



**Written Testimony of
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Ways and Means Committee
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INTRODUCTION

Good morning, Chairman McDermott, Ranking Member Weller, and members of the subcommittee. I am Erin Sullivan Sutton, director of the Division of Child Safety and Permanency for the Minnesota Department of Human Services. In this position I have responsibility for programs and policy in child abuse prevention, child protection, family support and preservation services, foster care, permanency, adoptions, Indian child welfare, and the Interstate Compact on the Placement of Children. I have been in the field of child welfare for nearly 25 years.

I am also on the Executive Committee of the National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Human Services Association (APHSA), and am here today in that capacity as well. APHSA is a nonprofit, bipartisan organization representing state and local human service professionals for over 76 years. NAPCWA, created as an affiliate in 1983, works to enhance and improve public policy and administration of services for children, youth, and families. As the only organization devoted solely to representing administrators of state and local public child welfare agencies, NAPCWA brings an informed view of the problems facing families today to the forefront of child welfare policy.

On behalf of APHSA, NAPCWA, and the state of Minnesota, I would like to thank the subcommittee for recognizing the importance of health and mental health care among children who are involved in the child welfare system. I appreciate the opportunity to testify before you today about how best to meet the many needs of the vulnerable kids that populate our child welfare systems.

HEALTH AND MENTAL HEALTH NEEDS AMONG CHILDREN IN THE CHILD WELFARE SYSTEM

The child welfare system serves some of our country's most troubled and vulnerable families. Each year, over three million children come to the attention of the child welfare system for alleged abuse or neglect. And each year, more than 800,000 children spend time in foster care.

Numerous studies have shown that these children have more health and mental health needs compared to not only the general population, but also children living in poverty. Research indicates that 80% of youth involved in the child welfare system have been diagnosed with emotional or behavioral disorders, developmental delays, or other mental health problems. It has also been documented that more youth coming out of the foster care system suffer from Post-Traumatic Stress Disorder than war veterans.

MEDICAID AND CHILDREN IN CARE

The child welfare system is responsible for caring for children when their families cannot. A large part of that responsibility is addressing the health and mental health needs for children in the state's care. State child welfare systems rely heavily on Medicaid funds to pay for health and mental health services for these vulnerable children. This is an appropriate relationship as all children in foster care and adoptive placements whose expenses are reimbursed through Title IV-E of the Social Security Act are categorically eligible for Medicaid. In addition, all states currently choose to extend Medicaid benefits to non-IV-E eligible foster children. Each state determines its own eligibility standards, services, and payment rates in its foster care and Medicaid programs within federal guidelines. Children in foster care, who are eligible for private insurance coverage through their caregivers, are still eligible for Medicaid wraparound coverage.

Nationally, children involved with child welfare system represent only a small portion of total Medicaid spending. For instance, in fiscal year 2001, \$3.7 billion in Medicaid funds were spent on children involved with child welfare agencies, accounting for just over 2 percent of the total \$180 billion in Medicaid spent that year. Children in foster care represent only a fraction of total Medicaid enrollees. Reducing services for children in foster care will not produce significant Medicaid savings. However, approximately 75 percent of foster children are enrolled in Medicaid. The remaining 25 percent of children in care receive benefits through other means, such as private health insurance. Foster children use mental health services that are reimbursed by Medicaid at a rate 8 to 15 times higher than Medicaid-enrolled children who are not in foster care.

MEDICAID TARGETED CASE MANAGEMENT AND REHABILITATION SERVICES

In addition to relying on Medicaid to pay for obvious health care services like surgeries and antibiotics that foster children need, State Child Welfare agencies also rely on two important Medicaid services that are critical to meeting the needs of this group of children: Medicaid Targeted Case Management (TCM) and Rehabilitative Services.

