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VIA EMAIL

May 31, 2019

Erin McMullen
Medicaid & CHIP Payment & Access Commission
1800 M Street NW
Suite 650 South
Washington, DC 20036

Re: Request for Comments for IMD ADDITIONAL INFO Act Mandated Report

Dear Ms. McMullen:

Thank you for the opportunity to provide input on Institutions for Mental Diseases (IMDs) receiving Medicaid payments. The National Health Law Program (NHeLP) is a public interest law firm working to protect and advance the health rights of low-income and underserved individuals. Founded in 1969, NHeLP advocates, litigates, and educates at the federal and state levels. Consistent with its mission, NHeLP works to ensure that all people in the United States have access to affordable, quality health care, including comprehensive behavioral health services.

As part of Support for Patients and Communities Act of 2018 (Support Act), Congress requested MACPAC report on IMDs, and consult with stakeholders in doing so. Congress requested specific information, including but not limited to: the contexts in which federal financial participation (FFP) is available for services provided Medicaid enrollees in IMDs; the discharge process and availability of outpatient services; state certification and licensure requirements for IMDs; and any "recommendations for policies and actions by Congress and the Centers for Medicare & Medicaid Services, such as on how State Medicaid programs may improve care and improve standards and including a

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recommendation for how the Centers for Medicare & Medicaid Services can improve data collection from such programs to address any gaps in information."[1]

The report is mandated by Subtitle B of the Support Act, which is entitled the "IMD ADDITONAL INFO Act"). The legislative history of the IMD ADDITONAL INFO Act suggests that Congress directed MACPAC to undertake this study based on a concern that the IMD exclusion creates barriers to residential services for individuals with opioid use disorder (OUD).[2] While NHeLP shares Congress' goal of increasing timely access to appropriate care for individuals with OUD, we are concerned that policymakers and legislators often focus on the IMD exclusion as the barrier to OUD treatment, to the exclusion of the many other state and federal policy choices that contribute to barriers in services. As MACPAC recognized:

> While policymakers have focused on the role played by the Medicaid payment exclusion for institutions for mental diseases (IMD) in creating gaps in residential SUD services, the IMD exclusion is not the only reason gaps in coverage exist. Many states do not take advantage of the various legal authorities available to them, such as the state plan rehabilitation option and the health home option, to expand their SUD treatment benefit. These policy choices reflect a variety of factors, including budgetary constraints.[3]

The IMD exclusion has ramifications far beyond residential treatment for OUD. Changing the IMD exclusion could lead to unintended consequences and new crises. It is within this context that we offer the following propositions to guide MACPAC's analysis and recommendations to Congress:

1. The IMD exclusion is a specific limitation on where services are provided, not on what services are provided. Any discussion must be take into account the history

[1] Pub. L. No. 115-271, Section 5012 (The IMD ADDITIONAL INFO Act).
[2] H.R. REP. NO. 115-717, at 3-4 (2018), https://www.congress.gov/115/crpt/hrpt717/CRPT-115hrpt717.pdf.
[3] Medicaid & CHIP Payment & Access Comm'n, Report to Congress on Medicaid and CHIP, Chapter 4: Access to Substance Use Disorder Treatment in Medicaid, 81 (June 2018), https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf.

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and purpose of the IMD exclusion, and the role it has played in preventing unnecessary institutionalization.
2. The various ways in which states currently obtain FFP for services providing in IMDs are highly problematic. Specifically, Section 1115 demonstration waivers that waive the IMD exclusion exceed the Secretary's statutory authority, and greater oversight is needed for services provided in IMDs via Medicaid Managed Care.
3. Changes to the IMD exclusion may jeopardize discharge planning and access to community-based services. Any proposed changes must anticipate and address such consequences, and protect the right to community integration.
4. Federal regulation and standards are essential for any behavioral health setting for which FFP is available, but regulations must be sensitive to the wide variety of settings that can be considered an IMD and the needs of the different populations served.

