July 10, 2019

VIA ELECTRONIC SUBMISSION

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

Re: District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide these comments on the District's proposed Section 1115 Medicaid Behavioral Health Transformation Demonstration Program.

While NHeLP is supportive of states using Medicaid to increase access to behavioral health services, there are at least four reasons the Secretary should not approve the requested waiver. First, the Secretary many only waive requirements of the federal Medicaid Act to conduct an experiment or test a novel approach to improve medical assistance for low-income individuals, and the District has not proposed a genuine experiment or novel approach. Second, the District asks the Secretary to waive provisions of the Medicaid Act the Secretary does not have authority to waive. Section 1115 only permits waiver of those requirements found in 42 U.S.C. § 1396a, and the District requests waiver of provisions outside of 42 U.S.C. § 1396a, including the "Institution for Mental Diseases" (IMD) exclusion. Third, the District's proposal risks diverting funding away from appropriate community-based services, undermining decades of progress towards increased community-integration. Fourth, the

Secretary lacks authority to waive provisions that are not necessary to test novel approaches, and the District has failed to demonstrate that the specific waiver authorities requested are necessary to achieve its goals.

I. Federal Financial Participation for IMDs Is Not an Experiment

Section 1115 allows HHS to waive some requirements of the federal Medicaid Act so that states can test novel approaches to improving medical assistance for low-income individuals, if such waivers are limited to the extent and time period needed to carry out the experiment or demonstration. This means that a Section 1115 demonstration waiver request must propose a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money through a Section 1115 demonstration waiver; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.

The "cornerstone of this demonstration" is the District's request to obtain federal financial participation (FFP) for IMDs, but there is nothing novel or experimental about this.[1] For the past 25 years, CMS has granted states authority to waive the IMD exclusion, despite the illegality of such waivers. The first waiver was granted in 1993, and by the early 2000s nine states had 1115 demonstration waivers to fund IMDs for psychiatric treatment, including Arizona, Delaware, Maryland, Massachusetts, New York Oregon, Rhode Island, Tennessee, and Vermont.[2] Some states only covered individuals at certain hospitals or for a set number of days—others were broader. As of 2009, CMS phased out all but one of these projects, precisely because they were no longer "innovative or experimental."[3] Although CMS has recently invited and encouraged states to apply for mental health-related Section 1115 IMD demonstration waivers, it has not provided any justification for its change in position.[4] With more than 25 years of

[1] District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program 14 (June 3, 2019) [hereinafter Proposal].
[2] U.S. Gov. Accounting Office, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* 29 (2017), https://www.gao.gov/assets/690/686456.pdf.
[3] *Id*.
[4] CMS, Dear State Medicaid Director Letter (Nov. 13, 2018) (SMD # 18-011) (Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf. This is in addition to two previous letters, the first in 2015, encouraging states to apply for demonstration waivers for SUDs, including IMD waivers. See CMS, Dear State Medicaid Director Letter (July 27, 2015) (SMD # 15-003) (New Service

these waivers, it is no longer plausible to claim that providing FFP for services to individuals residing in IMDs is a bona fide experiment or demonstration.

Section 1115 is not intended to provide long-term funding for settings that Congress explicitly carved out of Medicaid, yet that is exactly what the District seeks. Between 2012 and 2015, the District received FFP for IMDs via the federally-authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by Section 2707 of the Affordable Care Act.[5] In many ways, the current proposal is simply a request for an extension of federal funding that is no longer Congressionally authorized. This demonstration was phased out because a statutorily imposed condition of its continuation was that it be certified as cost-neutral to the federal government, and CMS actuaries could not certify it as such.[6] Now the District asks to recreate administratively what Congress has declined to do statutorily, complaining that "the MEPD created referral patterns and delivery system practices that have left a gap in service since the demonstration's end."[7]

The District does not propose any new theory that waiving the IMD exclusion could test. One hypothesis the District sets forward to test was already explicitly tested via the MEPD, and found to be unsupported. The District states it wants to decrease use of "medically inappropriate and avoidable high-cost emergency department and hospital services."[8] Yet the MEPD found that in those states that had sufficient data to draw conclusions, "[t]he results do not support our hypothesis that ER visits would decrease

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Delivery Opportunities for Individuals with a Substance Use Disorder), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf; CMS, Dear State Medicaid Director Letter (Nov. 1, 2017) (SMD # 17-003) (Strategies to Address the Opioid Epidemic), https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[5] Crystal Blyer et al, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf.