Medicaid Targeted Case Management pays for activities related to coordinating the many services and appointments these children require. Medicaid Targeted Case Management is an optional Medicaid benefit that helps subgroups of Medicaid beneficiaries identified by states, in this case foster children. Medicaid Targeted Case Management services cannot supplant child welfare case management activities; rather they supplement the child welfare treatment management with coordinating activities focused on securing health, mental health and other crucial support services. Common Medicaid Targeted Case Management activities include assessment of service needs, development of a care plan, referral to needed services, and monitoring of care plans and service delivery. Currently, 38 states extend the Medicaid Targeted Case Management option to children in foster care. In about one third of these states, at least 40 percent of Medicaid-enrolled foster children receive Medicaid Targeted Case Management.

The second critical group of Medicaid services needed by children in the child welfare system is called Medicaid rehabilitative services. Rehabilitative Services offer additional supports that improve or maintain the functioning of people suffering from mental illness, often reducing the need for ongoing inpatient treatment. These services are particularly important for this population of children, as children in the child welfare system are at high risk to be placed in costly institutional or residential treatment settings to address their behavioral and mental health needs. 48 states offer rehabilitative services to foster kids.

Both Medicaid TCM and rehabilitative services help develop and maintain community-based treatment and permanency options that meet the needs of children and youth in less restrictive and more cost-effective ways.

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) addressed Medicaid Targeted Case Management services in Section 6052. According to the DRA, Medicaid Targeted Case Management is primarily a support for assessment, linkage, and referral services; it is not intended to provide for any direct service delivery. Section 6052 of the DRA also limited the use of Medicaid Targeted Case Management for children in foster care. The limitations will shift an estimated \$350 million over five years, and \$940 million over 10 years to the federal foster care program.

Children who are served by Title IV-E funding are particularly reliant on Medicaid options like Medicaid Targeted Case Management and Rehabilitation Services because Title IV-E funding cannot be used to coordinate health care and mental health services. Due to limited state budgets and new and proposed federal restrictions, child welfare agencies are struggling to find the resources to meet the complex needs of children in care.

FY 2008 BUDGET PROPOSALS AFFECTING MEDICAID TARGETED CASE MANAGEMENT & REHABILITATION SERVICES

There are two FY 2008 budgetary proposals that would affect Medicaid Targeted Case Management and Rehabilitation services. First, as part of the President's legislative proposals that would reduce Medicaid spending by \$13 billion over five years, the reimbursement rate for Medicaid Targeted Case Management would be reduced to 50 percent. Currently, the reimbursement level for Medicaid Targeted Case Management for states is tied to the regular Federal Medical Assistance Percentage (FMAP) that is based on the average per-capita income of the state. In 2005, Medicaid Targeted Case Management reimbursement rates ranged from 50 percent to 77 percent. The President's proposal would disproportionately affect poorer states, where the prevailing match rate is greater than 50 percent due to the FMAP link to the per-capita income in each state. For example, with Mississippi's current FMAP rate at 77 percent, a 23 percent reduction in reimbursement would occur, severely limiting the state's ability to meet the health and mental health needs of foster children.

Second, as part of the President's administrative proposals to reduce Medicaid spending by \$12.7 billion over the next five years, the Centers for Medicare and Medicaid Services (CMS) would issue regulations defining allowable rehabilitation services. The Office of Inspector General (OIG) and CMS are already conducting audits and reviews around both rehabilitative services and Medicaid Targeted Case Management in several states, including Minnesota. These administrative actions are reducing the availability of community-based care for foster children with mental health needs.

THE DEFICIT REDUCTION ACT

The final effects of the DRA on states regarding allowable Medicaid Targeted Case Management activities have yet to be seen. Section 6052 of the DRA prohibited the use of Medicaid TCM for several specific activities, including the provision of direct care services in the foster care system. These specific changes were minor, however, the DRA also directed the Centers for Medicare & Medicaid Services (CMS) to issue a new regulation to further define any new standards states must adhere to in the provision of Medicaid Targeted Case Management services. That regulation has not yet been published, but states, including Minnesota, have experienced administrative actions by CMS and OIG regarding Medicaid Targeted Case Management services. Of great concern in these actions is the broad interpretation oversight agencies can give to the term "direct services" as well as the definition that is given to what constitutes "programs" other than Medicaid that can be interpreted to have primary responsibility for payment of a given services or activity.

