



History of Ambiguous Federal Guidance on Medicaid Billing has Undermined Children's Mental Health Services

Ambiguity Has Left States Unsure of Allowable Coverage and Billing Practices

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SUMMARY

Children in the child welfare system rely heavily on the rehabilitative and targeted case management (TCM) options of Medicaid to meet their mental health needs.² Federal Medicaid law provides very broad guidance on what services these options may cover, giving states a great deal of latitude in their coverage and billing practices.

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. These changes have been both direct (as when Congress passes a law or the Centers for Medicare and Medicaid Services issues a rule change) or indirect (as when CMS issues a letter to state Medicaid directors outlining its policy on an aspect of Medicaid or approves or denies a proposed state plan amendment). Much of this guidance has been vague, ambiguous, and enforced on a state-by-state basis, leaving states unsure of allowable practices.

This policy brief gives an overview of the history of federal guidance on the rehabilitative and TCM options and describes their current status.

FEDERAL GUIDANCE PRIOR TO 2005

Rehabilitative Services

Rehabilitative services are an optional Medicaid benefit covering treatments that reduce physical or mental disabilities or restore patients to their best possible level of functioning.³ Rehabilitative services are the highest single category of Medicaid spending for children in foster care, totaling \$493 million, or 13.1 percent of all Medicaid spending for children in foster care, in 2001.⁴ Nearly 12 percent of foster care enrollees, or about 100,000 children, receive treatment under this category of services.⁵ For children with serious emotional disturbances, these crucial health interventions include such services as

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² 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

³ Congressional Research Service Report for Congress: "Medicaid Rehabilitation Services." Updated June 20, 2008. Available online at: <http://aging.senate.gov/crs/medicaid13.pdf>

⁴ The only larger category is "Other." [Geen op. cit. (2)]

⁵ Geen op. cit. (2); Congressional Research Service op. cit. (3)

therapy, life skills training, psychiatric rehabilitation, and crisis intervention to help youth with severe mental health needs live in their own communities.⁶

While the rehabilitative services option covers a broad array of services, there is nonetheless some disagreement over the scope of allowable services. More specifically, there is some uncertainty about whether it covers therapeutic foster care (TFC) and so-called “habilitative” services. As described by CMS, “habilitative” services are intended to help individuals acquire or retain adaptive skills, in contrast to “rehabilitative” services, which help individuals restore lost function or reduce disabilities.⁷ During the 1970s and 80s, the Department of Health and Human Services (HHS) approved 17 state plans that covered “habilitative” services.⁸ HHS later withdrew its approval for habilitative services on the grounds that they did not qualify as rehabilitative services.⁹ However, in 1989, Congress overrode HHS, passing legislation that allowed the 17 states that had previously obtained approval to continue providing those services. States that had not already been approved were barred from gaining approval.¹⁰

Therapeutic foster care (TFC) is a type of treatment frequently reimbursed under the rehabilitative option. TFC places young people who have serious emotional and behavioral issues in a home with trained foster parents in a structured environment with close supervision.¹¹ Because the rehabilitative option is so broadly defined, it allows wide latitude in the development of unique courses of treatment for each child, encompassing interventions in home, group, community, and day care settings throughout the entire day.¹² Because children enrolled in TFC typically also receive a variety of other types of federal and state assistance (such as Title IV-E or TANF), most states use a combination of the Medicaid rehabilitation option and other funding streams to pay for these services. These funding streams are often combined into a single “bundled” rate that is paid to providers on a daily, per-child basis and covers the provision of all needed services during the course of a day. Bundled rates have come under criticism for including Medicaid funding, since the individual treatment components of TFC do not always fall neatly into the strict medical model of billable services under Medicaid.¹³

In 1992, CMS attempted to clarify some of the questions surrounding the rehabilitative option by issuing a letter to state Medicaid directors (FME-42). This letter is currently the most comprehensive written explanation of federal policy on rehabilitative services.¹⁴ The letter restated federal policy that rehabilitative services must be used for the purpose of “the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.”¹⁵ It also offered examples of services that states could cover and services that fell outside the definition of rehabilitation.¹⁶

