JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

July 11, 2019

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 the District of Columbia's Section 1115 Medicaid Behavioral Health Transformation Demonstration Program 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. We strongly support much of the District's proposed demonstration waiver, including expansion of key community-based services, but we are deeply concerned about the proposal to cover IMD services.

**The Proposal Includes Important Improvements to the District's Community Service System**

We strongly support some of the proposed changes to community-based services. In particular, we support the addition of coverage for vocational supported employment services, coverage of mobile crisis services, recovery support services for individuals with substance use disorders (SUD), and transition planning services to enable behavioral health providers to participate in discharge planning for individuals leaving inpatient, residential, criminal justice or other institutional settings. These services are critically important for individuals with significant psychiatric disabilities and/or SUD. We also support the proposed removal of cost-sharing for prescription drugs associated with Medication Assisted Treatment; as the District notes, removing barriers to accessing these medications is important. We urge CMS to require that the District use the Individual Placement and Support (IPS) approach for the supported employment services covered, to ensure that these services are effective; as far as we are aware, only one provider, Pathways to Housing, currently provides IPS in the District. With respect to residential crisis stabilization services, CMS should ensure that these services be delivered in small settings, consistent with the Americans with Disabilities Act (ADA) and the *Olmstead* decision.

## CMS Lacks Authority to Grant the Proposed Waiver of the IMD Rule for Acute Mental Health Services

First, we believe that CMS lacks authority under Section 1115 of the Social Security Act to approve waivers of the Medicaid statute's IMD rule, despite CMS's guidance to the contrary. Section 1115 of the Social Security Act permits waiver of particular, listed provisions of the Medicaid statute. The IMD rule is not among them. In light of the clear statutory prohibition on federal financial participation for services provided to individuals 22-64 in IMDs, CMS has no authority to grant the District's request.[1]

In any event, the District's proposal to cover IMD services fails to meet the requirements of CMS's November 2018 guidance concerning waivers of the IMD rule. That guidance provides that Section 1115 waivers of the IMD rule will only be granted to cover stays averaging no more than 30 days. While the District notes in its application that it is not requesting reimbursement for "long-term residential and long-term inpatient IMD stays,"[2] it admits that it "is not proposing a cap on IMD length of stays" but simply offers its view that "medically appropriate treatment of acute stays, in the aggregate, will average under thirty (30) days across eligible IMDs."[3] It offers no assurance that the waiver will not be used to finance longer stays.

## Evidence Does Not Support Expanding Federal Funding for Individuals in IMDs to Ensure Access to Appropriate Mental Health Care

Allowing federal reimbursement for care provided in IMDs would encourage overreliance on expensive and ineffective mental health services. It would be particularly damaging to the District of Columbia's ability to rebuild the community capacity needed in its behavioral health system for the District to expand institutional services. A review of the District's community services that surveyed adult consumers found declines in every practice indicator between the 2014 and 2016 fiscal years, with overall practice performance declining by 26% during that

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[1] As CMS acknowledged in its proposed Medicaid Managed Care rule in 2015, 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 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. Similarly, CMS's expenditure authority and authority to approve coverage of services "in lieu of" covered services are limited by the clear statutory ban. 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.

[2] District of Columbia, *District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program* 18 (June 3, 2019) (hereinafter DC Application).

[3] DC Application 33.

period.[4] Among growing core service agencies the decline in performance is particularly troubling, dropping from 78% in the 2014 fiscal year to 21% in the 2016 fiscal year.[5]

Although these findings in the District's own reports show a need for improvement in community services, the District reported a decrease in mental health service expenditures of nearly $12 million in fiscal year 2018.[6] The District already invested proportionally less in community services than the country as a whole in 2017 according to data reported to SAMHSA, with community health expenditures accounting for 66.7% of the state mental health agency's (SMHA) expenditures, compared to a U.S. average of 76.9%.[7] Along with its low rate of investment in community services, DC also has higher percentage of its population utilizing community-based services,[8] which suggests that the District's community service system is significantly under-resourced.

The District states that advocates and providers report that individuals being discharged from emergency rooms and general hospitals need more support or follow-up to ensure a smooth transition to the community, and thus more psychiatric hospital beds are needed. We note, however, that the federally mandated Medicaid Emergency Psychiatric Demonstration recently conducted found that providing federal reimbursement for short-term IMD stays did not result in improved follow-up care, nor did it decrease emergency department admissions or inappropriate general hospital admissions.[9] Expanding "residential and inpatient"[10] treatment in IMD settings will almost certainly limit the District's ability to expand community services and contribute to over-reliance on institutional care. Moreover, as CMS has indicated that it will not approve Section 1115 demonstration waivers unless they are cost neutral for the federal government, the additional federal spending on IMD services would mean reduced federal spending on other services. Investment in community services should be the District's focus.

The past fifty years have seen a clear and deliberate public policy shift away from the historic overreliance on psychiatric institutions and increase investment in community mental health services that reduce the need for psychiatric hospitalization and are more cost-effective. States have shifted resources away from psychiatric hospitals and toward community-based services for

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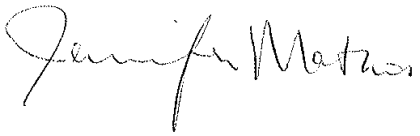
[4] District of Columbia Dep't of Behavioral Health, *FY 16 Adult Community Services Reviews Report* (Feb. 9, 2017) (hereinafter FY 16 Community Services Report), https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Adult%20Community%20Service%20Reviews%20Report%20FY%202016.pdf.
[5] FY 16 Community Services Report.
[6] District of Columbia Dep't of Behavioral Health, *Mental Health and Substance Use Report on Expenditures and Services* 13 (January 2019), https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20FY18.pdf.
[7] SAMHSA URS.
[8] SAMHSA URS (36.45 per 1,000 DC residents utilize community services, versus 22.37 per 1,000 in the U.S. on average).
[9] Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report* (Aug. 18, 2016), at 27, 37-51, 77.
[10] DC Application 4.

two reasons: (1) a recognition that many individuals served in psychiatric hospitals would receive better care and achieve recovery in home and community-based settings, and (2) an effort to come into compliance with the Americans with Disabilities Act's (ADA's) integration mandate and the Supreme Court's *Olmstead* decision, which require states to offer individuals with disabilities the opportunity to receive services in the most integrated setting appropriate.

To the extent that is difficult for individuals to access psychiatric hospital beds, building a well-functioning community system that has the capacity to resolve crises without hospitalization, that addresses mental health needs early to prevent needless hospitalizations, and that enables the earlier discharge of individuals from psychiatric hospitals, is widely recognized as an important solution. The District of Columbia should instead focus on building up the community services included in its application and other such community-based intensive mental health services that are a better use of federal dollars.

We appreciate the opportunity to provide comments on the District of Columbia's application. Our comments include citations to supporting research, including direct links for the benefit of HHS in reviewing our comments. We direct HHS to the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Respectfully submitted,



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