April 24, 2021

VIA ELECTRONIC SUBMISSION

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

Re: Alabama Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness

Dear Sir/Madam:

On behalf of the National Health Law Program (NHeLP), we appreciate the opportunity to provide these comments on Alabama's proposed Section 1115 Institution for Mental Disease Waiver for Serious Mental Illness. 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, 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 Alabama has not proposed a genuine experiment or novel approach. Second, Alabama 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 Alabama requests a waiver of provisions outside of 42 U.S.C. § 1396a, including the "Institution for Mental Diseases" (IMD) exclusion. Third, Alabama's proposal risks diverting funds away from community-based services, undermining decades of progress toward increased community integration. Last, Alabama proposes several reforms that simply do not require any wavier of the Medicaid Act. Such reforms should be pursued outside of the context of a waiver.

I. HHS authority under § 1115

For the Secretary to approve a project pursuant to § 1115, the project must:

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

Discussing each of these limitations a bit further:

First, the state must propose to conduct an "experimental, pilot, or demonstration" project. This demands a "novel approach" to program administration. *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act's objectives. Congress has made clear that the purpose of Medicaid is to enable states "to furnish[] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1; 1396d(a) (defining "medical assistance" as provision of, or payment for, specified health care and services). Thus, the "central objective" of the Medicaid Act is "to provide medical assistance." *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed … to address not health generally but the provision of care to needy populations" through a health insurance program).

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b-1396w-5. *See* Social Security Act, § 1115(a)(1)).

Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of "such project" are "regarded as expenditures under the State plan" and, thus, paid for under the same statutory formula that applies for a state's expenditures under its State plan. *Id.* § 1115(a)(2). Section 1115(a)(2) does not create an independent "expenditure authority" for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a "clean-up" provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Fourth, section 1115 allows approvals only "to the extent and for the period necessary" to carry out the experiment. *Id.* § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers).[1] Congress did not enact section 1115 to permit the Secretary to make long-term policy changes.

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.

[1] In 2017, a CMS Informational Bulletin announced the intent "[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*" Section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115's limitation of approvals to experimental, pilot, or demonstration projects (not for "routine" projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

Alabama's request is to obtain federal financial participation (FFP) for IMDs, but the State fails to explain why this would be an experiment. For the past 25 years, CMS has granted states authority to waive the IMD exclusion for adults with serious mental illnesses (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 recently invited and encouraged states to apply for Section 1115 IMD demonstration waivers for SMI/SED, it has not provided sufficient justification for why waiving the IMD exclusion would now constitute an experiment different from those waivers that ran from 1993 to 2009.[4] 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 is not intended to provide long-term funding for settings that Congress explicitly carved out of Medicaid, yet that is exactly what Alabama seeks. Between 2012 and 2015, Alabama District 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.[5] This demonstration was phased out because a

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[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] Crystal Blyer et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report*, Volume I MATHEMATICA POL'Y RSCH. (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf (hereafter "Blyer Volume 1")

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.[6] Now, Alabama asks to recreate administratively what Congress has declined to do statutorily, asking with this demonstration request "to regain and sustain the benefits achieved under the State's previous participation in the [MEPD] Demonstration[.]"[7] In many ways, the current proposal is simply a request for an extension of federal funding that is no longer Congressionally authorized.

Alabama fails to propose a new theory that waiving the IMD exclusion could test. One hypothesis that Alabama sets forward to test was already explicitly tested via the MEPD, and found to be unsupported. Alabama's Proposal aims to "reduce[] utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI or SED[.]"[8] Yet the MEPD found 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."[9] While the quantitative data in the original MEPD report for this particular issue is not disaggregated by state, the qualitative data from interviews with Alabama project directors, facility staff, and beneficiaries supports the finding that the demonstration did not have a significant impact on admission to emergency departments or length of stay within them.[10]

Alabama claims it wants to test whether this demonstration will improve care coordination and the transition from inpatient settings to community-based care.[11] However, this hypothesis has already been tested. The MEPD "did not reveal changes or improvements to discharge planning," including care coordination procedures.[12] Even though qualitative data from