Medicaid spending is projected to increase 7 percent per year in the next decade as more low-income Americans qualify for the program and health care costs continue to rise. We certainly recognize and respect efforts to bring these costs in line with budgetary spending limits. However, Medicaid Targeted Case Management exists for vulnerable populations that almost by definition are involved in multiple "programs" and government systems. The dangerous policy result integral to this administrative effort by CMS is that both Medicaid and IV-E prohibit use of their funds for this critical coordination activity, to the detriment of the very population that needs it.

While we applaud efforts to maintain the cost integrity of Medicaid services, states do not support a reduction in the reimbursement rate for Medicaid Targeted Case Management or an overly broad definition of prohibited services. This would mean a significant reduction in the amount of services available to one of the country's most vulnerable populations—children involved in the child welfare system, particularly children reliant on federal IV-E dollars, to meet the costs of their health and mental health care needs.

REASONS TO MAINTAIN THE MEDICAID TARGETED CASE MANAGEMENT REIMBURSEMENT RATE

Medicaid Targeted Case Management facilitates more services that are so clearly needed for more children involved in the child welfare system. A 2005 study showed that Medicaid Targeted Case Management recipients were more likely than non-Medicaid

Targeted Case Management recipients to receive several services, including physical health (68 percent of Medicaid Targeted Case Management recipients compared with 44 percent of non-Medicaid Targeted Case Management recipients); prescription drug (70 percent versus 47 percent); dental (44 percent versus 24 percent); and clinic (34 percent versus 20 percent). Children in the child welfare system must continue to be offered access to Medicaid Targeted Case Management that will maintain and increase their linkages with these needed services, not decrease it.

There are additional inherent systemic challenges in meeting the health and mental health needs of children in the child welfare system that Medicaid Targeted Case Management also helps to ameliorate. Systemic barriers often interfere in the screening, assessment, and service availability of needed health and mental health services. In a 2005 assessment of state child welfare agencies, the U.S. Department of Health and Human Services (HHS) found that more than 30 percent of the foster care cases reviewed did not demonstrate the provision of adequate services to children. Other studies have shown that more than 40 percent of children entering the child welfare system do not receive initial screenings for mental health or developmental delays.

The HHS report identified common challenges faced by states, including challenges in conducting adequate and timely health and mental health assessments. Medicaid Targeted Case Management enhances the ability of state child welfare agencies to assess and facilitate needed services through its support of screening and assessment activities.

Children in this system are also more likely to be placed in institutional or residential treatment settings to address their behavioral and mental health needs. These settings often carry significantly higher monetary costs for Medicaid as well as emotional costs for children and their families. Medicaid Targeted Case Management is an integral means of facilitating community-based treatment services for children who would otherwise be placed in institutional or residential treatment centers—at a significantly higher per-child expenditure rate. Institutional services are among the highest per-child expenditures for foster children, with costs averaging around \$54,916 per child. *In fact, among all Medicaid expenditures on inpatient psychiatric services, foster children account for 28 percent.* Reducing the amount of funds to Medicaid Targeted Case Management could contribute to this disturbing figure climbing still higher.

CHILD SCREENING AND ASSESSMENT IN MINNESOTA

Minnesota is one of 11 state-supervised, county-administered child welfare systems. We have 87 counties that provide direct services to vulnerable children and their families.

In 2006, 14,700 Minnesota children spent some time in out-of-home care; 59.7 percent of children entered care for reasons related to their parents, and 26 percent of the entries into care were attributed to the child's behavior or substance abuse. The majority of children in care in Minnesota are adolescents, ages 13 to 18.

Minnesota law requires that when an agency accepts a child for placement, it must determine whether a child has had a physical examination by or under the direction of a licensed physician within the 12 months immediately preceding the placement. If there is documentation that the child has had an exam within that time, the agency is responsible for seeing that the child has another physical exam within one year of the documented exam and annually thereafter. If the agency determines that the child has not had a physical examination within the 12 months preceding placement, the agency is required to ensure that the child has an examination within 30 days of coming into the agency's care and annually in subsequent years.

