July 6, 2018

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

The Bazelon Center for Mental Health Law submits these comments in response to Tennessee's Demonstration Amendment #35 1115 Wavier Application. The Bazelon Center is a national non-profit legal advocacy organization that promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, community living, housing, education, employment, voting, and other areas. Our comments focus on the lack of substantive elements to the application such that it fails to meet the requirements for an 1115 waiver.

Tennessee's proposal is not an experiment, pilot, or demonstration of the sort contemplated by the Medicaid statute.

Tennessee's waiver application does not meet the basic requirements for 1115 demonstrations and should be rejected. 1115 demonstrations must contain clearly defined goals, identify a specific problem that is being addressed, have a reasonable basis to believe that the demonstration is likely to address the problem effectively and without harm, and put measures in place to ensure that individuals are not harmed. Tennessee's application does none of the above.

Tennessee's frustration with the financing changes in the 2016 managed care regulations is not a basis for approving ae Section 1115 demonstration simply to allow coverage of services that the state is no longer permitted to cover through the "in lieu of" authority.[1] CMS has provided clear guidance on utilizing 1115 demonstrations to pay for substance use disorder (SUD) services in institutions for mental diseases (IMD) since July 2015.[2] This Administration revised that guidance last year, to streamline the process while also including goals and milestones that states should include in any application.[3] Tennessee's application includes none of the required information.

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[1] Tennessee, Division of TennCare, *TennCare II Demonstration (No. 11-W-00151/4), Amendment #35 Application*, 1 (May 25, 2018) (hereinafter Tennessee Waiver Application), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa3.pdf.

[2] Centers for Medicare & Medicaid Services, *Dear State Medicaid Director Letter Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder, SMD # 15-003* (Jul. 27, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf.

[3] Centers for Medicare & Medicaid Services, *Dear State Medicaid Director Letter RE: Strategies to Address the Opioid Epidemic, SMD # 17-003* (Nov. 1, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

1101 15th St. NW Suite 1212 Washington, DC 20005 P: 202.467.5730 TDD: 202.467.4232 F: 202.223.0409 www.bazelon.org

We also point out that the state itself acknowledges that it "is essentially requesting to maintain coverage of the same continuum of behavioral health care services that it previously offered under the "in lieu of" authority prior to the issuance of the 2016 managed care rule."[4] This is not an experiment, pilot, or demonstration. This is effectively a request to continue a prior practice that has been disallowed.

In addition, it is completely unclear from the application that Tennessee has even identified a problem. In the 2016 final managed care rule, CMS based the length of time restriction for IMD coverage on evidence showing that "the average length of substance use disorder inpatient stays was 5.9 days, and that over 90 percent of inpatient substance use disorder stays were 10 days or shorter."[5] Tennessee does not discuss what average length of stay is in the state—in fact, the state provides no data in the application beyond the approximate number of Medicaid and demonstration eligibles in Tennessee. The state also fails to discuss any of the important issues required in the Trump Administration's guidance, including any discussion of "how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state."[6] This is crucially important, as the Administration has pointed out, since "many people who receive acute care for withdrawal management do not become engaged in any form of treatment following discharge … [and] consequences of not engaging in treatment are rapid readmission to an intensive care facility and increased risk of overdose as an individual's acquired tolerance is lessened by withdrawal management therapies."[7] Tennessee's general assertions that the state maintains "sufficient" continuum of care does not address this concern nor is it responsive to the Administration's clear outline of what is required in a 1115 demonstration application on this particular subject.[8]

This is also entirely insufficient under the statutory requirements for an 1115 waiver application and Tennessee's waiver proposal should be denied.

Respectfully submitted,

Jennifer Mathis
Director of Policy and Legal Advocacy
jenniferm@bazelon.org

Bethany Lilly
Deputy Director of Policy and Legal Advocacy
bethanyl@bazelon.org

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[4] Tennessee Waiver Application, *supra* note 1, at 3.
[5] Centers for Medicare & Medicaid Services, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule*, 81 Fed. Reg. 88 (May 6, 2016).
[6] SMD # 17-003, *supra* note 4, at 2.
[7] *Id*. at 4.
[8] *See id*. at 5-11.