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NEW MEDICAID RULES WOULD LIMIT CARE FOR CHILDREN IN FOSTER CARE AND PEOPLE WITH DISABILITIES IN WAYS CONGRESS DID NOT INTEND

By Judith Solomon

On December 4, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services published interim final rules governing case management services provided by state Medicaid programs.¹ CMS claims the new rules are necessary to implement changes Congress made in the Deficit Reduction Act of 2005 (DRA). In fact, the rules go well beyond what Congress intended in the DRA and would have a detrimental impact on beneficiaries, particularly poor children in foster care and poor individuals with physical or mental disabilities or other chronic health conditions.

Background: Medicaid's Case Management Benefit

Medicaid defines case management services as those that help beneficiaries “in gaining access to needed medical, social, educational, and other services.” States *may* offer case management to adult beneficiaries who need it; they *must* provide it to child beneficiaries who need it.² States can target case management for particular beneficiaries based on their health condition or where they live. When case management is designed for a specific group of beneficiaries, it is called targeted case management (TCM).

The DRA did not change the definition of case management but did make some changes to the benefit. It listed certain specific services that may be included in case management, such as assessing a beneficiary's needs, developing a care plan, and referring beneficiaries to other services. It also clarified the scope of the benefit under the DRA:

- Case management includes contacts with family members and other individuals who are not themselves eligible for Medicaid when these contacts are necessary to manage the care of the beneficiary receiving case management, but it does not include management of the ineligible

¹ 72 Fed. Reg. 68077-68093 (Dec. 4, 2007). The effective date of the rules is March 3, 2008.

² Under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, states must provide all medically necessary services to children covered under Medicaid.

person's own needs for medical care and other services;

- Case management also does not include the actual delivery of a medical, social, educational, or other service to which the individual is referred. The DRA lists foster care services such as home investigations, transportation, and arranging placements as examples of services that are excluded.
- Federal funds are not available for case management if a third party is liable to pay for the service.

New CMS Rules Go Well Beyond Congress's Intention

According to CMS, the interim final rules would reduce federal Medicaid spending by \$1.28 billion over five years.³ However, the Congressional Budget Office (CBO) estimates that the rule would decrease federal Medicaid spending by \$2 billion over five years, far above the \$1.1 billion in Medicaid savings CBO estimated for the provision of the DRA that the rules are supposed to implement.⁴ This difference between the two CBO scores indicates that the rules go well beyond what Congress intended.

The rules would force states either to spend additional state funds to compensate for the lost federal funds or to cut services for beneficiaries. The rules also would significantly limit state flexibility to provide case management in the most effective and efficient manner possible.

Limiting Case Management for Beneficiaries Leaving Institutional Care

States may currently provide case management to help beneficiaries make the transition from an institution to the community. Specifically, federal Medicaid reimbursement is available for case management provided for up to the last 180 days of a stay in an institution. This policy was issued in 2000 in response to the U.S. Supreme Court's *Olmstead* decision, which found that the Americans with Disabilities Act requires states to provide services in the most integrated community settings that are appropriate to beneficiaries' needs.⁵

The interim final rules significantly restrict this policy. Under the rules, federal matching funds would be available for case management provided only during the last 60 days of a stay in an institution if the stay is 180 days or more, and for only the last 14 days of a stay that lasts fewer than 180 days. This usually is not enough time to arrange housing and other services needed for a successful transition.

³ The rules also forecast a \$369 million increase in federal spending on foster care services over the next five years. According to the preamble to the rule, this spending would occur because some foster care expenditures would no longer be paid for through Medicaid and would have to be paid for by other programs.

⁴ Congressional Budget Office, Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO's Baseline, at <http://www.cbo.gov/budget/factsheets/2008b/medicaremedicaid.pdf>. CBO estimates the rule will result in a \$500 million increase in federal expenditures for the foster care program. In its cost estimate of the statutory provision of the DRA, CBO estimated the provision would increase spending for the foster care program by \$350 million.

⁵ "Olmstead Update No. 3," issued by Health Care Financing Administration (precursor to CMS) on July 25, 2000.

Moreover, the rules would prohibit payment until an individual is actually living in the community. As a result, some providers would not be able to deliver transition services — because they lack the financial capacity to wait for payment and cannot take the risk that the individual will not be able to complete the transition to the community, in which case they would not be paid at all.

In addition, these changes would seriously undermine the “Money Follows the Person” demonstration, a centerpiece of the President’s New Freedom Initiative to help people with disabilities participate more fully in community life. Under the demonstration, which is intended to support efforts to move Medicaid beneficiaries from institutions to the community, some states are apparently allowing up to 180 days for case management services as allowed under current Medicaid policy.⁶

Forcing States to Fragment Services for Children in Foster Care

The DRA includes a list of activities that can not be included in case management for children in foster care. In addition to the activities noted above, these activities include assessing adoption placements, serving legal papers, and administering foster care subsidies. All of the excluded activities relate to the administration of foster care programs and are separate from the delivery of health care.

