



Despite Obama Regulatory Rollback, States Continue Bush-era Medicaid Policies on Children's Mental Health

Tens of Thousands of Children Could be Affected if Bush-era Restrictions are Implemented in all States

By Rebecca Farley¹
September 2, 2009

SUMMARY

Under President George W. Bush, the Centers for Medicare and Medicaid Services (CMS) implemented a series of policies restricting states' ability to provide rehabilitation, therapeutic foster care, and targeted case management to children in the child welfare system. These policies began through reviews of several states' Medicaid plans, were more clearly codified in a later set of proposed regulations, and continued to be enforced by CMS in some states even after Congress blocked the implementation of the regulations.

Due to a combination of state momentum and incomplete CMS reversals of the blocked policies, the implementation of these Bush-era policies has continued into President Obama's administration, despite his withdrawal of the regulations upon taking office. Many states are proceeding with the Bush-era policies of "unbundling" therapeutic foster care and targeted case management services. "Unbundling" refers to the separation of Medicaid treatment services from the comprehensive package of therapeutic programs. In this process, the treatment services are either billed separately or entirely eliminated from the program. The Alliance estimates that left unaddressed, these policies could reduce needed care for tens of thousands of children across the nation.

This policy brief draws on interviews with state association directors and nonprofit Medicaid providers to examine their experiences with CMS, therapeutic foster care, and targeted case management in the post-Bush era.² Reports indicate that the continuation of the Bush policies on unbundling has had many negative consequences for children, nonprofit Medicaid providers, and states, including:

- Funding cuts to therapeutic and rehabilitative services;
- Closures of TFC and residential programs providing children's mental health services; and
- Poorer health outcomes for children and damaging effects on community safety, in some cases leading to increased violence in schools or other harmful effects on communities

¹ For more information, please contact Rebecca Farley, Policy Analyst, at rfarley@alliance1.org or (202) 429-0400 x19.

² The states about which information was collected are: California, Colorado, Georgia, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee, West Virginia, and one state that requested to remain anonymous. While it is not a comprehensive 50-state survey, the information is sufficient to demonstrate the widespread nature of the problems outlined in this report. Not all of the 19 states experienced all problems discussed here.

BACKGROUND

Children entering the child welfare system because of severe trauma, abuse or neglect have a high incidence of mental and behavioral health problems.³ Among the health interventions most utilized by these children are rehabilitative services and targeted case management (TCM).⁴ Although rehabilitation and TCM are optional categories of Medicaid services, most states choose to cover them.

The rehabilitative option of Medicaid is also commonly used to fund therapeutic foster care (TFC). TFC is an evidence-informed intervention for children and youth with serious emotional disturbances who can live in a family setting, but who require more intensive treatment than a typical foster child. TFC places these children in homes with highly trained, certified foster parents under the oversight of Medicaid mental health professionals and case managers who provide medically necessary treatment and support. TFC programs typically provide treatment services such as therapy, life skills training, psychiatric rehabilitation, case management, and crisis intervention. These treatment services help children with serious behavioral health needs recover and thrive in their own communities.⁵

Federal Medicaid law provides only very broad definitions of what services the rehabilitation and TCM options may cover.⁶ In the decades since Medicaid's enactment, the federal government has tried several times to clarify or narrow the broad definitions of rehabilitation and TCM. However, much of its guidance has been ambiguous and enforced on a state-by-state basis.⁷

During President George W. Bush's administration, CMS instituted a series of policies that would have limited states' ability to receive federal matching dollars for TCM and rehabilitation. First imposed on some states through reviews of their Medicaid plans, these policies required the "unbundling" of rehabilitation and TCM services and denied Medicaid reimbursement for therapeutic foster care. CMS later codified these changes in a series of proposed regulations. Had the regulations gone into effect, all states would have been required to break their therapeutic and rehabilitative programs into discrete medical services that could be documented and billed in 15-minute increments of face-to-face time with the patient, forcing more use of administrative resources and less treatment resources.⁸ Evidence from states where the restrictions had already been imposed through CMS audits suggested that expanding them to other states would have resulted in significant cuts to child welfare health services by forcing states to absorb many treatment services under limited foster care funds or state general revenue.⁹ Congress responded by enacting moratoria on the implementation of the regulations. However,

³ Studies have shown that up to 80 percent of children involved with the child welfare system have developmental delays, emotional or behavioral disorders, or other issues requiring mental health treatment. [Geen, R., et al. "Medicaid Spending on Foster Children." The Urban Institute Child Welfare Research Program, Brief No. 2, Aug. 2005. Available online at: http://www.urban.org/UploadedPDF/311221_medicaid_spending.pdf]

⁴ Geen op. cit. (3); Bazelon Center for Mental Health Law. "Following the Rules: A Report on Federal Rules and State Actions to Cover Community Mental Health Services Under Medicaid." Nov. 2008. Online at: <http://www.bazelon.org/pdf/FollowingRules.pdf>

⁵ For a more complete description of therapeutic foster care, see: Foster Family-based Treatment Association. "Withstanding the Test of Time: What We Know About Treatment Foster Care: A Monograph on Treatment Foster Care." 2006. Available online at: <http://www.fftta.org/members/publications/monograph.pdf>. For a summary of the research on the clinical effectiveness of TFC, see: United States Office of the Surgeon General. "Mental Health: A Report of the Surgeon General, Chapter 3: Children and Mental Health." 1999. Available online at: <http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3>. For information regarding the effectiveness and utilization of other rehabilitative services and TCM, see: Geen op. cit. (3).

