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April 26, 2021

**VIA ELECTRONIC SUBMISSION**

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

**Re: New Mexico Centennial Care 2.0 1115 Waiver  
Amendment #2 Request—SMI Amendment**

To Whom It May Concern:

On behalf of the National Health Law Program (NHeLP), we appreciate the opportunity to provide these comments on the State of New Mexico's Human Services Department Centennial Care 2.0 1115 Waiver Amendment #2 Request.

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 seven reasons the Secretary should not approve this request:

- 1) The Secretary may only waive requirements of the federal Medicaid Act to the extent and for the period necessary to carry out an experiment or test a novel approach to improve medical assistance for low-income individuals. New Mexico's request to waive the "Institution for Mental Diseases" (IMD) exclusion does not constitute a valid experiment.

- 2) The Secretary does not have authority to waive the requested provision of the Medicaid Act. § 1115 only permits waiver of those requirements found in 42 U.S.C. § 1396a. New Mexico requests a waiver of a provision of the Medicaid Act – the IMD exclusion – that is outside of § 1396a, and therefore cannot be waived.
- 3) New Mexico’s request to waive the IMD exclusion risks diverting funds away from appropriate community-based services, undermining progress towards increased community integration.
- 4) New Mexico’s request to implement High-Fidelity Wraparound as an intensive care coordination model does not constitute an experiment or test a novel approach.
- 5) Intensive care coordination and High-Fidelity Wraparound services are already required to be provided as a medically necessary behavioral health service to children and youth under age 21 in the state pursuant to the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.
- 6) New Mexico has failed to articulate whether or how its request to establish a Graduate Medical Education program fund constitutes a genuine experiment.
- 7) New Mexico’s request to add vaccine coverage for individuals who have limited benefits coverage does not constitute an experiment.

#### **I. Overview of HHS’ authority under § 1115**

For the Secretary to approve any 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.<sup>1</sup>

Discussing each of these limitations 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

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<sup>1</sup> 42 U.S.C. § 1315(a).



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 §1396a of the Medicaid Act. The Secretary cannot waive requirements contained in §§1396b-1396w-5. See Social Security Act, § 1115(a)(1)).

Once the Secretary has acted under §1115(a)(1) to waive compliance with designated provisions in § 1396a, § 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). § 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 § 1396a or to rewrite the provisions in § 1396a or any other provision outside of § 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 § 1115(a)(1).

*Fourth*, § 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).<sup>2</sup> Congress did not enact § 1115 to permit the Secretary to make long-term policy changes.

Each of the project's components is discussed below. Common problems include the failure to propose a valid experiment and reliance on a purported expenditure authority.

## II. Seeking Federal Financial Participation for IMDs is not an experiment.

§ 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. A § 1115 demonstration request must propose a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money or shift costs to the federal government; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.

New Mexico 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 § 1115 demonstration waivers to funds IMDs for psychiatric treatment: Arizona, Delaware, Maryland, Massachusetts, New York, Oregon, Rhode Island, Tennessee, and Vermont.<sup>3</sup> 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.”<sup>4</sup>

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<sup>2</sup> In 2017, a CMS Informational Bulletin announced the intent “[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*” §1115(a) waivers for a period up to 10 years. CMCS, Section 1115 Demonstration Process Improvements 3 (Nov. 6, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf> (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, § 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).

<sup>3</sup> U.S. Gov. 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>.

<sup>4</sup> *Id.*



Although CMS has recently invited and encouraged states to apply for substance use disorder and mental health-related § 1115 demonstration waivers, it has not provided any justification for its change in position.<sup>5</sup> 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. § 1115 does not offer HHS a “back door” to provide funding for settings that Congress explicitly carved out of Medicaid.

New Mexico 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. New Mexico’s proposal falls short 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.”<sup>6</sup>

New Mexico has not provided any unique theory that can be tested by waiving the IMD exclusion. In fact, one of the goals that New Mexico 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.<sup>7</sup> The Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by § 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.”<sup>8</sup>

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<sup>5</sup> CMS, *Dear State Medicaid Director* (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* (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* (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>.