Any proposed changes to the IMD exclusion should be made with the utmost caution, and without undermining the purpose and history of the IMD exclusion, the important role it has played in preventing unnecessary institutionalization, and different needs of the various populations served in IMDs. Below, we provide information to address Congress' specific requests and resources to assist MACPAC with its mandate.

I. History of the IMD Exclusion: Encouraging States to Transition Provision of Services to Smaller Settings

As you are aware, an IMD is not a service, nor is the IMD exclusion a prohibition on payment for any specific kind of service. Instead, it is a limitation on <u>where</u> services are provided. States cannot obtain FFP for services provided to any individual under age 65 in a "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[4] While the statutory definition of IMDs only prohibits federal funding of services for residents of institutions "primarily engaged in providing diagnosis, treatment, or care of persons with mental

[4] 42 U.S.C. § 1396d(i). Exceptions to this general rule exist, and FFP is also available for youth under age 21 in specific delineated settings that would otherwise be considered an IMD. *See infra* notes 9-10.

diseases," HHS has interpreted this exclusion to include facilities that provide SUD treatment.[5]

The IMD exclusion does not prohibit states from providing mental health or SUD services. A state can receive FFP for providing the same mental health or SUD service available in an IMD as long as it is in a smaller setting. As MACPAC previously noted,

> States can cover all of the levels of care described in the ASAM [American Society of Addiction Medication] criteria through their state plan. However, many states do not do so, resulting in gaps in coverage for partial hospitalization and residential treatment in particular. Barriers to care often extend beyond the IMD exclusion.[6]

While the IMD exclusion does not prohibit a state from providing services, it has encouraged states to invest in community-based services and smaller settings. The IMD exclusion has existed since 1950, and was originally part of the Social Security Act. When Medicaid was established in 1965, this exclusion was incorporated into Medicaid, against the backdrop of an unprecedented rise in the rate of individuals confined to institutions with horrendous conditions.[7] The IMD exclusion reflects a Congressional determination both that these institutions are a state responsibility, and that it is appropriate for Congress to encourage community-based alternatives to large residential settings.[8] Congress reaffirmed its intent to encourage states to move away

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[5] CMS, STATE MEDICAID MANUAL § 4390.

[6] Medicaid & CHIP Payment & Access Comm'n, Report to Congress on Medicaid and CHIP, Chapter 4: Access to Substance Use Disorder Treatment in Medicaid, 97 (June 2018), https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf.

[7] Ari Ne'eman, *Another Tragedy, Another Scapegoat*, THE AMERICAN PROSPECT (Feb. 27, 2018), https://prospect.org/article/another-tragedy-another-scapegoat#.Wpf4lriOn61.facebook; CMS, STATE MEDICAID MANUAL § 4390.

[8] Medicaid was established in 1965, just two years after the Community Mental Health Centers Act of 1963 was passed. Even as Congress allowed for federal funding for individuals over 65 in IMDs, the legislative history suggests that Congress also wanted to encourage community-based alternatives to residential and custodial settings. See Comm. on Finance, S. Rep. 404 to accompany H.R. 6675, at 146 (June 30, 1965), https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%202.pdf ("The committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order make certain that the planning required by the committee's bill will become a part of the overall State mental health planning under the Community Mental Health Act of 1963, the committee's bill makes approvability of the State's

from large institutions and to invest in smaller facilities and community-based settings in 1988, when it amended the Medicaid Act to permit federal financial participation for services to individuals in facilities with 16 or fewer beds.[9] Exceptions and carve outs to the IMD exclusion exist, but the exclusion still serves Congress' initial purpose of pushing states to focus on community-based alternatives in integrated environments.[10]

II. Contexts in Which FFP is Available and States' Use of Waivers to Fund IMD Services

There are four primary ways states have obtained FFP for IMD services. First, states temporarily obtained FFP for IMDs through a demonstration program created by Section 2707 of the Affordable Care Act (no longer in effect).[11] Second, some states use

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plan for assistance for aged individuals in mental hospital dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program-including utilization of community mental health centers, nursing homes, and other alternative forms of care."). Even for individuals over 65, IMDs were never intended to be long-term placements, and the state option to receive FFP for service to enrollees over age 65 in IMDs was conditioned on a state showing "that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental disease." 42 U.S.C. § 1396a(21).