Attending to a child's mental health needs in Minnesota is also a priority. As a result of recommendations of a 2002 Children's Mental Health Task Force, our 2003 legislature required that mental health screenings be conducted for all children in our child welfare and juvenile justice populations.

We believe it is critical to identify children with mental health needs early, and to provide appropriate services. Research has clearly demonstrated that mental health needs can be identified and treated early and that early intervention is cost effective. Further untreated or under-treated mental health problems get worse over time.

We require mental health screening for children ages 3 months to 18 years who are receiving child protective services, for whom parental rights have been terminated, and who are in out-of-home care for 30 days or more. Mental health screening is also mandated for children ages 10 to 18 years in the juvenile justice system.

Mental health screening is a brief process to detect potential mental health problems. It is intended to identify children and youth in need of further evaluation. Children identified through the screening process are referred to a mental health professional for a diagnostic assessment. Those assessments are used to develop a treatment plan to address the identified issues.

MEDICAID TARGETED CASE MANAGEMENT IN MINNESOTA

In Minnesota, Medicaid Targeted Case Management is used for activities that assist eligible recipients to gain access to needed medical, social and educational services as identified in a child's individual service plan. Medicaid Targeted Case Management is available for children who are at risk of or are experiencing maltreatment, in need of protective services, or are at risk of or in out-of-home placement. We also offer Medicaid Targeted Case Management to children receiving mental health services. The mental health services covered include assessment of the recipient's need for services; development of an individual service plan; routine contact with recipients and any service providers; coordinating referrals and provision of services; coordinating facility discharge planning; and coordinating and monitoring the overall service delivery.

Activities that are related to foster care services such as placement or court proceedings are specifically excluded, since they are covered under Title IV-E.

The upcoming Medicaid Targeted Case Management regulation required under the DRA and pending CMS regulatory actions threaten the scope of services available to children in Minnesota's child welfare system. In addition to the integral role Medicaid Targeted Case Management plays in coordination of community-based services to prevent children from entering institutional or residential treatment, Medicaid Targeted Case Management also provides much-needed supports to families struggling to meet the needs of their own children, preventing potential out-of-home placement.

Anna is a 13 year-old child who lives with her great aunt. Anna's Aunt came to The Front Door (an agency) requesting assistance with Anna as she was having issues such as running away and not attending school. Anna moved to her aunt's home nine months ago after being removed from her mother based on issues with mental illness. The Front Door assigned a short term case manager for the family. As the case manager delved into the case, it became clear that the aunt did not have actual legal custody of Anna based on the New York child protective services involvement. The case manager also discovered that Anna was hospitalized in New York for a mental health crisis. Based on these findings, a long term case has been opened which will determine legal custody and put services in place for Anna. This will also allow Anna to receive the supports and services that make it possible for her to remain in the least restrictive environment with her family. Anna will also learn the skills and develop the supports she needs to gain a sense of permanence and likelihood of a successful transition into adulthood. Without Medicaid Targeted Case Management dollars available to provide these preventative services, it is likely that Anna would at some point have been hospitalized or placed in residential treatment costing large amounts of Medicaid dollars and placing Anna's life into utter chaos.

In addition, there are 11 federally recognized tribes in Minnesota. I am concerned that a reduction in the Medicaid Targeted Case Management reimbursement rate would negatively affect the tribes' ability to maintain their current service capacity in meeting the needs of children in care.

REHABILITATION SERVICES IN MINNESOTA

The rehabilitation option in Minnesota allows us to offer therapeutic services, including skills training and other supports for children with emotional disturbances. Our 2003 legislature passed what we call Children's Therapeutic Services and Supports (CTSS), which was implemented on July 1, 2004. CTSS is a mix of rehabilitative and professional mental health services. It was established as a flexible Medicaid rehabilitation option benefit with our state Medicaid plan that covers services such as individual or family skills training, mental health behavioral aides, and children's day treatment. These services may be provided by certified but non-licensed professionals under the direction and supervision of a professional. Minnesota utilizes a stringent oversight and certification process with all service providers.