⁶ Guidance on how states may use federal Medicaid dollars for these services is laid out in federal statute, with further clarifications issued by the Centers for Medicare and Medicaid Services (CMS) either directly (through the federal rulemaking process), or indirectly (for example, through letters issued to state Medicaid directors or approvals/denials of state plan amendments).

⁷ For a full analysis of the history of federal guidance on rehabilitative services and TCM, see: Farley, R. "History of Ambiguous Federal Guidance on Medicaid Billing has Undermined Children's Mental Health Services." Available online at: http://www.alliance1.org/Public_Policy/Health/federal_guidance_rehab.pdf

⁸ Secretary of Health and Human Services. "Report to Congress on Medicaid Regulations under Section 7001(c)(1) of the Supplemental Appropriations Act, 2008." 2008. Available online at: http://www.gregontheweb.com/Storage/RTC_Moratoria_120408.pdf

⁹ See discussions of Georgia and Colorado later in this paper. Additionally, states reported that they would have incurred losses of hundreds of millions of dollars that would have to be recouped through Medicaid cuts or taken out of their general funds. See Committee on Oversight and Government Reform. "The Administration's Medicaid Regulations: Summaries of State Responses." Supplement to the Committee Majority Staff report, *The Administration's Medicaid Regulations: State-by-State Impacts*. 3 Mar. 2008. Available online at: <http://oversight.house.gov/features/medicaid08/State%20One%20Page%20Summaries.pdf>

bypassing the moratoria, CMS continued to impose the changes on several additional states through state plan reviews.¹⁰

When President Obama entered office, he withdrew the Bush regulations.¹¹ However, seven months into his term, he still has not appointed a CMS director, leading to a situation in which the agency is described as “running on autopilot” rather than taking an active role in responding to the new administration’s policy changes.¹² ***Due to a combination of incomplete reversals of Bush policy by CMS and ongoing state momentum in implementing the outdated policies, nonprofit Medicaid providers and their state associations report they are facing restrictions that in many cases threaten their ability to provide vital health services to children most in need. The Alliance estimates that left unaddressed, these policies could reduce needed care for tens of thousands of children across the nation (see box below).***

How Many Children Could be Affected by the Continuation of the Bush Policies?

The Alliance for Children and Families estimates that tens of thousands of children could be affected if the Bush policies are implemented in all states.

In all, over 100,000 foster children receive treatment under the rehabilitative option of Medicaid.¹³ Some of these children live in states where unbundling has already been fully implemented; others live in states that do not offer comprehensive therapeutic programs. The Foster Family-based Treatment Association estimates that 50,000 children per year are served in therapeutic foster care.¹⁴ Thousands of additional children are served in therapeutic residential treatment programs. Thus, not all states nor all 100,000 children receiving rehabilitative services would be affected by the continuation of the Bush policies. Nonetheless, if the Bush policies are fully rolled out in all states, they could have an impact on tens of thousands of children.

BUSH-ERA POLICIES CONTINUE

Since the end of the Bush administration, many states have moved forward with the unbundling of therapeutic rates and services (described below) and the removal of Medicaid-reimbursable treatment services from their therapeutic programs. States and nonprofit providers of Medicaid services report that significant repercussions have arisen from the continued implementation of the Bush-era regulations, including:

- Funding cuts to therapeutic and rehabilitative services;
- Closures of TFC and residential therapeutic programs;
- Decreased integration of care;
- Poorer health outcomes for children and increases in community violence;
- The need for providers to invest already scarce resources in preparing for potential change;
- Increased risk to states of being determined to be out of compliance with CMS policies;
- Disincentives for states to make needed changes to their Medicaid plans; and
- Ongoing opportunities for CMS to sidestep congressional intent.

¹⁰ See case studies below.

¹¹ Emanuel, R. “Memorandum for the Heads of Executive Departments and Agencies, Subject: Regulatory Review.” 20 Jan. 2009. Available online at: <http://media.washingtonpost.com/wp-srv/politics/documents/emanuel-regulatory-review.pdf> ; Federal Register: 30 June 2009 (Vol. 74, No. 124). Available online at: <http://frwebgate6.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=325089272192+0+2+0&WAIAction=retrieve>

¹² Pear, R. “Lack of Medicare Appointee Puzzles Congress.” *The New York Times* 18 Aug. 2009. Available online at: <http://www.nytimes.com/2009/08/18/health/policy/18health.html>

¹³ Geen op. cit. (3)

¹⁴ Laura Boyd op. cit. (17)

States Continue Unbundling Services and Cutting Therapeutic Programs

In response to actual or anticipated guidance from CMS, many states have continued the process of unbundling the costs of their therapeutic and case management services.