Beginning in the early 2000s, CMS began issuing directives to certain states requiring them to “unbundle” their treatment services by removing the Medicaid rehabilitative portion from the bundled rate, breaking

⁶ Abt Associates, Inc. “Characteristics of Residential Treatment for Children and Youth with Serious Emotional Disturbances.” White Paper prepared for the National Association for Children’s Behavioral Health and the National Association of Psychiatric Health Systems.” Summer 2008. Available online at: http://www.naphs.org/documents/AbtFINALReport.8.4.08_000.pdf ; 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.ffa.org/members/publications/monograph.pdf>

⁷ Congressional Research Service op. cit. (3)

⁸ Congressional Research Service op. cit. (3)

⁹ Congressional Research Service op. cit. (3)

¹⁰ Congressional Research Service op. cit. (3)

¹¹ Congressional Research Service op. cit. (3); 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>

¹² Costigan op. cit. (12)

¹³ 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

¹⁴ 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. Available online at: <http://www.bazelon.org/pdf/FollowingRules.pdf>; “Rehabilitation Services for the Mentally Ill – Information Memorandum from Director, Medicaid Bureau, Health Care Financing Administration, U.S. Department of Human Services to All Regional Administrators,” June 1, 1992 (FME-42).

¹⁵ Congressional Research Service op. cit. (3)

¹⁶ Congressional Research Service op. cit. (3)

TFC into its component parts, and billing for those services in 15-minute increments. These requirements were not enforced uniformly across states, but on a piecemeal basis as CMS reviewed certain states' Medicaid plans. As a result, some states were required to unbundle services, while others kept their services intact.

In 2005, the Government Accountability Office (GAO) and the Health and Human Services Office of Inspector General issued reports criticizing state practices on rehabilitation and alleging that states did not fully comply with federal Medicaid rules.¹⁷ The GAO reports criticized CMS for not offering clearer guidance to states. GAO also pointed out that conflicting CMS regulations, contradictory actions by Congress, and the vagaries of the Medicaid state plan process (states often do not receive confirmation about whether or not they are in full compliance with federal law until they submit a state plan amendment or are audited) had created a patchwork of billing and coverage practices across the country without clear guiding principles on allowable practices.

Targeted Case Management

Case management is an optional benefit that most states use to coordinate medical, social, educational, and related services for Medicaid beneficiaries.¹⁸ Targeted case management (TCM) is used to provide case management services that are targeted toward specific groups of individuals; foster children are one group that commonly receives TCM. Medicaid spending on TCM for foster children totaled \$266 million in 2001, making it the seventh highest category of Medicaid spending for foster children.¹⁹ TCM recipients are more likely to receive needed health services than foster children who do not receive TCM. For example, 68 percent of TCM recipients had a physician visit in 2001, compared with only 44 percent of non-TCM recipients. Among other services, TCM recipients are also more likely to receive rehabilitative services.²⁰ As with rehabilitation, TCM payments are often combined with other funding streams and "bundled" into a single daily rate that covers multiple aspects of a child's support and health treatment.

Medicaid expenditures for TCM have increased rapidly over the last decade at a rate greater than overall Medicaid spending.²¹ This trend sparked concerns among federal officials, and in 2001, in the final days of the Clinton Administration, CMS issued a letter to state Medicaid directors addressing the use of TCM for children in foster care. This letter is often used as guidance for the TCM option more generally.²² The letter described examples of appropriate TCM claims and left states a great deal of latitude in structuring and defining their TCM services.²³

During the initial years of the Bush administration, states received additional unofficial guidance on how to utilize the TCM option. GAO and HHS reports criticizing state Medicaid practices, testimony before Congress, and CMS's denial of several state plan amendments proposing to cover TCM for foster children offered states indirect guidance on utilizing TCM.²⁴ However, these unofficial indicators also

