September 30, 2020

VIA ELECTRONIC SUBMISSION

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

Re: MassHealth - SMI-SED Supplemental Application Demonstration (Project Number I1-W-00030/1)

To Whom It May Concern:

On behalf of the National Health Law Program (NHeLP), we appreciate the opportunity to provide these comments on Massachusetts' proposed Section 1115 SMI-SED "Supplemental Application."

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 four reasons the Secretary should not approve the requested waiver. First, Massachusetts did not provide adequate state-level notice and opportunity to comment prior to submitting this amendment, violating the special terms and conditions of Massachusetts' current waiver. Second, 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 Massachusetts has not proposed a genuine experiment or novel approach. Third, Massachusetts 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 Massachusetts requests a waiver of provisions outside of 42 U.S.C. § 1396a, specifically a waiver of the "Institution for Mental Diseases" (IMD) exclusion. Fourth, Massachusetts' proposal risks diverting funds away from appropriate community-based services, undermining progress towards increased community-integration.

I. Massachusetts Has Not Provided Adequate State-Level Notice and Opportunity to Comment

Massachusetts requests an amendment to its current waiver, and therefore pursuant to the applicable Special Terms and Conditions (STC) of the governing waiver, must provide notice and opportunity for comment prior to submitting the request to CMS. The Commonwealth has failed to do so. CMS should require the Commonwealth to give proper notice and allow for meaningful comment on this amendment prior to accepting it for consideration.

A. Procedural History of Massachusetts' Requests for FFP for Services provided in IMDs

Massachusetts has operated a Section 1115 demonstration waiver since 1997, and from 1997 until 2007, Massachusetts obtained federal financial participation (FFP) for IMDs. CMS started phasing out this authority in 2006, and phased it out by 2007.[1] In November 2016, CMS approved an amendment effective immediately and an extension from July 1, 2017 through

[1] CMS, MassHealth Medicaid Section 1115 Demonstration Expenditure Authority, Demonstration Approval Period: July 1, 2005 through June 30, 2008, Amended May 2007 at 2, https://www.mass.gov/doc/approval-letter-and-special-terms-and-conditions-61907/download (hereinafter "MassHealth 2007 Amendment"). In the intervening years, Massachusetts was permitted to use Safety Net Care Pool funding to provide some federal funds to IMDs. CMS has also permitted Massachusetts to obtain limited FFP for diversionary behavioral health services provided in IMDs, such as 24 hour crisis centers. CMS, MassHealth Medicaid Section 1115 Demonstration, Demonstration Approval Period October 30, 2014 through June 30, 2019, at 68 (STC 61), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-2014-demo-ext-appvl-10302014.pdf (hereinafter "MassHealth 2014 Extension").

June 30, 2022, allowing Massachusetts to obtain FFP for substance use disorder (SUD) services provided in certain IMDs.[2]

In September 2017, ten years after CMS phased out Massachusetts' ability to obtain FFP for services provided in IMDs, Massachusetts submitted an amendment to CMS with a blanket request to allow FFP for all services provided in IMDs.[3] CMS approved parts of the waiver, but specifically declined to approve the broad request to waive the entire IMD exclusion: "CMS is not at this time approving Massachusetts's . . . request to waive all federal payments restrictions on care provided in Institutions for Mental Disease (IMDs) beyond what is already included in the state's approved demonstration."[4]

B. The Commonwealth failed to provide an opportunity for notice and comment for the pending amendment

Massachusetts is required to provide adequate state-level public notice to allow for an opportunity for input in the decision-making. The Commonwealth failed to do so, never giving the public notice that it was planning to submit the current pending amendment.

Massachusetts' current STCs requires "changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs . . ." to go through the "amendment process set forth in STC 7 below."[5] The procedure set forth in STC 7 requires the

---

[2] CMS, MassHealth Medicaid Section 1115 Demonstration, Demonstration Approval Period October 30, 2014 through June 30, 2019, Amended Nov. 4, 2016, at 34 (STC 40), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-stcs-11042016.pdf (hereinafter "MassHealth 2016 Amendment").

