



Elizabeth G. Taylor
Executive Director

Board of Directors

Ann Kappler
Chair
Prudential Financial, Inc.

William B. Schultz
Vice Chair
Zuckerman Spaeder LLP

Miriam Harmatz
Secretary
Florida Health Justice Project

Nick Smirensky, CFA
Treasurer
New York State Health Foundation

Arian M. June
Debevoise & Plimpton LLP

L.D. Britt, MD, MPH
Eastern Virginia Medical School

Ian Heath Gershengorn
Jenner & Block

Robert B. Greifinger, MD
John Jay College of
Criminal Justice

John R. Hellow
Hooper, Lundy & Bookman, PC (Ret.)

Michele Johnson
Tennessee Justice Center

Lourdes A. Rivera
Center for Reproductive Rights

Donald B. Verrilli, Jr.
Munger, Tolles & Olson

Robert N. Weiner
Arnold & Porter, LLP

Ronald L. Wisor, Jr.
Hogan Lovells

Senior Advisor to the Board
Rep. Henry A. Waxman
Waxman Strategies

General Counsel
Marc Fleischaker
Arent Fox, LLP

August 1, 2020

VIA ELECTRONIC SUBMISSION

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

Re: Oklahoma Section 1115 Institutions for Mental Disease (IMD) Waiver for Serious Mental Illness/Substance Use Disorder

Dear Sir/Madam:

On behalf of the National Health Law Program (NHeLP), we appreciate the opportunity to provide these comments on Oklahoma's proposed Section 1115 Institutions for Mental Disease (IMD) waiver for serious mental illness (SMI) and substance use disorder (SUD). 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 and SUD services, there are at least four reasons the Secretary should not approve the requested waiver. First, Oklahoma 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 Oklahoma requests a waiver of provisions outside of 41 U.S.C. § 1396a, including the IMD exclusion. 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 Oklahoma has not proposed a genuine experiment or novel approach. Third, Oklahoma’s proposal risks diverting funds away from community-based services, undermining decades of progress toward increased community-integration. Finally, the Secretary does not have authority to approve a Section 1115 waiver that would enable Qualified Residential Treatment Programs (QRTPs) to receive federal financial participation (FFP) for psychiatric treatment for individuals under 21 with SMI, and even if the Secretary had such authority, Oklahoma’s proposal fails to demonstrate compliance with the requirements CMS has outlined for FFP in these settings.

I. The Secretary Does Not Have Discretion to Waive the IMD Exclusion

Oklahoma’s central request is to receive FFP for services provided in IMDs. The Secretary does not have authority to waive the IMD exclusion. Section 1115 permits waiver of only those provisions contained in 42 U.S.C. § 1396a of the Medicaid Act, and the IMD exclusion is found in 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i). Requirements found outside of 42 U.S.C. § 1396a cannot be waived. Oklahoma attempts to circumvent this based on a theory that Section 1115(a)(2) creates an independent “expenditure authority.” 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. Section 1115(a)(2) merely provides for federal reimbursement of necessary expenditures for a project that already qualifies for a waiver. Therefore, the IMD exclusion cannot be waived.

II. FFP for IMDs is Not 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 Section 1115 demonstration waiver request must propose a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money through a Section 1115 demonstration waiver; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.



The main feature of Oklahoma’s request is to obtain FFP for IMDs, but the State fails to explain why it believes this waiver would test a novel or experimental idea.¹ For the past 25 years, CMS has granted numerous states authority to waive the IMD exclusion for adults with SMI and children with serious emotional disturbances (SED), 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.² 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.”³ Although CMS has, for the past five years, reversed that position and instead invited and encouraged states to apply for Section 1115 IMD demonstration waivers for both SMI/SED and SUD, it has not provided sufficient justification for why waiving the IMD exclusion in these instances would constitute an experiment different from those waivers that ran from 1993 to 2009.⁴ Similarly, Oklahoma fails to provide enough evidence that this proposal will test an experimental idea.

In fact, instead of testing novel ideas, Oklahoma’s request is designed to shift local costs to the federal government. Oklahoma seeks FFP for services provided at IMDs, despite the illegality of such a waiver (*infra*, Section II), but the State already provides funding for this service. While Oklahoma currently only operates one crisis center that qualifies as IMD, the State also operates nine crisis centers for adults that it hopes will increase capacity if there is continued access to Medicaid reimbursement.⁵ In other words, Oklahoma is seeking FFP to expand the number of IMDs providing services in the State, despite the fact that the same services are

¹ Oklahoma Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness/Substance Use Disorder (July 19, 2020) [hereinafter “Proposal”].

