



Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Room 445-G
Washington, D.C. 20201

May 28, 2009

Re: CMS-2287-P2; CMS 2213-P2; CMS 2237-P; Comments on Partial Rescission of Case Management Services Interim Final Rule

Dear Acting Administrator Frizzera:

The Child Welfare League of America (CWLA), representing hundreds of public and private child- and family-serving member agencies across the country, respectfully submits these comments strongly supporting HHS's proposed rule partially rescinding the Medicaid Case Management and Targeted Case Management (TCM) Services rule (CMS 2237-IFC). CWLA and many of our members who directly serve abused, neglected and otherwise vulnerable children and youth first commented on the TCM interim final rule during its initial comment period in early 2008. While the regulation attempted to interpret and implement policies established by the Congress in the Deficit Reduction Act (DRA, P.L. 109-171), CWLA amongst several other advocacy organizations and concerned parties commented that the rule as written went well beyond the statutory provisions of the DRA that were authorized by Congress. The regulation was also ripe with vague language, granting inadequate notice to impacted parties regarding exactly what case management and TCM services would continue to be reimbursed by Medicaid. And most importantly, the regulation as written threatened the continuance of TCM services for several needy populations, including children and youth with physical and/or mental health issues that are involved with our nation's child welfare and foster care systems.

Children and youth in our nation's child welfare and foster care systems represent a particularly vulnerable segment of society and very much need Medicaid TCM services. These children and youth have a higher rate of physical and mental health issues, stemming either from abuse and/or neglect or from preexisting health conditions and unmet long-term service needs. Before they walk through the service delivery door, many of these children have been exposed to multiple traumas, including domestic violence, physical and emotional abuse, neglect, community violence, and exposure to other risk factors such as parental mental health problems, substance abuse, and poverty. When compared to the general population, children younger than 6 in out-of-home care have higher rates of respiratory illness, skin problems, anemia, and poor vision. An estimated 54%–80% of children in out-of-home care meet clinical criteria for behavioral problems or psychiatric diagnosis. To help ensure that these children and youth receive coordination of care and access to medical, social, educational or other services, at least 38 states employ the TCM option for those in the foster care system. The immediate

and long-term impact of TCM services is overwhelmingly positive and cost-effective, as studies have shown that children in foster care who receive TCM services are more likely than non-recipients to receive physician services, prescription drugs, dental services, rehabilitative services, inpatient services, and clinic services, potentially restoring them to permanent secure placements in a more timely manner.

The TCM rule as written was problematic and restrictive for many reasons. As explained in our original comments when the interim final regulation was first published, the rule ambiguously would have prohibited Medicaid reimbursement for TCM services deemed “integral to” non-medical programs including child welfare and foster care. Going well beyond Medicaid third party liability rules, such a test also completely and wrongly shuts off Medicaid beneficiaries’ road to case management services if the other targeted programs (child welfare, etc.) are unable to pay. This would pose a particularly daunting problem now, as the nation is in a serious economic downturn and states in extreme budgetary constraints are being forced to cut off vital human services, including health services for low-income individuals.

The rule also would have prohibited Medicaid reimbursement for case management and TCM services offered by child welfare and CPS workers, as well as by those who contract with State child welfare and child protective services agencies—even if they are otherwise Medicaid qualified providers. Federal law explicitly allows Medicaid payment for health care and medical services to children and youth in foster care, while the Title IV-E Foster Care and Adoption Assistance program rules expressly prohibit the use of IV-E funds for medical services. In a January 21, 2001 letter to State Child Welfare and State Medicaid Directors regarding State plan case management, CMS clearly recognized this distinction, noting because Title IV-E is “not liable for the assessment, care planning, and monitoring of medical needs,” the cost for such case management activities “could be billed to the State Medicaid program.” As such, child welfare agencies are permitted and do contract with agencies providing physical and/or mental health services to provide eligible children and youth much needed physical and/or mental health services.

As discussed above, it is estimated that 50 to 80% of children and youth involved with our nation’s child welfare and foster care systems suffer from moderate to severe mental health problems. As the status quo stands, however, despite concerted efforts, the Children’s Bureau, within HHS, reported after the first round of Child and Family Service Reviews that only four states received a “strength” rating for properly addressing the mental and behavioral health needs of children in care and only 20 states received a strength rating for addressing the physical health needs of the children. In sum, some of our most vulnerable children’s needs are already not being met and were the interim final rule’s provision prohibiting Medicaid FFP for case management and TCM services performed by those who contract with child welfare and CPS agencies, as well as the workers themselves, to have been implemented, the already dire situation would have gotten worse. Services would have been further fragmented and the need for systems to work together towards the well-being of children in care would have been next to impossible. Congress affirmed the need for State Medicaid and child welfare systems to closely collaborate by requiring them through enactment of the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) to jointly develop a plan for the ongoing oversight and

coordination of health care services for every child in foster care. The TCM regulation's apparent dissection of the systems clearly conflicts with Congressional intent of this new law.