[3] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2017 MassHealth Amendment Request (Sept. 8, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf (hereinafter "MassHealth 2017 Amendment Request").

[4] CMS, MassHealth Medicaid Section 1115 Demonstration letter from Tim Hill to Daniel Tsai (June 27, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-demo-amndmnt-appvl-jun-2018.pdf.

[5] CMS, MassHealth Medicaid Section 1115 Demonstration, Demonstration Approval Period July 1, 2017 through June 30, 2022, Amended May 23, 2019, at 4 (STC 6), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf.

Commonwealth to provide "an explanation of the public notice process used consistent with the requirements of STC 15. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the statement in the final amendment request submitted to CMS."[6] STC 15 only states that no FFP is available until the effective date identified in the demonstration approval letter, and is presumably a typographical error that is intended to reference STC 14.[7] STC 14 requires the Commonwealth to "comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting a request."[8] These regulations give states a number of options for providing for notice and comment, but at a bare minimum, the Commonwealth must give CMS an opportunity to approve or reject Massachusetts' plan for notice and comment by either providing the Department with a "written description of the process the State will use for receipt of public input into the proposal prior to its submission to the Department" or by submitting "a description of the process that was used by the State to obtain public input, at the time it submits its demonstration proposal."[9] CMS has recognized that "people who may be affected by a demonstration project have a legitimate interest in learning about proposed projects and having input into the decision-making process prior to the time a proposal is submitted to the Department. A process that facilitates public involvement and input promotes sound decision-making."[10]

Massachusetts notes it conducted listening sessions and issued a Request for Information (RFI) in 2019, but neither of these appear to have even mentioned the IMD exclusion, let alone solicited feedback on the topic.[11] Massachusetts does not explain how it used any feedback it may have received via these listening sessions and RFI to craft the pending request, as required by STC 7. Instead, the Commonwealth nebulously claims that, "Massachusetts is carefully considering the input it has received throughout this process in order to inform the

---

[6] *Id*. at STC 7.
[7] *Id.* at STC 15.
[8] *Id.* at STC 14.
[9] 59 Fed. Reg. 49249, 49250 (Sept. 27, 1994).
[10] *Id*.
[11] Massachusetts Executive Office of Health and Human Services, "Creating a Behavioral Health Ambulatory Treatment System," (May 2019) https://www.mass.gov/files/documents/2019/06/13/bh-presentation_0.pdf. (listing questions the Commonwealth is seeking feedback on); Open Letter from Marylou Sudders, Secretary, Executive Office of Health and Human Services (Nov. 15, 2019), https://www.mass.gov/doc/letter-from-secretary-sudders-november-15-2019/download; Massachusetts Executive Office of Health and Human Services, Attend a Listening Session on Creating a Behavioral Health Ambulatory Treatment System, https://www.mass.gov/service-details/attend-a-listening-session-on-creating-a-behavioral-health-ambulatory-treatment (last visited Sept. 27, 2020).

initiatives it will implement as part of the redesign effort," without any specification as to how or when it might do so.[12] Such vague assertions lack sufficient detail to allow stakeholders to provide meaningful comment.

Massachusetts attempts to rely on the public notice and comment period that took place in 2017 to inform this amendment. CMS did not approve the amendment in 2017 in its entirety, and therefore it is technically still listed as "pending." But simply terming something an amendment or a "supplemental application" does make it so. The present submission is materially different from the earlier request, and is more appropriately deemed a separate amendment request, not a supplement to the previous request. Even something as basic as the "identified goals" of the demonstration in the 2020 amendment are almost completely different from those articulated in 2017, demonstrated below:

Goals	**2017[13]**	**2020[14]**
Goal 1	Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care	Reduce utilization and lengths of stay in emergency departments (EDs)
Goal 2	Improve integration of physical, behavioral and long-term services	Reduce readmission to acute care hospitals and residential settings
Goal 3	Maintain near-universal coverage	Improve availability of crisis stabilization services
Goal 4	Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals	Improve access to community-based services through increased integration of primary and behavioral health care
Goal 5	Address the opioid addiction crisis by expanding access to a broad spectrum of	Improve care coordination and continuity of care