[6] https://www.gao.gov/assets/690/686456.pdf.

[7] Proposal at 13. Congress declined to reauthorize the MEPD demonstration, but has provided a path for states to obtain temporary IMD funding for SUD treatment via a State Plan Amendment. The SUPPORT Act amended 42 U.S.C. § 1396n to permit states to amend their State Plan, starting October 1, 2019, to obtain FFP for IMDs for five years, as long the individual is receiving treatment for SUD (and not primarily psychiatric treatment), the state complies with Congressionally mandated guardrails regarding maintenance of effort requirement regarding funding of community based services and other safeguards. The SUPPORT Act § 5052, (codified at 42 U.S.C. §1396n(l)). If the District wishes to obtain FFP in IMDs for SUD treatment, Congress has spoken regarding the appropriate approach.

[8] Proposal at 17.

as a result of MEPD."[9] The District has not explained why waiver of the IMD exclusion would be necessary to test any other hypothesis or meet any other goal included in its waiver application.

The District's request is designed to shift local costs to the federal government, not test novel ideas. For example, the District seeks FFP for "discharge planning" up to 30 days prior to discharge from an IMD or DC jail, despite the illegality of such a waiver (infra, Section II), but the District already provides local funding for this service, and has done so for years. Local regulations require community-based mental health providers to provide discharge planning from institutional facilities, and local policy clarifies that such services must be provided at least 60 days prior to release from jail, and 30 days for other institutional placements.[10] Allowing FFP for these services would shift costs to the federal government without providing any new service.[11]

II. The Secretary Does Not Have Discretion to Grant this Waiver

The District's central request is to receive FFP for services provided in IMDs. The Secretary does not have authority to waive the IMD exclusion. Section 1115 permits waiver of only those provisions contained in 42 U.S.C. § 1396a of the Medicaid Act, and the IMD exclusion is found in 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i). The District also seeks permission to receive FFP for services to DC residents in jail, which would violate the Medicaid Act's prohibition on obtaining FFP for services provides to "inmate[s] of a public institution." This provision also lies outside of 42 U.S.C. § 1396a, and therefore similarly the Secretary does not have authority to waive it.[12]

A. The IMD Exclusion Cannot Be Waived

As noted above, Section 1115 authorizes HHS to waive only those requirements found in 42 U.S.C. § 1396a. Requirements found outside of 42 U.S.C. § 1396a cannot be

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[9] Crystal Blyer et al, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* 49 (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf.

[10] *Id*.

[11] District of Columbia Department of Behavioral Health, Bulletin 111, Medical Necessity Criteria for Treatment Planning Services Provided to Department of Behavioral Health Consumers in Institutional Settings (Feb. 22, 2017), https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/2017%20Bulletin%20111%20Institutional%20Services%20medical%20necessity%20criteria.pdf.

[12] 42 U.S.C. § 1396d(a)(30)(A).

waived. The IMD exclusion is contained in 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i), and therefore cannot be waived. The District attempts to circumvent this based on a theory that Section 1115(a)(2) creates an independent "expenditure authority." This interpretation flatly misreads the statute. Section 1115(a)(2) does not give the Secretary an independent, unlimited power to ignore, waive, impose, or re-write Medicaid program features. Section 1115(a)(2) merely provides for federal reimbursement of necessary expenditures for a project that already qualifies for a waiver. Therefore, the IMD exclusion cannot be waived.