CWLA also had serious concerns with the rule's single case manager requirement and the rule's unbundling requirement. While CWLA understands the desire to provide streamlined services and avoid duplication, the rule's blanket mandate that case management services be furnished by a single case manager was unrealistic given the complexities of many beneficiaries' situations. For example, imagine a Medicaid-eligible youth in care who is mildly retarded, suffers from post-traumatic stress as a result of severe sexual abuse as a child, and has been suicidal at various points in her life. Such an individual has multiple diagnoses and has likely been navigated over the years through numerous placements, including residential facilities and hospitals. It is unlikely in complex, multiple condition cases like this that there would be a single case manager with diverse, cross-system expertise that can sufficiently, expeditiously, and comprehensively assist the beneficiary.

Similarly unworkable was the rule's requirement that fee-for-service payments for case management services be billed in increments of fifteen minutes or less. This requirement goes against a primary principle of the Medicaid program—that states have flexibility, within federal parameters, to establish and duly follow reasonable payment policies. Case rates, per diem rates, and other currently allowed payment methodologies support many evidence-based practices and interventions that help some of our most vulnerable Medicaid-eligible citizens, including children and youth suffering from severe mental health issues. Were this flexibility to have been taken away, CWLA is certain that efficiency would plummet, as case managers would face significant administrative burdens, ultimately taking time away from the child and reducing services' impact and the child's progress.

It is important to note that the TCM regulation was not alone and instead, was issued alongside several other similarly restrictive Medicaid regulations that, in the aggregate, would have devastated our nation's health care safety net. CMS estimated that these rules would save the Medicaid program at least \$15 billion of federal money over five years, but many of these savings were accomplished by shifting cost onto states and similarly struggling programs. A U.S. House Oversight and Government Reform Committee report issued in March 2008 reported the aggregate Medicaid regulations' reductions of federal payments to states at a much higher expense of nearly \$50 billion over five years. This report was compiled after surveying each of the states and receiving responses from 43 states and the District of Columbia. Many states specifically commented on the TCM regulation's likely harmful impact on vulnerable populations and some noted its potentially devastating consequences for the child welfare and foster care systems and the children, youth, and families they serve.

This House Oversight and Government Reform report and action by leaders in Congress, particularly on the Senate Finance Committee and the House Energy and Commerce Committee, led to Congressional moratoria being placed on most of the controversial Medicaid rules, including the TCM rule. The TCM rule was placed under moratorium as part of the Supplemental Appropriations Act (P.L. 110-252) and its moratorium was extended to July 1, 2009 with enactment of the American Recovery and Reinvestment Act (P.L. 111-5). CWLA

thanks Congress for taking initial action to protect Medicaid TCM services for vulnerable populations such as children and youth in foster care and applauds CMS for similarly recognizing the inherent danger in the TCM rule as drafted and rescinding its most harmful provisions. Two other rules discussed as problematic in the Oversight and Government Reform report and placed under various moratoria along the way, the Medicaid School-Based Rule and the Medicaid Outpatient Services Definition Rule, are entirely rescinded by CMS 2287-P2 and CWLA supports their rescission as well.

CWLA strongly supports CMS 2287-P2's rescission of the TCM interim final rule's restrictive and controversial provisions, particularly rescission of the "integral to" test that would have shifted significant costs onto the child welfare and foster care systems to continue providing TCM services, the single case manager requirement, and the requirement to unbundle Medicaid TCM services. CWLA also supports CMS 2287-P2's reiteration of the clear boundaries for Medicaid case management and TCM services established by Congress through Section 6052 of the Deficit Reduction Act (P.L. 109-171). Section 6052 of the DRA and CMS 2287-P2 clarifies that Medicaid will not reimburse the foster care system for the direct delivery of foster care services, included but not limited to: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; or making placement arrangements. This language provides clear, logical, and sufficient guidance for the proper use and reimbursement of Medicaid TCM services for all populations, including those in the foster care system. Should further clarification be needed, CWLA stands ready to assist CMS on questions related to use of Medicaid case management and TCM for children and youth involved with the child welfare and foster care systems, to help ensure that the option remains a viable stream of care for this vulnerable population.

CONCLUSION

On behalf of CWLA, its members, and the children and families we serve, we thank you for the opportunity to comment on this rule and for its rescission of previously proposed restrictive boundaries contained in CMS 2237-IFC. We support CMS 2287-P2's affirmation of the current statutory definition of the Medicaid case management/TCM option and desire to work with CMS, should your agency seek to address ongoing policy and financing issues surrounding the TCM option.

Sincerely,



Christine James-Brown
President/CEO
Child Welfare League of America