² U.S. GOV’T ACCT. OFF., *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> [hereinafter “GAO Report”].

³ *Id.*; see also, MaryBeth Musumeci et al., *State Options for Medicaid Coverage of Inpatient Behavioral Health Services*, KFF (Nov. 6, 2019), <https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/>.

⁴ 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>. 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>.

⁵ Proposal, *supra* note 1, at 13.



already provided in smaller facilities that are not IMDs. Allowing FFP for treatment services at IMDs would simply shift costs to the federal government without providing any new service.

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

Because Medicaid reimbursement is available for mental health and SUD services in the community rather than institutions, historically the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated settings. This financial incentive to rebalance treatment towards community-based services is particularly important due to “bed elasticity,” where supply drives demand.⁶ 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 harder to access.

Regardless of whether individuals with SUD or individuals under 21 with SMI 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.⁷ For example, they often need ongoing community-based services such as case management, medication-assisted treatment (MAT), and peer support services to maintain their recovery, prevent relapse, and quickly return to treatment if relapses occur.⁸ Expanding incentives to utilize residential treatment by permitting FFP for services provided in IMDs could actually undermine efforts to ensure the appropriate continuum of care. 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

⁶ 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>.

⁷ 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>.

⁸ 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>.



encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option.”⁹ Furthermore, increasing funding to inpatient facilities could increase dangers to patients with opioid use disorder 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.¹⁰

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.¹¹ 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.¹² 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.”¹³ Providing FFP for large institutional settings could reify discriminatory presumptions about the ability of individuals with disabilities to receive services in community-based settings, undermining the integration mandate articulated by the Supreme Court in

⁹ 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>.

¹⁰ *Id.*

¹¹ 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>.

¹² 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.”).

¹³ 42 U.S.C. § 12101.



Olmstead v. LC, and the network of community-based services painstakingly established via *Dixon v. Gray*.¹⁴

IV. The QRTP Proposal Fails to Meet Statutory and Regulatory Requirements for FFP for Inpatient Psychiatric Treatment of Individuals under 21

Oklahoma seeks FFP to pay for treatment of individuals under age 21 in QRTPs, facilities created by the Family First Prevention Services Act that are designed to address the needs, including clinical needs, of children in the foster care system with SED.¹⁵ The proposal explains that the State is in the process of transitioning state-operated congregate care facilities for children in state custody into QRTPs by October 1, 2021. As such, Oklahoma requests authority for Medicaid reimbursement of stays of 60 days or less in future QRTPs that the State determines are IMDs.¹⁶ The Secretary, however, does not have authority to approve a Section 1115 waiver that seeks to increase funding for residential behavioral health treatment for minors because Congress has already prescribed the conditions under which youth under 21 could get Medicaid funded inpatient services and these conditions are not waivable. In addition, the State's proposal fails to demonstrate compliance with CMS guidance reaffirming the statutory conditions of participation.

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).¹⁷ A PRTF is a specific kind of longer-term facility for youth that was created via regulation, with prescribed staffing and reporting requirements and other specific conditions of participation, including:

¹⁴ *Olmstead v. L.C.*, 527 U.S. 581 (1999); *Dixon v. Gray*, settlement agreement, <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/DixonSettlementAgreement.pdf>.

¹⁵ Proposal, *supra* note 1, at 3.

¹⁶ Proposal, *supra* note 1, at 6.

¹⁷ 42 C.F.R. § 441.151.



- a) Facility must ensure that services are overseen by a physician and delivered pursuant to a plan of care that is developed by an “interdisciplinary team of physicians and other personnel.”¹⁸
- b) Facility must submit attestations to CMS regarding compliance with regulatory schemes;
- c) Facility must make reports of specific adverse events to the Protection and Advocacy agency, the state Medicaid agency, and CMS within prescribed timeframes.¹⁹
- d) Facility staff must undergo specific trainings and may only use restraint and seclusion in extremely limited circumstances.²⁰

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. Given that CMS regulations do not authorize QRTPs to receive FFP as psych under 21 providers, Oklahoma’s 1115 request for FFP for QRTPs should not be granted. The state may enroll QRTPs as providers, if and only if the QRTP also meets the definition and conditions of participation of psychiatric hospitals or PRTFs. Section 1115 waivers are not available when used as a workaround to comply with psych under 21 requirements.

