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VIA ELECTRONIC SUBMISSION

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

**Re: Idaho Behavioral Health Transformation Section 1115
Medicaid Waiver Demonstration Application**

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 Idaho's proposed waiver.

NHeLP is supportive of states using Medicaid to increase access to mental health and substance use disorder (SUD) services. However, the Secretary should not approve Idaho's request because it is inconsistent with the provisions of § 1115.

To be approved pursuant to § 1115, Idaho's request must:

- propose an "experiment[], pilot or demonstration,"
- waive compliance only with requirements in 42 U.S.C. § 1396a,
- 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

For the following four reasons, the Secretary should not approve Idaho's requested waiver:

1. Idaho has not proposed a genuine experiment, and the Secretary may only waive requirements of the federal Medicaid Act to the extent and for the period necessary to carry out an experiment or test a novel approach to improve medical assistance for low-income individuals;
2. Idaho does not need the requested waiver authority to achieve its behavioral health delivery system reform objectives. Idaho should pursue the identified reforms via state plan amendments and necessary changes to its managed care contract;
3. The Secretary does not have authority to waive the requested provision of the Medicaid Act. Section 1115 only permits waiver of those requirements found in 42 U.S.C. § 1396a. Idaho requests a waiver of a provision of the Medicaid Act referred to as the "Institution for Mental Diseases" (IMD) exclusion. The IMD exclusion is found outside of 42 U.S.C. § 1396a, and therefore the Secretary does not have authority to waive it; and
4. The proposal does not contain sufficient evidence that Idaho 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. Idaho 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.

¹ 42 U.S.C. § 1315(a).

² See 42 U.S.C. § 1396-1.

A true experiment must have stated goals, a hypothesis, and a way to measure that hypothesis. 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.”³

There is nothing novel or experimental about Idaho’s request for federal financial participation (FFP) for services provided in IMDs. For the past 25 years, CMS has 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.⁴ 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.”⁵ 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.⁶ 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.

Idaho does not propose a novel approach to providing behavioral health services. Instead, the state takes the six SUD goals from CMS’ Dear State Medicaid Director Letters, and applies these goals to both individuals with “serious mental illness” (SMI)

³ H.R. Rep. No. 3982, pt. 2 at 307-08 (1981).

⁴ 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>.

⁵ *Id.*

⁶ 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>.



and individuals with SUD.⁷ Idaho then pairs those goals with a summary of “some tentative hypotheses and a high level evaluation plan.”⁸ This kind of cookie-cutter waiver request is not the type of unique demonstration contemplated by Congress, nor does it provide the public with sufficient information to allow for meaningful comment.

Because Idaho does not propose a genuine experiment designed to test articulated hypothesis via a detailed evaluation plan, the Secretary should not approve this waiver.

II. Idaho does not need the requested waiver authority to achieve its behavioral health delivery system reform objectives.

Idaho laudably identifies concrete “primary objectives for behavioral health delivery system improvements” and proposes a roadmap with specific interventions to achieve these objectives.⁹ Idaho states it will “leverage this demonstration to implement targeted reforms to (1) expand coverage of Medicaid reimbursable services for individuals with SMI/SED and/or SUD; (2) increase access and availability of behavioral health services across the state; and (3) improve coordination of care, including transitions of care, for Medicaid beneficiaries.”¹⁰ Under each general objective, Idaho lists specific interventions it wishes to take to achieve these objectives. As noted above, it is unclear how these objectives align with the six stated goals listed in Idaho’s hypothesis and evaluation plan.¹¹ But equally important, almost all of the interventions listed can be achieved via a state plan amendment and are unrelated to the requested waiver authority. The requested waiver authority will not help Idaho obtain its objectives.

One of Idaho’s general stated objectives is to expand coverage of Medicaid reimbursable services.¹² The state intends to add “recovery coaching” as a new Medicaid service, and fold the Assertive Community Treatment that is currently being provided by the state into the Medicaid fee schedule.¹³ These types of services are the building blocks of any functioning system of care, and can be provided without a

⁷ See SMD # 17-003 (Re: Strategies to Address Opioid Epidemic); Idaho Behavioral Health Transformation Section 1115 Medicaid Waiver Demonstration Project Application (Jan. 3, 2020) at 21-23. (Hereinafter “Idaho Application.”)

