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November 17, 2023

Xavier Becerra, Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

**RE: California Behavioral Health Community-Based
Organized Networks of Equitable Care and Treatment
Demonstration**

Dear Secretary Becerra:

The National Health Law Program (NHeLP) is pleased to provide comments on California's proposed Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration. NHeLP protects and advances health rights of low-income and underserved individuals and families. We advocate, educate and litigate at the federal and state levels to advance health and civil rights in the U.S. We appreciate the opportunity to comment.

We begin by emphasizing that we strongly support the overall goals of BH-CONNECT as set forth in this proposal. See Cal. Dept. Health Care Servs., *The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration* (2023), <https://www.medicaid.gov/sites/default/files/2023-10/ca-bh-connect-pa-10202023.pdf> (hereafter "*Proposal*"). We commend the ongoing efforts the Department of Health Care Services (DHCS) has made to strengthen California's behavioral health system, particularly for individuals on Medi-Cal with the highest needs and experiencing the greatest disparities. DHCS has made unprecedented investments in expanding behavioral health services and supports for Medi-Cal beneficiaries through California Advancing and Innovating

Medi-Cal (CalAIM), including efforts to build out a comprehensive continuum of care for beneficiaries with the highest level of behavioral health needs. We appreciate that BH-CONNECT seeks to continue this work by expanding the range of community-based mental health services available to Medi-Cal beneficiaries, especially evidence-based practices (EBPs). We also are pleased to see DHCS acknowledge that there are still significant gaps remaining in the current continuum of care available to Medi-Cal members living with SMI/SED, particularly among children and youth, and agree that strengthening the statewide continuum and improving accountability are critical steps to achieve these goals.

We also understand that the focus populations of this demonstration will be Medi-Cal beneficiaries most in need of enhanced behavioral health services and supports, including youth involved in child welfare, individuals who are experiencing or at risk of homelessness, and individuals who are justice-involved. We certainly appreciate the focus on these particular high need groups, and appreciate that the proposed benefit expansions will also reach other Medi-Cal beneficiaries when they need them. We also strongly endorse the aim of reducing use of institutional care by those individuals most significantly affected by significant behavioral health needs and expanding services and supports available in the community.

As discussed in more detail below, however, we strongly encourage HHS to require DHCS to adopt a statewide approach to implementing new benefits, and to reject requests to waive statewideness to restrict benefits to certain counties. We also urge HHS to reject California's request for federal financial participation for psychiatric stays in IMDs. Our detailed comments and feedback on the various components of the draft proposal are below.

Section 1115 Waiver Hypotheses and Evaluation Plan

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). Thus, 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).

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

As discussed in more detail below, NHeLP has serious questions about whether this proposal constitutes a genuine experiment. For the waiver as a whole, DHCS states that the proposal “will test whether the granted waiver and expenditure authorities increase access to community-based behavioral health services and improve outcomes for Medi-Cal members living with SMI/SED and/or a SUD.” *Proposal* at 13. Yet, as described in more detail below, many of its proposed hypotheses and evaluation methodologies designed to test this hypothesis fall short.

In addition, NHeLP continues to oppose the proposed extension of existing waivers of statewideness, and amount, duration, and scope and comparability. Behavioral health delivery system and access problems are a statewide problem and therefore the solutions must be statewide. Beneficiaries should not be penalized with less access to behavioral health services simply because of the county they live in. We remain concerned about DHCS’s continued approach of making benefits available on a county “opt-in” approach through the 1115 waiver. This approach adds to the statewide confusion and complexity about what benefits are available to whom and where. It is particularly concerning that DHCS is continuing to allow this level of variation in the behavioral health delivery system at the same time it is working through CalAIM to standardize benefits and enrollment in managed care. We provide additional comments about DHCS’s proposed hypotheses and evaluation plans for various components of the demonstration in more detail below.

BH-Connect Features Available Statewide

As discussed above, we oppose the use of Expenditure Authority to ignore the requirements of the Medicaid Act. Notwithstanding those legal concerns, we offer the below comments on the various components of the proposal as a matter of policy.