<sup>6</sup> H.R. Rep. No. 3892, pt. 2, at 307-08 (1981).

<sup>7</sup> Crystal Blyer *et al.*, *Mathematica Pol’y Rsch., Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (2016), <https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf>.

<sup>8</sup> *Id.* at 49.



Instead of testing novel ideas, New Mexico's proposal is simply designed to shift costs from the state to the federal government to obtain FFP to increase the number of IMDs operating throughout the state. New Mexico currently operates five IMDs and provides inpatient behavioral health services in a variety of other settings.<sup>9</sup> This proposal does not offer any new or innovative type of service. In other words, New Mexico is proposing to shift the cost of operating inpatient facilities with more than 16 beds from the state to the federal government.

This simply does not qualify as an experiment. Because New Mexico does not propose an actual experiment, with stated goals, hypothesis, and measures, the Secretary should not approve this request.

### **III. The Secretary does not have the authority to waive the IMD exclusion.**

New Mexico seeks a waiver of a provision of Medicaid that prohibits FFP for IMDs for individuals under age 65 – the IMD exclusion. This provision is found at 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i). § 1115 permits a waiver of only those provisions contained in 42 U.S.C. § 1396a of the Medicaid Act. Because the IMD provision lies outside of § 1396a, this is not a provision that can be waived via § 1115, and the request is not approvable.

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

### **IV. New Mexico's proposal to waive the IMD exclusion risks diverting resources away from community-based mental health services and undermining community integration.**

New Mexico seeks a blanket waiver of the IMD exclusion with no guardrails or limitations. While other states have requested funding for short-term stays or committed to maintaining an average length of stay of less than 30 days, New Mexico seeks a blank check to provide funding to IMDs regardless of length of stay.<sup>10</sup> Such proposals risk exacerbating current gaps in services by creating more incentives to increase institutional capacity instead of developing

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<sup>9</sup> Centennial Care 2.0 Amendment #2 at 5

<sup>10</sup> *Id.*



community-based resources. This in turn would worsen any shortages and continue a negative cycle of viewing institutional settings as the preferred treatment approach to address the needs of people with serious mental illness or serious emotional disorders (SMI/SED). This is particularly concerning given the evidence of the risk of “bed elasticity,” a phenomenon in psychiatry where supply drives demand.<sup>11</sup> 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.<sup>12</sup>

This is particularly concerning in New Mexico, where the state has struggled to provide Medicaid enrollees with appropriate, community-based behavioral health services. In 2013, New Mexico experienced chaos in its behavioral health system when the New Mexico Human Services Department suspended payments to 15 behavioral health organizations (BHOs) due to accusations of fraud. At the time, these 15 organizations provided 85% of behavioral health services to Medicaid managed care enrollees throughout the state. Though these organizations were eventually cleared of wrongdoing, 13 of the 15 organizations went out of business.<sup>13</sup> This caused huge disruptions in access to behavioral health services for Medicaid enrollees.

Despite New Mexico’s efforts to rebuild its community-based behavioral health system, a 2019 report by the HHS Office of the Inspector General found that New Mexico had large gaps in

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<sup>11</sup> 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>.

<sup>12</sup> See Barbara Dickey et al., *The Cost and Outcomes of Community-Based Care for the Seriously Mentally Ill*, 32 HEALTH SERVS. RSCH. 599 (1997), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070217/>.

