JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

August 17, 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 Rhode Island's Comprehensive Section 1115 Demonstration Waiver 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 Rhode Island's proposal to waive the institutions for mental diseases (IMD) exclusion[1] in its entirety and the application's failure to include any analysis of the need for and appropriateness of the requested waiver.

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

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. Rhode Island's waiver application does not meet the basic requirements for 1115 demonstrations and should be rejected.

Contrary to the state's assertion that "Federal financial participation is not available for services provided to people between the ages of 22 and 64 years even if they are otherwise Medicaid eligible," CMS made clear in the 2016 Medicaid Managed Care rule that it would allow FFP for Medicaid managed care enrollees to receive services during short-term stays in IMDs providing mental health or SUD inpatient or crisis residential services.[2] CMS also provided clear guidance

[1] Rhode Island, Executive Office of Health and Human Services, *The Rhode Island 1115 Waiver Extension Request (Project No. 11-W-00242/1)* (July 11, 2018) (hereinafter Rhode Island Waiver Application), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-pa2.pdf.

[2] 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). When CMS proposed the limited exception to the IMD rule in 2015, we commented that the exception was inconsistent with the Medicaid statute. As CMS acknowledged in its proposed Medicaid Managed Care rule, Title XIX's statutory IMD exclusion prohibiting federal financial participation (FFP) for services provided to individuals 21-64 in IMDs is a "broad exclusion" and it is "applicable to the managed care context." While 42 U.S.C. § 1396(n)(b)(3) permits states to offer Medicaid beneficiaries "additional services" not covered under the state plan if they realize cost savings through managed care, the

on utilizing 1115 demonstrations to pay for substance use disorder (SUD) services in since July 2015[3] and this Administration revised that guidance last year in response to the opioid epidemic, to streamline the process while also setting forth goals and milestones to be included in any application for a Section 1115 demonstration waiver.[4]

Rhode Island's request to waive the IMD exclusion ignores these clear parameters laid out in guidance and regulation and "seeks to waive this IMD exclusion for persons who have mental health or substance use disorders and are participating in residential treatment programs with a census of 16 or more beds."[5] It is beyond dispute that the Medicaid statute does not permit the sweeping waiver of the IMD exclusion requested by the state and CMS should reject this part of the application.

Rhode Island's Application Does Not Reflect Current Evidence-Based Practices or Mental Health Recovery Principles

Rhode Island's application also fails to incorporate evidence-based practice and basic concepts of recovery. The state's assertion that "[e]ven with today's advanced medications and the best available outpatient treatment services, a small but **significant** number of persons with psychiatric illnesses are treatment-resistant and require residential and institutional psychiatric care" reflects an outdated and regressive view at odds with modern mental health systems.

Moreover, the state does not provide any information, data, or analysis of its mental health service system to demonstrate why its requested waiver of the IMD rule is necessary. The application does not indicate whether there is sufficient access to the core community services such as Assertive Community Treatment, supported housing, peer support services, and mobile crisis teams. These services reduce inpatient admissions and should be available to those who need them before developing additional inpatient capacity. Inpatient beds are not a substitute for a community service system that is insufficiently resourced; using them in this way would violate the Supreme Court's *Olmstead* decision and would entail needless costs as well as damage to people's lives.

In fact, Rhode Island's shortage of community-based mental health services has been repeatedly documented. A 2015 report to the state by Truven Analytics stated:

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capitation payments for such "additional services" include FFP and thus cannot pay for services for individuals 22-64 who reside in an IMD, as the statute explicitly forbids FFP for such services. The statute does not say that FFP for individuals staying short times in IMDs is permitted; it prohibits FFP for individuals 21-64 residing in IMDs. CMS disagreed and included the exception in its final rule. We continue to believe our statutory analysis is correct. Regardless, what Rhode Island proposes goes far beyond the limited exception that CMS has read into the statutory IMD rule.

[3] 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.

[4] 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.

[5] Waiver Application, *supra* note 1, at 54.

> Although Rhode Island has invested significantly in hospital care for the behavioral health population, the state's mental health agency budget per capita is one of the smallest in the nation and lowest among the New England States. It has no Assertive Community Treatment (ACT) teams. Among Rhode Island Medicaid beneficiaries who were hospitalized for a mental illness, one in five had no follow-up mental health treatment in 30 days. Furthermore, there are not enough mental health professionals working in some of Rhode Island's FQHCs.[6]

The Truven report recommended "[S]hifting the financing of services towards evidence-based and promising practices that facilitate better care coordination and are community based, which will help avoid high-cost hospitalizations."

The unavailability of community services remains a problem. In 2017, a report by Rhode Island state senators concerning the mental health system indicated:

> Numerous barriers to care exist, including many patients' and families' feeling of shame and stigma, a **shortage of mental-health service professionals and community services**, a lack of integrated physical and behavioral care, and the need to continuously train first-responders and educators to identify mental health crises.[7] (emphasis added)

Even if the Medicaid statute permitted the type of waiver of the IMD rule requested by Rhode Island, CMS should not approve such a waiver in light of the state's failure to develop the community services that would prevent the need for expansion of IMD beds.

The application also lacks important information about the need to waive the IMD rule for residential SUD providers. It is unclear, for example, if the nine residential providers mentioned in the application provide access to all three types of Medication Assisted Treatment (MAT). The state does not specify, although not even half of residential treatment facilities in the United States provide even one form of MAT. Nor does the proposal discuss the "Medicaid-funded services and supports required for people to make successful transitions back to the community" in any detail, as required by the statutes governing 1115 research and demonstration waivers.

We also note that the state mischaracterizes the purpose of the IMD exclusion—while Congress partially enacted the rule to reflect "its view that serving individuals in mental institutions was a state responsibility," the IMD exclusion also "reflected congressional intent to promote a shift toward community-based services."[8] Rhode Island does not have sufficient community capacity. Consistent with the Americans with Disabilities Act, the *Olmstead* decision, and good practice,

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[6] Truven Analytics, *Rhode Island Behavioral Health Project: Final Report* (Sept. 15, 2015) ,at 24, http://www.bhddh.ri.gov/mh/pdf/Truven%20Rhode%20Island%20Behavioral%20Health%20Final%20Report%209%2015%202015.pdf.

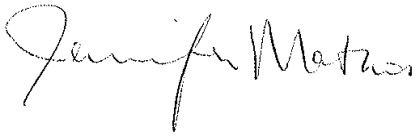
[7] G. Wayne Miller, *Senate Plan Aims to Reform Troubled Mental Health System in R.I.*, Providence Journal, Feb. 15, 2017, http://www.providencejournal.com/news/20170215/senate-plan-aims-to-reform-troubled-mental-health-system-in-ri.

[8] Scattergood Think Do Support, Peg's Foundation, Jennifer Mathis, *Medicaid's Institutions of Mental Diseases (IMD) Exclusion Rule: A Policy Debate* (Spring 2018), http://www.scattergoodfoundation.org/sites/default/files/IMD_Exclusion_Rule_Debate_053118.pdf.

no waiver of the IMD rule—including a partial waiver—should be approved while community-based services are insufficiently available.

The State also misunderstands the Mental Health Parity and Addiction Equity Act (MHPAEA). The federal government's choice to incentivize states to increase and provide sufficient community-based services, like other payment rules designed to reduce usage of hospitals or emergency rooms, is not a parity violation. Indeed, inadequate access to community-based services both before and after a behavioral health crisis, and needless institutionalization, discriminate against people with behavioral health conditions.

Respectfully submitted,



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