[9] Jeffery Buck, Dep't Of Health & Human Servs., HCFA Pub. No. 03339, *Medicaid and Institutions for Mental Disease: Report to Congress II-3* (Dec. 1992), https://babel.hathitrust.org/cgi/pt?id=mdp.39015034439359;view=1up;seq=19.

[10] For example, federal financial participation is available for services for individuals under age twenty-one in inpatient psychiatric hospitals and other settings designated by HHS, 42 U.S.C. §§ 1396d(a)(16), 1396d(h). Payment is also available to managed care organizations (MCOs) for enrollees in IMDs for up to 30 days. 42 C.F.R. § 438.6(e) (allowing payments to MCOs for up to 15 days in an IMD in any given month and permitting two consecutive months, meaning payment for an enrollee could be made for up to 30 consecutive days). Congress has also enacted a temporary state option (up to 5 years) for states to lift the IMD exclusion for a small subset of facilities used to treat SUD. In order to be eligible for this last option, a state must ensure that the facility implements evidence-based practices, provides access to Medication Assisted Treatment, and adheres to a strict maintenance of effort requirement regarding community based services. 42 U.S.C. §§ 1396d(a)(30)(B); 1396n(l).

[11] Section 2707 of the Affordable Care Act authorized a three-year IMD demonstration, which specifically examined whether waiving the IMD exclusion would decrease the wait time for individuals presenting in EDs to access inpatient care. The study suggests that funding inpatient institutional beds increased federal costs without increasing accessing care, but the authors also urged caution, noting that "[d]ata limitations prevent us from drawing strong conclusions about the effect of MEPD on access to inpatient care, length of stays, ER visits, and costs." Crystal Blyer, *et al*, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf.

disproportionate share hospital payments to pay for IMDs.[12] Third, for over twenty-five years, states have received Section 1115 demonstration waivers to receive FFP for services provided to residents IMDs, even though these waivers are beyond the Secretary's authority to approve. Last, starting in 2016, federal regulations authorized states to make capitated payments to Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Programs (PIHPs) that offer IMD services for up to 15 days per month.

The comments below highlight concerns with, and opportunities for, increased oversight and regulation regarding two common ways states obtain FFP for services in IMDs: Section 1115 demonstration waivers and MCO contracts.

A. IMD Waivers Exceed the Secretary's Authority

While states have a long history of funding IMDs via Medicaid Section 1115 demonstration waivers, the Secretary does not have the authority to grant waivers of the IMD exclusion.[13]

Section 1115 allows HHS to waive some requirements of the federal Medicaid Act so that states can test novel approaches to improving medical assistance for low-income individuals. Section 1115 authorizes HHS to waive only those requirements found in 42 U.S.C. § 1396a.[14] Requirements found outside of 42 U.S.C. § 1396a cannot be waived. The IMD exclusion is contained in 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i), and therefore cannot be waived.

Moreover, all Section 1115 demonstration waivers must be limited to the extent and time period needed to carry out the experiment or demonstration, and must also promote Medicaid's objectives, which are to furnish medical assistance and rehabilitation and other services to eligible individuals. This means that states must conduct a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money

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[12] MaryBeth Musumeci, Kaiser Family Found., *Key Questions About Medicaid Payment for Services in "Institutions for Mental Disease"* (June 18, 2018), https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/
[13] 42 US.C. § 1315.
[14] HHS has argued that Section 1115(a)(2) creates an independent "expenditure authority," but this interpretation flatly misreads the statute. Section 1115(a)(2) does not give the Secretary an independent, unlimited power to ignore, waive, impose, or re-write Medicaid program features, including the IMD exclusion. Section 1115(a)(2) merely provides for federal reimbursement of necessary expenditures for a project that already qualifies for a waiver.

through a Section 1115 demonstration waiver; the state must seek to “test out new ideas” and ways of addressing problems faced by enrollees.