“Bundling” refers to a process in which all services in a multifaceted treatment program are combined into a single package with a single (usually daily) cost per child. The cost of these bundled interventions is then reimbursed by the state, which often draws on multiple state and federal funding streams. TFC and certain types of therapeutic residential treatment are typically billed under a combination of Medicaid rehabilitation and other funding streams, which could include Temporary Assistance to Needy Families (TANF), Title IV-E, state general funds, and others. Medicaid targeted case management (TCM) is often wrapped into the bundled rate as well. The flexibility of a daily capitated (per-person) rate allows providers to develop and maintain unique courses of treatment for each child, encompassing interventions in home, group, community, and day care settings throughout the entire day.¹⁵

However, CMS challenged the broad use of Medicaid for these services on the grounds that states were billing Medicaid for non-covered treatments or services intrinsic to the scope of other public programs.¹⁶ Over the eight years of the Bush administration, CMS began a process of denying federal financial participation for the Medicaid treatment portions of states’ therapeutic rates, essentially forcing states to separate out the bundled components of their programs and bill for each service individually. In many cases, states were required to break their bundled treatment services into distinct units billable in 15-minute increments. This decision was intended to reduce the number of Medicaid-reimbursable services that could be provided to children and other beneficiaries through the rehabilitative and TCM options.¹⁷

Today, the process of unbundling services is proceeding in some states, despite the change in policy and presidential administrations. For example, Montana was directed to unbundle therapeutic foster care in 2007, and as of August 2009, CMS had not reversed that directive.¹⁸ Other states, recognizing CMS’s drive toward unbundling over the last eight years, have voluntarily elected to unbundle their treatment services because they feel it is the best way to avoid future problems with CMS.¹⁹ For example, Indiana is currently asking residential providers to bill separately for treatment services – with the understanding that if they do not voluntarily participate, the state will remove reimbursement for those services from their bundled rates.²⁰ As these examples illustrate, the absence of a prohibition on bundling has not provided an assurance that states wishing to maintain a bundled rate will be able to do so.

Furthermore, many states have found they cannot comply with the requirements of unbundling while continuing to provide Medicaid treatment services through their therapeutic programs. Therapeutic treatment services are funded through the rehabilitative option of Medicaid, which allows them to be provided in a home or residential setting. TFC is a type of home- or community-based therapeutic service; residential therapeutic services could include similar interventions provided in a residential setting. As noted above, they are often bundled into the array of services provided to children in the child welfare system. When therapeutic treatment is combined with case management, room and board, and the other components of these programs, it allows for full integration of care under the oversight of mental health professionals.

¹⁵ Costigan, T. “Written Testimony of Twila Costigan, Program Manager for the Intermountain Adoption and Family Support Program, Helena, MT.” CWLA Testimony to U.S. House Committee on Oversight and Government Reform: Hearing on the Administrations’ Regulatory Actions on Medicaid: the Effects on Patients, Doctors, Hospitals, and States. 1 Nov. 2007. Available online at: <http://www.cwla.org/advocacy/medicaid071101.htm>

¹⁶ Secretary of Health and Human Services op. cit. (8)

¹⁷ Secretary of Health and Human Services op. cit. (8)

¹⁸ Jani McCall, Vice President of Government Relations, Yellowstone Boys and Girls Ranch. Interview by author, May 27, 2009.; Policy Director for a South Carolina association. Interview by author, July 16, 2009.

¹⁹ Executive Director of a state association in Missouri. Interview by author, July 16, 2009.; Laura Boyd, Public Policy and Government Relations Consultant, Foster Family-based Treatment Association. Interview by author, July 22, 2009.

²⁰ Laura Boyd op. cit. (17)

In conjunction with unbundling, some states have continued with the Bush-era policy of restricting TFC by eliminating the treatment portions of their therapeutic programs. For example, Georgia was forced to remove rehabilitation services from its therapeutic and residential placement programs in 2005.²¹ No reversal in CMS policy has occurred, despite the change in presidential administrations and the strong opposition of Congress to the Bush regulations. Other states, anticipating that CMS will eventually bar them from using the rehabilitative option to finance TFC or other therapeutic treatment programs, have begun the process of voluntarily removing these services from their child welfare systems. Illinois, Indiana, Missouri, Michigan, and North Carolina are five examples.²²

States and child welfare providers report that the continuation of Bush-era policies on unbundling and the elimination of TFC has resulted in:

- **Funding Cuts to Therapeutic and Rehabilitative Services:** Unbundling has led to funding and service cuts in many states, as some components of therapeutic programs may not qualify for Medicaid reimbursement when broken out of the bundled package. Some states have been able to maintain their services by replacing the lost federal funding with state money; others have been forced to discontinue services. Providers in Georgia and North Carolina report experiencing or anticipating funding cuts as a result of unbundling.²³ In Colorado, the unbundling of therapeutic services, combined with the economic slowdown, has resulted in significant reductions in funding for child welfare provider services. Because therapeutic treatment can no longer be matched by federal dollars, many children who once could have received treatment in a residential or community-based therapeutic setting are now either entering the juvenile justice system or simply being denied services.²⁴ “Our state system is crippled right now. It is in fiscal crisis,” stated the director of the Colorado Association of Family and Children’s Agencies.²⁵
- **Closures of TFC and Residential Therapeutic Programs:** With therapeutic services removed from their allowable scope of service, child welfare agencies in many states are no longer able to operate residential therapeutic programs. For example, in Georgia, dozens of residential facilities have closed as a result of unbundling, the elimination of therapeutic services from their practices, reductions in the number of foster children, and elimination of excess capacity.²⁶ Although residential programs have been the hardest hit so far, providers in other states fear that TFC programs may also be threatened. For example, in Montana, the promulgation of the Bush regulations left providers not knowing whether they would continue to be able to provide high-quality services to meet the future need. As a result, the number of therapeutic foster care beds in Montana dropped from 211 to 184, a nearly 13 percent decrease.²⁷ As noted above, CMS has not given any indication that it will reverse course. North Carolina, which is in the process of removing therapeutic services from its child welfare programs, has not yet seen the full effects of this change – yet providers there expressed concern that when the implementation of the changes is complete, the availability of TFC will be greatly reduced.²⁸ Nearly every state interviewed for this study reported concern that TFC programs could be cut or eliminated if CMS proceeds with the Bush-era policies.
- **Decreased Integration of Care:** Children in the child welfare system receive many types of medical services from a variety of federal and state programs. For children in treatment, many of these services are coordinated through the child welfare agency, which provides for the health

²¹ Normer Adams, Executive Director, Georgia Association of Homes and Services for Children. Interview by author, July 20, 2009.