<sup>13</sup> HHS, Office of the Inspector Gen. (“OIG”), *Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico’s Medicaid Managed Care* 2-3 (2019), <https://oig.hhs.gov/oei/reports/oei-02-17-00490.pdf> [hereinafter OIG Report].



service to Medicaid managed care enrollees.<sup>14</sup> The report cited a shortage of behavioral health providers, and that they were unevenly distributed throughout the state. Further, the report noted that the BHOs which served the bulk of Medicaid managed care enrollees reported difficulties scheduling timely appointments and providing coordinated care to these enrollees.<sup>15</sup> As required, New Mexico has included a maintenance of effort provision in this proposal, which claims that the state will “ensure the authority for more flexible inpatient and residential treatment does not reduce the availability of outpatient community-based behavioral health.”<sup>16</sup> New Mexico should continue its work to build a comprehensive community-based behavioral health system. Approving the state’s request for FFP for IMD beds will simply undercut this effort.

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.<sup>17</sup> 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.”<sup>18</sup> 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 undermine the integration mandate articulated by the Supreme Court in *Olmstead v. LC*. In short, this request promotes the segregation of people with mental illnesses.

#### **V. New Mexico’s proposal to implement High-Fidelity Wraparound (HFW) as an intensive coordination model for children and youth is not an experiment.**

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<sup>14</sup> Nearly 80% of Medicaid enrollees in New Mexico receive services through one of three Medicaid managed care plans in the state. OIG Report at 3.

<sup>15</sup> OIG Report at 10-22.

<sup>16</sup> Centennial Care 2.0 Amendment #2 at 9.

<sup>17</sup> 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>.

<sup>18</sup> 42 U.S.C. § 12101(a)(2).



As noted earlier, § 1115 requests must propose a genuine experiment to test novel approaches or ideas. (Please see discussion *supra* Section I.) New Mexico has failed to provide sufficient evidence that implementing HFW for children and youth would constitute such an experiment. Intensive care coordination (ICC) that includes wraparound services is a robust, comprehensive form of targeted case management that is designed to support children with significant mental health needs.<sup>19</sup> A wealth of research and evidence demonstrates that this is a well-established and effective intervention.<sup>20</sup> Over the past decade, many states have successfully adopted and implemented various forms of ICC that include wraparound services.<sup>21</sup>

New Mexico has also requested that it be permitted to implement HFW in two phases, first seeking to make these service available to children and youth in New Mexico’s Children, Youth & Families Department’s (CYFD) custody, and later expanding it to a wider range of beneficiaries. Additionally, the state has requested permission to use a limited provider pool. Neither of these approaches constitutes an experiment. The state already can and, is required to, implement HFW and ICC through EPSDT (see *infra* Section VI). Additionally, the state already has the capacity to limit the provider pool by establishing minimum qualifications for ICC providers. New Mexico has failed to establish that there is anything innovative or new about the program they wish to test. Because New Mexico does not propose an actual experiment, with stated goals, hypothesis, and measures, the Secretary should not approve this amendment.

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<sup>19</sup> CMS and SAMHSA, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* (May 7, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>.

<sup>20</sup> See e.g., Ctr. for Health Care Strategies, *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles* 6 (July 2014), <https://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf> [hereinafter CHCS State and Community Profiles]; CMS, *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* 11-12 (June 2014), [https://www.medicaid.gov/sites/default/files/2019-12/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf) (noting that wraparound services are part of an array of home and community based services that have “proven to significantly enhance positive outcomes for children and youth.”) [hereinafter CMS EPSDT Guide for States]; see generally Jennifer Schurer Coldiron et al., *A Comprehensive Review of Wraparound Care Coordination Research, 1986-2014*, 26 J. CHILD & FAM. STUD. 1245 (2017).

<sup>21</sup> CHCS State and Community Profiles at 8-58.



