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October 11, 2019

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Indiana SMI/SED Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide these comments on the Indiana's proposed waiver amendment.

While NHeLP is supportive of states using Medicaid to increase access to mental health services, there are at least three reasons the Secretary should not approve the requested waiver:

1. Indiana has not proposed a genuine experiment, and the Secretary may only waive requirements of the federal Medicaid Act to conduct an experiment or test a novel approach to improve medical assistance for low-income individuals;

2. The Secretary does not have authority to waive the requested provisions of the Medicaid Act. Section 1115 only permits waiver of those requirements found in 42 U.S.C. § 1396a, and Indiana requests a waiver of provisions outside of 42 U.S.C. § 1396a—specifically a waiver of the "Institution for Mental Diseases" (IMD) exclusion; and

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3. The proposal does not contain sufficient evidence that Indiana will continue to invest in community-based services, as is required by CMS's own guidance. Instead, the proposal risks diverting funding away from appropriate community-based services, undermining decades of progress towards increased community-integration.

I. HHS authority and § 1115

To be approved pursuant to § 1115, Indiana's amendment must:

- propose an "experiment[], pilot or demonstration,"
- waive compliance only with requirements in 42 U.S.C. § 1396a,
- be likely to promote the objectives of the Medicaid Act, and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[1]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain the capacity for independence and self-care.[2]

The Secretary should not approve Indiana's requested waiver because it is inconsistent with the provisions of § 1115.

II. Indiana has not proposed an experiment.

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, if such waivers are limited to the extent and time period needed to carry out the experiment or demonstration. This means that a § 1115 demonstration request must propose a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money or shift costs to the federal government through a § 1115 demonstration waiver; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.

There is nothing novel or experimental about Indiana's request for financial participation (FFP) for services provided in IMDs during acute stays. For the past 25 years, CMS has

[1] 42 U.S.C. § 1315(a).
[2] *See* 42 U.S.C. § 1396-1.

granted states 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.[3] 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."[4] Although CMS has recently invited and encouraged states to apply for mental health-related § 1115 IMD demonstration waivers, it has not provided any justification for its change in position.[5] With more than 25 years of these 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. Section 1115 does not offer HHS a "back door" to provide permanent funding for settings that Congress explicitly carved out of Medicaid.

An experiment must have stated goals, a hypothesis, and a way to measure that hypothesis. Indiana's proposal is inadequate with respect to all of these. According to Congress, "States can apply to HHS for a waiver of existing law to test a unique approach to the delivery and financing of services to Medicaid beneficiaries … contingent upon development of a detailed research methodology and comprehensive evaluation for the demonstration."[6]

The vast majority of Indiana's stated goals are unrelated to the requested authority—likely because they are copied from the potential goals outlined in CMS' Dear State Medicaid Director Letter, without modification.[7] For example, Indiana includes a goal related to increased integration of primary and behavioral health care, but the requested amendment does not contain any proposed changes regarding behavioral health

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[3] 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.
[4] *Id.*
[5] 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. (hereinafter "SMD #18-011"). This is in addition to two previous letters, the first in 2015, encouraging states to apply for demonstration waivers for SUDs, including IMD waivers. See 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.
[6] H.R. Rep. No. 3982, pt. 2 at 307-08 (1981).
[7] SMD #18-011.

integration. The application *discusses* behavioral health integration, but does not identify any proposed changes that could increase behavioral health integration. The three areas of integration the application discusses include one that was launched in 2012 and is not part of this application; another which is a separate 1915(i) state plan amendment and has been in place since 2014; and a third that targets children—a population carved out of this demonstration. Indiana has not provided sufficient information to allow a reader to understand how the articulated goals relate to the proposed experiment. Likewise, Indiana's proposed hypotheses are also insufficient, because each hypothesis is merely a restatement of the unrelated proposed goals, with no additional information.

Many of the proposed measures lack any relationship to the stated hypothesis or the goal. Again, they appear to be merely cut and paste from the examples in CMS' guidance. For example, Indiana inexplicitly proposes to use the child-specific measure of "use of first-line psychosocial care for children and adolescents on antipsychotics," even though the demonstration population is limited to ages 21-64.[8]

The only goal that has a potential direct relationship to the authority sought is Goal 1: reduced utilization and lengths of stay in emergency departments (EDs) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized setting. But the hypothesis that increasing FFP for short term services in IMDs will reduce utilization and lengths of stay in EDs was already explicitly tested via the Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by Section 2707 of the Affordable Care Act.[9] The MEPD found that in those states that had sufficient data to draw conclusions, "[t]he results do not support our hypothesis that ER visits would decrease as a result of MEPD."[10] Increasing federal funding for IMDs did not decrease use of emergency departments. Indiana has not explained why it believes that the requested waiver would test anything new or lead to any different result.

Because Indiana does not propose an actual experiment, with stated goals, hypothesis, and measures, the Secretary should not approve this amendment.