CMS’s IMD waiver guidance has also reaffirmed that QRTPs must first demonstrate compliance with all psychiatric hospital and PRTF requirements before receiving FFP. The agency has stated that the Secretary will not grant any IMD exclusion waivers for children and youth in settings that do not “meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit.”²¹ CMS has further explained that, because QRTPs typically would not meet the definition of “inpatient” under Medicaid regulations, the facilities would not qualify as psychiatric hospitals or psychiatric units of a general hospital.²² Similarly, CMS has stated that it is unlikely that QRTPs meet the requirements to qualify as PRTFs. Regardless of whether it is possible for QRTPs to meet the requirements, the current

¹⁸ 42 C.F.R. § 441.155–56.

¹⁹ 42 C.F.R. § 483.374.

²⁰ 42 C.F.R. § 483.351–76.

²¹ SMD # 18-011, *supra* note 4, at 13.

²² CMS, *Qualified Residential Treatment Programs and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers* (Sept. 20, 2019), at 4, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf> (hereinafter “CMS QRTP Guidance”).



proposal fails to specify how the State plans to comply with the conditions that CMS has established for approval of IMD waivers.

Oklahoma's proposal falls short of even acknowledging the requirements outlined in federal Medicaid law, regulations, and guidance, much less providing sufficient evidence to guarantee compliance. While CMS's guidance states that IMD exclusion waivers may be available for QRTPs that have more than 16 beds and are considered IMDs, the guidance is also clear that states must demonstrate that QRTPs are or will be complying with the psych under 21 requirements, including those regarding the use of restraint and seclusion.²³ Because Oklahoma has failed to demonstrate that its QRTPs will comply with these requirements, which are paramount to the protections in federal Medicaid law against institutionalization of individuals under 21 with SMI, the Secretary should reject the proposal.

Finally, even if the Secretary were considering approving Oklahoma's request to use FFP for treatment of individuals under 21 in QRTPs, the demonstration would be of limited utility for expanding residential psychiatric beds. The Family First Act limits QRTP designation of public facilities to those facilities with fewer than 25 beds.²⁴ Pursuant to the proposal, the congregate care facilities that Oklahoma seeks to convert to QRTP are all state-operated.²⁵ As such, the 25-bed limit applies and the State will be unable to convert those facilities with more than 25 beds to QRTPs by 2021 unless the State also reduces their inpatient bed capacity. In other words, through the 1115 demonstration, the State would only be able to receive FFP for psychiatric treatment in facilities with a capacity of 16–25 beds (given that those under 16 beds are not considered IMDs, and are already eligible for FFP, and those over 25 beds do not qualify for QRTP designation and are ineligible for FFP under CMS's guidance).

²³ In its September 2019 guidance, CMS stated that states seeking IMD waivers for services at QRTPs should demonstrate compliance with "CMS regulations regarding seclusion and restraint found in 42 C.F.R. Part 483 Subpart G." CMS QRTP Guidance, at 5. While this statement appears to be more limiting than SMD # 18-011, which requires compliance with all the psych under 21 requirements, we believe CMS did not intend for the CMS QRTP Guidance to override the agency's 2018 Dear Medicaid Director letter. As such, Oklahoma QRTPs should be required to demonstrate that compliance with all psych under 21 benefits before being able to receive FFP.

²⁴ 42 U.S.C. 672(c)(2). See CMS QRTP Guidance, at 1–2.

²⁵ Proposal, *supra* note 1, at 6.



V. Conclusion

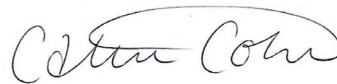
While NHeLP generally supports Oklahoma's goal to expand access to behavioral health treatment for Medicaid beneficiaries, we believe this Section 1115 waiver request is not the appropriate vehicle to achieve this goal. For the reasons stated above, we urge the Secretary to reject Oklahoma's application.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Héctor Hernández-Delgado (hernandez-delgado@healthlaw.org) or Cathren Cohen (cohen@healthlaw.org).

Sincerely,



Héctor Hernández-Delgado
Staff Attorney



Cathren Cohen
Staff Attorney