B. The Inmate Exclusion Cannot Be Waived

The District proposes "transition planning services," for individuals with SMI/SED and/or SUD who are being discharged from inpatient, residential, criminal justice, or other institutional settings. As explained above, to the extent that any of these services are provided to adults in IMDs, FFP is prohibited.[13] FFP is also prohibited for services provided to all individuals in the criminal justice system regardless of age, to the extent that such individuals meet the definition of "inmates of a public institution."[14] Implementing regulations define an "[i]nmate of a public institution" as "a person who is living in a public institution."[15] This includes individuals who have been adjudicated and sentenced and those who are held as pretrial detainees.[16] A "public institution" is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control" and therefore includes jails.[17]

The District attempts to justify its request for FFP for services provided to individuals in DC jails by citing to Section 5032 of the SUPPORT Act, claiming that the legislation mandates "that CMS allow states a waiver to provide services to incarcerated individuals within thirty (30) days of an individual being discharged."[18] This is wholly inaccurate. First, the Secretary is never required to grant a 1115 waiver – instead, the Secretary may waive specific sections of the Medicaid Act which in his judgment are "likely to assist in promoting the objectives" of the Medicaid Act, and which meet certain

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[13] As of January 2019, states can obtain FFP for providing these transition services to individuals under 21. *See* 42 U.S.C. § 1396d(a)(16).
[14] 42 U.S.C. § 1396d(a)(30)(A).
[15] 42 C.F.R. § 435.1010.
[16] *Ohio Dept. of Medicaid v. Price*, 864 F.3d 469 (6th Cir. 2017) (upholding HHS' decision to reject an Ohio Medicaid State Plan Amendment that proposed claiming FFP for pretrial detainees under age 19).
[17] 42 C.F.R. § 435.1010.
[18] Proposal at 21.

other criteria articulated above.[19] Moreover, Section 5032 does not give states authority to waive the inmate exclusion—it only requires CMS to issue guidance on providing transition services via Section 1115 demonstration programs. Section 5032 does not create new authority for the Secretary to grant 1115 waivers, and it definitely does not mandate such waivers, as the District suggests.[20] CMS has not yet issued the guidance, let alone articulated how a state may legitimately obtain FFP for Medicaid funded health services while an individual is an inmate of a public institution. CMS simply does not have the authority to issue guidance or approve a waiver that circumvents the clear statutory language of the inmate exclusion and the statutorily imposed limits on Section 1115 demonstration waivers.

While NHeLP strongly believes states can and should provide transition services to returning citizens, there are other avenues for the District to pursue this laudable goal without running afoul of the Medicaid Act.[21]

III. FFP for IMDs risks diverting resources away from community-based services and undermining community-integration

Because Medicaid reimbursement is available for mental health and SUD services in the community rather than institutions, historically the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated settings. This financial incentive to rebalance treatment towards community-based services is particularly important due to

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[19] 42 U.S.C. § 1315(a).

[20] SUPPORT Act § 5032, Pub. L. No. 115-271 ("[T]he Secretary of Health and Human Services . . . shall issue a State Medicaid Director letter . . . regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX of such Act, including systems for, with respect to a period (not to exceed 30 days) immediately prior to the day on which such individuals are expected to be released from such institution— 1) providing assistance and education for enrollment under a State plan under the Medicaid program under title XIX of such Act for such individuals during such period; and (2) providing health care services for such individuals during such period.").

[21] See, *e.g.,* Jess Jannetta, Urban Institute, *Strategies for Connecting Justice-Involve Populations to Health Coverage and Care* (March 2018), https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf (describing opportunities for states to use Medicaid administrative claiming to allow state employees, MCOs, carved out behavioral health systems, or community based organizations to provide assistance with enrollment, eligibility, and identification and linkages to providers in the community).

"bed elasticity," where supply drives demand.[22] That is, if the beds are available, they will be filled, siphoning resources from community-based services. But when beds are not available, other options adequately meet individuals' needs. When states have limited resources, spending money on more costly institutional settings results in less available funding for more cost-effective community-based programs, making community-based services harder to access.

