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August 18, 2021

VIA ELECTRONIC SUBMISSION

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

**Re: Maryland HealthChoice Program Section 1115
Waiver Renewal Application**

Dear Secretary Becerra:

The National Health Law Program (NHeLP) protects and advances health rights of low-income and underserved individuals and families. We advocate, educate and litigate at the federal and state levels to advance health and civil rights in the U.S. We appreciate the opportunity to comment on Maryland's HealthChoice Program Section 1115 Waiver Renewal Application.

While NHeLP is supportive of states using Medicaid to increase access to mental health services, we have serious concerns about Maryland's new request to waive the institutions for mental diseases (IMD) exclusion for certain private psychiatric facilities, as this request does not comply with the requirements of § 1115 of the Social Security Act.

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.¹ 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.”² Thus, the “central objective” of the Medicaid Act is “to provide medical assistance.”³

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-5.⁴

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

¹ *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

² 42 U.S.C. § 1396-1; 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services).

³ *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).

⁴ *See* Social Security Act, § 1115(a)(1).

same statutory formula that applies for a state's expenditures under its State plan.⁵ 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).⁶ Congress did not enact section 1115 to permit the Secretary to make long-term policy changes.

II. Maryland's Request to Waive the IMD Exclusion for Mental Health

Via Maryland's HealthChoice Program Section 1115 Waiver Renewal Application, Maryland requests that CMS expand its waiver to permit federal financial participation (FFP) for services provided in mental health institutions for mental diseases (IMDs).

For the following four reasons, this request should not be approved.⁷ First, the IMD exclusion lies outside of 42 U.S.C. § 1396a, and it cannot be waived. Second, Maryland has

⁵ *Id.* § 1115(a)(2).

⁶ 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).

⁷ Because Maryland has a unique and long history of mental health IMD waivers, we are focusing our comments on Maryland's request for a mental health IMD waiver. However, we note that Maryland is also requesting a renewal of a waiver of the IMD exclusion for residential substance use disorder (SUD) services. This is also an impermissible use of Section 1115, for many of the same reasons that Maryland's request for FFP for enrollees in mental health IMDs is impermissible. *See, e.g.* Cathren Cohen et al., Nat'l Health Law Program, *Medicaid Section 1115 Waivers for Substance Use Disorders: A Review* 8-11 (June 8, 2021), <https://healthlaw.org/resource/medicaid-section-1115-waivers-for-substance-use-disorders-a-review/>.

not limited its request to the period and extent necessary to conduct any experiment. Third, Maryland has not explained how obtaining FFP for services rendered at IMDs constitutes a valid experiment under the Medicaid Act. And fourth, the waiver risks diverting funds from community-based mental health into institutional services and undermining community integration and the *Olmstead* mandate

A. The Secretary Does Not have Authority to Waive Compliance with Provisions Outside of § 1396a

The IMD exclusion lies outside of 42 U.S.C. § 1396a, and it cannot be waived.⁸ The IMD exclusion is contained in 42 U.S.C. § 1396d, which specifically excludes from the definition of medical assistance “any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases...”⁹ Moreover, as noted above, § 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.

B. Failure to Limit the Request to the Extent and Period Necessary

Section 1115 allows approvals only “to the extent and for the period necessary” to carry out the experiment, yet Maryland is essentially requesting a “repeat” waiver. Maryland has obtained FFP for IMDs on and off via various mechanisms since 1996.¹⁰ Congress did not enact § 1115 to permit the Secretary to make long-term policy changes, yet this is exactly what Maryland seeks.

Maryland first received an IMD waiver for services provided to residents of psychiatric facilities in 1997, almost 25 years ago.¹¹ In 2004, CMS started to phase out all “IMD waivers,” including Maryland’s, after determining they were no longer innovative or experimental.¹² CMS completely phased out Maryland’s waiver by fiscal year 2008.¹³

⁸ Social Security Act § 1115(a)(1).

⁹ 42 U.S.C. § 1396d(a)(30)(B).

¹⁰ Social Security Act § 1115(a).

¹¹ Maryland Dep’t of Health, *Maryland HealthChoice Program Section 1115 Waiver Renewal Application* 11 (June 30, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/md-healthchoice-pa4.pdf> [hereinafter “Application”].

¹² U.S. Gov. Accountability 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>.

¹³ Maryland Dep’t of Health, Fact Sheet, Institutions for Mental Disease (IMD) Exclusion Waiver,

Maryland's application only mentions this previous waiver in passing, failing to provide any details regarding what that initial § 1115 tested or the outcome of the evaluation.¹⁴

Between 2012 and 2015, Maryland again received FFP for services provided to residents of IMDs.¹⁵ Just four years after CMS phased out Maryland's first IMD waiver, Maryland began participating in the federally authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program.¹⁶ The MEPD was a three-year demonstration ending in 2015 that was authorized by Section 2707 of the Affordable Care Act.¹⁷ The demonstration allowed twelve states, including Maryland, to obtain FFP for acute services provided in private psychiatric IMD facilities.¹⁸

Now, after a six year hiatus, Maryland is again seeking FFP for services provided to residents age 18 to 64, in private psychiatric IMD facilities.¹⁹ Notably, this is the same population that participated in federal MEPD from 2012 to 2015.²⁰ With over thirteen years of experience with IMD waivers for psychiatric facilities spread over a quarter of a century, Maryland can no longer claim it is conducting a time-limited experiment.

C. Failure to Propose an Experiment

Maryland is not proposing a genuine experiment, demonstration, or novel approach. As noted above, 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. Maryland has not provided this information.

<https://health.maryland.gov/docs/IMD%20Exclusion%20Waiver%20Fact%20Sheet-%20Final.pdf>

¹⁴ Application at 24. Maryland's original application or any subsequent applications are not included on CMS' website as part of the administrative record.