²² Executive Director of a state association in Missouri op. cit. (17); Laura Boyd op. cit. (17); Fred Waddle, Sr. Vice President, Governmental Relations, Easter Seals UCP North Carolina. Interview by author, July 22, 2009.; Jim Scherrer, Chief Executive Officer, Child and Family Services of Northwestern Michigan. Interview by author, 21 July 2009.

²³ Policy Director for a South Carolina association op. cit. (16); Normer Adams op. cit. (19); Fred Waddle op. cit. (20); Kathy Dobbs, Professional Development Coordinator, Children and Family Services Association-NC. Interview by author, July 21, 2009.

²⁴ Dr. Skip Barber, Executive Director, Colorado Association of Family and Children’s Agencies. Interview by author, July 20, 2009.

²⁵ Dr. Skip Barber op. cit. (22)

²⁶ Normer Adams op. cit. (19)

²⁷ Twila Costigan, Program Manager for the Intermountain Adoption and Family Support Program. Interview by author, May 28, 2009.

²⁸ Fred Waddle op. cit. (20)

treatment, case management, behavioral supervision, room and board, social services, and other key services the children need. In states where rehabilitative or therapeutic services have been removed from the scope of child welfare providers' services, children must go to an external provider for their mental health treatment. This has led to problems in some states with fragmentation of care and accountability in the provision of services billed, for example, in Georgia (see case study below). Fragmentation of care has generally been linked with poorer health outcomes,²⁹ and child welfare agencies' therapeutic programs are effective in part because they coordinate multiple aspects of a child's care.³⁰

- **Poorer Health Outcomes for Children and Increases in Community Violence:** Service cuts and uncertainty about future funding streams mean that children risk losing access to vital health treatments. For example, Georgia has experienced an erosion of services for the neediest children, resulting in poorer health outcomes as described in more detail below. Loss of access to health treatments not only causes worse health outcomes for children, it can also affect community safety. For example, since the unbundling of therapeutic services in Colorado, the state has experienced escalating levels of violence in schools, caused in part by children who would formerly have had access to therapeutic treatment options but who are now funneled into a school system that is ill-equipped to handle their behavioral issues. The erosion of the service system for the children with the highest need has caused a "spiraling" of community violence.³¹

Lack of Clear Federal Billing Guidance Puts Additional Administrative and Financial Burdens on States and Providers

States and providers report that the simultaneous withdrawal of the regulations by President Obama and the incomplete reversals of the Bush policies by CMS has left them with unclear federal guidance and the use of Medicaid rehabilitation and TCM services. Without clear information on allowable billing and coverage practices, states are facing problems that in many cases threaten their ability to continue to provide vital health services to children.

The lack of clarity in federal guidance on rehabilitative services and TCM has resulted in:

- **The Need for Providers to Invest Already-Scarce Resources in Preparing for Potential Changes:** Nonprofit Medicaid providers in many states across the country are facing severe budget reductions as a result of the economic crisis.³² The lack of clarity in federal guidance on Medicaid mental health billing has placed an additional financial burden on providers: not knowing whether they will continue to be able to collect bundled rates, providers are beginning to invest already-scarce resources in preparing for the prospect of unbundling. The switch to billing in 15-minute increments adds a significant administrative burden on child welfare providers.³³ To adapt, they must purchase new billing software or develop homegrown systems for time reporting, conduct training on the new billing methodology, and take additional time out of their daily schedules to document the 15-minute increments. For example, providers in Missouri have already begun preparing for unbundling, although the state has not yet completed its process of renegotiating child

²⁹ Shih, A., et al. "Organizing the U.S. Health Care Delivery System for High Performance." The Commonwealth Fund. August 2008. Available online at: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx>; Cebul, R., et al. "Organizational Fragmentation and Care Quality in the U.S. Health Care System." *Journal of Economic Perspectives*, 22.4(2008): 93–113.

³⁰ Bryant, B. "Treatment Foster Care: A Cost-Effective Strategy for Treatment of Children with Emotional, Behavioral, or Medical Needs." July 2004. Available online at: http://fta.org/publicpolicy_advocacy/TFCAdvocacyPaper.pdf

³¹ Dr. Skip Barber op. cit. (22)

³² Families USA. "A Painful Recession: States Cut Health Care Safety Net Programs." December 2008. Available online at: <http://www.familiesusa.org/assets/pdfs/a-painful-recession.pdf>