¹⁷ Congressional Research Service op. cit. (3); U.S. Government Accountability Office. *Medicaid Financing, States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, Report to the Chairman, Committee on Finance, U.S. Senate. June 2005. Available online at: <http://www.gao.gov/new.items/d05748.pdf>; Department of Health and Human Services, Office of Inspector General. *Audit of Iowa's Adult Rehabilitation Services Program*, (A-07-03-03041), 23 March, 2005.; *Review of Medicaid Community Mental Health Center Provider Services in Indiana*, (A-05-05-00057), 5 April, 2007. Available online at: <http://oig.hhs.gov/oas/oas/cms.html>

¹⁸ First Focus. "Addressing the Health Care Needs of Foster Care Children." Policy brief, May 2008. Available online at: <http://www.firstfocus.net/Download/FosterCareHealth.pdf>

¹⁹ Geen op. cit. (2)

²⁰ Geen op. cit. (2); 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>

²¹ Congressional Research Service Report for Congress: "Medicaid Targeted Case Management Benefits." March 27, 2008. Available online at: <http://www.pascenter.org/documents/RL34426.pdf>

²² Congressional Research Service op. cit. (22)

²³ Congressional Research Service op. cit. (22)

²⁴ U.S. Government Accountability Office op. cit. (17); Congressional Research Service op. cit. (22); Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services. Testimony to Senate Committee on Finance hearing on Medicaid Fraud and Abuse, 28 June, 2005. Available online at: <http://finance.senate.gov/hearings/testimony/2005test/DStest062805.pdf>.

contributed to the ambiguity, since many states with existing TCM programs were not forced to change their practices.²⁵ TCM expenditures continued to rise during this period.²⁶ Audits and reports by administration officials claimed that states were improperly using TCM in cases where similar services were covered by another public program, thus shifting the costs of those programs onto Medicaid.²⁷

ATTEMPTS AT CLARIFICATION: THE DRA AND PROPOSED REGULATORY CHANGES

By 2005, lack of clear guidance had enabled states to use a variety of methods for defining and billing the rehabilitative and TCM options – leaving themselves open to criticism that Medicaid funds were being improperly spent on non-covered services or services that should be paid for by another public program. In an attempt to provide some clarity to the tangle of state practices and federal guidance on rehabilitation and TCM, Congress made several key changes to Medicaid in the Deficit Reduction Act of 2005 (DRA). These changes were further codified in a set of proposed regulatory changes issued by CMS.

Deficit Reduction Act of 2005

Section 6052 of the DRA, entitled “Reforms of Case Management and Targeted Case Management,” clarified the definition of TCM by narrowing the services that may be considered case management and providing examples of allowable case management services. It also reiterated that case management may not include the direct delivery of medical or social services.²⁸ The DRA instructed CMS to promulgate regulations to implement these changes.

President Bush had also urged lawmakers to include restrictions on the rehabilitative option in the DRA, sending Congress a proposal that would have denied federal Medicaid reimbursement both for “habilitative” services and for rehabilitative services that were “intrinsic” to the scope of another public program. However, Congress did not include this proposal in the final version of the DRA, and the Bush administration opted to pursue the changes through the regulatory process.²⁹

2007-08 Proposed Regulatory Changes

In 2007 and 2008, CMS issued several proposed rules that were intended to clearly define allowable services under the rehabilitative and TCM options. However, the proposed regulations went beyond the scope of the DRA in restricting allowable services.³⁰

The proposed rehabilitation regulation would have denied Medicaid coverage for any service deemed an intrinsic part of another program. It sharply limited the definition of rehabilitative services to include only those services used to help *restore* an individual to his or her highest level of functioning, denying reimbursement for “habilitative” services. It also restricted the methodologies states could use for reimbursing providers by prohibiting the bundling of daily rates and requiring providers to bill for their services in 15-minute increments. Included in the regulation was provision explicitly denying reimbursement for therapeutic foster care, on the grounds that TFC is a “model of care,” not a rehabilitative service.³¹

