September 17, 2020

VIA ELECTRONIC SUBMISSION

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

Re: Utah Section 1115 Institutions for Mental Disease (IMD) Waiver for Adults with Serious Mental Illness (11-W-00145/8, 21-W-00054/8)

To Whom It May Concern:

On behalf of the National Health Law Program (NHeLP), we appreciate the opportunity to provide these comments on Utah's proposed Section 1115 Institution for Mental Disease (IMD) Waiver for Adults with Serious Mental Illness (SMI).

Founded in 1969, NHeLP protects and advances the health rights of low-income and underserved individuals. We advocate, educate, and litigate at the federal and state levels to advance health and civil rights in the U.S.

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. First, 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, and Utah has not proposed a genuine experiment or novel approach. Second, Utah asks the Secretary to waive provisions of the Medicaid Act the Secretary does not have the authority to waive. Section 1115 only permits the waiver of those requirements found in 42 U.S.C. § 1396a, and Utah requests a waiver of provisions outside of 42 U.S.C. § 1396a, specifically a waiver of the "Institution for Mental Diseases" (IMD) exclusion.

Third, Utah's proposal does not contain sufficient evidence that it has invested and will continue to invest in community-based services, as is required by CMS's own guidance. The proposal risks diverting funds away from appropriate community-based services, undermining any progress towards increased community-integration.

I. Utah Has Not Proposed an Experiment

To be approved pursuant to § 1115, Utah'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] With this background, we will address the proposed demonstration.

Section 1115 allows HHS to waive some requirements of the federal Medicaid Act, allowing states to 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 Section 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 Section 1115 demonstration waiver; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.

Utah requests federal financial participation (FFP) for IMDs, but there is nothing novel or experimental about this proposal. 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 Section 1115 demonstration waivers to funds IMDs for psychiatric treatment: Arizona, Delaware, Maryland, Massachusetts, New York, Oregon, Rhode Island, Tennessee, and Vermont.[3] Some of these states only covered individuals at certain hospitals or for a set number of days; others offered broader coverage. As of 2009, CMS phased out all but one of these projects, precisely because they were no longer "innovative or experimental."[4]

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

Although CMS has recently invited and encouraged states to apply for substance use disorder and mental health-related Section 1115 demonstration waivers, it has not provided any justification for its change in position.[5] With more than 25 years of 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 funding for settings that Congress explicitly carved out of Medicaid.

Utah fails to provide evidence that this proposal will test an experimental idea. An experiment must have stated goals, a hypothesis, and a way to measure that hypothesis. Utah's proposal in inadequate with respect to all of these preconditions. 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]

There is nothing experimental in how Utah seeks to offer services or to whom. Utah already provides inpatient and residential mental health coverage for all beneficiaries.[7] The state is not proposing any modifications to the current delivery system for services, nor is it adding any new services with this proposal. Instead, Utah seeks to shift the cost of inpatient services in facilities with more than 16 beds from the state to the federal government. That is simply not an experiment.

Further, the hypotheses Utah offers in this application have little to do with the actions it proposes to take. One hypothesis identified by Utah in this application—that waiving the IMD exclusion will reduce utilization and lengths of stay in emergency departments (EDs)—was already explicitly tested and found to be unsupported by the federally-authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by the Section 2707 of the Affordable Care Act.[8] Utah states that it wants to "reduce the utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI and claims that "[a]t times, non-psychiatric beds have to be temporarily used

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[5] CMS, *Dear State Medicaid Director Letter* (Nov. 1, 2017) (SMD #17-003) (Strategies to Address the Opioid Epidemic), https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf (hereinafter "SMD #17-003"); 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"); *see also* 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.

[6] H.R. Rep. No. 3892, pt. 2, at 307-08 (1981).

[7] Utah Behavioral Health Services for Adults with Serious Mental Illness Section 1115 Demonstration Amendment # 22, 8 (hereinafter "Utah Demonstration Amendment").

