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August 12, 2021

VIA ELECTRONIC SUBMISSION

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

***Re: California Section 1115 Demonstration Five-Year Renewal and
Amendment Request: CalAIM Demonstration***

To Whom It May Concern:

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 Request for Amendment and Five-Year Renewal of California's Section 1115 Demonstration.

While we fully support the overall goals of California's Advancing and Innovating Medi-Cal (CalAIM) to improve health outcomes and advance equity for Medi-Cal beneficiaries and other low-income people in the state, we have concerns with the state's use of § 1115 to accomplish them. While NHeLP is supportive of states using Medicaid to increase access to health and behavioral health services, there are legal reasons the Secretary should either reject select elements or require modifications to the requested waiver.

For the Secretary to approve a project pursuant to § 1115, the project must:

- be an "experimental, pilot or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.

Discussing each of these limitations a bit further:

First, the state must propose to conduct an “experimental, pilot, or demonstration” project. This demands a “novel approach” to program administration. *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act’s objectives. Congress has made clear that the purpose of Medicaid is to enable states “to furnish[] medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1; 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services).

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b-1396w-5. *See* Social Security Act, § 1115(a)(1). Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of “such project” are “regarded as expenditures under the State plan” and, thus, paid for under the same statutory formula that applies for a state’s expenditures under its State plan. *Id.* § 1115(a)(2). Section 1115(a)(2) does not create an independent “expenditure authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a “clean-up” provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Fourth, section 1115 allows approvals only “to the extent and for the period necessary” to carry out the experiment. *Id.* § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of “state-wide, comprehensive demonstration projects” to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers).¹ Congress did not enact section 1115 to permit the Secretary to make long-term policy changes.

¹ In 2017, a CMS Informational Bulletin announced the intent “[w]here possible, . . . [to] approve the extension of routine, successful, non-complex” Section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115’s limitation of approvals to experimental, pilot, or demonstration projects (not for “routine” projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

1. Waiving the IMD Exclusion for SUD Services.

Through this Section 1115 waiver application, California is requesting renewal of its Institutions for Mental Diseases (IMDs) exclusion waiver for SUD services (already extended for an additional year effective January 1, 2021). In 2015, California became the first state in the nation to receive approval to waive the IMD exclusion to provide for residential treatment to Medicaid beneficiaries with SUD. Since then, over thirty additional states have received approval for similar applications, opening the door to a substantial increase in funding available for residential SUD facilities across the country. However, we caution that continuing to renew these waivers runs counter to the purpose and requirements of Section 1115, which requires waivers to test new and innovative policies that are likely to assist in promoting the objectives of the Medicaid program. From the outset, we note that California has failed to establish a clear experiment to be tested with an IMD exclusion waiver, as simply stating that additional funding for residential facilities is needed is not enough to satisfy the experimental requirement. This lack of an experimental component is even more evident now that California will have implemented the IMD exclusion waiver for six years. We fail to see how the State would need a renewal of its IMD exclusion waiver in order to test a novel idea at this point.

NHeLP recognizes that if CMS were to reject California's request to renew its IMD exclusion waiver for SUDs it would cause significant disruption in the State's SUD system of care. But California is not without options. First, as we explain further below, there are currently significant gaps in Medi-Cal's coverage of community-based SUD services that we believe have been exacerbated by the IMD exclusion waiver. Funding for residential SUD services has come at the expense of providing the same type of services in lower levels of care that are more effective and better positioned to meet people's needs. We continue to be concerned that funneling more federal dollars to residential institutions, when such gaps in community-based services remain, will create a situation whereby beneficiaries will inevitably need to receive SUD services in residential settings for lack of community and outpatient providers even if they do not need that type of supervised care. In lieu of renewing the State's IMD exclusion waiver, California should ensure that Medi-Cal beneficiaries with SUD have access to all DMC-ODS services on an outpatient basis and that residential care is reserved for only the more serious cases that warrant that level of intervention.