Workforce Initiative to Ensure Access to Critical Medi-Cal Behavioral Health Services

We believe that the workforce initiative component of the demonstration is one of the most critical aspects of the proposed demonstration. As the rest of the nation, California

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).



faces mounting challenges with regards to lack of availability of behavioral health providers and services.² It is effectively meaningless for Medi-Cal to cover certain services if no or few providers are available to deliver them. The situation is particularly stark when it comes to community-based mental health services, which is why it is essential that HHS work with DHCS to implement a proactive approach to address provider infrastructure. To that end, we appreciate the examples provided by DHCS regarding long-term investments to expand the pipeline of behavioral health professionals and short-term investments to support recruitment efforts for key behavioral health services. Because of HHS's emphasis on community-based services, we believe HHS should prioritize those types of investments as part of this initiative.

Despite our general support, we caution that by the way it is currently described, the workforce initiative continues to be too open-ended in a way that allows for investment in less effective, and sometimes harmful, services and settings, such as residential and institutional behavioral health care. The hypothesis for this initiative is that the availability of behavioral health providers will increase over the course of the demonstration. DHCS proposes to collect data specific to the initiative to determine whether its hypothesis is correct: (1) the number of providers expanding clinical capacity attributable to the behavioral health workforce initiative; and (2) the number of new college/university slots funded through behavioral health workforce initiative. *Proposal* at 17. We urge HHS to encourage DHCS to explicitly limit the funding tied to the workforce initiative to efforts to increase availability of Medi-Cal covered community-based behavioral health services. Because the evidence shows that such care settings are significantly more effective and appropriate for individuals living with SMI/SED, we suggest that HHS require California to limit the use of the proposed short-term investments, such as hiring and retention bonuses, to those professionals who are primarily providing community-based services. We are encouraged by the investment examples provided by DHCS, but in order to fully support this initiative we would like to see HHS encourage DHCS to explicitly commit to using their funding exclusively to incentivize effective and evidence supported community-based services.

Activity Stipends

We support DHCS's proposal to develop a new stipend for children and youth involved with the child welfare system to be used for activities and supports to promote social and emotional well-being and resilience, manage stress, build self-confidence, and

² Jocelyn Wiener, *Unanswered Cries: Why California faces a shortage of mental health workers*, CALMATTERS, Sept. 8, 2022, <https://calmatters.org/health/2022/09/california-shortage-mental-health-workers/>.

counteract the harmful physical and mental health effects of trauma. We agree that children and youth involved in the child welfare system need access to after-school and extracurricular activities that support physical health, mental wellness, healthy attachment and social connections to support social and emotional development, promote and enhance long-term mental health and prevent substance use.

That said, we strongly suggest that the stipends be available to keep kids who are at risk of coming into foster care or child welfare involvement altogether as these activities can be an effective way to improve outcomes and mitigate the impact of poverty, trauma and poor health for all low-income children and youth, not just those involved in child welfare. For example, children and youth at risk of juvenile justice involvement should also have access to these activities and supports. Broadening it will have a more equitable impact on the Medicaid BIPOC population who are at particularly high risk and have worse outcomes.

We encourage HHS to work with DHCS to ensure that the stipend funding is not used to pay for services that should be paid for with other Medicaid funds for covered services under EPSDT. For example, these funds should not be used to pay for non-traditional therapeutic interventions such as art therapy, movement therapy, music therapy, and equine therapy, since those interventions can and should be covered under EPSDT. HHS has repeatedly stated that pursuant to the EPSDT mandate, if a service can be authorized under the state plan, it may not be authorized under a waiver.³ We emphasize that purely extracurricular activities and supports are different from non-traditional therapeutic interventions. We urge HHS to work with DHCS to ensure that Title IV-E funds be utilized for activity stipends where such funds can be so Medicaid funds are available for additional children and youth that need them. We encourage HHS to work with DHCS to flesh out how these funds will be distributed and monitored.

Finally, the hypothesis for this waiver request states that outcomes for children and youth involved with child welfare will improve over the course of the demonstration. *Proposal* at 16. Yet the proposed evaluation approach says nothing about how the stipends will improve outcomes or what outcomes they are seeking to change with these activity stipends. See *id.* Moreover it is not clear what data about the use and distribution of Activity Stipends, if any, will be collected as part of the claims or cross-sector incentive data. We strongly encourage HHS to work with DHCS to amend the

³ CMS, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* 26 (2014), https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

evaluation approach to look at and measure true outcomes specific to Activity Stipends, not only mental health access or penetration rates or use of residential treatment.