[8] Crystal Blyer et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report*, , MATHEMATICA POL'Y RESEARCH (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf (hereinafter "MEPD Evaluation").

until an appropriate bed can be made available.[9] However, the MEPD evaluation 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] The MEPD evaluation also found that the MEPD did not reduce psychiatric admissions to non-psychiatric beds, often called "scatter-bed" admissions.[11]

Another hypothesis Utah offers is that the requested demonstration will improve access to community-based services by increasing integration of primary and behavioral health care.[12] However, the State fails to articulate any steps that it will take integrate behavioral health care, and has thus failed to propose any actions that could be used to test a hypothesis.

Moreover, Utah's application claims the state seeks to "improve access to community-based services," and has copied a number of the "milestones" from CMS' Dear State Medicaid Director letter on this topic, but fails to include any information about how the demonstration would meet these stated goals. The state already woefully underfunds community based services, and has not articulated any steps it would take to improve this. Utah currently ranks 50th in Mental Health America's state adult rankings, indicating that it has a high prevalence of need and a low rate of access to care.[13] A 2019 Report from the Gardner Policy Institute found that Utah lacks mental health providers, particularly in rural areas, and that the State lacks treatment facilities for patients who don't require inpatient care.[14] The state fails to provide the type of community-based service that individuals need when leaving acute care settings, such as Assertive Community Treatment (ACT). Only 1.1% of individuals with SMI receive ACT in Utah, compared with a national utilization rate of 1.9%.[15] Experts estimate that the need is actually much greater.[16] Utah's application fails to explain how funding IMDs will fill the existing gap in community-based services that are desperately needed to address mental health needs in the State.

Instead of testing novel ideas, Utah's request is designed to shift local costs to the federal government. Utah seeks FFP for services provided at IMDs, despite the illegality of such a waiver (*infra*, Section IV). As acknowledged by the State in its request, Utah already "invests millions annually across the state to cover inpatient psychiatric care[.]"[17] In this request, Utah is seeking FFP to expand the number of IMDs

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[9] Utah Demonstration Amendment at 6, 1.
[10] MEPD Evaluation at 49.
[11] *Id.* at 41.
[12] Utah Demonstration Amendment at 6-7.
[13] MENTAL HEALTH AMERICA, *Adult Data 2020*, https://www.mhanational.org/issues/ranking-states#six.
[14] Laura Summers et al., *Utah's Mental Health System,* KEM C. GARDNER POL'Y INST., 6 (August 2019), https://gardner.utah.edu/wp-content/uploads/MentalHealthReportAug2019.pdf [hereinafter "Gardner Report"] at 7, 13.
[15] SAMHSA, *Utah 2019 Mental Health National Outcome Measures (NOMS)*, https://www.samhsa.gov/data/sites/default/files/reports/rpt27978/Utah%202019%20URS%20Output%20Tables/Utah%202019%20URS%20Output%20Tables.pdf.
[16] 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.
[17] Utah Demonstration Amendment at 1.

providing services in the State, despite the fact that the same services are already provided and funded by the State. In other words, Utah is seeking to shift the costs of inpatient psychiatric care to the federal government, which would provide a windfall to the State to fund existing services without reinvesting its savings in community-based services. Section 1115 is not intended to provide long-term funding for settings that Congress explicitly carved out of Medicaid, yet that is exactly what Utah seeks.

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

II. The Secretary Lacks Authority to Grant Waivers of Provisions Outside § 1396a

Utah seeks a waiver of a provision of Medicaid that prohibits FFP for IMDs for individuals under age 65. This provision is found at 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 Section 1115, and the request is not approvable.

Because Utah requests a waiver of a provision of Medicaid that lies outside in 42 U.S.C. § 1396a of the Medicaid Act, the Secretary does not have authority to approve this demonstration request.

III. Utah's Proposal Risk Diverting Resources Away from Community-Based Services and Undermining Community-Integration

Utah proposes FFP for inpatient treatment in IMDs but fails to articulate how services provided in an IMD "will supplement and coordinate with community-based care in a robust continuum of care in the state."[18] Instead, Utah's own demonstration request demonstrates it is 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, Utah states individuals with SMI "will continue to have access to an array of mental health services throughout the state,"[19] including 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.[20] As noted above, only

[18] SMD #17-003 at 2.
[19] Utah Demonstration Amendment at 3.
[20] SMD #18-011 at 8, 16. *See also* CMS, *Dear State Medicaid Director Letter* (June 7, 1999), https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD060799b.pdf.