## VI. ICC and HFW Services can and should be provided to children and youth through EPSDT.

While NHeLP supports New Mexico's objective to establish a HFW Service as an intensive care coordination model, the state should already be providing this service to all children eligible through EPSDT. Medicaid's broad EPSDT benefit entitles beneficiaries under age twenty-one to medically necessary mental health services targeted to effectively ameliorate identified conditions.<sup>22</sup> Specifically, if a service is listed under 42 U.S.C. § 1396d(a) (the section of Medicaid statute that defines "Medical Assistance"), and the service is medically necessary, then the state must provide the service.<sup>23</sup> This mandate applies to all categories of Medical Assistance, even if the service is generally classified as an "optional" service.<sup>24</sup> In other words, "while a state may choose which medical services beyond the mandated seven it may offer to eligible adults, states are bound, when it is medically necessary, to make available to Medicaid-eligible children all of the twenty-eight types of care and services included as part of the definition of medical assistance in the Act."<sup>25</sup>

Courts have clearly established that states must provide intensive care coordination, including wraparound services, when it is medically necessary. For example, in *Rosie D. v. Romney* the U.S. District Court for the District of Massachusetts found that EPSDT must cover services like intensive care coordination, stating "comprehensive assessments and scrupulous service coordination are essential parts of the Commonwealth's EPSDT responsibility to children with SED."<sup>26</sup> Similarly, in *Katie A. v. Douglas* the Ninth Circuit also found that EPSDT mandated the coverage of intensive behavioral health services, including wraparound services.<sup>27</sup>

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<sup>22</sup> 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r); see also *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 590 (5th Cir. 2004) (services that are appropriately defined as "medical assistance" under the Medicaid regulations and are medically necessary to correct or ameliorate a condition" must be provided to children under 21.).

<sup>23</sup> The EDPST benefit, while broad, is not boundless. For example, states do not have to cover services that are experimental. CMS, STATE MEDICAID MANUAL § 5112. States may also choose the most cost effective treatment, as long as that treatment is equally effective and actually available. CMS, *EPSDT Guide for States*, at 24.

<sup>24</sup> *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 590 (5th Cir. 2004) (states must offer children "such other necessary health care, diagnostic services, treatment, and other measures described in § 1396d(a), "whether or not such services are covered in the state's Medicaid plan").

<sup>25</sup> *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 25 (D. Mass. 2006).

<sup>26</sup> *Id.* at 32.

<sup>27</sup> *Katie A. v. Douglas*, 481 F.3d 1150 (9th Cir. 2007).



New Mexico's two-phased implementation proposal would make initially make HFW services available only to children and youth in CYFD's custody. This approach would not be consistent with the state's EPSDT obligations. ICC and HFW are services that should currently be available to all Medicaid-eligible children for whom this intervention is medically necessary. Because it is a service that should already be provided by the state under EPSDT, the Secretary should not approve this requested amendment.

**VII. New Mexico's request to establish a Graduate Medical Education funding program does not clearly articulate a genuine experiment.**

While we appreciate New Mexico's need to recruit additional providers to the state, New Mexico has not provided enough information to determine whether the funds the state is seeking for GME constitute a legitimate experiment, nor has New Mexico articulated a provision of § 1396a that they are seeking authority to waive. For this reason, CMS should not approve the request.

**VIII. New Mexico's request to add vaccine coverage for individuals who have limited benefits coverage is not an experiment.**

New Mexico's request to add vaccine coverage for individuals who have limited benefits coverage is not an experiment, and is also unnecessary. § 9811(a)(2) of the American Rescue Plan (ARP) mandates that states provide coverage for vaccines and their administration to all individuals covered under the state plan (or waiver), even if they are eligible only for a limited type of benefit or service. This coverage is reimbursed through a 100% Federal Medicaid Assistance Percentage (FMAP) and is required for one year following the end of the Public Health Emergency (PHE).<sup>28</sup>

While NHeLP supports expanded COVID-19 vaccine coverage after the end of the PHE, the request for vaccine coverage for individuals in limited benefit categories is not a valid

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<sup>28</sup> The American Rescue Plan, P.L. 117-2, § 9811(b) (2021). Secretary Becerra recently renewed the PHE to at least July 2021. See HHS., *Renewal of Determination That a Public Health Emergency Exists* (April 15, 2021), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-15April2021.aspx>. Moreover, the administration has stated the PHE is likely to extend at least through the end of 2021. CMS, Letter to State Governors, 1 (Jan. 22, 2021), <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.



experiment and is thus an impermissible use of § 1115 waiver authority. (Please see *supra*, Section I, for NHeLP’s discussion of HHS’ authority under § 1115).