Regardless of whether individuals with mental health needs or SUD begin their treatment in residential or community-based settings, people need access to a full array of community-based treatment options tailored to their individual needs, which will change as they progress in their recovery.[23] For example, they often need ongoing community-based services such as case management, medication-assisted treatment (MAT), and peer support services to maintain their recovery, prevent relapse, and quickly return to treatment if relapses occur.[24] Expanding incentives to utilize residential treatment by permitting FFP for services provided in IMDs could actually undermine efforts to ensure the appropriate continuum of care. For example, if states receive more funds for IMDs, but this is not balanced out by additional funding incentives for chronically underfunded community-based services, it "may simply encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option."[25] Furthermore, increasing funding to inpatient facilities could increase dangers to patients with opioid use disorder if such facilities primarily focus on detoxification:

> Indeed, it may increase the potential for overdose if patients do not remain in treatment since, with detoxification, their tolerance for opioids is significantly reduced. In fact, recent data suggest that inpatient detoxification is an important predictor of overdose, largely because many who receive inpatient care aren't

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[22] Martha Shumway et al., *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*¸ 63 PSYCHIATRIC SERVS. 135 (2012), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201000145.

[23] Hannah Katch & Judith Solomon, Ctr. on Budget & Policy Priorities, *Repealing Medicaid Exclusion for Institutional Care Risks Worsening Services for People With Substance Use Disorders* (April 24, 2018), https://www.cbpp.org/research/health/repealing-medicaid-exclusion-for-institutional-care-risks-worsening-services-for.

[24] Jennifer Lav, Nat'l Health Law Prog., *Policy Implications of Repealing the IMD Exclusion* (May 17, 2018), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/04/MedicaidIMD-Exclusion-51718docx-1.pdf.

[25] Michael Botticelli and Richard Frank, Congress needs a broader approach to address opioid epidemic, THE HILL (June 10, 2018), https://thehill.com/opinion/healthcare/391544-congress-needs-a-broader-approach-to-address-opioid-epidemic.

then connected to community-based treatment programs or put on a medication, leaving them extremely vulnerable to relapse and overdose.[26]

Changes to the IMD exclusion could also undermine hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.[27] IMDs are by definition residential settings where individuals with disabilities receive services, and decisions regarding funding for services in IMDs will inevitably have an impact on where people with disabilities receive services.[28] In passing the Americans with Disabilities Act, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[29] The District just recently emerged from an almost 40-year old case regarding the right to receive psychiatric treatment in the community. It is troubling that the District appears to be reversing direction and seeking to fund a 130-bed facility. Providing FFP for large institutional settings could reify discriminatory presumptions about the ability of individuals with disabilities to receive services in community-based settings, undermining the integration mandate articulated by the Supreme Court in *Olmstead v. LC*, and the network of community-based services painstakingly established via *Dixon v. Gray*.[30]

Furthermore, the District's application does not offer sufficient assurances of quality. CMS has stated that it expects states to "include actions to ensure good quality of care

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[26] *Id*.
[27] President's New Freedom Comm'n on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.
[28] While the ADA excludes individuals who are currently using illicit substances from the definition of an "individual with a disability," the definition of disability should include individuals in an IMD, as individuals in IMDs are generally not currently using ilicit drugs and are in a supervised rehabilitation program. 42 U.S.C. § 12210; 28 C.F.R. § 35.131 ("(2) A public entity shall not discriminate on the basis of illegal use of drugs against an individual who is not engaging in current illegal use of drugs and who—(i) Has successfully completed a supervised drug rehabilitation program or has otherwise been rehabilitated successfully; (ii) Is participating in a supervised rehabilitation program; or (iii) Is erroneously regarded as engaging in such use.").
[29] 42 U.S.C. § 12101(a)(2).
[30] *Olmstead v. L.C.*, 527 U.S. 581 (1999); *Dixon v. Gray*, Settlement Agreement, https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/DixonSettlementAgreement.pdf.