Cross-Sector Incentive Program for Children Involved in Child Welfare

DHCS is proposing the Cross-Sector Incentive Pool to establish a program for cross-agency collaboration - MCPs, county behavioral health delivery systems, and county child welfare systems - to address the needs of children and youth involved in child welfare who are living with or at high-risk for SED. While we strongly support greater accountability, data-sharing and establishing outcome measures for children and youth in the child welfare system, we don't understand how this is different from what ECM is supposed to be providing for this population, which is similar if not the same. It is also unclear if or how children and youth involved in child welfare who are in fee-for-service Medi-Cal will benefit from this. This is almost half the entire foster youth in the state. We still need to understand how these incentives will work to improve outcomes and accountability between MCPs, county behavioral health and child welfare agencies, who will be responsible for this program, and how it will achieve what the MCP's ECM benefit (which began being provided to child welfare involved youth and former foster youth in July 2023) hasn't yet been given time to accomplish for this ECM target population. This proposal presents more questions than answers. Little information is provided about how the Statewide County Incentive Program will be funded or how benchmarks will be selected. To be successful, DHCS will have to ensure that the incentives provided through this program are sufficiently meaningful to achieve the intended outcomes and not duplicative to existing new CalAIM efforts.

Centers of Excellence

We support the establishment of Centers of Excellence to offer training and technical assistance to behavioral health delivery systems and providers to support fidelity implementation and delivery of EBPs and community-defined evidence practices for Medi-Cal members living with SMI/SED and/or a SUD. But more information is needed to assess the effectiveness of this proposal and clear outcomes need to be developed statewide. The hypothesis proposed for this proposal is that the availability of trainings, technical assistance and incentives will strengthen the provision of community-based care and improve outcomes will increase over the course of the demonstration.

Proposal at 16. Yet the evaluation doesn't address outcomes, but merely seeks to review training numbers and participation rates in trainings and in fidelity reviews. *Id.* at 16. If DHCS wants to claim and demonstrate success with these Centers, it needs to look at and measure outcomes of these EBPs based on support from the Centers.

Statewide Incentive Program

We support the statewide incentive program in concept. *Proposal* at 23. It is critical to strengthen counties' quality monitoring infrastructure and ensure counties are equipped to track and report on key measures and demonstrate improved outcomes among Medi-Cal members. We also believe this is important to ensure appropriate implementation of the demonstration features that will be available statewide. Yet the proposal is confusing in terms of being statewide when it states: "Counties that *participate* in the statewide incentive program will be required to reinvest the FFP received through earned incentives into Medi-Cal behavioral health service provision or capacity expansion." *Proposal* at 24. The need for a quality monitoring infrastructure should not be based on county participation if this is described as statewide. This should be clarified and all counties should be required to demonstrate consistent reporting on key quality measures, not just those that elect to. We also recommend HHS require DHCS to utilize the statewide incentive program to support and prioritize availability of behavioral health community-based services over institutional care, and emphasizing quality measures that evaluate effective transitions of care, cultural and race, ethnicity and language responsiveness, and other factors that are determinant for provision of quality behavioral health services in appropriate settings. While we understand that DHCS intends to establish a stakeholder process to determine the specific measures to be evaluated, we would request HHS to require more context and details about what DHCS expects before the this proposal is approved. To date, DHCS has not articulated a hypothesis for this initiative or described how it will be evaluated and instead just seeks funding to incentivize improved performance on key measures not yet defined.

BH-CONNECT Features Available at County Option

We strongly encourage HHS to reject DHCS's proposal to waive statewideness, as discussed further below, and instead work with DHCS to adopt a statewide approach. DHCS's proposal would allow each county to choose whether or not to provide additional covered benefits. But behavioral health delivery system and access problems are a statewide problem and therefore the solutions must be statewide. Individuals should not be penalized with less access to behavioral health services simply because of the county they live in. That is an ongoing approach through the 1115 waiver and 1915(b) waiver which remains a concern and also simply adds to the statewide confusion and complexity about what is available, to whom and where. This proposed demonstration builds on that approach by seeking county by county changes and authorizations that will impact some beneficiaries or populations, but not all.

Further, as discussed above, we oppose the use of Expenditure Authority to ignore the requirements of the Medicaid Act. Again, notwithstanding the legal concerns discussed above, we offer the below comments on the various components of the proposal as a matter of policy.

