October 20, 2022

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: New Hampshire Section 1115 Demonstration, Amendment #2 Request

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 New Hampshire's requested amendment to its section 1115 demonstration.

While NHeLP is supportive of states using Medicaid to increase access to mental health services, we have serious concerns about New Hampshire's amendment request to waive the institutions for mental diseases (IMD) exclusion for services for enrollees in residential and inpatient services with settings that qualify as IMDs. 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

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[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. New Hampshire's Request to Waive the IMD Exclusion for Mental Health

In this amendment, New Hampshire requests CMS permit federal financial participation (FFP) for services provided to enrollees who are residents of mental health institutions for mental diseases (IMDs).

For the following three reasons, this request should not be approved. First, the IMD exclusion lies outside of 42 U.S.C. § 1396a, and it cannot be waived. Second, New Hampshire has not explained how obtaining FFP for services rendered at IMDs constitutes a valid experiment under the Medicaid Act. And third, the waiver risks diverting funds from community-based mental health into institutional services and undermining community integration and the *Olmstead* mandate

[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).

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.[7] 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…"[8] 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 Propose a Novel 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. An experiment must have stated goals, a hypothesis, and a way to measure that hypothesis. 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."[9] 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.

FFP for mental health services in IMDs is not an experiment, and it certainly is not a new idea or approach to addressing needs of enrollees. For almost 30 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 section 1115 demonstration waivers to funds IMDs for psychiatric treatment: Arizona, Delaware, Maryland, Massachusetts, New York, Oregon, Rhode Island, Tennessee, and Vermont.[10] Some of these states only covered individuals at certain hospitals or for a set number of

[7] Social Security Act § 1115(a)(1).
[8] 42 U.S.C. § 1396d(a)(31)(B).
[9] H.R. Rep. No. 3892, pt. 2, at 307-08 (1981).
[10] U.S. GOV. ACCOUNTING OFFICE, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* 29 (2017), https://www.gao.gov/assets/690/686456.pdf.

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."[11]

Although CMS has recently encouraged states to apply for mental health-related section 1115 demonstration waivers that would allow for FFP for services provided in IMDs, CMS has not provided any justification for its change in position.[12] With almost 30 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. Section 1115 does not offer HHS a permanent "back door" to provide funding for settings that Congress explicitly carved out of Medicaid.

The main goal of New Hampshire's amendment request is to create more inpatient psychiatric bed capacity. [13] The state writes: "Increasing inpatient and residential psychiatric bed capacity for short-term treatment is one part of the infrastructure required to support . . . [New Hampshire's] vision. This is the State's primary motivation for requesting this amendment to its authority granted under the SUD-TRA demonstration waiver."[14]

New Hampshire proposes to evaluate how the "SMI [serious mental illness] demonstration activities contribute to reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings" and hypothesizes that the SMI/IMD waiver will reduce waitlists at its state hospital and long wait times in emergency departments (EDs).[15] However, the very same hypothesis was already explicitly tested and found to be unsupported by the federally-authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by the Section 2707 of the Affordable Care Act.[16] The MEPD evaluation found that in those states that had sufficient data to draw conclusions, "[t]he results do not

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[11] *Id.*
[12] 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 Duisturbance), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf (hereinafter "SMD #18-011").
[13] New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver, Amendment #2 Request (Sept. 3, 2021) at 8 (hereinafter "Amendment #2 Request").
[14] *Id.* at 8.
[15] *Id.* at 11-12.
[16] Crystal Blyer et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report*, , MATHEMATICA POL'Y RESEARCH (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf (hereinafter "MEPD Evaluation").

support our hypothesis that ER visits would decrease as a result of MEPD."[17] The MEPD evaluation also found that the MEPD did not reduce psychiatric admissions to non-psychiatric beds, often called "scatter-bed" admissions.[18] Qualitative interviews with stakeholders in states participating in the MEPD instead suggested that long wait times in EDs were attributable to factors unrelated to the availability of beds, including time waiting for specialists to do evaluations, the need for detox prior to transfer, waits for appropriate transportation, and time spent completing the involuntary commitment process.[19]

New Hampshire's request to waive the IMD exclusion does not propose a novel experiment, nor does it posit a reasonable hypothesis. CMS now has over twenty-five years of evidence from state-level IMD waiver demonstrations, making waiver of the IMD exclusion no longer a novel approach to meeting the needs of enrollees. Furthermore, New Hampshire's hypothesis is not reasonable, because the same was already been tested by a national demonstration, and found to be unsupported. Therefore, the Secretary should not approve this demonstration request.

C. 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.[20] This incentive is particularly important due to "bed elasticity," where

[17] MEPD Evaluation at 49.
[18] *Id.* at 41.
[19] *Id.* at 77.
[20] 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.

supply drives demand.[21] 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.[22] 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.

Waivers of the IMD exclusion via section 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.[23] 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."[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. L.C.*

State level comments on New Hampshire's waiver contain evidence that the very problem New Hampshire seeks to solve--long waits in EDs--is caused by the kind of unnecessary segregation *Olmstead* was intended to remedy. Disability Rights Center-NH noted in state level comments that the Chief Executive Office of the New Hampshire Hospital presented evidence to the House of Representatives Finance Committee that adult referrals for state hospital services actually remained relatively flat from July 2017 to January 2021, while the waitlist for beds in the hospital rose.[25] The data presented suggest that ED boarding is

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[21] 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.
[22] *Id.*
[23] 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.
[24] 42 U.S.C. § 12101.
[25] Amendment #2 Request at 68 (Comments of Disability Rights Center-NH), citing State of New Hampshire Dept. of Health and Human Servs., *New Hampshire Hospital (NHH) Presented to House Finance Division III (*Mar, 1, 2021), http://www.gencourt.state.nh.us/LBA/Budget/House_Finance_Division_III/3-1-21/NH_Hospital.pdf (attached).

growing, but that it is being driven not by an increase in demand for inpatient psychiatric services, but rather by individuals boarding in the ED who are not appropriate for hospitalization admission. [26] The wait for beds at New Hampshire Hospital is also attributable to her estimate that on any given day "approximately 50% of patients at New Hampshire Hospital could be better served in a less restrictive environment."[27] As Disability Rights Center-NH observes:

> These descriptions are not of a system in need of new capacity to respond to increased demands for acute psychiatric treatment, but rather one that is unable to meet steady demands on its resources because it is crowded at the pre-admission stages with persons who are not actual candidates for inpatient treatment, and at the post-admission stage with persons who are ready for discharge.[28]

This kind of unnecessary institutionalization of individuals ready for discharge is exactly the kind of discrimination that *Olmstead* is intended to remedy. Funding more beds only makes it easier for states to engage in unnecessarily institutionalization, and is certainly not a remedy for it.

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-based system is inadequate. An MOE cannot correct for chronic under-funding and shortages of community-based services, it cannot solve problems that are caused by a lack of community-based services, and it will not address strains on the system caused by unnecessary institutionalization of people with disabilities.

III. Conclusion

In summary, NHeLP generally supports New Hampshire's efforts to expand access to behavioral health treatment for Medicaid beneficiaries. However, 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 approve this waiver.

[26] *Id.*
[27] *Id.*
[28] *Id.*

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

Sincerely,

Jennifer Lav
Senior Attorney