⁸ *Id.* at 21.

⁹ *Id.* at 3.

¹⁰ *Id.* at 11.

¹¹ *Id.* at 3; 21-22.

¹² *Id.* at 12.

¹³ *Id.* at 12-13.



waiver.¹⁴ The state also proposes expanding Medication Assisted Treatment (MAT) by covering methadone maintenance at Opioid Treatment Programs (OTPs) and by ensuring it is reimbursing providers at levels that make it viable for the providers to expand to more parts of the state. Again, methadone maintenance treatment is a basic service that should be included in even the most bare bones strategy to provide SUD services, and does not require a waiver.¹⁵ The vast majority of states (41 as of 2018) already cover methadone via Medicaid.¹⁶

The second proposed objective is to expand the availability and access to services across the state, particularly in rural and frontier areas.¹⁷ Idaho plans to expand crisis stabilization services—another intervention for which waiver authority is unnecessary. In fact, the state has already made permanent changes to add “crisis response” and “crisis intervention” to its state plan, and these changes have already been approved.¹⁸ The state also proposes pursuing an accountable care model with behavioral health quality measures and billing simplifications, enhancing the use of telehealth, and improving transportation for providers and enrollees in rural areas of the state.¹⁹ These interventions are unrelated to the waiver authority Idaho requests.

The third primary objective is to improve coordination of care, including transitions of care.²⁰ Again, the proposed intervention to achieve this objective does not require a

¹⁴ Jennifer Lav, Nat'l Health Law Program, *Policy Implications of Repealing the IMD Exclusion*, (May 17, 2018), <https://healthlaw.org/resource/policy-implications-of-repealing-the-imd-exclusion/>.

¹⁵ Corey Davis et al., *Medication-Assisted Treatment for Opioid Use Disorder: The Gold Standard*, Nat'l Health Law Program (May 16, 2018), <https://healthlaw.org/resource/medication-assisted-treatment-for-opioid-use-disorder-the-goldstandard/>; see also Sarah Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, 3(2) JAMA NETWORK OPEN (Feb. 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032>.

¹⁶ Kaiser Family Found., *Medicaid Behavioral Health Services: Methadone for Medication Assisted Treatment (MAT)* (2018), <https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-methadone-for-medication-assisted-treatment-mat/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹⁷ Idaho Application at 14.

¹⁸ CMS, Idaho State Plan Amendment (SPA) Transmittal Number 18-0007 Approval Letter (Apr. 26, 2019), <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ID/ID-18-0007.pdf>; CMS, Idaho State Plan Amendment (SPA) Transmittal Number 18-0006 Approval Letter (Apr. 26, 2019), <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ID/ID-18-0006.pdf>.

¹⁹ Idaho Application at 15-16.

²⁰ *Id.* at 17.



waiver, and moreover, approving the waiver prior to implementing the proposed charges could exacerbate the identified problems. Currently, behavioral health is provided via a carved out managed care delivery system for ambulatory care called the Idaho Behavioral Health Plan (IBHP). Idaho states that due to this carve out, its managed care contractor is not incentivized to “decrease unnecessary inpatient admissions and reduce lengths of stay by efficiently transitioning individuals with SMI/SED and/or SUD to the most effective lower level of care,” nor is it “held accountable and incentivized for high performance on hospital readmissions.”²¹ To address this, Idaho plans to carve in all behavioral health services into a future behavioral health managed care contract that will cover both inpatient and outpatient services, and implement new minimum standards for discharge planning and enhanced case management.²² This reform will be made when Idaho rebids the contract at some unidentified date in 2021, and does not require a waiver of the IMD exclusion.