Restricting Enhanced Community-Based Services to Select Counties

We urge HHS to reject DHCS's proposal to waive statewideness with respect to important behavioral health services. DHCS proposes adding six adult behavioral health services, but limiting the availability of these services to certain counties. These services – Assertive Community Treatment (ACT); Forensic ACT (FACT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Individual Placement and Support (IPS) model of Supported Employment; Community health worker (CHW) services; and Clubhouse services – are core services for any functioning adult mental health system.⁴ In fact, in 2022, the vast majority of states (39) covered ACT via Medicaid.⁵

We are pleased that DHCS intends to submit a state plan amendment to authorize delivery of ACT, FACT, and CSC for FEP, as well as for Clubhouse services. We note that many states cover services such as ACT and FACT as a bundled service without

⁴ See, e.g., Bazelon Center, *Diversion to What?* (2019), http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (describing evidence bases for ACT, supported employment, peer support, mobile crisis, and supported housing).

⁵ Kaiser Fam. Found., *Medicaid Behavioral Health Services: Assertive Community Treatment* (2022), <https://www.kff.org/medicaid/state-indicator/medicaid-behavioral-health-services-assertive-community-treatment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

use of a Section 1115 demonstration.⁶ Similarly, FEP services may be covered as a Medicaid service, under various Medicaid state plan 1905(a) benefit categories.⁷

We commend DHCS for recognizing the effectiveness of CHW services as an essential community-based service to help provide recovery support for populations most in need of enhanced behavioral health services. However, CHW services have already been established as a benefit under the State Plan and are made available statewide.⁸ We recommend that HHS refrain DHCS from categorizing the CHW services as an optional benefit for counties to cover, when CHW services are required to be available as a benefit in all counties through Medi-Cal managed care and fee-for-service.

By categorizing CHW services as optional or adding a “new” or “different” CHW benefits, it would only raise concerns and cause confusion that (a) the CHW services benefit is not already available statewide, and (b) the county MHPs/DMC-ODS plans can deny people with SED/SM/SUDSI access to CHW services by stating that their county decided not to add the benefit. The option to include CHW services would go against state policy since state plan CHW services must be available to all Medi-Cal members, regardless of their condition. DHCS should ensure and reinforce that the counties are providing Medi-Cal members with access to their CHW benefits similar to any other state plan benefit that is not a part of SMHS/SUD. In addition, MCPs can contract with CBOs and FFS providers who focus on providing support to select populations, such as populations with SED/SMI/SUD, by contracting directly with MHPs or SMHS providers. To ensure that Medi-Cal members’ access to CHW services is seamless, we recommend that HHS refrain from allowing DHCS to complicate and divide CHW services by carved out systems. We strongly agree that these services

⁶ For example, even states with Section 1115 waivers, such as the District of Columbia, still cover ACT as a single rehabilitative service, via state plan authority. See D.C. Mun. Regs., tit. 29, § 5210; District of Columbia State Plan Amendment, effective April 1, 2022, <https://www.medicaid.gov/medicaid/spa/downloads/DC-22-0005.pdf>. While many states reimburse ACT in 15 minute increments, Rhode Island covers ACT as a single bundled *monthly* service. Rhode Island State Plan Amendment, effective 12/1/2021, <https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0025-A.pdf>; see also CMS, Dear State Medicaid Director Letter (Aug. 15, 2007) (SMD # 07-011) (guidance on Medicaid reimbursement for peer support services), <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf> (noting state plan authority to cover peer services).

⁷ CMS, NIMH & SAMHSA Joint Informational Bulletin, *Coverage of Early Intervention Services for First Episode Psychosis* (Oct. 16, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>.

⁸ 42 C.F.R. § 440.130(c)(1)–(3); CMS, *Approval Letter for Cal. State Plan Amendment # 22-001* (July 26, 2022), <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf>.



should be available to Californians who need them, which is why they should be (and in fact are already) available statewide.

We note that DHCS still proposes using Section 1115 to request authority to implement the IPS model of Supported Employment. While it may be more difficult to cover supported employment via 1905(a), numerous states have covered supported employment for individuals with serious mental illness via a 1915(i) state plan amendment, which must be provided on a statewide basis.⁹ We have encouraged DHCS to explore this option, which would require the service to be offered statewide.

