and related activities may include transportation and an escort when the special health and mental health needs of the child necessitate it in order for the child to access the service and no other appropriate transportation or escort service is available.

Requiring a Comprehensive Assessment (Sec. 440.169 (d); 72 Fed. Reg. 68081)

We are pleased that the interim final rule recognizes the need for a comprehensive assessment that includes the gathering of information from family members and others, even when they themselves are not Medicaid eligible. In order to further strengthen the description of the assessment, we recommend that the case management regulation include the language that the assessment must address all areas of need, including "the individual's strengths and preferences, and consider the individual's physical and social environment" that is in the Provisions of the Interim Final Rule (page 68081.) Such an addition would help to ensure that, particularly for children and youth, these assessments are strength-based and take into account the children's performance at home, in school and in interactions with others – all central components of a child's social environment.

Recommendation: Insert at Sec. 440.169 (d)(1) after "These assessment activities" the following "must address all areas of need, including the individual's strengths and preferences, and consider the individual's physical and social environment."

Thank you for the opportunity to comment on the Interim Final Rule for Medicaid Optional State Plan Case Management Services. Medicaid case management services are essential to link children and youth with complex medical needs – in and out of the child welfare system – to the health and mental health services they need. We appreciate your consideration of our comments and would be pleased to discuss any of our concerns or recommendations with you further.

Thank you.

Sincerely yours,

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