in IMDs."[31] Not only has the District failed to include any meaningful assurances, but the District has not proved a credible partner in protecting the safety and rights of individuals in psychiatric facilities. Just recently, the District defended the practice of placing individuals in seclusion for weeks at time—a practice that is both illegal and traumatizing.[32] The CEO of the IMD where this took place, a District employee, attempted to justify the long-term seclusion by referring to it as a "safety suite," and claiming that a "safety suite is an intensive therapeutic intervention." A CMS spokesperson openly disagreed, noting that "CMS is unable to identify any situation in which a patient is kept alone for long periods of time in a locked room that would not be considered seclusion."[33] The District only agreed to revisit the policy after the press became involved.[34] Nothing in the District's waiver application ensures that it has made the changes necessary to ensure safety in its IMDs. For individuals with SMI, the District only states that treatment staff will be licensed "or otherwise credentialed or regulated by DBH." In light of the District's recent actions, and its long history of failing to ensure its IMDs adhere to basic standards of care, the District's plan is clearly insufficient.

IV. The District Can Accomplish Its Stated Goals through State Plan Authority

While NHeLP supports the District's decision to expand access to behavioral health services for Medicaid beneficiaries, many of the services the District seeks authority for may be provided through a State Plan Amendment (SPA). Section 1115 only gives the Secretary authority to waive certain provisions of the Medicaid Act "to the extent and for the period he finds necessary to enable such State or States to carry out such project." The Secretary has no authority to approve a section 1115 waiver if the goals of the proposal may be achieved without the need to waive federal requirements.[35]

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[31] CMS, Dear State Medicaid Director Letter (Nov. 13, 2018) (SMD # 18-011) (Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance) 13, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[32] Disability Rights DC at University Legal Services, *Solitary Confinement at St. Elizabeths* (Jan. 28, 2019), http://www.uls-dc.org/media/1173/reportfinal12819.pdf.

[33] Joshua Kaplan, *Advocates Say That St. Elizabeths Has Been Illegally Locking Patients Alone in a Room for Weeks on End*, WASH. CITY PAPER (June 11, 2019), https://www.washingtoncitypaper.com/news/city-desk/article/21072559/disability-rights-lawyers-say-that-st-elizabeths-has-been-illegally-locking-psychiatric-patients-alone-in-a-room-for-weeks-on-end.

[34] *Id*.

[35] 42 U.S.C. § 1315(a)(1).

The District seeks authority and FFP for several new behavioral health services that could be added to the District's State Plan via a SPA without the need to waive any of the requirements contained in the Medicaid Act. Services that could be covered via a SPA include: recovery support services (RSS) for individuals with SUD; clubhouse services for individuals with SMI; and Trauma Recovery and Empowerment Model (TREM) and Trauma Systems Therapy (TST) services. The District also seeks to modify billing methods for mobile crisis services, to add additional certified behavioral health providers, and to eliminate the $1 copay for MAT. All of these goals can be achieved with a SPA. Therefore, approval of this request would be improper.

A. FFP for Recovery Support Services

The District seeks to obtain FFP for recovery support services (RSS) for individuals with SUD, which are "nonclinical services and supports designed to support and maintain ongoing recovery," including care coordination, recovery coaching and mentoring, life skills support, education support services, and transitional housing support.[36] A recent study from the Medicaid and CHIP Payment and Access Commission (MACPAC) found that "states predominantly use State Plan rehabilitative [services] option to pay for [RSS]."[37] The District already covers similar services for individuals with mental health diagnoses via the "community support" benefit in its state plan.[38] Via this demonstration, the District seeks to extend similar services to individuals with SUD, but most if not all of the services the District lists under RSS can be covered in their entirety via 42 U.S.C. § 1396a(a)(13). Expanding the list of specific covered services may be achieved by submission of a SPA, and therefore a waiver is unnecessary.[39]

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[36] Proposal at 19.