.6% of individuals with serious mental illness receive ACT, compared with a national utilization rate of 2.1%.[21] Experts estimate that the need is actually much greater.[22]

While Utah touts the passage of Utah House Bill 35 from the 2020 General Session as providing for an additional ACT Team and some supportive housing for those discharged from the State Hospital, much of this funding was gutted just two months later during a special session, via S.B. 5001, the "Budget Balancing and Coronavirus Relief Appropriations Adjustments." Furthermore, the proposed expansion was only a modest start, and would not have fundamentally altered the state's meager community-based offerings. The solution for any shortage of community-based services is to invest more in those services, because they are often the optimal and most effective treatment modality. The proposed amendment pays lip service to not diverting resources but offers no plan to actually bolster the inadequate system of community-based supports for adults with SMI in Utah.

Further, the proposed demonstration risks exacerbating current gaps in services by creating more incentives to increase institutional capacity instead of developing community-based resources. This in turn could worsen any shortages and continue a negative cycle of viewing institutional settings as the solution to SMI treatment needs. This is particularly concerning given the evidence of the risk of "bed elasticity," a phenomenon in psychiatry where supply drives demand.[23] That is, if 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. Community-based treatment is often more effective and frequently more cost-effective than inpatient or residential care.[24]

Even though Utah's application provides assurances that Utah will maintain state funding for community-based services that is "not less" than the amount of funding currently provided, such assurances are cold comfort when the state already underinvests in community based services.[25] The current levels of community-based services are insufficient to meet the increasing need for mental health treatment in the State. The Gardner Policy Institute Report mentioned above found that 17.5 percent of adults in Utah experience poor mental health and illness in Utah did not receive mental health treatment

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[21] SAMHSA, *Utah 2018 Mental Health National Outcome Measures (NOMS), available at* https://wwwdasis.samhsa.gov/dasis2/urs.htm.
[22] 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.
[23] Martha Shumway et al., *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*, 63 PSYCH. SERVS. 135 (2012), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201000145.
[24] *See* Barbara Dickey et al., *The Cost and Outcomes of Community-Based Care for the Seriously Mentally Ill*, 32 Health Serv. Res. 599 (1997), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070217/.
[25] Utah Demonstration Amendment at 2-3.

or counseling.[26] FFP for IMDs sought by the State risks exacerbating the existing lack of treatment for individuals at times they do not require inpatient care, particularly in rural areas.[27] The State also faces additional shortages due to decreased funding for mental health services because of budget cuts resulting from COVID-19, which has impacted the future of several mental health bills previously passed by the legislature.[28]

Finally, 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.[29] IMDs are by definition institutional 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."[30] 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.* In short, this request promotes the segregation of people with mental illnesses.

Because Utah's request risks diverting resources from community-based services and undermining the civil rights of people with disabilities, the Secretary should not approve this demonstration request.

IV. Conclusion

The Secretary should not approve Utah's requested demonstration amendment. While NHeLP supports all efforts to expand access to mental health treatment for Medicaid beneficiaries, we believe this 1115 waiver request is not the appropriate vehicle to achieve this goal. The State is not proposing a valid experiment, is requesting a waiver of provisions that the Secretary does not have authority to waive, and the state has not articulated sufficient safeguards to prevent siphoning of funds from community-based services into institutional ones. Further, the proposal risks perpetuating discrimination against and the unlawful segregation of people with disabilities in Utah. We believe the State would be better served by investing in community-based services.

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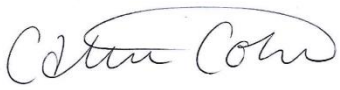
[26] Gardner Report at 4-6
[27] *Id.* at 7, 13.
[28] *See* Aley Davis, *COVID-19 Budget Cuts Could Impact Mental Health Funding*, KSL TV (June 15, 2020), https://ksltv.com/439467/covid-19-budget-cuts-could-impact-mental-health-funding/.
[29] President's New Freedom Comm'n on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.
[30] 42 U.S.C. § 12101(a)(2).

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

Sincerely,



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