



May 18, 2001

The Honorable Tommy Thompson
Secretary of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

The National Association of State Mental Health Program Directors (NASMHPD) represents the \$23 billion public mental health system serving 6.1 million people in 50 states, four territories, and the District of Columbia. On behalf of NASMHPD, we are writing to welcome you to your position as Secretary of Health and Human Services (HHS) and to begin a dialogue regarding ways in which HHS can better support states in their efforts to provide comprehensive, effective community services to children and adults with mental illnesses.

We are encouraged by President Bush's recognition that the federal government must focus on the challenges facing the country's mental health system, and we applaud his commitment, as confirmed in his New Freedom Initiative, to creating a National Commission on Mental Health. The Commission presents a unique opportunity for collaboration among the federal government and states in the development of a comprehensive national mental health strategy. NASMHPD is articulating its interest in the mission of the Commission in a letter to the President which we are enclosing.

In addition, we appreciate the Administration's interest, also expressed in the President's New Freedom Initiative, in the "swift implementation" of the U.S. Supreme Court's decision in Olmstead v. L.C. State mental health agencies share your goal of enhancing and expanding community-based services for people with mental illnesses. As the former governor of a state with exemplary systems of community-based care, you already are well aware of the demonstrated effectiveness of these approaches to treatment and of the important role that federal programs such as Medicaid, Medicare, and the Community Mental Health Services Performance Partnership Block Grant play in supporting these programs and the individuals who need them.

However, as you know, certain federal policies actually obstruct the efforts of states, providers, and consumers to enable individuals with mental illnesses to receive effective treatment and participate fully in community living. People with mental illnesses continue to face discrimination and other barriers in federal programs, including:

1. The IMD Exclusion

The vast majority of individuals with mental illnesses can be treated effectively in community-based settings. However, because of the cyclic nature of mental illnesses, many people require episodes of acute care in a specialized psychiatric setting. A small minority may require ongoing or continuing care in an inpatient or residential setting.

Current Medicaid policy bars from coverage all services provided to adults ages 22 to 64 in Institutions for Mental Disease (IMDs), which includes psychiatric hospitals and may include community-based residential facilities. This policy isolates individuals with mental illness from all other Medicaid-eligible populations, contradicts the principles of equal treatment and insurance parity for treatment of mental illnesses, and undermines the ability of states to develop comprehensive systems of care.

There exists no sound rationale for the IMD Exclusion. This policy is not based on concerns about individual Medicaid eligibility, the medical necessity of services provided, the appropriateness of the service setting, or the quality of care provided. Nor does the policy reflect system trends over the last four decades, demonstrating a dramatic reduction in the use of inpatient care and the lengths of inpatient stays. Instead, the policy dates back to the origins of the Medicaid program and appears to be premised on the outdated assumption that the federal government should not share responsibility for providing treatment to individuals with mental illnesses. The contrast with services covered by Medicaid for other populations, such as individuals with developmental disabilities, whose services are appropriately covered, is striking and not acceptable.

2. Barriers to Utilizing Home- and Community-Based Medicaid Waivers

Perhaps the most significant negative consequence of the IMD Exclusion is its role as a barrier to the use of home- and community-based waivers (known as “HCB waivers” or “1915(c) waivers”) under Medicaid to serve individuals with mental illnesses.

Current law permits states to request waivers of certain portions of Medicaid law in order to provide home- and community-based services to individuals who would otherwise require institutional care. However, the law also requires states to show that the cost to the Medicaid program of providing these services does not exceed the cost to Medicaid of providing services in a hospital, nursing home, or ICF/MR.

HCB waivers are a principal means of financing home- and community-based services to individuals with disabilities. However, since the IMD Exclusion bars Medicaid reimbursement for hospital services, federal law also precludes granting waivers to serve individuals who would be in an IMD absent the services provided under the waiver. In addition, the technical language of the statute has been interpreted to bar states from using Medicaid expenditures in Residential Treatment Facilities for children and adolescents as a cost-offset to access HCB waivers to serve children in community settings.

It is ironic that, at a time when states and the federal government are united in their commitment to providing services in the least restrictive settings appropriate for an individual’s needs, the Medicaid law

perpetuates barriers to the expansion of such services. We are eager to explore with you a range of policy options, including administrative as well as legislative strategies, to remedy this problem.

3. Funding for the Mental Health Block Grant

We were very pleased that, during your April 26, 2001 testimony before the Health Subcommittee of the House Energy and Commerce Committee, you affirmed the importance of mental health funding and expressed your willingness to reconsider the Administration's proposed FY2002 appropriation for the Community Mental Health Services Performance Block Grant (MHBG). As you know, according to SAMHSA's current calculations, the Administration's proposal to "freeze" funding for the MHBG actually will lead to reduced allocations for 33 states. This is particularly troubling given the Administration's and the states' mutual desire to enhance and expand community-based public mental health services.

The MHBG is the principal federal program designed to support community-based public mental health services, and it provides critical support and flexibility for states to improve effective community-based services and to reduce their reliance on hospitalization. Each state mental health agency tailors its programs to meet the unique needs of priority populations in that state. Many states creatively use the MHBG to initiate new, innovative programs to ensure the effectiveness of community-based treatment, such as respite care for families of individuals with mental illnesses, early intervention services for children whose parents are hospitalized, or pilot projects to facilitate the integration of mental health and primary health care. Often, MHBG funding is used to initiate these programs and to demonstrate their effectiveness in order to attract other funding sources.

Some states use MHBG funding to serve special populations or to facilitate the development of strategic partnerships necessary to provide effective community-based treatment. Still others rely on these dollars to support non-medical services, such as housing or supported employment, that are essential to individuals with mental illnesses for successful recovery in the community but are not reimbursable by any other federal or private source.

4. Discrimination in Medicare

As the Administration becomes focused on efforts to reform the Medicare program, several issues will continue to have a significant impact on individuals with mental illnesses.

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Current Medicare law includes higher co-payments and more restrictive limitations on the number of reimbursable interventions for mental health services than for services designed to address other medical needs. This discriminatory approach to mental health services for older adults and individuals with disabilities reinforces the existing stigma around mental health treatment. Equally important, it creates a real obstacle to services for many individuals with serious mental illnesses, including those who receive disability payments under the Social Security Disability Insurance (SSDI) program and for whom Medicare is generally the only insurer.

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In addition, as you know, Medicare does not provide prescription drug coverage to its recipients. This is a critical issue for many individuals with serious mental illnesses who rely on medication as a first-line defense against disabling symptoms.

Thank you for your consideration of these issues. Given our mutual support for advancing mental health policy, we are enthusiastic about working with you and your staff to fulfill our joint commitment to improving and expanding the delivery of community-based mental health services to children and adults with mental illnesses. Please call either of us if you have questions or if we can be of further assistance.

Sincerely,



Barry S. Kast, M.S.W.
President



Robert W. Glover, Ph.D.
Executive Director

cc: Mary Kay Mantho, Counselor to the Secretary
Jim Mason, Acting Director, Office of Intergovernmental Affairs
Michael McMullan, Acting Deputy Administrator, HCFA
Penny Thompson, Acting Director, CMSO, HCFA
Joseph Autry, M.D., Acting Administrator, SAMHSA
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