



August 27, 2001

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

Dear Mr. Secretary:

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, thank you for the opportunity to participate in a dialogue regarding ways in which the federal government can better support community-based services for individuals with disabilities.

Mental health leaders applaud the New Freedom Initiative and, in particular, the creation of a National Commission on Mental Health. These actions signal a timely and important commitment to examine and correct the barriers in federal laws, regulations, policies and programs that affect people striving to recover from mental illness. Although federal programs such as Medicaid, Medicare, Supplemental Security Income (SSI), and education and housing programs provide a critical lifeline for individuals with mental illnesses, they are not designed specifically for this population. As a result, these programs often impose barriers to the delivery of community-based services and supports needed for individuals to recover successfully in the community.

In prior correspondence with the Department of Health and Human Services (HHS), NASMHPD has identified many specific barriers that impede the ability of states to use federal programs to develop effective community-based service delivery systems. These barriers include a lack of coordination among federal agencies administering programs affecting individuals with mental illnesses, fragmented funding streams, acute shortages of housing options for individuals with disabilities, and a bias that continues to persist in federal health insurance programs favoring institutional, "medical model" care over comprehensive community-based services and supports.

As a first step in addressing these barriers, we urge the Administration to take the following specific actions:

(1) Expand Access to Home- and Community-Based Services Waivers under Medicaid.

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. These waivers (known as "HCBS waivers" or "1915(c) waivers") are designed to be a principal source of

funding for community-based services for individuals with most disabilities. However, these waivers are generally unavailable to states to provide services to individuals with mental illnesses.

Lack of access to these waivers to serve people with mental illnesses is a direct result of Medicaid policy barring reimbursement for services provided in an Institution for Mental Disease (IMD). Section 1915(c) requires states applying for a 1915(c) waiver to show that the cost to the Medicaid program of providing home- and community-based services will not exceed the cost to Medicaid of providing services in a hospital, nursing home, or ICF/MR. Since adults with mental illnesses who would otherwise require institutional care likely would receive that care in an IMD, which cannot be reimbursed by Medicaid, the IMD exclusion poses an almost insurmountable barrier to the use of 1915(c) waivers to serve this population.

This effect of the IMD exclusion on the 1915(c) waiver program is certainly one of the most glaring barriers in federal law regarding access to community-based services by individuals with mental illnesses. Remedying this problem in the law is a priority for state mental health agencies and must be addressed as part of any serious comprehensive effort to modify federal programs to support community-based services. To do so, NASMHPD urges the Administration to pursue one or more of the following legislative and administrative changes:

- A. Initiate and support legislation to repeal the IMD Exclusion.
- B. Initiate and support legislation to provide an exception to cost-neutrality requirements for waivers designed to provide services to individuals with mental illnesses.
- C. Permit states to count all state mental health general fund expenditures, including hospital expenditures, in calculating cost neutrality for the purposes of the 1915(c) waiver program.
- D. Clarify that 1915(c) waivers may be granted to serve people with mental illnesses who, absent home- and community-based services, would be eligible to receive general hospital inpatient services or nursing facility care. In the alternative, HHS could adopt regulatory changes to clarify that, for the purpose of determining what the alternative institutional placement and costs would be, states may assume that people with mental illnesses would receive inpatient psychiatric services in a Medicaid-reimbursable general hospital or in a Medicaid-reimbursable nursing facility, rather than in an IMD.

A few states have been able to use 1915(c) waivers to serve children with severe emotional disturbances in the community (since the IMD exclusion only applies to adults ages 22 to 64). However, most states have been unable to obtain a waiver for this purpose because the statute authorizing the waiver program identifies only hospitals, nursing facilities, or ICF/MRs as institutional alternatives to community-based care. This barrier could be minimized through the adoption of legislation explicitly permitting states to use facilities providing Medicaid inpatient psychiatric services to children and adolescents (“psych under 21” facilities), such as residential treatment facilities, as institutional alternatives for the purposes of calculating cost-neutrality for 1915(c) waivers. A provision fixing this problem is included in the Family Opportunity Act (S. 321), sponsored by U.S. Senator Charles E. Grassley with broad bipartisan support

in both the Senate and House. HHS should support and encourage adoption of this provision in that bill or in other legislation.

