



National Association of State Mental Health Program Directors

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Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2237-IFC  
P.O. Box 8018  
Baltimore, MD 21244-8018

To Whom It May Concern:

Reference: File Code CMS-2237-IFC

The National Association of State Mental Health Program Directors (NASMHPD) is submitting comments on the Interim Final Rule for Medicaid coverage of case management services, as published in the Federal Register, December 4, 2007. The regulation is in response to changes called for in the Deficit Reduction Act of 2005 (DRA) and is an attempt to clarify when Medicaid will pay for case management services. Case management services provide invaluable assistance to individuals with chronic mental illness and others in accessing vital services to aid in their recovery and maximize their potential for a full life in the community.

NASMHPD represents the \$29.5 billion public mental health service delivery systems serving 6.1 million people annually in all 50 states, four territories, and the District of Columbia. It is the only national association to represent state mental health commissioners/directors and their agencies. In addition, NASMHPD has an affiliation with the approximately 220 state psychiatric hospitals. Our members administer and manage community-based systems of care for the millions of individuals with serious mental illness who at times require immediate access to a variety of inpatient facilities and psychiatric units in general hospitals but are often cared for successfully in the community.

The federal savings from the changes recommended in the interim final rule is estimated to be \$1.28 billion over 5 years, with a total reduction of \$2.842 billion when combined with state matching funds. The changes recommended to realize this level of savings far exceed congressional intent, achieving \$520 million more than the Congressional Budget Office's projected savings of \$760 million. Because the rule exceeds legislative intent and would severely curtail vital case management services, NASMHPD strongly urges CMS to withdrawal the rule and work closely with Congress and the states to meet the goals of the DRA without harming individuals or placing undue burdens on the states. This regulation comes at a time when many states are struggling economically and coping with cost shifts from other Medicaid regulatory changes.

## **Definition of Case Management Services---§440.169**

This section establishes the time period that services can be provided when an individual is transitioning from an institution to the community. It states that services can be provided in the last 60 days of an institutional stay of 180 days or longer and in the last 14 days of stays of less than 180 days. This significant reduction in the number of days a person is eligible for services is extremely problematic. Individuals who are eligible for Medicaid such as those with mental illnesses often require specialized services in order to acquire and sustain housing and employment. Case management services are often required over a longer period of time than is called for in the regulation because of the complexity of circumstances that result from serious mental illness. Since many institutional stays are for less than 180 days, the two-week limitation is especially troubling.

In addition, the criteria that must be met before services are reimbursed are unduly restrictive and burdensome especially for the smaller provider organizations. Factors beyond the control of the provider such as delayed discharge or unavailability of services could prevent payment for services that have been delivered efficiently and appropriately.

The regulation also states that persons aged 22-64 residing in institutions of mental disease (IMDs) are excluded from these services. While this requirement is clear in federal law and cannot be changed by this regulation, it is unfortunate that Medicaid case management services are not available to assist these individuals make a successful transition back to the community.

## **Limitations on Case Management---§441.18**

The regulation expands on two important elements of case management in the Medicaid statute: the prohibition on case managers serving as gatekeepers and the prohibition on states to require individuals to receive case management services as a prerequisite to receiving other services. NASMHPD believes that a gatekeeper function runs counter to the goals of case management and therefore supports this prohibition on the whole. The process should encourage a unified and coordinated approach and give significant weight to the case manager's recommendations. We do not, however, support a prohibition on requiring individuals to utilize case management services. For the population served by state mental health agencies, requiring case management is the best way to ensure that these vulnerable individuals receive services. As long as case management services serve as a gateway to appropriate services, NASMHPD does not oppose this requirement.

### Limitations on reimbursement for case management---§441.18(c)

The regulation specifies that the case management benefit does not include, and Federal Financial Participation (FFP) is not available for, "activities that are an integral component of another Medicaid service." It states that duplicate coverage and payment could result without this restriction and that "This activity would not be consistent with proper and efficient operation of the program." NASMHPD wholeheartedly supports the important role CMS must play to ensure the fiscal integrity of the Medicaid program but does not believe the regulation provides adequate guidance on activities that are integral components of other services. We urge CMS to strengthen its efforts to reduce fraud and abuse and increase accountability and cost effectiveness through the audit process and improved utilization review.

Similar to the concerns we expressed in our comments on the rehab option on restrictions on FFP for services that are “intrinsic elements” of other programs, NASMHPD urges CMS to provide additional clarification on the meaning of “integral component” and ensure that case management services can be provided by Medicaid to eligible individuals who “are paroled, on probation, on home release, in foster care, in a group home or other community placement...” when services are needed as the result of a medical condition as stated in the background section of the regulation.

NASMHPD is concerned about the statement in the rule that “...Medicaid cannot pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they otherwise would be qualified Medicaid providers, because they are furnishing direct services of the programs of that agency.” If this restriction means that an individual employed by a provider cannot both provide direct services and case management services to the same person, it is reasonable to expect that even small provider organizations would be able to comply. If, however, this restriction means that an organization is prohibited from providing direct services if they are also providing case management services, the impact could be quite detrimental. Since it is not an uncommon situation for there to be limited numbers of provider organizations in a certain geographic area, e.g., rural locations, this requirement could prevent individuals from getting the services they need.

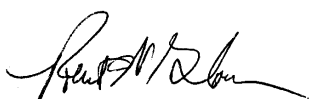
The regulation would require “case management services to be provided on a one-to-one basis to eligible individuals by one case manager.” In theory, this requirement would advance coordinated case management across agencies but in practice, it could not be implemented without extreme risk to very vulnerable populations. Because people with serious mental illness are often in poor overall health, a single case manager may not have both the clinical expertise and knowledge of provider networks to provide all of the case management services needed to maintain quality of care. For this reason, NASMHPD opposes the one case manager requirement.

The requirement in the rule for billing in increments of 15-minutes or less is of great concern to NASMHPD. We have heard from a number of states that it will be expensive and time-consuming to retool their billing systems to change from bundled rates and that it is not feasible to make such massive changes in the short time period allowed. It is also a widely held assessment that billing in short time increments also undermines the comprehensive nature of the services being delivered. This is true for evidenced-based practices such as Assertive Community Treatment (ACT) under the rehab option as well as case management services covered under this regulation. NASMHPD is concerned at a prohibition against per diem, weekly, and monthly rates will add significantly to the administrative burden and cost of billing for Medicaid reimbursement.

### Conclusion

NASMHPD urges CMS to suspend the interim final rule and work with the states to develop a Notice of Proposed Rulemaking (NPRM) that reflects congressional intent and does not jeopardize vital services for Medicaid beneficiaries.

Sincerely yours,



Robert W. Glover, PhD  
Executive Director