In short, while DHCS is framing this section of its demonstration as a request to cover additional services, it is in fact a request to restrict coverage of Medicaid services to certain counties. Instead of covering these essential services for all Californians when medically necessary, the proposal would use Section 1115 and 1915(b) waiver authority to restrict their availability. Allowing these services 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, DHCS has not articulated how allowing counties to opt-in to providing these important services constitutes a test of some hypothesis, nor could it. Allowing counties to opt in to providing these services 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.

It is also unclear what the evaluation of this proposed demonstration will be under the waiver. The hypothesis in Table 2 merely states: availability and utilization of community-based behavioral health services will increase over the course of the demonstration. *Proposal* at 16. The evaluation is to merely look at claims data to see who accessed the multitude of community based behavioral health services, including these transitional rent services. *Id.* This simple analysis does not demonstrate anything related to the utility or effectiveness of these services, and does not look at outcomes as a result of getting these services. This does not meet the test of a true novel demonstration or experiment.

⁹ See generally HHS, *Making Mental Health Evidence-based Practices Work for Medicaid Beneficiaries: Supported Employment* (Oct. 2009), <https://eadn-wc03-6094147.nxedge.io/cdn/wp-content/uploads/sites/default/files/Hendler%20Supported%20employment%20and%20Medicaid10--09%20%282%29.pdf> (describing the extent of 1915(i) authority, 1905(a) authority, and managed care authority to pay for supported employment). The District of Columbia, Iowa, Texas, and Ohio all have 1915(i) state plan amendments to provide supported employment to individuals with serious mental illness.

Moreover, the proposal as currently devised will not promote the objectives of the Medicaid Act. As explained above, these services have been demonstrated to be medically necessary for adults with SMI and SUD. 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).

Limiting Medi-Cal members access to services based solely on where they live is plainly inconsistent with this objective. The proposal restricts access geographically solely based on a county’s choice, and not based on member needs, but cloaks the request as a waiver of statewideness, amount, duration, and scope, and comparability. Instead of approving the proposal as submitted which will restrict services to counties that elect to opt-in, we encourage HHS to work with California to instead use Section 1905(a) and 1915(i) state plan authority, in addition to leveraging managed care flexibilities, to cover the aforementioned essential services for all Californians on Medi-Cal with behavioral health conditions who need them.

Moreover, as discussed above, the state already can, and is required to, implement these services through EPSDT statewide for beneficiaries under age 21. HHS must work with DHCS to ensure that all counties are delivering these services to beneficiaries under age 21 when necessary to correct or ameliorate their behavioral health conditions.

Transitional Rent

Housing supports, including services that help individuals find, move into and retain housing, are essential to the treatment and recovery of individuals living with serious behavioral health conditions. We understand housing supports are particularly critical for high-need members who are homeless and living with SMI/SED and/or SUD, especially those at risk of or transitioning out of institutional care or congregate settings, correctional facilities, or the child welfare system.

This request for coverage of up to 6 months of transitional rent for the demonstration period for eligible individuals in the Behavioral Health Delivery Systems essentially mirrors the state's companion request for the Medi-Cal Managed Care Plans. Rather than repeat our comments here again, we urge HHS to review our companion comments to the [transitional rent waiver submission](#) by DCHS that were submitted along with this BH-CONNECT waiver proposal as they address our concerns in more detail.

This proposal should put additional emphasis on pre-tenancy services and tenancy sustaining services.¹⁰ It should also clarify how DHCS will ensure that the necessary behavioral health supports will be provided to ensure these Medi-Cal recipients maintain successful housing, especially when ACT, FACT, CSC for FEP, IPS Supported Employment, CHW services, and clubhouse services are also only going to be available at county option and are all not required to be in place with the transitional rent services.

Last, in the event that HHS approves this demonstration, we encourage HHS to work with California to identify long-term resources to support essential housing. Demonstrations are not intended to last forever, and it would be appropriate for HHS to require California, as a condition of approval, to create a transition plan in the event that the States wants to continue funding this program on a permanent basis.

Short-Term Residential and Inpatient Psychiatric Stays in IMDs

California requests that HHS permit FFP for services provided to enrollees with SMI/SED who are residents of mental health IMDs. As we have repeatedly expressed in the past, NHeLP remains strongly opposed to waiving the IMD exclusion through Section 1115 in all circumstances, but particularly for SMI/SED. For the below reasons, we urge HHS to reject California's IMD waiver request.