For the past twenty-five years, states have obtained authority to waive the IMD exclusion, despite the illegality of such waivers. The first waiver was granted in 1993, and by the early 2000s nine states had 1115 demonstration waivers to fund IMDs for psychiatric treatment, including Arizona, Delaware, Maryland, Massachusetts, New York Oregon, Rhode Island, Tennessee, and Vermont.[15] Some states only covered individuals at certain hospitals or for a set number of days—others were broader. As of 2009, CMS phased out all but one of these projects, precisely because they were no longer “innovative or experimental.”[16]

Notwithstanding the lack of authority of CMS to waive the IMD exclusion, and the fact that such waivers are not innovative or experimental and therefore should not be allowed, there has been a recent renewed effort to obtain such waivers. A new wave of applications started in 2015, when CMS published a Dear State Medicaid Director letter stating that states can apply for such waivers to enable FFP for inpatient SUD treatment in IMDs, and again in 2017 when CMS inappropriately loosened requirements for obtaining such a waiver.[17] Currently, there are twenty-one states using 1115 demonstration waivers to fund SUD treatment, with an additional seven states with pending waivers.[18] In 2018, CMS invited and encouraged states to apply for mental health-related Section 1115 demonstration waivers without any justification for changing its position. In fact, CMS made no mention of the long history of such waivers from the 1990s nor gave any explanation as to why the current waivers would meet Section 1115’s threshold requirement of being “innovative or experimental.”[19]

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[15] 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/products/GAO-17-652.
[16] *Id.*
[17] CMS, Dear State Medicaid Director Letter (July 27, 2015) (SMD # 15-003) (New Service Delivery Opportunities for Individuals with a Substance Use Disorder), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf; CMS, Dear State Medicaid Director Letter (Nov. 1, 2017) (SMD # 17-003) (Strategies to Address the Opioid Epidemic), https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.
[18] Kaiser Family Found., *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* (Apr. 18, 2019), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.
[19] CMS, Dear State Medicaid Director Letter (Nov. 13, 2018) (SMD # 18-011) (Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf; U.S. Gov. Accounting Office, *States Fund Services for*

Furthermore, critical questions regarding the waivers of the 1990s remain unanswered, such as: Did such waivers actually expand access to treatment or did they simply supplant state funds with federal funds? Was there an impact on the availability of community-based services? What was the average length of stay and what factors influenced the length of stay? What were the outcomes for individuals who received services in the IMD, including re-hospitalization rates and involvement in the criminal justice system? To our knowledge, no comprehensive analysis of the outcomes of these demonstrations was done nor has it been cited as a reason to encourage states to seek such waivers once again. MACPAC must highlight this gap in knowledge.

These Section 1115 demonstration waivers are no longer "experiments." With more than twenty-five years of these waivers, the questions above should be readily answerable and the data should be made available and summarized by CMS. At a minimum, it would be prudent for MACPAC to call on law and policymakers to halt changes to the statutory IMD exclusion itself or efforts to loosen the IMD waiver process, until such detailed analysis is undertaken and publicly reported. This would allow policymakers and legislators to glean any benefit from the numerous previous experiments and gather lessons learned before determining if any changes are necessary.

MACPAC should use this opportunity to: 1) raise important questions about the Secretary's lack of legal authority to grant waivers to the IMD exclusion given the limits of Section 1115, 2) acknowledge the major gaps in knowledge regarding the results of earlier mental health waivers, and 3) recommend analysis of the extensive history of IMD waivers prior to any additional discussion regarding legislative or policy changes.