³³ Costigan op. cit. (13); Consortium for Citizens with Disabilities. "Re: File Code CMS-2261-P." Letter to CMS. 10 Oct. 2007. Available online at: http://www.c-c-d.org/task_forces/health/CCD%20Comments%20final%20final.pdf; Child Welfare League of America. "CWLA Comments to CMS on Proposed Rule CMS-2261-P: Coverage for Rehabilitative Services." Letter to CMS. 12 Oct. 2007. Available online at: <http://www.cwla.org/advocacy/medicaid071012.htm>; Child Welfare League of America. "Re: CMS-2237-IFC; Comments on Interim Final Rule Medicaid Program; Optional State Plan Case Management Services." Letter to CMS. 1 Feb. 2008. Available online at: <http://www.cwla.org/advocacy/medicaid080201.htm>

welfare contracts. One agency has developed an Excel spreadsheet to be used for time reporting; another is attempting to reprogram its computerized billing system.³⁴ At a recent seminar in Philadelphia for executives of nonprofit human service providers around the country, preparing for unbundling was a central topic of discussion.³⁵

- **Increased Risk to States of Being Determined to be Out of Compliance with CMS Policies:** Even in states where TFC and bundled payments have not undergone forced changes, providers and state agencies are worried about the potential for CMS audits. Given CMS's drive towards unbundling, states fear that an audit may find their programs are not in compliance with federal law, despite their Medicaid plans having been approved by CMS in the past.³⁶ As described by several providers, the conventional wisdom is that CMS will always force states to unbundle when it reviews their Medicaid plans.³⁷ States currently using bundled rates are in what some have described as a "holding pattern," believing they might be forced to unbundle, but not knowing when.³⁸
- **Disincentives for States to Make Needed Changes to Medicaid Plans:** While CMS may choose to audit a state at any time and force changes in its program, filing a State Plan Amendment (SPA) automatically opens up the entire state plan to CMS review. As a result, many states are reluctant to make necessary updates or changes to their Medicaid plans for fear of losing their ability to provide rehabilitative services or targeted case management. The consequence of this reluctance is that many states are unable to implement important cost-saving measures, service expansions, or other changes that could improve the quality and cost-effectiveness of their Medicaid plans. For example, under its current state plan, one state that requested to remain anonymous does not receive a federal match for the health costs of children aging out of foster care. To make this change, the state would need to file a SPA, thus opening its entire plan to CMS review and likely losing its ability to use bundled rates for therapeutic foster care and TCM.³⁹ In Montana, a 2008 report to the state legislature recommended many needed changes to improve mental health treatment for Medicaid enrollees; however, the report also noted that these changes would open the plan to federal review of its use of the rehabilitative option. The report advised the Montana Department of Public Health and Human Services to avoid taking any steps that would open the plan to CMS review.⁴⁰
- **Ongoing Opportunities for CMS to Sidestep the Intent of Congress:** CMS's continued enforcement of the Bush policies even after the enactment of the congressional moratoria exposed a rift between the executive and legislative branches. Between 1981 and 2007, Congress had delayed only three Medicaid regulations.⁴¹ The fact that CMS continued to implement its policies in direct contradiction to the moratoria and the clearly stated Sense of Congress⁴² that such policies would not be implemented reveals a significant tension between the two branches' interpretations of regulatory authority. Although President Obama has rolled back the Bush regulations, there is no guarantee that a CMS under a future administration will not promulgate the same restrictions once again. Furthermore, without direct congressional leadership, there is no assurance that the current or future CMS will not continue to use creative methods for sidestepping congressional directives.

³⁴ Executive Director of a state association in Missouri op. cit. (17)

³⁵ "Health and Human Services Funding: What You Need to Know in Today's Environment." An OPEN MINDS Seminar Co-Produced with the Alliance for Children and Families. 29 April, 2009 at Public Health Management Corporation in Philadelphia, PA.

³⁶ Interviewees from these states wished to remain anonymous.

³⁷ Policy Director for a South Carolina association op. cit. (16), Kathy Dobbs op. cit. (21)

³⁸ Jani McCall op. cit. (16)

³⁹ Executive Director of the state association representing child and family service agencies. Interview by author, July 2, 2009.

⁴⁰ DMA Health Strategies. "Report to the State of Montana: Legislative Mental Health Study." 18. Nov. 2008. Available online at: http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/finalmhreport.pdf

⁴¹ Kaiser Commission on Medicaid and the Uninsured. "Medicaid: Overview and Impact of New Regulations." Issue Paper, January 2008. Available online at: http://www.bazelon.org/pdf/1-08Kaiser_MedicaidRegs.pdf

⁴² Section 5003(d)(3) of the American Recovery and Reinvestment Act (Public Law 111-5. 2 Feb. 2009). Relevant section available online at: <http://thomas.loc.gov/cgi-bin/query/F?c111:8:./temp/~c111RkzsWZ:e1228793>.

SELECTED CASE STUDIES

Georgia

Georgia was one of the first states in the country that was instructed by CMS to unbundle its therapeutic treatment services, several years before the promulgation of the regulations. The process resulted in an upheaval of the Georgia child welfare system, which undermined service integration and drove several therapeutic programs to close.