Second, California could implement the optional IMD service available under Section 5052 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Communities (SUPPORT) Act. This provision allows states to use federal funding for residential SUD services at IMDs as long as certain conditions are met. In general, these conditions serve as guardrails against improper institutionalization of individuals with SUD by requiring states and residential facilities to be able to provide the whole continuum of services, including outpatient and community-based services, and by ensuring that beneficiaries receive treatment in levels of care that are appropriate for their condition. It is striking that there are currently no states using this optional benefit, while an increasing number of states continue to receive CMS approval for Section 1115 waivers that enable provision of the same residential services, but without the guardrails and guarantees of Section 5052. We are concerned that California may be circumventing the important requirements of the SUPPORT Act by renewing their IMD



exclusion waiver for an additional five years when Congress has explicitly spoken on the matter and made it clear that necessary protections should be put in place. While we understand the SUPPORT Act option is only available through 2023, we think that factor is irrelevant to the application at hand. If states want to continue using federal funds for SUD services in IMDs, Congress could act to extend the option beyond 2023. Absent congressional action, however, CMS should not continue using Section 1115 to funnel Medicaid dollars to institutional settings without proper protections in place. Further, approval of such requests only incentivizes states to over-rely on institutional care, further undermining and eroding states' community integration obligations under the Supreme Court's *Olmstead* decision to not inappropriately put people with disabilities in institutions.

2. Expanding DMC-ODS Program IMD Days and Length of Stay.

While we strongly support continuation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) program and many of the additional services that have become available in the past five years, we are concerned about the proposal to remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period as part of State's IMD exclusion waiver. The DMC-ODS waiver was the first in the nation to authorize the use of federal dollars for reimbursement for SUD treatment received in IMDs, psychiatric or substance use residential facilities with more than 16 beds. While we have overall concerns, both legal and policy, with the state's expanded desire to seek approval for reliance of IMDs for people with SUD conditions in order to obtain federal financial participation (FFP) (discussed above), we are also concerned with the state's request to expand the number of days to authorize its use. The IMD exclusion waiver was originally intended to expand access to inpatient substance use treatment in participating counties as part of the whole ASAM continuum of care.

Importantly, however, because of the risk of institutionalization to which individuals with mental health and SUD have been historically subjected, reliance on residential treatment must be carefully balanced with sufficient availability of community-based services and limitations to avoid overreliance on institutionalization at the expense of evidence-based and patient-tailored community-based care. For that reason, the original waiver limits Medi-Cal coverage to two non-continuous residential stays of up to 90 days in a one-year period. The waiver renewal request seeks to remove that limitation with the only protection being an ambiguous promise that the state "will aim for a statewide average length of stay of 30 days," despite a clear limitation that is already contained in the current waiver's terms and conditions.

We believe this change will excessively incentivize residential care even in situations where community-based services are more appropriate, feasible, and would yield more effective results. Furthermore, the Department has failed to provide sufficient evidence to demonstrate the need to increase reimbursable residential treatment days beyond what is already provided in the current waiver. One of the end goals of the DMC-ODS program is to facilitate transfer of beneficiaries from higher levels of care to lower levels of care. For this goal to be achievable, certain limitations on residential treatment must be imposed so that providers are incentivized to work with beneficiaries towards the target of moving to a less restrictive level of care as soon as the individual is admitted to the



IMD. The current maximum of two non-continuous 90-day episodes should be sufficient to achieve this goal and should not be expanded through the renewal request.

3. Availability of DMC-ODS Services

While we understand that all DMC-ODS services (except for those provided in IMDs) have been moved to a Section 1915b waiver, we use this opportunity to express our disappointment that California has elected to continue waiving statewideness requirements for these important services. Despite its focus on residential services, the expansion of SUD services through the DMC-ODS program has been vital in ensuring that Medi-Cal beneficiaries have access to medically necessary and, in some cases, life-saving treatment to address their conditions. Even with the advances regarding access to care, the overdose and SUD epidemic in California and the nation is still rampant. This is particularly true in various rural counties in the State that are still not participating in the DMC-ODS program. After six years of expansion of services, we see no reason why these counties should be given the opportunity to elect not to provide essential services, such as buprenorphine treatment at narcotic treatment programs (NTPs), case management and recovery services, and partial hospitalization, to their beneficiaries.