B. Greater Oversight is Needed for Managed Care "In Lieu of" Services Provided in IMDs

In 2016, HHS finalized a rule allowing states to make payments to MCOs and PIHPs for enrollees who stay up to 15 days per month in an IMD. In doing so, HHS also formalized a long-standing policy regarding "in lieu of" services and stated that "[t]he provision of inpatient psychiatric or substance use disorder treatment in an IMD must

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Adults in Institutions for Mental Disease Using a Variety of Strategies 29 (2017), https://www.gao.gov/products/GAO-17-652.

meet the requirements for in lieu of services. . . ."[20] This means that the state must ensure:

1. Services provided in IMDs are medically appropriate and a cost effective substitute for the covered service or setting under the State Plan;
2. The enrollee is not required to use the alternative service or setting; and
3. The approved services are authorized and identified in the managed care contract, and offered to enrollees at the option of the managed care organization.[21]

HHS posited the "in lieu of" requirement will ensure that those who could benefit from community-based care will not be placed in medically inappropriate IMDs, and that IMD services will not be forced on anyone.[22] But as a practical matter, many individuals in crisis are either not in the position to demand different services or settings or are not given the option to choose. As discussed more fully below, funding of IMDs has a relationship to the availability of alternative settings, as there is evidence that the need for psychiatric beds is "elastic."[23] That is, if the beds are available, they will be filled, siphoning resources from community-based services. But when beds are not available, other options adequately meet individuals' needs. When states have limited resources, spending money on more costly institutional settings results in less available funding for more cost-effective community based programs, making community-based services hard to access. The "choice" between services immediately in an IMD setting, for example, versus a wait for limited community-based services is really a false choice, since individuals in crisis cannot wait for services. In fact, the lack of readily available community-based alternatives can force people into IMDs, creating a cycle of

[20] 42 C.F.R. § 438.6
[21] 42 C.F.R. § 438.3(e)(2)(i)-(iii).
[22] 81 Fed. Reg. 27498, 27559 (May 6, 2016).
[23] 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. While, to the best of our knowledge, there are not current studies that investigate the elasticity of beds in facilities that primarily serve individuals with SUD, this is an area ripe for investigation.

institutionalization. For this reason, NHeLP has consistently objected to the use of "in lieu of" payments for IMDs.[24]

Since HHS formally authorized the use of "in lieu of" payments for this purpose, at least twenty-six are using this authority.[25] Now that more than half the states currently use "in lieu of" payments via MCOs to fund IMDs, MACPAC should investigate whether MCO enrollees truly have choices to receive services outside of IMDs and how they are informed of such a choice if, in fact, it exists.

III. Discharge Planning: Access to Community-Based Services May Be Jeopardized by Changes to the IMD Exclusion

Congress specifically asked for information regarding "the discharge process used by such institution, including any care continuum of relevant services or facilities provided or used in such process."[26]

Discharge planning should start from the moment an individual enters an inpatient institution. Individuals should meet with a treatment team and develop a plan with clear goals and services to meet those goals. When the person reaches those goals, the person should be discharged, and not spend additional time in a facility waiting for access to community-based services. However, even the best discharge planning cannot prevent unnecessary institutionalization if community-based services and supports are not available in adequate quality and quantity.

Because Medicaid reimbursement is available for mental health and SUD services in the community rather than institutions, the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated environments. This financial incentive to rebalance

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[24] Nat'l Health Law Prog., *Comments* on Proposed Medicaid and CHIP Managed Care Regulations (July 27, 2015), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2015/07/2015_07_27_CMS-2390-P.pdf; Nat'l Health Law Prog., *Comments Regarding Proposed Rule Changes on Medicaid Managed Care and CHIP* (Jan. 14, 2019), https://healthlaw.org/resource/national-health-law-program-comments-regarding-proposed-rule-changes-on-medicaid-managed-care-and-chip/.
[25] Kathleen Gifford et al., Kaiser Family Found., Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018 (Oct. 19, 2017), https://www.kff.org/report-section/medicaid-moving-ahead-in-uncertain-times-managed-care-initiatives/.
[26] Pub. L. No. 115-271, Section 5012 (The IMD ADDITIONAL INFO Act).