Moreover, California is not proposing a genuine experiment. With respect to the proposal to draw down FFP for mental health services in IMDs, this is not a new idea or approach to addressing the needs of enrollees. As we have noted in our previous comments on such waivers, for almost 30 years, HHS has granted states authority to waive the IMD exclusion, despite the illegality of such waivers. The first waiver was

¹⁰ Ctrs. Medicare & Medicaid Servs., *Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)* (2021), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

granted in 1993, and as of 2009, HHS phased out all but one of these projects, precisely because they were no longer “innovative or experimental.”¹¹

Although over the past several years HHS has encouraged states to apply for mental health-related section 1115 waivers that would allow for FFP for services provided in IMDs, HHS has not provided any justification for its change in position.¹² With almost 30 years of 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. Furthermore, the IMD exclusion lies outside of section 1396a, and therefore cannot be waived. 42 U.S.C. § 1315(a)(1). As noted above, 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. Section 1115 does not offer HHS a permanent “back door” to provide funding for settings that Congress explicitly carved out of Medicaid. The Secretary has no legal authority to approve this request.

There are also policy reasons to oppose California’s IMD waiver request. Waiving the IMD exclusion will increase the risk of institutionalization for Medi-Cal beneficiaries with SMI/SED, undermining hard-won civil rights for people with disabilities and decades of federal and state policy initiatives stressing the importance of increasing community integration. We understand and appreciate that California is proposing to tie funding for residential services at IMDs to certain activities to improve access to community-based services, including coverage of the full array of enhanced community-based services that would otherwise be optional for counties. However, the fact remains that the availability of funds for IMDs will likely incentivize the use of these facilities because of the concept of “bed elasticity,” where supply drives demand.¹³ That is, if the beds are available, they will be filled, siphoning resources that could be used to improve and expand community-based services. But when beds are not available, other options adequately meet individuals’ needs.¹⁴

¹¹ 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>.

¹² See HHS, Dear State Medicaid Director Letter, SMD #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf> [hereinafter “SMD #18-011”].

¹³ 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>.

¹⁴ *Id.*



Adding new community-based services, while important, is not sufficient to avoid the risk of institutionalization that waiving the IMD exclusion carries. California faces a long-standing problem regarding lack of community-based mental health providers, even for services that are already covered by Medi-Cal.¹⁵ In our estimation, lack of providers offering community-based services, not lack of residential beds, is the biggest reason why Medi-Cal beneficiaries often face delays in accessing mental health services and commonly go without services altogether. Spending money on large residential mental health institutions, which often provide subpar care at a higher price tag, will only exacerbate the lack of more cost-effective community-based services. California should prioritize heavily investing in efforts to increase mental health community-based provider capacity and availability and the Secretary should incentivize those actions by rejecting the request to waive the IMD exclusion for beneficiaries with SMI/SED.

While our concerns with the proposed IMD exclusion waiver for SMI/SED extend to all Medi-Cal beneficiaries, we are particularly troubled about the impact the proposal could have on children and youth. It has been widely documented that large residential mental health facilities for minors are particularly susceptible to low quality services and instances of abuse in the form of unnecessary and excessive use of restraint and seclusion.¹⁶ What has been less discussed is the fact that waiving the IMD exclusion for children and youth fixes a nonexistent legal problem. Not only is federal funding available for smaller facilities where the risk of harmful institutionalization is lower, but Congress has also specifically allowed states to use federal funding for inpatient psychiatric care in larger institutions for beneficiaries under 21 as part of the optional “psych under 21” Medicaid benefit. Section 1905 permits HHS to define additional settings, beyond hospitals, where individuals under 21 can receive inpatient services, but requires HHS to make this designation via regulation. In turn, HHS—via an extensive regulatory process—created the category of psychiatric residential treatment facilities

¹⁵ See, e.g., Dep’t of Just., Letter to Gov. Janet Mills Re: United States’ Investigation of Maine’s Behavioral Health System for Children Under Title II of the Americans with Disabilities Act (June 22, 2022), <https://www.justice.gov/opa/press-release/file/1514326/download>; See also USA Today, Locked Away Investigation (Nov. 2021), [Kids suffer inside dismal North Carolina psychiatric centershttps://www.usatoday.com › news › nation › 2021/11/10](https://www.usatoday.com › news › nation › 2021/11/10).