New Mexico’s request likely responds to CMS’ declaration in its COVID-19 Vaccine Toolkit that “state[s] generally lack authority to cover COVID-19 vaccinations for [limited benefit category] groups, unless it obtains § 1115 demonstration authority to provide this coverage.”<sup>29</sup> We urge CMS to reconsider this assessment.

In our view, New Mexico and other states could continue COVID-19 vaccine coverage beyond the ARP mandate under their state plans. The ARP establishes vaccine coverage minimums, not limits.<sup>30</sup> Moreover, nothing in the underlying statutes expressly precludes vaccine coverage as part of the benefits provided under limited benefits categories.<sup>31</sup> In fact, limited benefit categories provide many of the same types of services, such as physician services, clinical services, and inpatient and outpatient hospital services, that CMS identified as benefits through which states could provide vaccines.<sup>32</sup>

Finally, states already have significant discretion to define what services are necessary to treat an “emergency medical condition,” and several states have already issued guidance covering COVID-19 vaccines and administration through their emergency Medicaid programs.<sup>33</sup> Accordingly, no waiver is needed.

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<sup>29</sup> CMS, *Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children’s Health Insurance Program, and Basic Health Program* 17 (March 15, 2021), <https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf> [hereinafter *CMS COVID-19 Vaccine Toolkit*].

<sup>30</sup> See *supra* note 28. Congress limited the 100% FMAP for COVID vaccines for one year after the PHE expires.

<sup>31</sup> See 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXIII)(COVID services for uninsured); 42 U.S.C. § 1396b(v)(3) (requiring coverage for treatment of an emergency medical condition), 42 U.S.C. § 1396a(a)(10)(C)(ii)(II) (pregnancy-related services).

<sup>32</sup> These include inpatient hospital services (42 C.F.R. § 440.10), outpatient hospital services (42 C.F.R. § 440.20(a)), rural health clinic services (42 C.F.R. § 440.20(b)), Federally Qualified Health Centers (FQHCs), and physicians’ services (42 C.F.R. § 440.50). Limited benefit categories can also provide vaccine coverage through several optional Medicaid service categories, including preventive services (42 C.F.R. § 440.130(c)), other licensed practitioners (42 C.F.R. § 440.60), or clinic services (42 C.F.R. § 440.90). *CMS COVID-19 Vaccine Toolkit* at 10.

<sup>33</sup> See, e.g., Mich. Dep’t of Health & Human Svcs., *Bulletin: COVID-19 Response: Coverage of COVID-19 Vaccine Services*, 2 (Dec. 23, 2020) [https://www.michigan.gov/documents/mdhhs/MSA\\_20-75-Vaccine-New\\_711334\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSA_20-75-Vaccine-New_711334_7.pdf).



We remain concerned that using waivers for COVID-19 vaccine coverage will perpetuate a piecemeal, patchwork, and haphazard approach to an ongoing and deadly pandemic. CMS should reject New Mexico's request and instead issue guidance and provide technical assistance to states seeking to provide COVID-19 vaccine coverage to enrollees in limited benefit categories beyond the period mandated in the ARP.

## **IX. Conclusion**

In summary, NHeLP supports New Mexico's efforts to expand access to behavioral health coverage, to provide intensive care coordination for children and youth with intensive needs, to expand graduate medical education, and to ensure that individuals in limited benefit categories have access to the COVID-19 vaccine. However, for all the reasons listed above, a §1115 waiver amendment is not the appropriate vehicle to achieve these objectives.

We appreciate consideration of your comments. If you have any questions please contact Dania Douglas ([douglas@healthlaw.com](mailto:douglas@healthlaw.com)).

Sincerely,



Dania Douglas  
Senior Attorney

