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January 9, 2017

Michael Nardone
Director, Disabled and Elderly Health Programs Group
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: CMS-2404-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program: Request for Information (RFI): Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services

Dear Mr. Nardone:

The National Association of Mental Health Program Directors (NASMHPD)—the organization representing the state executives responsible for the \$41 billion public mental health service delivery systems serving 7.5 million people annually in 50 states, 4 territories, and the District of Columbia—appreciates the opportunity to respond to the Request for Information (RFI) on Federal Interventions to Ensure the Provision of Timely and Quality Home and Community-Based Services (HCBS).

The foremost message NASMHPD’s members want to send in response to the RFI is that, for the move to home and community-based services to be accelerated, there needs to be greater flexibility granted the states in authorizing and implementing state plans and waivers providing for HCBS services. NASMHPD members also strongly believe that further acceleration of the move to home and community-based services cannot be achieved without greater state access to the financial and capital resources and technical assistance needed to acquire, install, and implement the information technologies necessary to track and monitor program services, sites, quality measure outcomes, and the enrollees themselves.

The Disabled and Elderly Health Programs Group is to be commended on the progress made over the last two years in achieving full compliance with the Olmstead decision mandate within state Medicaid programs, beginning with the adoption—after years of delay—of the final HCBS regulations in January 2014. Technical assistance provided through webinars, the Medicaid Innovation Accelerator Program, and publication of Frequently Asked Questions (FAQs) and other guidance documents have proven very useful to the states.

However, as you know, despite this generous assistance, the states have struggled over the intervening months in responding appropriately to sometimes ad hoc staff interpretations of compliance in developing the required state transition plans. In fact, CMS and the DEHPG have struggled themselves in providing timely clarifying guidance to the states on such issues as conflict of interest. The concept of the isolating non-residential setting has proven especially difficult for states and providers struggling to maintain services for those enrollees with the most significant intellectual disabilities and most severe mental illnesses who are most in need of those services. It has proven just as difficult for states to grasp the concept

of heightened scrutiny, which they had been told initially would be a state responsibility, but for which regulators at the Federal level have prescribed a process so structured as to virtually eliminate state flexibility and discretion.

As CMS notes in its own RFI, limited state budgets have made compliance difficult with a Federal process that requires multiple man-hours in the coordination and submission at the Federal level of multiple contributions by multiple state agencies. And, as CMS also notes, the scarcity of the contemplated provider and service configurations necessitated to provide services in non-isolating and integrated community settings is making state and provider transitions difficult and will make full transitions by the 2019 deadline unlikely in some states, and for many providers.

Need to Increase Resources and Technical Assistance for Information Technology to Track and Monitor Program Services, Sites, Quality Measure Outcomes, and the Enrollees Themselves

All states are in need of greater resources and technical assistance to access and implement the information technology that will be needed to monitor program services, sites, quality measure outcomes, and enrollees who will be more dispersed throughout their respective communities. Even where resources—such as enhanced Federal matching funds for administrative services—are available, those resources may be under-utilized because states and providers are unaware of their availability or lack the bandwidth to apply to the Federal government to receive that assistance.

Behavioral health providers—both those providing mental health services and substance use disorder services—are particularly behind the adoption curve for health information technology due to their exclusion from the Medicaid and Medicare meaningful use incentive programs that facilitated most other providers in adopting the technology. It is particularly critical that behavioral health providers be provided the necessary technical assistance, incentives, and resources to acquire, install, and implement the information technologies crucial to providing successful and meaningful HCBS services.

CMS Suggestions for Accelerating Transitions to HCBS

Rate-Setting for Home Care Workers. NASMHPD finds troubling the suggestion in the RFI that CMS might “expand its rate-setting approval authority to support [home care] provider infrastructure” and focus on home care worker wages. Such an approach would single out home care workers for a more specific reimbursement review than the standard for compliance with § 1902(a)(30)(A) standards required for all other provider payments of (1) “consistency with efficiency, economy, and quality of care” and (2) reimbursement rates “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” While NASMHPD recognizes that home care workers are in limited supply, making access to home care services difficult, the same could be said of all workers in the behavioral health care arena, and of a wide variety of workers in more rural, frontier, and central urban communities. Rate-setting has historically been left to the states, and NASMHPD would strongly encourage CMS to continue to follow that principle.

Quality Measurement. NASMHPD encourages CMS to continue to work toward HCBS outcome measures that are aligned across the Medicare, CHIP, and Medicaid programs. For services provided to individuals with mental illness or substance use disorders in community-based settings, NASMHPD strongly urges that the Substance Abuse and Mental Health Services Administration be an active and vocal partner in the development of outcome measures and in the National Quality Forum’s Measures Application Partnership’s process for adopting measures appropriate to both the HCBS setting and, more broadly, for individuals with mental illness or substance use disorders.

Providing Home- and Community-Based Waiver Services to Children and Youth Eligible for Psychiatric Residential Treatment Facilities. NASMHPD would strongly support expanding the non-institutional options available to those Medicaid beneficiaries who meet an institutional level of care.

Expansion of Eligibility for the § 1915(i) HCBS State Plan Option to Individuals with Incomes Above 150 Percent of the Federal Poverty Level (FPL) Who Otherwise Meet Targeting Criteria. NASMHPD supports enabling states to enroll clients who are financially eligible for Medicaid under their existing state plans and who meet targeting criteria, without reference to the additional 150 percent FPL income ceiling. The additional ceiling creates an administrative burden for states. NASMHPD would also support interpreting the statute to provide states the option to expand eligibility to 300 percent FPL for individuals who meet the needs-based criteria and risk factors articulated in the state's HCBS state plan amendments. Currently this optional category is restricted to individuals who meet HCBS waiver criteria.

Allowing Full Medicaid Benefits for Medically Needy Individuals in an HCBS State Plan Option. NASMHPD would support this option, again, so long as state flexibility were maintained with regard to what benefits were to be offered.

Thank you for your attention to these suggestions and expressions of concern. Please feel free to contact NASMHPD's Director of Policy, Stuart Yael Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552, with any questions regarding this response to the RFI.

With respect and appreciation for this opportunity,

A handwritten signature in black ink that reads "Brian M. Hepburn". The signature is written in a cursive style with a large initial "B" and "H".

Brian Hepburn, M.D.

Executive Director

National Association of State Mental Health Program Directors (NASMHPD)