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[6] GAO Report at 35.
[7] Alabama Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness 3 (March 1, 2021) [hereinafter "Proposal."]
[8] *Id.* at 10 ("Hypothesis 1").
[9] Blyer, Volume 1., *supra* note 5, at 49.
[10] *Id.* at I2; *see also* HHS, Medicaid Emergency Demonstration Project Report to Congress 43 (Sept. 30, 2019), https://innovation.cms.gov/files/reports/mepd-curesact-rtc.pdf (In a follow up report to Congress, such data was disaggregated. However, this data was only based on one to three hospitals per state. In Alabama, the average amount of time an individual spent in that emergency department for a psychiatric crisis was 11.7 hour prior to the MEPD, and during the MEPD it was 10.1 hours, suggesting small change. However, the report to Congress indicated that time spent in emergency departments varied widely between hospitals and the data was only from one to three emergency departments per state, and therefore may not be generally reflective of the state. Further, the study did not conclude that the MEPD generally reduced time spent in emergency departments.).
[11] Proposal at 8.
[12] Blyer, Volume I, *supra* note 5, at 55.

Alabama's experience in the MEPD suggests that stakeholders believed that the demonstration improved some aspects of discharge planning *within facilities*, the demonstration also noted that "[both] ED and IMD staff in Alabama expressed concerns about the residences [that beneficiaries were discharged to], alleging that many of them providing inadequate support to residents, leading to increased ED visits and inpatient admissions for psychiatric emergencies."[13] Alabama has not explained why it is reasonable to hypothesize that that FFP for IMDs would "improve continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities," or "reduce readmissions to acute care" given the challenges faced by the state.[14] The state has not even suggested undertaking any new actions regarding discharge planning. The proposal states that "Alabama administrative code requires psychiatric hospitals to have in effect a written discharge planning process" which includes arrangements with post-hospital care and services.[15] If such services are already required and being provided, there is simply no new experiment.

To the extent Alabama is merely seeking FFP for IMDs, such a proposal is not an experiment. FFP for IMDs does not test novel ideas. It simply shifts local costs to the federal government.

III. The IMD Exclusion Cannot Be Waived

Alabama's central request is for federal financial participation (FFP) for services provided in IMDs.[16] Additionally, Alabama asks for a waiver of "statewideness" in order to restrict FFP for IMDs to facilities in certain counties. 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). 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.

IV. FFP for IMDs Risks Diverting Resources Away from Community-Based Services and Undermining Community-Integration

Because Medicaid reimbursement is available for mental health services in the community rather than institutions, historically the IMD exclusion has provided important incentives to

[13] *Id*. at 54.
[14] Proposal at 14, 12 ("Hypothesis 5" and "Hypothesis 2").
[15] *Id.* at 8.
[16] *Id.* at 15.

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.[17] 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 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. 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 encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option."[18] In Alabama, this risk of an imbalance is exacerbated because there are already significant gaps in community-based care. As noted above, during the MEPD, stakeholders noted concerns that the poor quality group homes in the community may be a driving factor in IMD admission.[19] The Alabama Disabilities Advocacy Program (ADAP), the federally-mandated protection and advocacy center for the state, commented on this risk in state level comments.[20] ADAP calls instead for more targeted crisis intervention and diversion services, such as peer operated crisis and respite services, noting that "smaller, community-based centers often are more patient centered and, because they are more spread throughout the state, allow an individual to maintain closer ties to her community, family, supports, etc."[21]

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[17] 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.

[18] 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.

[19] Shumway et al., *supra* note 16.

[20] *See* Proposal at 19.

[21] Alabama Disabilities Advocacy Program, Objections to State of Alabama's Proposed Section 1115 Institutions for Mental Disease (IMD) Waiver for Serious Mental Illness (Feb. 4, 2021), Attachment 1.

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.[22] 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.[23] 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."[24] 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 *Olmstead v. LC*, and the network of community-based services painstakingly established over thirty years of litigation via *Wyatt v. Sawyer*.[25]

Further, Alabama's definition of "acute" care further risks violating of *Olmstead*. The proposed demonstration seeks reimbursement for "clinically appropriate short term stays for acute psychiatric care[,]" but specifies that "acute" care reimbursement is limited to stays of no "more than 60 *consecutive* days" (emphasis supplied).[26] This means that, if granted the waiver, Alabama could receive FFP for even longer-term stays as long as an individual was discharged, no matter how briefly, in between stays. This cycle could be repeated indefinitely. As a result, the proposal risks increasing institutionalization of individuals with SMI and diverting of resources away from more appropriate community-based services. In response to

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[22] 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.