4. Availability of Peer Support Specialist Services

Legislation passed last year (SB 805) directed DHCS to allow counties to certify peer support specialists and pay for their services for individuals receiving specialty mental health or SUD services. We agree that peer support is an important component of mental health and substance use disorder services. The way that DHCS is currently proposing to implement this benefit, based on counties opting in, through a combination of state plan, 1115, and 1915(b) authorities, raises serious legal questions.

As a matter of policy, peer support services should be available to all Medi-Cal beneficiaries who need it throughout the state, in the state plan, and not contingent on whether the person's county of residence has opted in to providing the service. Allowing the service to be offered piecemeal based on particular counties' willingness to contribute the non-federal share is not an appropriate way to extend such important services to Medi-Cal beneficiaries, nor does it constitute a valid experiment for 1115. Here, the state has not articulated how allowing counties to opt-in to providing peer support constitutes a test of some hypothesis, nor could it. Allowing counties to opt in to providing the service does not ensure that there will be any way to make valid comparisons between those who received the service and those who did not to evaluate their outcomes.

Moreover, the proposal will not promote the objectives of the Medicaid Act. Decades of research have established that peer support is a medically necessary intervention for people with behavioral health conditions, which is why it is already a covered Medicaid service in the majority of states. *See Kaiser Family Found., Medicaid Behavioral Health Services: Peer Support Services (2018), <https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-peer-support-services>.* Withholding a medically necessary service from beneficiaries based only on the county in which they live does not promote the purpose of Medicaid, which is to enable states "to furnish[] medical



assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1; 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services). The “central objective” of the Medicaid Act is “to provide medical assistance.” *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting “promoting health” as an independent objective because the Medicaid Act is “designed ... to address not health generally but the provision of care to needy populations” through a health insurance program).

Punishing beneficiaries by limiting their access to services based on where they live is plainly inconsistent with this objective. CMS must not approve a waiver of statewideness for peer support services. It is neither a valid experiment, nor does it promote the objectives of Medicaid.

5. Justice-Involved Populations

We are glad to see that California and DHCS are taking efforts to ensure that individuals leaving incarceration are connected with low-cost health coverage and services in a timely manner. It is well-established that justice-involved populations have high health needs, including mental health and substance use disorder needs, and Medi-Cal coverage is essential to achieve continuity of care, better post-release health outcomes, and to reduce recidivism. We strongly support the CalAIM proposal to require a mandatory Medi-Cal application process for individuals being released from jails and juvenile facilities.

However, we do not believe that an 1115 waiver is the proper mechanism by which to implement such policies. In addition to being outside the scope of provisions which the Secretary is authorized to waive, as discussed above, it is not necessary to use a waiver in order to implement programs to connect justice-involved populations with Medicaid upon reentry. Several states have contracted with managed care plans to engage with incarcerated individuals prior to release. *See* CAL. HEALTH POL’Y STRATS., *Policy Brief: Medicaid Managed Care Organizations and Reentry* (Jan. 2019), <https://calhps.com/wp-content/uploads/2019/01/Policy-Brief-MC-Managed-Care-model-Final.pdf> (hereinafter “CHPS Policy Brief”). For example, the state of Ohio has a pre-release Medicaid enrollment program where the selected plan initiates care 15 to 30 days before the individual is released. Jocelyn Guyer et al., *Issue Brief: Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States 4*, STATE HEALTH REFORM ASSISTANCE NETWORK (Nov. 2015), <https://www.shvs.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf>. During the final few weeks of their incarceration, the individual meets with the plan via video conference to develop a transitional plan and is provided with needed documents and their Medicaid ID card upon release. *Id.* In Arizona, the managed care organization schedules appointments within seven days of release. *See* CHPS Policy Brief.

6. Conclusion



In summary, NHeLP generally supports California's efforts to expand access to Medi-Cal services. However, some elements of the waiver are problematic or not the appropriate vehicle to achieve this goal.

We appreciate your consideration of our input. If you have questions about these comments, please contact Kimberly Lewis (lewis@health.org).

Sincerely,

A handwritten signature in blue ink that reads "Kimberly Lewis". The signature is written in a cursive style with a large initial "K".

Kimberly Lewis
Managing Attorney