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[8] Indiana SMI/SED Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver, 17-18 (hereinafter "Amendment.").
[9] 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.
[10] *Id.*

III. The Secretary lacks authority to grant waivers of provisions outside § 1396a.

The only waiver Indiana seeks through this amendment is waiver of a provision of the Medicaid Act that prohibits FFP for IMDs for individuals under age 65. This provision is found in 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i). Section 1115 permits waiver of only those provisions contained in 42 U.S.C. § 1396a of the Medicaid Act. Because the IMD provision lies outside of § 1396a, this is not a provision that can be waived via § 1115, and the request is not approvable.

IV. FFP for IMDs risks diverting resources away from community-based services and undermining community-integration.

Indiana proposes FFP for acute hospital stays, but fails to document that it has a sufficient system of community-based services. Nor does Indiana articulate how it will ensure that a "full continuum of care is available to address more chronic, on-going mental health care needs . . . [or how it will] provide a full array of crisis stabilization services. . . ."[11]

Instead, Indiana appears to be underutilizing some of the most effective community-based interventions available for individuals at risk of hospitalization, while requesting more funding for inpatient crisis services. For example, Indiana states it provides Assertive Community Treatment (ACT), but its utilization rate is far below the national average. ACT is an evidence-based, highly individualized service designed to support individuals with the most intensive mental health needs, who might otherwise be at risk of using an IMD.[12] In Indiana, .8% of individuals with serious mental illness receive ACT, compared with a national utilization rate of 2.1%.[13] Experts estimate that the need is actually much greater.[14]

The solution for any shortage of community-based resources is to invest more in those resources, because they are often the optimal and most effective treatment modality.

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[11] SMD #18-011 at 13.

[12] SMD #18-011 at 8, 16. *See also* CMS Dear State Medicaid Director Letter on Assertive Community Treatment (June 7, 1999), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD060799b.pdf.

[13] Indiana 2018 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System, available at: https://wwwdasis.samhsa.gov/dasis2/urs.htm.

[14] Gary S. Cuddeback et al., *How Many Assertive Community Treatment Teams Do We Needs?* 57 PSYCHIATRIC SERVS. 1803 (2006), https://ps.psychiatryonline.org/doi/full/10.1176/ps.2006.57.12.1803.

The proposed amendment risks exacerbating current gaps in services by creating more incentives to create institutional capacity instead of developing community-based resources. This in turn could worsen any shortages and continue a negative cycle. This concern is particularly acute, given the evidence of the risk of "bed elasticity," a phenomenon in psychiatry where supply drives demand.[15] That is, if the beds are available, they are 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 harder to access. Historically, the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated settings. We urge the Secretary not approve this amendment.

Our concerns about creating a negative cycle for community-based services are confirmed by Indiana's approach to maintenance of effort (MOE). Indiana is seeking an exemption to CMS' usual requirement that a state seeking FFP for an IMD commit to a MOE for community-based services. The state lists five separate reasons why it should not be beholden to a financial MOE. These excuses range from the tautological ("any potential future program changes may affect expenditures") to the tenuous and vague ("movement to managed care may affect expenditures, as managed care companies may negotiate different levels of reimbursement or apply different criteria for treatment.")[16] The state instead suggests replacing the CMS-proposed financial MOE with a system for tracking the number of outpatient mental health recipients or the percentage of recipients receiving outpatient services compared to those receiving institutional services.[17] Neither of these measures are an adequate short-term safeguard. If the state is only tracking the number or percentage of people receiving a service, the state could provide just one or two services to a large number of people, and still meet the proposed MOE requirement without actually providing for the full array of necessary services for individuals with SMI. The impact of such an approach as

[15] 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.
[16] Amendment at 20.
[17] *Id.*

manifested in an increase of inpatient services may not be felt until long into the duration of the waiver, when it would be too late for CMS to require course correction.

Indiana's articulated interest in circumventing a financial MOE should raise serious questions about its ability to "ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential services at the expense of community-based services."[18]

Providing FFP for IMDs could also undermine hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.[19] IMDs are by definition residential settings where individuals with disabilities receive services, and decisions regarding funding for services in IMDs will inevitably have an impact on where people with disabilities receive services. 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."[20] 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 undermining the integration mandate articulated by the Supreme Court in *Olmstead v. LC*.

V. Conclusion

The Secretary should not approve Indiana's requested amendment for three reasons. First, the state is not proposing a valid experiment. Second, the state is requesting waiver of provisions that the Secretary does not have authority to waive. Third, the state has not articulated sufficient safeguards to prevent siphoning of funds from community-based services in favor of institutional ones.

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[18] SMD #18-011

[19] President's New Freedom Comm'n on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.

[20] 42 U.S.C. § 12101(a)(2).

We appreciate your consideration of our comments. If you have questions about these comments, please contact Jennifer Lav (lav@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director