In 2005, CMS notified Georgia that the state's payment policies for its Level of Care child welfare system were not in compliance with Medicaid.⁴³ The Level of Care system had been implemented in 2003⁴⁴ as a way to improve children's ability to receive necessary therapeutic services in the appropriate residential or community-based setting.⁴⁵ Payments to providers in the Level of Care system were made on a daily bundled basis by combining funding from Medicaid, Temporary Assistance for Needy Families (TANF), Title IV-E, and other state and federal funding streams.⁴⁶ This included payments to therapeutic foster care providers as well as providers of therapeutic services in a residential setting. By 2003, when the system was fully rolled out, provider agencies' reimbursements were equal to their costs for the first time in Georgia's history; previously, reimbursement had averaged only around 60 percent of costs.⁴⁷ The new system also fully integrated services for children.⁴⁸

However, after reviewing Georgia's program in September 2005, CMS objected to the state's use of Medicaid rehabilitation funding for residential therapeutic services.⁴⁹ By January 2006, Georgia was directed to cut placements to residential Level of Care providers while the state worked on developing a plan of correction. The state's official notification to unbundle rates came in August 2006. CMS gave Georgia until June 30, 2007 to implement the change. Starting at that time, therapeutic services that had previously been provided in a residential or TFC setting would have to be moved to community-based mental health providers who would bill Medicaid directly. Room, board, and "watchful oversight"⁵⁰ could continue to be provided in a residential setting, but Medicaid would no longer be billed under the daily rate that residential providers received for their services.⁵¹

Nonprofit providers were caught unprepared for this sudden and substantial change in policy. "It was like a bomb was set off in our child welfare system," said the director of the state association for children's agencies.⁵² Removing Medicaid services from residential care would mean huge cuts to agency budgets. It would also force the creation of a new classification of providers, child and adolescent community mental health providers. The state spent the next year working to enact these changes. Creating the new class of providers was particularly difficult: out of 300 providers who initially volunteered to become child and adolescent community mental health providers, less than half made it through the approval process, and only 80 are operating today.⁵³

The child welfare system in Georgia today is quite different from 2005. With therapeutic interventions no longer covered in residential settings, children entering residential care cannot receive all needed

⁴³ Georgia Association of Homes and Services for Children. "History of Proposed Level of Care System, Intervention by CMS, and Debundling of LOC." March 2008. Available online at: <http://www.gahsc.org/nm/pp/perdiem/ppbackground.html>

⁴⁴ Implementation began in 2001 but was not completed until 2003. See: Georgia Association of Homes and Services for Children op. cit. (41)

⁴⁵ Georgia Association of Homes and Services for Children op. cit. (43); Normer Adams op. cit. (19)

⁴⁶ Normer Adams op. cit. (19)

⁴⁷ Normer Adams op. cit. (19)

⁴⁸ Normer Adams op. cit. (19)

⁴⁹ Centers for Medicare and Medicaid Services. Letter to Tim Burgess, Commissioner. "Re: Deferral Control Number GA/2005/2/E/01/MAP." 22 Sept. 2005. Available online at: <http://www.gahsc.org/nm/2009/ccsindex.html#Internal>

⁵⁰ "Watchful oversight" refers to the supervision of residents and other behavior management services needed in an environment where many children may exhibit disruptive or destructive behavioral displays.

⁵¹ Georgia Department of Human Resources. "An Open Letter to Our Providers from Commissioner B.J. Walker, Georgia Department of Human Resources (DHR)." 31 Aug. 2006. Available online at:

<http://www.gahsc.org/nm/pp/2006/dhropenlettertoproviders20060831.pdf>

⁵² Normer Adams op. cit. (19)

⁵³ Normer Adams op. cit. (19)

services in one location. Instead, they must travel to community mental health clinics to receive Medicaid-reimbursable services, while other components of treatment take place in the residential facility. Children enrolled in therapeutic foster care also must receive Medicaid-reimbursable services from an external provider or agency separate from that administering the TFC program. The result, as described by the director of the state association, is a “huge problem” with integration of care.⁵⁴

By May 2007, due to a combination of the drop in funding, decreased numbers of children entering foster care, and the elimination of excess capacity, over 45 residential agencies had closed.⁵⁵ That number increased to 165 by October 2008.⁵⁶ Although psychiatric residential treatment facilities (PRTF) were not as severely affected, many found they could no longer provide certain services, and several were forced to close their residential treatment programs.⁵⁷

Despite these changes having been in effect for over two years, CMS still has not issued its final approval for Georgia’s revised state Medicaid plan. While the recent changes have had at least several positive effects (such as the elimination of excess capacity in residential treatment and the creation of the new class of child and adolescent community mental health providers), the negative consequences of the changes are far-reaching. Many in the state would prefer to reinstate the crucial aspects of the Levels of Care system by re-bundling rates and once again allowing therapeutic services to be provided to children where they live.⁵⁸ Although President Obama has withdrawn or rescinded the TCM and rehabilitation regulations, no corresponding change in CMS policy has yet occurred. With no word from CMS on what practices are now allowable, Georgia is unable to restore any of the eliminated services.

Montana

Throughout the 2000s, CMS continued requiring states to unbundle payment rates and reduce or eliminate TFC despite the strong evidence of negative consequences in states such as Georgia where the changes had already been enforced. One of the next states that CMS instructed to meet these requirements was Montana, which was verbally directed to unbundle its payments by October 2007.⁵⁹ While CMS has not pressured Montana to enact the changes under the new administration, neither has it withdrawn its unbundling directive.⁶⁰ As a result, the future of therapeutic services in Montana is unclear.