[37] Medicaid & CHIP Payment & Access Comm'n, *Recovery Support Services for Medicaid Beneficiaries with Substance Use Disorder* (March 2019), https://www.macpac.gov/publication/recovery-support-services-for-medicaid-beneficiaries-with-substance-use-disorder/.

[38] District of Columbia Medicaid State Plan, Supplement 6 to Attachment 3.1-A, 5, https://dhcf.dc.gov/node/192262.

[39] The District also seeks to provide additional employment supports to individuals with SMI, and to start providing supported employment services to beneficiaries with SUD, which will be piloted through two providers designated by the District. Proposal at 20, 36. We take no position as to whether an 1115 waiver is required for implementation of these services because the District has not provided enough information about the proposal. While states may cover certain recovery-oriented employment supports via their state plan, the District has not provided enough specificity to allow for comment on whether the vocational services suggested are coverable, at least partially, under the state plan. Many employment related supports can be covered via 42 U.S.C. § 1396a(a)(13), and the District already covers interventions for individuals with SMI that assist with adapting to and managing symptoms within work environments. As such, the Secretary should not approve this demonstration without an

B. FFP for Clubhouse Services

The District also seeks to provide clubhouse services for adults with SMI and/or co-occurring SUD.[40] These services, also known as psychosocial rehabilitation services, are already covered in 29 states.[41] As with RSS, most states cover clubhouse services via the rehabilitative services option.[42] Since the District is not proposing to limit these services to certain populations or by geographic regions, the District is free to request a SPA that would expand rehabilitative services to include clubhouse services without the requested 1115 waiver. District regulations already include clubhouse services as part of its array of services available for individuals with SMI.[43] While the state plan does not provide for FPP for these services, the District could remedy this via a SPA.

C. Delineating Trauma Recovery and Empowerment Model and Trauma Systems Therapy Services

The District asks to add additional counseling benefits--Trauma Recovery and Empowerment Model (TREM) and Trauma Systems Therapy (TST) services.[44] The District states that adding TREM and TST will prevent providers from billing for those therapies under the general umbrella of "counseling services." This, in turn, will allow the District to reimburse TREM and TST at different rates and track utilization. The District does not need to waive any provision of the Medicaid Act to achieve this outcome. Nothing prevents the District from submitting a SPA to include the specific trauma-informed therapies included in the District's 1115 proposal.

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explanation of the services the District seeks to provide, why a waiver is needed and why a SPA would not suffice.

[40] Proposal at 19–20.

[41] Kaiser Family Found., Medicaid Behavioral Health Services: Psychosocial Rehabilitation (e.g. "Clubhouse model"), https://www.kff.org/medicaid/state-indicator/medicaid-behavioral-health-services-psychosocial-rehabilitation-e-g-clubhouse-model/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Jul. 7, 2019).

[42] *Id*.

[43] D.C. MUN. REGS. tit. 22A § 3900.

[44] Proposal at 20.

D. Modifying Billing Units for the Comprehensive Psychiatric Emergency Program and Mobile Crisis Services

The District seeks to alter how services are reimbursed under the comprehensive psychiatric emergency program (CPEP) and mobile crisis and outreach services. Specifically, the District seeks to reimburse these services at an hourly rate, instead of the current practice of billing in 15-minute increments.[45] These changes do not amount to modifications in Medicaid coverage for which 1115 waiver authority is necessary. Section 1115 does not authorize the Secretary to approve mere changes in billing methodology as these are not considered experimental without additional modifications to the services covered. The District could instead submit a SPA to implement such changes.

E. FFP for Psychiatric Residential Crisis Stabilization Services

Similarly, the District does not need an 1115 waiver to obtain FFP for psychiatric residential crisis stabilization services. Psychiatric residential crisis services currently provided at two different locations for up to 15 beds. Since the facilities do not exceed 16 beds, FFP for these services would not violate the IMD exclusion. As such, the District could receive FFP for the mental health services provided at the two locations by submitting a SPA. In any event, these services are already provided for District Medicaid beneficiaries using District funding.[46] The District fails to explain how obtaining FFP for services it already provides constitutes a legitimate experiment, and not simply a funding shift.