Even in the absence of federal legislation, CMS should address this issue administratively by clarifying that residential treatment centers and facilities may be considered institutional alternatives for the purposes of calculating cost-neutrality under the waiver. This approach would be consistent with CMS' position that these facilities qualify as psychiatric hospitals for the purposes of providing services under Medicaid's "psych under 21" option.

(2) Eliminate Discrimination in Medicare. As the Administration continues to focus on efforts to reform the Medicare program, several issues will have a significant impact on individuals with mental illnesses.

Current Medicare law includes higher co-payments and more restrictive limitations on the number of reimbursable interventions for community-based 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 recovery in the community 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.

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 receive services in the community and rely on medication as a first-line defense against the disabling symptoms of their illnesses. As the Administration continues to work on plans to reform Medicare and provide prescription drug coverage to its enrollees, we urge you to work closely with states and with the disability advocacy community to ensure that the needs of individuals with disabilities, including severe and persistent mental illnesses, are met.

(3) Clarify and Expand the Rehabilitation Option Under Medicaid. Some states have used Medicaid's Rehabilitation Option to provide a broad array of necessary services and supports for people with mental illnesses. Other states have encountered barriers that include a lack of information and technical assistance about permissible services under the Rehabilitation Option and conflicting guidance from Center for Medicare and Medicaid Services (CMS) regional offices.

We urge HHS to work collaboratively with the states to clarify and expand the range of services that may be provided under the Rehabilitation Option. Such a process should ensure that, at a minimum, all services currently provided by states continue to be eligible for reimbursement. In addition, this process should be used to expand the option to include essential home- and community-based services such as respite, mentoring, and community support.

(4) Increase Funding for the Community Mental Health Services Performance Partnership Block Grant. We were very pleased that, in Congressional testimony this spring, you affirmed the

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importance of mental health funding and expressed your willingness to work with the Congress to ensure that adequate levels of funding are available in FY2002.

The Community Mental Health Services Performance Partnership Block Grant ("Block Grant") is the principal federal program designed to support community-based public mental health services. Although it represents a small portion of the community mental health services budget in most states, it provides critical support and flexibility for states to improve effective community-based services and to reduce their reliance on hospitalization.

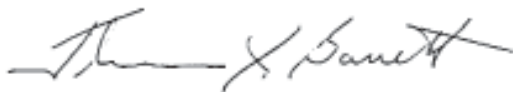
Each state mental health agency tailors its Block Grant program to meet the unique needs and priority populations in that state. Many states creatively use the Block Grant to initiate new, innovative programs to ensure the effectiveness of community-based treatment, such as respite care for families 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, Block Grant funding is used to initiate these programs and to demonstrate their effectiveness in order to attract other funding sources.

Other states use Block Grant funding to serve special populations or to facilitate the development of strategic partnerships necessary to provide effective community-based treatment. Still others rely on Block Grant 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.

The Administration's proposal to fund the Block Grant at the same level in FY2002 as was available in FY2001 is not consistent with your goals of encouraging and facilitating community-based services for individuals with disabilities. In fact, because the formula for distributing the Block Grant to states includes several components that will be updated to reflect population and other changes, level-funding the Block Grant will actually result in reduced funding for 32 states. We urge the Administration to identify Block Grant funding as an essential element of its strategy to expand community-based services for individuals with mental illnesses.

Thank you, again, for the opportunity to provide these recommendations regarding improving federal programs to better support the delivery of community-based services for individuals with mental illnesses. We would be pleased to discuss our comments in more detail with you and the relevant HHS agency heads at any time. In the meantime, if you have questions or need additional information, please call Andrew D. Hyman, NASMHPD's Director of Government Relations and Legislative Counsel, at (703) 739-9333, ext. 28.

Sincerely,



Tom Barrett, Ph.D.
President



Robert W. Glover, Ph.D.
Executive Director