[12] Massachusetts SMI-SED Supplemental Application, (Aug. 21, 2020), at 5, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-pa4.zip (hereinafter "2020 SMI-SED Application").
[13] MassHealth 2017 Amendment Request. While the 2017 request specified that the portion of the demonstration that sought FFP for services in IMDs was related to Goal 2--"improve integration of physical, behavioral and long-term services"-- the vast majority of the request related to other experiments.
[14] 2020 SMI-SED Application at 3.

	recovery-oriented substance use disorder services	

Stakeholder comments submitted in 2017 are likely no longer relevant as to whether the present request is a legitimate experiment. The problems identified by the Commonwealth over three years ago are not static, and the data the Commonwealth is relying upon to justify this waiver has changed over the course of three years. Therefore, the present request is more appropriately categorized a separate amendment to the waiver, and state-level stakeholders should have an opportunity to comment on how these different goals and the design of the proposal fits within MA's current array of services. CMS should reject this request until Massachusetts can demonstrate that it provided such an opportunity.

II. Massachusetts Has Not Proposed an Experiment

To be approved pursuant to § 1115, Massachusetts' 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.[15]

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.[16]

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

[15] 42 U.S.C. § 1315(a).
[16] *See* 42 U.S.C. § 1396-1.

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.

Massachusetts requests federal financial participation (FFP) for IMDs, but there is nothing novel or experimental about this proposal. Insofar as Massachusetts requests FFP for inpatient psychiatric services in IMDs, Massachusetts is actually asking for a "repeat" of a demonstration it was already granted in 1997, and phased out by 2007.[17] Massachusetts' pending application fails to even mention this history, let alone provide any analysis of how the present request is any different from its previous demonstration or is in any way innovative or experimental.

Although CMS has recently invited and encouraged states to apply for mental health-related Section 1115 demonstration waivers, CMS has not provided any justification for its change in position.[18] 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. Furthermore, demonstrations should only be approved "to the extent and for the period necessary" to carry out the experiment.[19] A "repeat" demonstration, without any clear distinction from a state's previous waiver, is not sufficiently limited to the extent and time period required to carry out the experiment. Section 1115 does not offer HHS a "back door" to provide ongoing funding for settings that Congress explicitly carved out of Medicaid.

Massachusetts 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. Massachusetts' proposal in inadequate with respect to these preconditions. According to Congress, "States can apply to HHS for a waiver of existing law to test a unique approach to

---

[17] MassHealth 2007 Amendment, *supra* note 1, at 2. Although Massachusetts' authority to obtain FFP directly for services in IMDs was phased out, Massachusetts did obtain permission to use federal funding to make payments to IMDs through its Safety Net Care Pool for uncompensated care. At that time, nine other states, besides Massachusetts, had waivers to fund psychiatric services in IMDs during the late 1990s and early 2000s, including Tennessee, Arizona, Delaware, Maryland, New York, Oregon, Rhode Island, Tennessee, and Vermont. All other states had their waivers completely phased out. 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.

[18] 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").

[19] 42 U.S.C. § 1315(a).

the delivery and financing of services to Medicaid beneficiaries . . . contingent upon development of a detailed research methodology and comprehensive evaluation for the demonstration."[20]

Massachusetts has failed to articulate *any* hypothesis or method to measure that hypothesis. Instead, the Commonwealth admits that it does not have a hypothesis or any plan to measure the hypothesis at this time. The supplement states that "MassHealth will work without Independent Evaluator to revise our current Evaluation Design to include hypotheses and research questions to evaluate the goals of this demonstration . . ."[21]

Further, one of the goals Massachusetts offers in this application—to reduce utilization and lengths of stay in emergency departments--was already the subject of a federally funded national IMD demonstration, where it was found that federal funding for short-term stays in IMDs did not reduce emergency room utilization. The Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by the Section 2707 of the Affordable Care Act, 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."[22]