Idaho’s request to obtain FFP for inpatient settings prior to addressing the identified “coordination challenges for members transitioning into and out of hospital or residential settings” is troubling.²³ Idaho has not adequately explained how it will improve transitions from acute care to community-based care prior to the new contract. A concrete plan to improve transitions that can be implemented in a *timely manner* should be a prerequisite to any increase in federal funding for residential or inpatient services. At the very least, CMS should require Idaho to align the contractual modifications with the proposed timeframe of the waiver. If the contract cannot be rebid sooner, then any increased funding for inpatient settings should be delayed.

The only intervention Idaho articulates that could possibly relate to the state’s request for waiver authority for FFP for psychiatric services in IMDs is Idaho’s desire to “reduce over-reliance on general acute care settings.”²⁴ However, evidence suggests federal funding for IMDs does not decrease acute hospital utilization. Between 2012 and 2015, ten states received FFP for IMDs via the federally-authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by Section 2707 of the Affordable Care Act.²⁵ This three-year demonstration already explicitly tested the hypothesis that Idaho suggests and found it to be

²¹ *Id.* at 18.

²² *Id.*

²³ *Id.* at 17.

²⁴ *Id.* at 12. Idaho places this under the general objective of expanding coverage of Medicaid reimbursable services.

²⁵ 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>.



unsupported.²⁶ The demonstration 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.”²⁷ The MEPD was phased out because a statutorily imposed condition of its continuation was that it be certified as cost-neutral to the federal government, and CMS actuaries could not certify it as such.²⁸ Idaho has not explained why it would reasonably anticipate a different result.

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

The only waiver Idaho seeks through this application 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.

Idaho proposes FFP for “short-term” IMD stays, but does not define the term “short-term.”²⁹ At the same time, the state admits that “the current Idaho behavioral health system of care creates bottlenecks and barriers to accessing specialized services, leading to increased lengths of stay in hospitals and emergency departments.”³⁰

Idaho does not specify which specialized services are causing the increased length of stay, but if a lack of *community-based* specialized services are the culprit, as Idaho’s narrative suggests, the proposed waiver risks exacerbating the problem.³¹ This is because of the risk of “bed elasticity,” a phenomenon in psychiatry where supply drives

²⁶ *Id.*

²⁷ *Id.*

²⁸ U.S. Gov. Accounting Office, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* 35-36 (2017), <https://www.gao.gov/assets/690/686456.pdf>.

²⁹ Idaho Application at 28.

³⁰ Idaho Application at 5.

³¹ *Id.* at 5 (noting that a “Given the rural and frontier nature of the state, specialized providers are not easily accessible and health professional shortages may cause available appointment schedules to be months out.”)



demand.³² 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. Bottlenecks and bed shortages are often a reflection of a lack of a robust community-based system, and should not be used to justify increased institutional funding.³³ Historically, the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated settings.

Our concerns about creating a negative cycle for community-based services are deepened by Idaho's complaints about CMS' approach to maintenance of effort (MOE) requirements. These excuses range from the tautological ("any potential future program changes may affect expenditures") to the tenuous and vague ("if the state transitions to more value-based reimbursement, may [sic] decline slightly without any loss of access or quality").³⁴ Idaho does not suggest any alternative framework to replace the CMS-proposed financial MOE.

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.³⁵ 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."³⁶ Providing FFP for large institutional settings could reify discriminatory presumptions about the ability of

³² 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>.

³³ Jennifer Mathis, *Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate—Argument to Retain the IMD Rule*, 70 PSYCH. SERVS.1 (Jan. 2019), <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201800413>

³⁴ Idaho Application at 28.

³⁵ 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>.

³⁶ 42 U.S.C. § 12101(a)(2).



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 Idaho's requested waiver for four reasons. First, the state is not proposing a valid experiment. Second, the state does not need the requested waiver authority to address its behavioral health delivery system reform objectives. Third, the state is requesting waiver of provisions that the Secretary does not have authority to waive. Fourth, the state has not articulated sufficient safeguards to prevent siphoning of funds from community-based services in favor of institutional ones.

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

Sincerely,



Jennifer Lav
Senior Attorney