At the time CMS issued its unbundling directive, Montana provided TCM, TFC, and therapeutic group home services to eligible foster children. The state served about 800 youth in therapeutic foster care in state fiscal year 2007, and an additional 500 youth in four- to eight-bed therapeutic group homes.⁶¹ TCM was billed in 15-minute increments, and TFC and therapeutic group homes were paid a bundled daily rate using money from Medicaid, Title IV-E, and state general revenue.⁶² Although the funds for TFC were bundled into single per-child daily payments, the rate was structured so that Medicaid would cover the treatment portion, while room and board would be covered by IV-E and state general funds.⁶³

Under the direction of CMS, Montana began working on a plan to unbundle its rates for TFC and therapeutic group homes. Therapeutic group homes were the first to be slated for unbundling, with TFC to follow. Shortly after this work began, the Bush administration began issuing its proposed regulations

⁵⁴ Normer Adams op. cit. (19)

⁵⁵ Georgia Association of Homes and Services for Children op. cit. (41)

⁵⁶ Normer Adams op. cit. (19)

⁵⁷ Normer Adams op. cit. (19)

⁵⁸ Normer Adams op. cit. (19)

⁵⁹ Children, Families, Health, and Human Services Interim Committee, 60th Montana Legislature. Letter to U.S. Senator Jon Tester regarding the federal government’s efforts to restrict Medicaid payments for therapeutic group care and therapeutic foster care. 2 Aug. 2007. Available online at: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/staff_reports/tester-unbundlingtr.wpd.pdf

⁶⁰ Steve Nelsen, Executive Director, Montana Children’s Initiative. Interview by author, Aug. 11, 2009.

⁶¹ Children, Families, Health, and Human Services Interim Committee, 60th Montana Legislature. Letter to CMS regarding the proposed rule on rehabilitative services. 11 Oct. 2007. Available online at: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/staff_reports/cms-unbundlingtr.pdf

⁶² DMA Health Strategies op. cit. (38); Jani McCall op. cit. (16)

⁶³ Jani McCall op. cit. (16)

that would have expanded the changes to all states. A report to the Montana state legislature after the promulgation of the regulations assessed the state's risk if the regulations were to go into effect. The report concluded that Montana's exposure was generally low compared to other states, but noted that the changes outlined in the TCM and rehabilitation rules covered nearly \$30 million in services provided in Montana at that time.⁶⁴

The unbundling directive and the promulgation of the regulations threw Montana's child welfare providers into uncertainty about the future of their services. As described by state agency officials and providers, the changes would have created "undue reporting and documentation requirements" for providers,⁶⁵ and could have drastically reduced the availability of Medicaid money to fund those services.⁶⁶ This cut would have to be made up with a proportional increase in the state general fund appropriation for room and board, or by cutting services.⁶⁷

Providers' uncertainty about the future of their services had a long-term effect on the availability of TFC in Montana. Recruiting and training therapeutic foster parents is a time-consuming process. It may take many months from the beginning of the process to when the foster family is ready to accept a child for placement.⁶⁸ Not knowing whether they would be able to continue to provide high-quality training and support services for therapeutic placements, Montana's child welfare providers began reducing their recruitment efforts. As a result, the number of therapeutic placement slots dropped from 211 to 184.⁶⁹ Providers report that children who would have gone into those eliminated therapeutic placements have ended up in higher levels of care.⁷⁰ This has resulted both in higher costs to the Medicaid program⁷¹ and in children losing access to treatment in a family- or community-based environment.

Montana has formulated a plan for the unbundling of therapeutic group homes, but the plan is on hold until the state receives further instructions from CMS. Despite the withdrawal of the Bush regulations, CMS has not given Montana any indication of whether it must proceed with unbundling or whether it may continue using a bundled rate.⁷² Montana child welfare providers are concerned that continuing implementation of the Bush policies could result in drastic funding cuts and service reductions, but they are being kept in a "holding pattern" until CMS clarifies its policies.⁷³

CONCLUSION AND RECOMMENDATIONS

This policy brief examined states' experiences with the continuation of Bush-era policies on rehabilitation, TFC, and TCM. These policies have had far-reaching consequences for children, providers, and states. Providers have experienced funding cuts, closures of their therapeutic programs, and increased fragmentation of the services they had formerly provided in one place. States are at greater risk of being determined to be out of compliance with CMS policies and are facing strong disincentives to make needed changes or updates to their state Medicaid plans. Taken together, these effects on states and providers ultimately harm children's access to crucial health services. Moreover, the Bush-era policy changes that states and CMS have continued to implement are coming at a time when Congress is

⁶⁴ DMA Health Strategies op. cit. (38)

⁶⁵ DMA Health Strategies op. cit. (38)

⁶⁶ Montana Department of Public Health and Human Services Rates Commission. "2008 Report to the Legislature." Available online at: <http://leg.mt.gov/content/For%20Legislators/Publications/DPHHS%20rates%20commission.pdf>

⁶⁷ DMA Health Strategies op. cit. (38); Children, Families, Health, and Human Services Interim Committee, 60th Montana Legislature op. cit. (60); Montana Department of Public Health and Human Services Rates Commission op. cit. (64)

⁶⁸ Twila Costigan op. cit. (25)

⁶⁹ Twila Costigan op. cit. (25)

⁷⁰ Twila Costigan op. cit. (25)

⁷¹ Higher levels of placement are more costly than less restrictive settings. "Medicaid Mental Health and Mental Health Services Plan Individuals Under 18 years of Age Fee Schedule: July 1, 2009." Available online at: <http://www.dphhs.mt.gov/mentalhealth/children/feeschedule.pdf>

⁷² Steve Nelsen op. cit. (58)