As noted above, the present application is substantially different from the 2017 request. Even so, the 2017 amendment does not provide any additional insight into what Massachusetts is seeking to test, nor why its request qualifies as an experiment. As NHeLP noted at that time, Massachusetts' "request is not tied to specific, detailed policies the state wishes to implement," and the "[s]tate's proposal is insufficiently detailed for meaningful public comment, does not establish a clear experimental goal, and requests a broad and ill-defined waiver of an important Medicaid provision."[23]

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

---

[20] H.R. Rep. No. 3892, pt. 2, at 307-08 (1981).
[21] 2020 SMI-SED Application at 4.
[22] 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"). At 49 MEPD Evaluation at 49.
[23] Nat'l Health Law Prog., Comments on Amendment Request for MassHealth 1115 Demonstration (Oct. 20, 2007), https://healthlaw.org/resource/nhelp-comments-on-massachusetts-amended-sec-1115-waiver-project/.

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

Massachusetts 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.

Further, Massachusetts calls this amendment an "SMI-SED" request, but nowhere does the amendment address whether Massachusetts is seeking FFP to IMDs that serve children with Serious Emotional Disturbance (SED). To the extent Massachusetts is seeking FFP for IMDs for individuals under age 21, the Secretary does not have authority to approve the request. Congress has already prescribed the conditions under which youth under 21 could get Medicaid funded inpatient services and these conditions cannot be waived. Under 42 U.S.C. § 1396(a)(16), states are authorized to use FFP for inpatient psychiatric hospital services for individuals under 21 (often referred to as the "psych under 21" or "psych 21" benefit). However, 42 U.S.C. § 1396(h) limits FFP availability to services provided "in a psychiatric hospital…or in another inpatient setting *that the Secretary has specified in regulations*" (emphasis added). Through regulation, the Secretary has specified three settings that would normally be considered IMDs as eligible for FFP for provision of inpatient behavioral health treatment for individuals under 21: a psychiatric hospital; a psychiatric unit of a general hospital; and a psychiatric residential treatment facility (PRTF).[24] Because the statutory limits for the psych under 21 benefit are found outside of 42 U.S.C. § 1396a, those limitations cannot be waived. As such, FFP is only available for the three inpatient settings that the Secretary has defined through regulation.

Because Massachusetts 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.

[24] 42 C.F.R. § 441.151.

IV. Massachusetts' Proposal Risk Diverting Resources Away from Community-Based Services and Undermining Community-Integration

Massachusetts is requesting a blanket waiver of the IMD exclusion for psychiatric services provided in IMDs, without any guardrails or limitations. While other states have requested funding for short-term stays and committed to maintaining an average length of stay of less than 30 days, Massachusetts appears to be requesting a blank check with no such restrictions. Such proposals risk 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.[25] 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.[26]

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.[27] 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

---

[25] 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.

[26] *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/.

[27] 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.

problem."[28] 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 Massachusetts' 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.

V. Conclusion

The Secretary should not approve Massachusetts' requested demonstration amendment. While NHeLP supports all efforts to expand access to mental health treatment for Medicaid beneficiaries, we believe this 1115 waiver amendment is not the appropriate vehicle to achieve this goal. The Commonwealth has not provided state-level notice and opportunity to comment, in violation of the current STCs of its wavier. Additionally, the Commonwealth has not proposed a valid experiment, is requesting a waiver of provisions that the Secretary does not have authority to waive, and has not articulated sufficient safeguards to prevent siphoning of funds from community-based services into institutional ones. Last, the proposal risks perpetuating discrimination against and the unlawful segregation of people with disabilities in Massachusetts. We believe the Commonwealth would be better served by investing in community-based services and this request should be denied on multiple grounds.

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

Sincerely,

Jennifer Lav
Senior Attorney

[28] 42 U.S.C. § 12101(a)(2).