treatment towards community-based services is particularly important due to “bed elasticity,” where supply drives demand. (See section II.B.)[27]

Regardless of whether individuals with mental health needs or SUD begin their treatment in residential or community-based settings, people need access to a full array of community-based treatment options tailored to their individual needs, which will change as they progress in their recovery.[28] For example, they often need ongoing community-based services such as case management, medication-assisted treatment, and peer support services to maintain their recovery, prevent relapse, and quickly return to treatment if relapses occur.[29] Expanding incentives to utilize residential treatment through greater FFP could actually undermine efforts to ensure the appropriate continuum of care for individuals with OUD. For example, if states receive more funds for IMDs, but this is not balanced out by additional funding incentives for chronically underfunded community-based services, it “may simply encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option.” [30] Furthermore, increasing funding to inpatient facilities could increase dangers to patients with OUD if such facilities primarily focus on detoxification:

> Indeed, it may increase the potential for overdose if patients do not remain in treatment since, with detoxification, their tolerance for opioids is significantly reduced. In fact, recent data suggest that inpatient detoxification is an important predictor of overdose, largely because many who receive inpatient care aren’t then connected to community-based treatment programs or put on a medication, leaving them extremely vulnerable to relapse and overdose.[31]

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[27] 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.

[28] Hannah Katch & Judith Solomon, Ctr. on Budget & Policy Priorities, *Repealing Medicaid Exclusion for Institutional Care Risks Worsening Services for People With Substance Use Disorders* (April 24, 2018), https://www.cbpp.org/research/health/repealing-medicaid-exclusion-for-institutional-care-risks-worsening-services-for.

[29] Jennifer Lav, Nat’l Health Law Prog., *Policy Implications of Repealing the IMD Exclusion* (May 17, 2018), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/04/MedicaidIMD-Exclusion-51718docx-1.pdf

[30] Michael Botticelli and Richard Frank, Congress needs a broader approach to address opioid epidemic, THE HILL (June 10, 2018), https://thehill.com/opinion/healthcare/391544-congress-needs-a-broader-approach-to-address-opioid-epidemic.

[31] *Id.*

Changes to the IMD exclusion could also undermine hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.[32] IMDs are by definition residential settings where individuals with disabilities receive services, and decisions regarding the IMD exclusion will inevitably have an impact on where people with disabilities reside and receive services.[33] In passing the Americans with Disabilities Act, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[34] Many IMDs are quite large, and the size of such facilities increases the risks of segregation and isolation. For example, the average bed capacity of an IMD participating in the three year federal IMD demonstration was over 100 beds, and one had a capacity of over 400 beds.[35] Providing FFP for large institutional settings could reify discriminatory presumptions about the ability of individuals with disabilities to receive services in community based settings, and undermine the integration mandate articulated by the Supreme Court in Olmstead v. LC.[36]

There is a strong interrelationship between the IMD exclusion and state incentives to fund community-based services. Without adequate community-based services, discriminatory segregation is inevitable. Given the serious civil rights implications, MACPAC should recommend more analysis to better understand the effect that altering the IMD exclusion would have on the development and funding of community-based services.

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[32] President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.
[33] While the ADA excludes individuals who are currently using illegal substances from the definition of an "individual with a disability," the definition of disability should include individuals in an IMD, as individuals in IMDs are generally not currently using illegal drugs and are in a supervised rehabilitation program. 42 U.S.C. § 12012; 28 C.F.R. § 35.131 ("(2) A public entity shall not discriminate on the basis of illegal use of drugs against an individual who is not engaging in current illegal use of drugs and who—(i) Has successfully completed a supervised drug rehabilitation program or has otherwise been rehabilitated successfully; (ii) Is participating in a supervised rehabilitation program; or (iii) Is erroneously regarded as engaging in such use.").
[34] 42 U.S.C. § 12101.
[35] Crystal Blyer, *et al*, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf.
[36] 527 U.S. 581 (1999).