⁷³ Jani McCall op. cit. (16); Conference call with 15 child welfare agencies in Montana, May 29, 2009.

considering a health reform policy that utilizes bundled payments and greater integration of health services as important cost control and quality improvement techniques.⁷⁴

Policy changes take time for any administration to implement. As noted earlier, CMS is still without an administrator, which is hampering the agency's efforts to respond to policy changes.⁷⁵ There are some indications that CMS is aware of states' difficulties with the ongoing implementation of the Bush-era policies on bundled payments. In a recent communication to state mental health programs, CMS acknowledged that billing in 15-minute intervals should not be required, and stated that it had reviewed this policy with its regional offices. CMS also stated its commitment to providing more transparent, consistent guidance to states on developing reimbursement rates for these services. However, CMS did not give any indication of reversing the Bush policies on denying Medicaid reimbursement for therapeutic foster care, alluding only to the fact that states must demonstrate they are excluding non-Medicaid costs from their treatment rates. CMS also did not clearly state its position on the bundling of services, leaving states no guarantee that they will be able to continue to provide Medicaid treatment services as part of their therapeutic program packages.⁷⁶ Thus, despite these initial steps by CMS, additional action by CMS or Congress may be required to firmly establish states' prerogative to cover and bill for therapeutic services in the manner that best fits their overall plans and goals for service delivery to citizens, especially children.

Recommendations

- ***CMS should consider issuing written guidance to states confirming that the Bush policies will be reversed and that therapeutic foster care may be covered by Medicaid.*** As noted earlier, CMS has already acknowledged in a communication to state mental health program directors that bundled payment rates are an appropriate reimbursement methodology for rehabilitative and TCM services.⁷⁷ However, CMS's communication did not explicitly acknowledge the reversal of the Bush policies and did not provide any assurances that states will continue to be able to use Medicaid to finance the health treatment of children in TFC or therapeutic residential placement. Written guidance from CMS clearly establishing TFC as an allowable Medicaid service would address states' current uncertainty about the future of their programs, would allow providers to stop preparing for the potential of unbundling, and would allow states to reverse their ongoing planning for unbundling.
- ***Congress should consider amending federal Medicaid law to include TFC as an allowable service under the rehabilitative option.*** Although written guidance from CMS would immediately address states' concerns, it would not prevent similar restrictions from being implemented under a future presidential administration. To permanently protect TFC, Congress should consider including it in health care reform. The House Energy and Commerce Committee has already approved an amendment to its version of health reform legislation that clearly establishes TFC as an allowable Medicaid service through the rehabilitative option. The amendment, offered by Rep. Tammy Baldwin (D-WI), states that nothing in federal Medicaid law shall prevent a state from covering TFC through Medicaid.⁷⁸ Two other House committees have approved their own versions of health care reform legislation that do not include the TFC provision. The Senate Finance Committee, which has jurisdiction over Medicaid issues in the Senate, has not yet released its health reform bill.

⁷⁴ H.R. 3200, "America's Affordable Health Choices Act of 2009." Introduced 14 July 2009. Available online at: <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3200>; Draft Senate Bill, "Affordable Health Choices Act." Introduced 9 June, 2009. Available online at: http://help.senate.gov/BAI09A84_xml.pdf

⁷⁵ Pear op. cit. (12)

⁷⁶ National Council for Community Behavioral Healthcare. "Information from CMS on State Implementation of 15 Minute Billing Requirement for Rehab & Case Management Services." *Public Policy Update* 20 Aug. 2009. Available online at: http://www.thenationalcouncil.org/cs/latest_issue

⁷⁷ National Council op. cit. (76)

⁷⁸ Available online at: http://energycommerce.house.gov/Press_111/20090730/hr3200_baldwin_1.pdf

- **Congress should consider passing S. 1217, the Medicaid Services Restoration Act.** S. 1217, introduced by Sen. Debbie Stabenow in June 2009, makes several changes to federal Medicaid law that clarify allowable coverage and billing practices for rehabilitation and TCM. Specifically, the bill creates a new category of medical assistance under Medicaid for TFC and allows states to select their own “reasonable” payment methodologies, including daily bundled rates, for rehabilitative and TCM services.⁷⁹

— 0 —

About the Alliance for Children and Families and United Neighborhood Centers of America

The Alliance for Children and Families, a nonprofit association, was formed by the 1998 merger of Family Service America and the National Association of Homes and Services for Children. The Alliance represents over 370 nonprofit organizations across the nation that provide services and economic empowerment to children and families. Alliance agencies cover a wide spectrum of providers, including a diversity of faith-based organizations and nonsectarian agencies. Together, these organizations deliver more than \$2 billion annually in services to more than 8 million people in nearly 6,700 communities across the United States. More information about the Alliance is available at www.alliance1.org.

United Neighborhood Centers of America (UNCA) is a voluntary, nonprofit, national organization with neighborhood-based member agencies throughout the United States. Formerly known as the National Federation of Settlements and Neighborhood Centers, it was founded in 1911 by Jane Addams and other pioneers of the settlement movement. More information about UNCA is available at www.unca.org.

For more information, contact the Washington office of the Alliance and UNCA at:

Alliance for Children and Families / United Neighborhood Centers of America
1001 Connecticut Ave., NW, Suite 601
Washington, DC 20036
(202) 429-0400
policy@alliance1.org

⁷⁹ Available online at: <http://thomas.loc.gov/cgi-bin/query/z?c111:S.1217>.