

June 3, 2008
Centers for Medicare & Medicaid Services
Dept. 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 Council for Community Behavioral Healthcare is submitting the following comments on the Proposed Rule for Home and Community-Based State Plan Services provided under the Medicaid program, as published in the Federal Register, April 4, 2008.

National Council members serve nearly six million adults, children, and families in communities across America. We offer a vital safety net to some of the poorest and most vulnerable in our society — Medicaid beneficiaries, the uninsured, the destitute and homeless, children in foster care, older adults, those with HIV/AIDS, veterans, and those in our criminal and juvenile justice systems. The people our members treat live with their families or alone; some are in hospitals, jails, or juvenile detention facilities and others are in residential programs, foster care, or group homes.

We advocate for policies that ensure that people who are ill can access services. And we offer state-of-the-science education and practice improvement resources so that services are efficient and effective.

We encourage you to address certain issues in the proposed rules to ensure that individuals with disabilities retain access to essential services.

PROVISIONS OF THE PROPOSED RULE

Section 441.556: Eligibility for home and community-based services under section 1915(i)(1) of the Act

In Section 441.556 (a) (3), CMS proposes that to be eligible for services, individuals must live in the home or community, according to standards for community living facilities prescribed by the Secretary. More specifically, CMS proposes to require that if an individual resides in a setting with four or more persons and provides one or more services or treatments, the independent assessment must include documentation that the individual is truly living in a community setting.

We applaud CMS for its efforts to ensure a person-centered, individualized evaluation of the home and community based criteria. However, there are living situations, such as adult day care homes, that are vital to individuals with mental illness and assist them to live outside of an institutional environment. Due to the nature of adult day care homes, they often house more than four people, but are nevertheless part of the community.

Recommendation:

Revise the threshold of additional documentation requirements to living situations that include up to ten individuals. This will reduce the administrative burden that will result from setting the threshold at four or more individuals and acknowledges that wide array of living situations that assist individuals with mental illness to live within the community.

Section 441.559: Needs-based criteria and evaluation

In Section 441.559 (e), CMS proposes that individuals receiving services under the State plan HCBS benefit must be independently reevaluated at a frequency determined by the State, but not less than every 12 months, to meet the needs-based criteria established by the State.

Although we applaud CMS' efforts to provide flexibility to States in the administration of the State plan HCBS benefit, we are concerned that this requirement will result in individuals who need the HCBS benefit losing access to services, simply because this administrative task was not completed in accordance with State-defined rules. In this situation, one of the goals of the State plan HCBS benefit, to provide services "to prevent progression to institutionalization" in accordance with Olmstead v. L.C., will not be achieved (pg. 12).

Recommendation:

We recommend that the independent reevaluation be conducted every two years, with a review of the plan of care conducted at least every 12 months, as CMS proposed in Section 441.565. If this were the case, the State can still ensure that only those that meet the needs-based criteria are receiving necessary State plan HCBS services while not placing an undue burden on agencies by making them complete an independent evaluation on, at the least, an annual basis.

Lastly, we would like to highlight our concern over the statutory requirement that states cannot target their 1915 (i) services through specific eligibility criteria, as they do for 1915(c) waivers. As CMS points out, under 1915(c) eligibility criteria, "States can provide services for certain high need target groups" (pg. 13). We find it disappointing that the same deference to high-need populations is not included within the 1915 (i) State plan HCBS benefit. Without this, we are concerned that States will see this as an impediment to implementation and usage of 1915 (i).

Sincerely,



Linda Rosenberg, MSW, CSW
President and CEO