Evidenced-based practice demonstrates that skills training is an effective way of reducing symptomology in children with mental health needs. The flexibility in the Rehabilitation option has allowed us to deliver these services in locations that are the most practical for the child or adolescent—typically, their own homes so that they may be better prepared to utilize these skills in their daily lives. This means of service delivery is both practical and cost effective.

One of my case managers recently shared this story, “CB is a 10 year-old boy whose behavior and moods swings were seriously interfering with his functioning at home and school. He was highly aggressive with peers and teachers requiring restraints at school on a regular basis. He was so annoying to neighborhood kids that parents were constantly at his door complaining to his parents about his behaviors. He was so difficult at home his mother counted herself lucky when she got through the day with only one or two serious tantrums. C.B. then received Medicaid Rehabilitation Services in several different ways that have made a significant difference. His mother was able to open a case with Hennepin County Children's Mental Health where I was assigned C.B.'s case and began case management services. His mother and I were able to get C.B. in to a Day Treatment Program that could address his behaviors and mental health diagnosis while also providing him with an education. We also engaged an in home family counseling agency that began intensive weekly individual and family counseling services.

Additionally, C.B. was receiving Rehabilitation Services through seeing a psychiatrist every six weeks who also prescribed medication for C.B.'s disorder. When C.B.'s behavior and moods cycled out of control, he was able to go to Willmar Hospital in Willmar, Minnesota for stabilization for four weeks. After this he was able to return home significantly improved--he seemed like a different kid! He is now functioning at a much higher level at his day treatment elementary school where he no longer requires restraints and he is learning at a much more productive level. At home, he is not causing his parents any problems beyond the norm, and most happily for C.B., he is getting along with the kids in the neighborhood, who now seek him out to play!”

CMS has disapproved a recent Minnesota State Plan Amendment related to Rehabilitative Services. CMS objects to two previously approved elements of this service. It disagrees with Minnesota's use of bundled rates to pay for groups of services (similar to a hospital per diem). And it disagrees with Minnesota's approved use of paraprofessionals who do not have a medical license, who execute the services documented in a care plan.

The educational degree and licensure requirements for rehabilitative service providers vary based on the services they are certified to provide. With a significant shortage of licensed mental health professionals throughout the state, the Rehabilitation option allows my state to deliver a full continuum of services to children and their families that otherwise would not be possible.

In addition, CMS has announced its intention to issue regulations governing rehabilitation services. The actual proposed regulation has not yet been released, but the Office of

Management and Budget's (OMB) published description of it concerns us. The description prohibits Medicaid coverage of any rehabilitative services that are "available as part of other services or programs," including child welfare and foster care. Our concern is that CMS may broadly interpret this language to categorically exclude populations of children in the child welfare system from Medicaid coverage of critical and cost-effective services, including rehabilitation.

MEDICAID TARGETED CASE MANAGEMENT AND REHABILITATION SERVICES RECOMMENDATIONS

Because Medicaid Targeted Case Management serves as an indispensable resource in serving the health and mental health needs of children involved in the child welfare system, we strongly recommend that the reimbursement rate for Medicaid Targeted Case Management services not be cut to 50 percent. In light of the DRA's clarifications of Medicaid Targeted Case Management terms and definitions, IV-E foster children are particularly reliant on this funding stream to meet their service needs.

We also recommend that Congressional oversight be applied to ensure that CMS regulatory actions support the valid use of Medicaid Targeted Case Management and Rehabilitation Services in serving the health and mental health needs of children within the child welfare system continues. Populations that rely on these services should have their access restricted by overly broad interpretations of federal law. Finally, states need to maintain flexibility in providing coordination of services that are identified by individual plans of care under these two benefit options, and should not be subject to blanket disallowances.

CONCLUSION

Both Medicaid Targeted Case Management and Rehabilitation Services options play a crucial role in allowing child welfare agencies to meet the many physical and mental health needs of children in their care. Federal policies and regulations should permit and support substantial collaboration between state Medicaid and child welfare systems, rather than continue trends that attempt to restrict the use of Rehabilitation Services and Medicaid Targeted Case Management that serve the legitimate needs of these most vulnerable children.

Thank you for the opportunity to testify, and I'm happy to answer any questions you may have.