¹⁶ Cal. Health Care Found., *Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions* (Sept. 2021), <https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions>; Jocelyn Wiener, Unanswered Cries: Why California Faces a Shortage of Mental Health Workers (Sept. 8, 2022), <https://calmatters.org/health/2022/09/california-shortage-mental-health-workers>; Hum. Rts. Watch, *Children with Disabilities: Deprivation of Liberty in the Name of Care and Treatment*, (Mar. 7, 2017), <https://bit.ly/3FW9Ihb>.

(PRTFs) PRTFs are the *only* type of large standalone non-hospital residential setting where FFP is allowed. 42 C.F.R. § 441.151.

Because California has adopted the “psych under 21” benefit, Medi-Cal beneficiaries under 21 may already receive inpatient and residential mental health care. As publicly expressed by supporters of increased residential bed availability, the only thing standing in the way of access to these services was California’s failure to establish the parameters for PRTFs within the State. That concern is no longer at issue since Governor Newsom signed AB 2317 into law last year, enabling the establishment, licensing, and regulation of these facilities. We fail to comprehend what an IMD exclusion waiver for children and youth with SMI/SED will achieve that the establishment of PRTFs within the State, which stands on much firmer ground under federal Medicaid law, will not achieve.

We also oppose the request to exercise flexibilities regarding average and maximum length-of-stay requirements as applied to children and youth involved in the child welfare system and who reside in STRTPs that are Qualified Residential Treatment Programs (QRTPs). Children do best in family-like settings, and the harm from ongoing institutionalization of children has been well-documented.¹⁷ If children must be placed in inpatient or residential settings, their length-of-stay should be minimized; we are unaware of any literature supporting the contrary assertion. California has offered no reasons why it wants to permit long-term stays and what problem the State is seeking to address. We do not believe such authority is appropriate or necessary and believe existing provider efforts to reduce the size of STRTP facilities (to under 16 beds) and other efforts to keep foster children and youth in family and community settings instead of group residential care is the direction the State should be pursuing instead. Addressing the gaps in community based behavioral health services for foster youth is the best way to do that.

Finally, we are deeply concerned about the effect that the proposed IMD policy could have on non-IMD counties’ decision on whether to participate in the expansion of

¹⁷ American Academy of Pediatrics, et al, *The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care* (Jan. 18, 2022), <https://familyfirstact.org/sites/default/files/QRTP%20and%20IMD%20One%20Pager.pdf>; Think of Us, *Away From Home Youth Experiences of Institutional Placements in Foster Care* (July 2021), https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; Philip S. Goldman et al., Institutionalization and Deinstitutionalization of Children 2: A Systematic and Integrative Review of Evidence Regarding Effects on Development, 4 *Lancet Psychiatry* 606, 609 (Aug. 2020), <https://bit.ly/465xqCs>.

mental health services. Since counties would have the option to adopt IMD and other mental health services coverage, counties will likely have an incentive to decline the expansion of services and instead send beneficiaries to IMDs in counties that are participating in the program. This result will essentially amount to out-of-county patient dumping and a way for counties to avoid their responsibility towards beneficiaries.

For all the legal and policy reasons outlined above, we ask HHS to reject California's request to use FFP for beneficiaries with SMI/SED residing in IMDs.

Incentive Program for Opt-In Counties

NHeLP generally supports the goals of the opt-in incentive program component of the demonstration, despite relying on expenditure authority. We agree that effectively rolling out new behavioral health community based services will require significant investment and resources to evaluate outcomes and quality of care in each county. Moreover, we are encouraged to see this part of the demonstration emphasizing investment in community-based services and we believe this opportunity provides an important, albeit not absolute, check on potential overutilization of institutional treatment in IMDs.

However, as with other non-IMD components of the proposed demonstration, we strongly object to making the incentive program optional for counties. Following our recommendation that California require all counties to provide enhanced community-based behavioral health services, we similarly urge HHS to require that this particular incentive program be extended to all counties in order to provide sufficient funding and resources for infrastructure development and quality evaluation as the services are rolled out. In fact, we believe California should combine the opt-in incentive program with the proposed statewide incentive program.

Conclusion

Thank you for considering our feedback. Please do not hesitate to contact me (lewis@healthlaw.org) should you have any questions.

Sincerely,



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