¹⁵ See 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>.

¹⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2707, 124 Stat. 119, 326.

¹⁷ *Supra* note 15.

¹⁸ *Id.*

¹⁹ Application at 3.

²⁰ Dep't of Health and Human Servs., *Medicaid Emergency Psychiatric Demonstration: Response to 21st Century Cures Act Requires, Report to Congress* 6-7 (Sept. 30, 2019), <https://innovation.cms.gov/files/reports/mepd-curesact-rtc.pdf>.

Maryland states it seeks to test whether FFP for IMDs results in “increased access to health care across the continuum of care and improved health outcomes for individuals with SMI [serious mental illness].” It is unclear from the application why Maryland believes FFP for services provided in IMDs will increase access to health care, how the state plans to measure any increase, or what affect FFP for services provided to residents of psychiatric IMDs might have on health outcomes. There is no additional detail in the application explaining this broad hypothesis, and thus not enough information for the Secretary to determine what Maryland wants to test and how it will be tested.

Maryland also states that it seeks to test whether an “IMD exclusion waiver for psychiatric services” will support Maryland’s “total cost of care” model by “potentially decreasing ED utilization in acute care hospitals (thereby decreasing wait times) as well as avoidable readmissions.”²¹

First, Maryland does not propose a genuine experiment regarding “avoidable readmissions” in this application, as the application does not include any additional information regarding how it might track or even define “avoidable readmissions.” It is unclear what Maryland is seeking to test.

Second, the MEPD, which Maryland participated in, already tested the hypothesis regarding ED utilization, and found that FFP for services in IMDs did not reduce ED utilization. The MEPD hypothesis was that federal funding for IMDs would reduce ED visits and lengths of stay in the ED. The MEPD evaluation concluded that “[c]ontrary to expectations that access to IMD care would decrease the time beneficiaries spent awaiting inpatient beds, no changes in ED boarding times were observed during MEPD.”²² Further, the analysis noted that “the finding was robust across statistical models, making it one of our strongest findings,” though it noted that such a finding could be masked by an increased need for emergency and inpatient service during the demonstration period.²³ The MEPD evaluation also 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.”²⁴ A further evaluation of the data on a state level found that in Maryland there was no

²¹ Application at 26.

²² *Supra note 15* at 77.

²³ *Id.*

²⁴ *Id.* at 49.

significant difference between MEPD-eligible individual visits to the ED before the demonstration and during it.²⁵

Because Maryland has not articulated a genuine experiment, demonstration, or novel approach, the Secretary should not approve this part of Maryland’s waiver.

D. Diverting Resources Away from Community-Based Services and Undermining the Community-Integration Mandate

Historically, the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated settings. Medicaid reimbursement is available for mental health services in the community rather than institutions, creating a financial incentive to rebalance treatment towards community-based services.²⁶ This incentive is particularly important due to “bed elasticity,” where supply drives demand.²⁷ That is, if the beds are available, they will be filled, siphoning resources that could be used to improve and expand community-based services. But when beds are not available, other options adequately meet individuals’ needs.²⁸ When states have limited resources, spending money on costlier institutional settings results in less available funding for more cost-effective community-based programs, making community-based services harder to access.

CMS has required other states that have received IMD waivers to abide by a “maintenance of effort” (MOE) provision, thus preventing a state from reducing spending on community based services. However, such mechanisms are inadequate if the underlying community-

²⁵ See Rachel Machta et al., *Evaluation of the Maryland Total Cost of Care Model: Implementation Report* 65 (July 2021), <https://innovation.cms.gov/data-and-reports/2021/md-tcoc-imp-eval-report>.

²⁶ One of the original reasons Congress incorporated the IMD exclusion into Medicaid was to encourage states to rebalance spending towards community-based care. In adopting the IMD exclusion, Congress explained that community mental health centers were “being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963,” that “[o]ften the care in [psychiatric hospitals] is purely custodial,” and that Medicaid would provide for “the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals.” Comm. on Finance, S. Rep. 404 to accompany H.R. 6675, at 46, 144, 146 (June 30, 1965), <https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%202.pdf>.

²⁷ 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>.

²⁸ *Id.*

based system is inadequate. An MOE cannot correct for chronic under-funding and shortages of community-based services, and it cannot solve problems that are caused by a lack of community-based services.

Further, an MOE requirement is only as good as the enforcement. Maryland's application suggests it is already looking for an exception to the modest MOE requirement, noting that "[b]ased on discussions with CMS to date, the Department notes that certain quality improvement activities may result in savings to the Department driving a decline in community-based outpatient expenditures, which should not be assessed for purposes of calculating expenditures under the maintenance of effort requirements."²⁹ Maryland complains it is seeing a "disproportionate growth in expenditures attributable to [community-based] psychiatric rehabilitation programs" and it is "currently evaluating possible drivers for these costs. . . ." ³⁰ Such statements raise doubts about the state's commitment to expanding community-based services, as it is likely that any state planning to substantially invest in and expand community-based services would be able to comply with an MOE, even if that state achieved efficiencies in some subset of their programs.

Waivers of the IMD exclusion via § 1115 waivers risk undermining hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.³¹ 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. 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."³² 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. L.C.*

²⁹ Application at 28.

³⁰ *Id.*

³¹ 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>

³² 42 U.S.C. § 12101.

III. Conclusion

In summary, NHeLP generally supports Maryland's efforts to expand access to behavioral health treatment for Medicaid beneficiaries. However, this § 1115 waiver request is not the appropriate vehicle to achieve this goal. The Medicaid Act does not grant the Secretary the authority to approve this waiver.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Lav".

Jennifer Lav
Senior Attorney