F. Including independent behavioral health practitioners as qualified providers

The District requests waiver authority to reimburse for screening, behavioral health assessment and diagnostic counseling, and other behavioral health treatment provided to individuals with SMI or SUD by psychologists and other licensed behavioral health providers.[47] These services are currently covered under the State Plan rehabilitative

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[45] Proposal at 19.
[46] *See, e.g.,* D.C. Council, Comm. on Health, Dept. of Behavioral Health Oversight Hearing, FY 18-19, noting that crisis stabilization services are funded locally at a rate of $331.87 per day. https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf. The District funds residential crisis services at two different locations, one run by Woodley House ("Crossing Place") and the other via So Others Might Eat ("Jordan House") for a total of fifteen residential crisis beds.
[47] Proposal at 20–21.

option if provided at free standing mental health clinics, core service agencies, or Federally-Qualified Health Centers (FQHC).[48] While expanding coverage of these services to include additional independent providers is a legitimate and important goal, it is unclear why the District needs an 1115 waiver to achieve this goal. Since the District is not proposing to limit these services to certain populations or by geographic regions, the District should be able to expand reimbursable services by simply submitting a SPA request proposing to expand covered services under the rehabilitative behavioral health services option.

G. Removing cost-sharing for prescription drugs associated with MAT

The District seeks to remove the $1 co-payment cost-sharing requirements currently in effect under the State Plan for beneficiaries using prescribed medications associated with MAT, such as methadone, buprenorphine, and naltrexone.[49] While we strongly support removing barriers to MAT for individuals with SUD, we oppose the District's intention of doing so through an 1115 waiver. Nothing in the Medicaid Act prohibits the District from imposing variations on cost-sharing on prescription drugs depending on the type of treatment. In fact, federal law allows the District to "waive or reduce the cost sharing otherwise applicable for preferred drugs within such class."[50] Moreover, the District is not seeking to impose different cost-sharing for MAT depending on the population or geographic region, situations which are likely to necessitate approval of an 1115 waiver request. Since the District is merely seeking to remove cost-sharing for one type of treatment applicable to all populations who need MAT, the District may simply submit a SPA request proposing to remove the $1 co-payment.

V. Conclusion

In summary, NHeLP generally supports the District's efforts to expand access to behavioral health treatment for Medicaid beneficiaries. However, we believe this 1115 waiver request is not the appropriate vehicle to achieve this goal.

In its application, the District has failed to explain how obtaining FFP for services rendered at IMDs, the cornerstone of the application, constitutes a valid experiment

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[48] Proposal at 21.
[49] Proposal at 21–22.
[50] *See* 42 U.S.C. § 1396o-1(c)(1)(B) (allowing states to waive or reduce cost-sharing for certain classes of drugs). *See also* 42 U.S.C. §§ 1396o-1(b)(3)(C) & (b)(6)(C) (clarifying that the statute does not prevent states from exempting certain services from cost-sharing and/or limiting cost-sharing beyond the limitations already established by the statute).

under the Medicaid Act given that such waivers have been approved by CMS as far back as 1993. In addition, we firmly believe the Medicaid Act does not grant the Secretary the authority to waive the IMD exclusion or the inmate exclusion, as the District seeks here. Regarding the IMD exclusion, we further believe that approval of the waiver would divert funds from community-based mental health and SUD services into institutionalized services, in potential violation of the Olmsted mandate.

Finally, as we have explained, most of the services and actions the District seeks through this waiver request may already be achieved through State Plan authority. The District simply needs to submit a SPA to achieve its goal of expanding availability of mental health and SUD services, as well as its goal of removing barriers, such as cost-sharing, to access necessary care.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Jennifer Lav (lav@healthlaw.org) or Héctor Hernández-Delgado (hernandez-delgado@healthlaw.org).

Sincerely,

Jennifer Lav
Senior Attorney

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