IV. Regulations Should Vary Depending on the Populations Served, but Must Protect Enrollees

Because of the different types of institutions that can be considered IMDs and the large range of ages, disabilities, diagnoses, and treatment needs of individuals in IMDs, is not possible to make generalizations regarding the type of safeguards necessary or advisable to regulate IMDs. Any recommendations for regulation must be sensitive to the various settings that can be considered IMDs and the different populations served. Allowing additional funding for such settings without providing additional treatment guidelines, staffing, and monitoring specific to these various settings will not ensure provision of SUD treatment or mental health care that meets the specific needs of the population served, as well as the relevant medical standards of care.[37]

At the federal level, regulations exist only for those settings that been statutorily carved out of the IMD exclusion, including settings such as psychiatric residential treatment facilities (PRTFs) for children under 21, and free-standing psychiatric hospitals for individuals over age 65 (at the state option) or under age 21. No comparable set of federal regulations exists for the many settings that fall under the IMD exclusion.

PRTFs are a telling example of the need for regulations that account for the particular needs of the population served. When Congress carved PRTFs out from the IMD exclusion in 1990, CMS engaged in a ten-year process with stakeholders to come up with regulations intended to account for the vulnerable position and risks facing children in such settings. The regulations, published in 2002, require certain staffing and medical oversight and accreditation by an outside organization.[38] The regulations also place essential limitations on the use of physical and chemical restraint, and seclusion, and contain protections specific to children, such as requiring facilities to notify parents or guardians as soon as possible of any restraint or seclusion, and requiring that any emergency interventions be appropriate in light of a child's personal history, including

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[37] See e.g. Julia Lurie, *"Mom, When They Look At Me They See Dollar Signs*," MOTHER JONES (March/April 2019), https://www.motherjones.com/crime-justice/2019/02/opioid-epidemic-rehab-recruiters/ (discussing abuse, neglect, and exploitation in facilities for SUD that are covered by insurance but lack necessary federal regulation).

[38] 42 C.F.R. § 441.150-184.

any history of physical or sexual abuse.[39] That is, the regulations account for the specific needs of children with significant psychiatric needs in congregate settings.

In contrast, through the administrative process HHS has recently increased opportunities to fund IMDs while resisting calls to regulate such facilities.[40] For example, in response to comments suggesting HHS should set quality standards for IMDs if permitting FFP via managed care contracts, HHS replied:

> The final rule does not regulate IMDs and CMS has not identified authority in this rule to regulate IMDs. As discussed in the proposed rule (80 FR 31117), this provision is intended to provide states with flexibility to address concerns about ensuring access to and availability of short-term inpatient psychiatric and SUD services in Medicaid programs.[41]

There are important differences in how all these different settings need to be regulated. It is unlikely that a one-size-fits-all approach will be appropriate, but simply allowing expanded use of IMDs with no regulation at all is not appropriate. To the extent that there is any proposal to expand the settings where FFP can be claimed, it is essential that both Congress and CMS carefully consider the unique needs of the population served. There should also be a transparent process to develop regulations that complies

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[39] 42 C.F.R. §§ 483.366; 483.356.
[40] While the guidance from HHS on Section 1115 SUD/IMD Demonstration waivers states that the facilities will need to obtain national accreditation and be licensed by the state, such accreditation is not a substitute for federal regulation. Furthermore, neither the new state option to obtain funding for IMDs for SUD treatment for a 5 year period nor the Medicaid Managed Care rule require such national accreditation.
[41] 81 Fed. Reg. 27498, 27563 (May 16, 2016) (Medicaid Managed Care Rule).

with the Administrative Procedures Act and includes an opportunity for public comment and stakeholder input.

V. Conclusion

Thank you for the opportunity to provide comments related to MACPAC's report regarding the IMD ADDITIONAL INFO Act. If you have any questions regarding this topic or these comments, please contact Jennifer Lav at lav@healthlaw.org.

Sincerely,

/s/ Jennifer Lav
Senior Attorney