[23] 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.").

[24] 42 U.S.C. § 12101.

[25] *Olmstead v. L.C.*, 527 U.S. 581 (1999); Wyatt ex rel. Rawlins v. Sawyer, 105 F.Supp.2d 1234 (M.D. Ala. 2000) (approving proposed settlement and recounting the thirty-year history of the seminal mental health litigation).

[26] Proposal at 14.

a state-level comment that was critical of the request for 60 consecutive days, Alabama replied that "length of stay for Alabama under the MEPD demonstration was seven days and the average length of stay was ten days. The State anticipates similar results under this waiver."[27] However, nowhere in the proposal does Alabama commit to any average length of stay, let alone an average length of stay of ten days.

V. Alabama Can Accomplish Its Stated Goals through State Plan Authority

While NHeLP supports Alabama's desire to expand access to behavioral health services for Medicaid beneficiaries, many of the services the State describes providing or proposes to provide in the future may be provided through a State Plan Amendment (SPA). Section 1115 only gives the Secretary authority to waive certain provisions of the Medicaid Act "to the extent and for the period he finds necessary to enable such State or States to carry out such project."[28] The Secretary should only use section 1115 waiver authority to the extent that is "necessary" to enable a state to carry out an experiment. Thus, the secretary should not approve waivers for actions that could be carried out via state plan authority.

As noted above, the only specific authority sought via this waiver is to allow Alabama to obtain FFP for services provided in three IMDs. However, in coordination with this, Alabama proposes that it will require these three hospitals to provide psychiatric consultation services to enrollees in general hospitals who need such consultations. We note that there is no need to seek an 1115 waiver to allow for consultations by employees of IMDs. The prohibition on FFP is for services rendered to *residents of an IMD.* There is no prohibition on employees of an IMD providing consultation services (and receiving FFP for such services) for enrollees that are being served in non-IMD settings. In addition to this consultation service, Alabama has also proposed a plan to build three crisis diversion centers, which are set to open in the second quarter of 2021.[29] The Alabama Department of Mental Health has apparently already requested and been granted the funding to proceed. No waiver authority is necessary for this.

The state apparently understands that no specific waiver authority is necessary to achieve either of the two above-described reforms, as the state does not request any specific waiver authority to execute these changes. Instead, Alabama simply describes these future changes. However, some state level commenters specifically stated that they supported the waiver

[27] *Id.* at 20.
[28] 42 U.S.C. § 1315(a)(2)(A).
[29] Proposal at 9.

because it provides a "comprehensive plan to expand behavioral health services with wraparound support to adults with SMI . . . ."[30] We believe that such support is based on a misunderstanding of the mechanics of the waiver. There is nothing in the waiver that will create comprehensive community-based services. While we certainly support greater availability of community-based services, no waiver is required to accomplish this. The waiver simply requests FFP for services provided in IMDs. We are supportive of these other initiatives, but every initiative *except* for FFP for services in IMDs can and should be undertaken regardless of the waiver.

VI. Conclusion

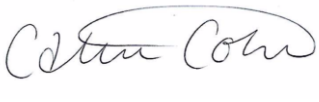
In summary, NHeLP generally supports Alabama's efforts to expand access to behavioral health treatment for Medicaid beneficiaries. However, we believe this Section 1115 waiver request is not the appropriate vehicle to achieve this goal. The Medicaid Act does not grant the Secretary the authority to waive the IMD exclusion

Further, Alabama has failed to explain how obtaining FFP for services renders at IMDs, the cornerstone of the application, constitutes a valid experiment under the Medicaid Act. Approval of the waiver risks divert funds from community-based mental health into institutionalized services, a potential violation of the *Olmsted* mandate. Finally, the State does not need waiver to achieve, many of the reforms the described in its waiver application. For example, the state can seek FFP for the new crisis diversion centers absent a waiver, and similarly there is no need for a waiver to permit outside psychiatric consults at general hospitals.

[30] Proposal at 18.

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

Sincerely,



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