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Robert W. Glover, Ph.D.  
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June 3, 2008

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS—2249—P  
P. O. Box 8016  
Baltimore, MD 21244-8016

To Whom It May Concern:

Reference: File Code CMS—2249—P

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the opportunity to comment on the proposed Medicaid rule on the Home and Community-Based Services (HCBS) State plan amendment provided under the new 1915(i) option, created in the Deficit Reduction Act (DRA) of 2005.

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.

NASMHPD’s overall assessment of the proposed rule is favorable. It provides valuable guidance to the states on creating a program that is person-centered and is consistent with the intent of the underlying statute. It is nevertheless unfortunate that the DRA did not include the “other services” category allowed in 1915 (c) waiver service packages. NASMHPD is concerned that excluding valuable wrap-around services for individuals with mental illness will adversely affect quality of care. While the statute limits services to individuals at or below 150 percent of the Federal Poverty Level, we are hopeful that Congress will

revisit this restriction, especially if States forego using this option because the income limitation excludes a critical mass of people who need services but whose income exceeds the FPL limit. We also are concerned that some individuals who need services will be denied access since enrollment caps and waiting lists are permitted.

Even though the option has been available beginning January 2007, a small number of states have submitted applications. One obstacle could be that States are limited to one version of the option and must develop needs-based criteria to capture a range of services geared to different populations who need services. If applications do not increase over time, it may be useful for CMS to survey the States to determine greater flexibility in program design is needed.

### **Eligibility for Home and Community-Based Services (Section 441.556)**

The regulation proposes an overly restrictive definition of home and community-based residences, limiting settings to four or fewer persons unrelated to the proprietor. NASMHPD recommends that residences meet certain standards to provide services in a person-centered environment rather than limiting the number of people residing in one location. It is important that the process does not place an undue burden on States by requiring them to make case-by-case determinations.

### **Needs-based Criteria and Evaluation (441.559)**

The preamble notes that the statute does not limit the factors a State may take into account in the independent evaluation and specifically notes that “instrumental activities of daily living (IADLs) could be considered.” NASMHPD recommends strongly that the regulation include a recommendation that the states include support with IADLs, along with ADLS, since this support is especially important for individuals with mental illness.

### **Independent Assessment (Section 441.562)**

NASMHPD would appreciate clarification that Federal Financial Participation (FFP) will be allowed for both the independent evaluation and the independent assessment of need at the administrative level.

### **Plan of Care (Section 441.565)**

A requirement is proposed in this section that “the State develops (or approves, if the plan is developed by others) a plan of care through a person-centered planning process.” The plan of care is developed as part of the independent assessment of need of each individual who has been determined to be eligible for HCBS benefits. While it would seem impractical on its face for the state Medicaid agency to approve each individual plan of care, we would appreciate confirmation that the State can delegate this responsibility to qualified entities while maintaining oversight responsibility over the process. For example, the State could review a sample of plans of care.

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### **Conclusion**

NASMHPD appreciates the opportunity to comment on the proposed regulation and believes that the 1915(i) plan amendment option has potential to provide thousands of beneficiaries with services in the community. It is an especially important alternative to 1915(c) waivers for States to provide services for people with mental illness in the home and community settings.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Robert W. Glover".

Robert W. Glover, PhD  
Executive Director