²⁵ Congressional Research Service op. cit. (22)

²⁶ Congressional Research Service op. cit. (22)

²⁷ Congressional Research Service op. cit. (22)

²⁸ Congressional Research Service op. cit. (22)

²⁹ Coalition to Preserve Rehabilitation. “Medicaid Rehabilitative Services.” Available online at: <http://www.preserverehab.org/medicaidrehabservices.htm>

³⁰ Costigan op. cit. (12); Child Welfare League of America op. cit. (21); 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

³¹ Secretary of Health and Human Services op. cit. (14); Congressional Research Service op. cit. (3) ; Consortium for Citizens with Disabilities op. cit. (29)

The TCM regulation went beyond the language of the DRA by limiting the length of time that individuals transitioning from an institution to their communities could receive TCM services through Medicaid. It also limited those receiving services to a single case manager, regardless of the individual's specific needs. Furthermore, it required states to "unbundle" daily rates and forced providers to bill in 15-minute increments.³²

With these regulations, CMS took the position that certain services currently provided by states under the TCM and rehabilitative options fell outside the scope of Medicaid and should be reimbursed instead by other federal or state programs.³³ If implemented, the two regulations would have reduced federal Medicaid spending by over \$3 billion in fiscal years 2008-2012.³⁴ 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.³⁵ States and providers also reported that the regulations would almost certainly result in service cuts, thus decreasing children's access to care.³⁶

Congressional Moratoria on the Regulations and Rescission of TCM Rule by President Obama

The child welfare, mental health, juvenile justice, and disabilities communities mobilized to fight the proposed regulations. With strong support from a broad spectrum of state agencies and human service providers, Congress passed a series of moratoria on the regulations, with the most recent moratorium delaying their implementation until July 1, 2009.³⁷ Then-Senator Obama supported the moratorium, and on becoming president, did not pursue the implementation of the rehabilitation regulation.³⁸

Unlike the rehabilitation rule, the TCM rule had already been in final form at the time of the congressional moratorium, meaning that it could still go into effect after on July 1. However, on June 30, 2009, the U.S. Department of Health and Human Services issued its final rule rescinding the most restrictive portions of the TCM rule and returning it to the original language of the DRA.³⁹

BACK TO SQUARE ONE: CURRENT SITUATION

With the proposed regulations withdrawn, the state of federal guidance on rehabilitation and TCM is back to that outlined in the DRA. Although the DRA did provide some additional clarity on TCM services, it did not address any of the ambiguity surrounding the rehabilitative option, and general federal guidance on TCM and the rehabilitative option is still vague. This lack of clarity leaves states at risk for the ongoing implementation of Bush-era CMS policies that drastically restricted Medicaid services for children in the child welfare system. Without clear information on allowable billing and coverage practices, states are facing restrictions that in many cases threaten their ability to continue to provide vital health services to

³² Secretary of Health and Human Services op. cit. (14)

³³ Secretary of Health and Human Services op. cit. (14)

³⁴ 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_MedicaidReqs.pdf

³⁵ 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>

³⁶ Costigan op. cit. (12); Child Welfare League of America op. cit. (21); Consortium for Citizens with Disabilities op. cit. (29)

³⁷ Kaiser Commission on Medicaid and the Uninsured op. cit. (33); Title VII, Section 7001 of the Supplemental Appropriations Act of 2008 (P.L. 110-252. 30 June 2009). Relevant section available online at: <http://thomas.loc.gov/cgi-bin/query/F?c110:9:./temp/~c110Ep3u1T:e194515;> ; 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;>

³⁸ 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>

³⁹ 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&WASAction=retrieve>

children most in need.⁴⁰ Additional action by CMS or Congress may be needed to clearly outline allowable practices for utilizing the rehabilitative and TCM options.

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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.

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⁴⁰ For more information, see: Farley, R. "Despite Obama Regulatory Rollback, States Continue Bush-era Medicaid Policies on Children's Mental Health." Available online at: www.alliance1.org