The interim final rules, however, go substantially beyond the DRA — they prohibit federal Medicaid funds for *all* case management services provided by child welfare and child protective services agencies and their contractors, even if the contractors are qualified Medicaid providers.

In an April 5, 2006 letter to HHS Secretary Michael Leavitt, Senator Charles Grassley (R-Iowa), then chair of the Senate Finance Committee, explained Congress’s intention in the DRA in order to guide CMS in implementing the case management provision. He wrote: “[Case management] services, which the Congress intended would be appropriately considered a Medicaid expense, are particularly important to children in foster care. These are children who have multiple social, educational, nutritional, medical and other needs.” The letter cautioned that the “disallowance of reimbursement under Medicaid for services specified in the DRA for TCM for children in foster care . . . is in *direct contradiction to Congressional intent*” [emphasis added].

Disregarding Senator Grassley’s letter, the interim final rules prohibit any federal funding for case management services that child welfare agencies (or qualified Medicaid providers that have contracts with these agencies) provide to children in foster care. Under the new rules, only a Medicaid provider operating *outside* the child welfare system could provide case management services to children in foster care. This would force states to fragment the services provided to children in foster care — a result directly contrary to the purpose of the case management benefit, which is to *coordinate* needed medical, social, and educational services.

⁶ The announcement for the “Money Follows the Person” demonstration project lists transition coordinators as an element of a state’s plan and says that if case managers are not already in place to act as transition coordinators, the state must add this element. http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf

Almost half of all children in foster care have a disability or a chronic medical problem, and up to 80 percent have serious emotional problems. Almost all children in foster care are Medicaid beneficiaries. States have used the case management benefit to better coordinate the medical, social, and educational services these children need with the foster care services they receive.⁷ Senator Grassley's letter makes clear that the DRA was intended *not* to restrict this use of case management services, but instead to prevent states from using federal Medicaid funds to deliver the foster care services themselves.

Restricting Case Management for Some Children with Disabilities

All children in Medicaid are eligible for case management services when the services are medically necessary. Some states provide medically necessary case management services to children with disabilities in school settings in order to ensure that they receive an appropriate public education, as required by both the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. (Section 504 prohibits the denial of a "free and appropriate" education for children with disabilities regardless of whether a child receives special education services under the IDEA.)

The interim final rules would allow case management for children with disabilities in schools only when it is designated as a required service in the child's Individualized Education Program (IEP) or an infant's or toddler's Individualized Family Service Plan (IFSP). The new rules specifically *disallow* the provision of case management when it is part of a child's plan under Section 504 even if a child's disability requires the coordination of multiple medical, social, and educational services in order for the child to participate in school programs.⁸

Limiting States' Flexibility to Manage Medicaid Efficiently

A central tenet of the federal-state partnership to operate Medicaid is that states must follow federal guidelines while retaining broad flexibility over payment rates and policies. The new rules disregard this tenet, arbitrarily restricting state flexibility in a way that could make Medicaid payments less efficient.

The rules would prohibit states from making fee-for-service payments for case management services in increments that exceed 15 minutes of a given service. This would be a significant change for states, which often use case rates, per diem rates, or other methodologies to pay for case management when these approaches are more efficient.

The highly prescriptive approach in the new rules would make it difficult or impossible for states to provide case management as part of assertive community treatment (ACT), a comprehensive, evidence-based treatment program for people with serious mental illness that provides services 24

⁷ Studies cited in D. Rubin *et al.*, "The Deficit Reduction Act of 2005: Implications for Children Receiving Child Welfare Services," Casey Family Programs, Washington, DC, December 2006.

⁸ This is a change from current policy under which states have been allowed to provide case management services to children with 504 plans.

<http://www.chcpf.state.co.us/HCPF/State%20Plan/State%20Plan%20Files/Sup%201A%20to%203%201-A%20TN95003.pdf>

hours a day, seven days a week. Paying for case management services on the basis of 15-minute increments would not work for programs like ACT, where case managers must be on-call and ready to respond at all times.

The rules would also limit state flexibility by prohibiting a state from providing a beneficiary with more than one case manager, even when the complexity of the beneficiary's condition demands the expertise of more than one such individual. In most cases, having one case manager is beneficial to avoid duplication. But if a beneficiary has multiple conditions — for example, HIV/AIDS, mental illness, and an intellectual disability — no single case manager may be able to coordinate housing, health care, and social needs across multiple systems.

Conclusion

Senator Grassley's letter to Secretary Leavitt explains that the DRA's case management provisions were intended "to insert clarity as to what is an appropriate [case management] service under Medicaid, and therefore appropriately claimed under Medicaid, and what is not." The interim final rules published by CMS go well beyond that, cutting funds for legitimate case management services for children in foster care and individuals with disabilities and serious chronic health conditions. CMS should withdraw these rules and provide appropriate guidance to states that is in line with Congressional intent regarding case management services.