November 17, 2021

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: Montana Healing and Ending Addiction through Recovery and Treatment (HEART) 1115 Demonstration Application

Dear Secretary Becerra:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to comment on Montana's demonstration waiver request, "Healing and Ending Addiction through Recovery and Treatment" (HEART).

NHeLP has serious concerns about Montana's demonstration request. Specifically, Montana's request to waive the institutions for mental diseases exclusion for mental health facilities should be rejected, as it does not comply with the requirements of Section 1115 of the Social Security Act.

I. HHS Authority Under Section 1115

For the Secretary to approve a project pursuant to Section 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 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

[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).
[5] *Id.* § 1115(a)(2).

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.[6] Congress did not enact section 1115 to permit the Secretary to make long-term policy changes. We acknowledge that, in 2017, CMS issued an Informational Bulletin announcing its intent "[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*" Section 1115(a) waivers for a period up to 10 years.[7] However, we urge CMS to disregard this Bulletin because it is contrary to Section 1115. It conflicts with, among other things, the statute'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).

II. The Request Seeks Waivers of Provisions Beyond the Secretary's Authority

Montana requests federal financial participation (FFP) for services provided in institutions for mental diseases (IMDs) to adults with serious mental illness (SMI), serious emotional disturbance (SED), or substance use disorder (SUD).[8] This request should not be approved. The IMD exclusion lies outside of Section 1396a, and it cannot be waived.[9] As noted above, 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.

In addition, Montana includes "children ages 18-20" as an eligible group affected by the requested demonstration. The Secretary, however, does not have authority to approve a Section 1115 waiver that seeks to increase funding for residential behavioral health treatment for minors because Congress has already prescribed the conditions under which youth under 21 could get Medicaid funded inpatient services and these conditions are not waivable. Under

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[6] *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)).

[7] Ctr. for Medicaid & CHIP Servs., *CMS, CMCS Informational Bulletin 3* (Nov. 6, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf (emphasis added).

[8] We are focusing our comments on Montana's request for an IMD waiver for SMI and SED. However, we note that Montana is also requesting a waiver of the IMD exclusion for residential SUD services. This is also an impermissible use of Section 1115, for many of the same reason that Montana's request for FFP for individuals with SMI/SED treated in 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/.

[9] Social Security Act § 1115(a)(1).

42 U.S.C. § 1396d(a)(16), states are authorized to use FFP for inpatient psychiatric hospital services for individuals under 21 (often referred to as the "psych under 21" or "psych 21" benefit). Because the statutory limits for the psych under 21 benefit are found outside of 42 U.S.C. § 1396a, those limitations cannot be waived. Specifically with respect to IMD waiver requests, CMS has stated that the Secretary will not grant any IMD exclusion waiver for children and youth in settings that do not "meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit."[10] Consistent with this guidance, and because Montana has failed to provide any information to demonstrate that the IMDs will comply with these requirements, which are paramount to the protections in federal Medicaid law against institutionalization of individuals under 21 with SED, the Secretary should reject the proposal as it relates to children under age 21.

III. Montana Has Not Proposed an Experiment

Montana is not proposing a genuine experiment, demonstration, or novel approach. A Section 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.

Montana requests to obtain FFP for IMDs, but there is nothing novel or experimental about this proposal. For the past 25 years, CMS has granted states the authority to waive the IMD exclusion for adults with SMI, 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.[11] 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."[12]

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[10] 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.

[11] 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"].

[12] *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/.

Although CMS has, for the past five years, invited and encouraged states to apply for Section 1115 IMD demonstration waivers for both SMI/SED and SUD, it has not provided sufficient justification for why waiving the IMD exclusion in these instances would constitute an experiment different from those waivers that ran from 1993 to 2009.[13] 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 does not offer HHS a "back door" to provide funding for settings that Congress explicitly carved out of Medicaid.

There is nothing experimental about how Montana seeks to offer services. Montana already provides inpatient mental health and SUD coverage for all beneficiaries under its Medicaid state plan.[14] With respect to IMDs, the State is not proposing any modifications to the current delivery system for services for which the state requires a waiver, nor is it adding new services with this proposal that the state could not otherwise add via a state plan amendment.[15] Instead, Montana seeks to shift the cost of inpatient services in IMD facilities from the state to the federal government. That is simply not an experiment, and Section 1115 is not intended to provide long-term funding for settings that Congress explicitly carved out of Medicaid.

Because Montana does not propose an actual experiment, with stated goals, hypothesis, and measures, the Secretary should not approve the demonstration's request to waive the IMD exclusion.

IV. Montana's Proposal Risks Diverting Resources Away from Community-Based Services and Undermining Community-Integration

Montana proposes FFP for inpatient treatment in IMDs but fails to articulate how services provided in an IMD "will supplement and coordinate with community-based care in a robust continuum of care in the state."[16] Instead, Montana's own demonstration request demonstrates

[13] 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.

[14] Application at 7.

[15] *See* Application at 22.

[16] SMD #17-003 at 2.

it is underutilizing some of the most effective community-based interventions available for individuals at risk of hospitalization, while requesting more funding for inpatient crisis services.

In its application, the State itself identifies a number of gaps in community-based services that currently exist in the state. They state that there are 11 counties in Montana which have no licensed mental health practitioners and 19 counties were no mental health practitioners are enrolled in Medicaid.[17] Further, the State reports that there are 27 counties which do not have a physical Community Mental Health Center at which individuals can access intensive outpatient services, "which leaves members in those locations to receive services with limited or no options for in-person services."[18] Specifically, the demonstration request states that, upon assessing the current availability of mental health services, the State identified a lack of outpatient providers to treat individuals with mental illness.

Disability Rights Montana raised concerns about this lack of mental health providers in their comments on the waiver at the state level, and discussed how, given this reality, the requests in this waiver are "out of touch."[19] Despite this, Montana's application fails to explain how funding IMDs will fill the existing gap in community-based services that are desperately needed to address mental health needs in the State.

Further, the proposed demonstration risks exacerbating the current gaps in services by creating more incentives to increase institutional capacity instead of developing community-based resources. This in turn could worsen any shortages and continue a negative cycle of viewing institutional settings as the solution to SMI treatment needs. This is particularly concerning given the evidence of the risk of "bed elasticity," a phenomenon in psychiatry where supply drives demand.[20] 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.[21] Disability Rights Montana expressed concerns that approving the IMD exclusion requested in this waiver risks increasing reliance on large congregate care settings and

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[17] Application at 63.
[18] *Id.*
[19] Application at 79-80.
[20] 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.
[21] *See* Barbara Dickey et al., *The Cost and Outcomes of Community-Based Care for the Seriously Mentally Ill*, 32 HEALTH SERV. RES. 599 (1997), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070217/.

diverting resources away from community-based treatment: “At best, [FFP for services in IMDs] will send more people away from their homes for treatment in a large, congregate care setting with limited access to health care professionals for therapy. At worst, it will serve as a way to avoid encouraging and funding better treatment alternatives in the community[.]”[22]

Finally, permitting FFP for behavioral health treatment in IMDs could undermine hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.[23] IMDs for SMI/SED 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.”[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 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. In fact, Disability Rights Montana flagged this concern in their comments at the state level, noting the particular risk of segregation given the facilities that exist in Montana. Specifically, they expressed concern that the waiver would cause more individuals to be placed or involuntarily committed into the Montana State Hospital, a large congregate care facility which they state “could [not] be fairly called ‘community based’” and which is “situated far away from most population centers in Montana and can be quite hard to access for family and friends of patients, which makes it difficult for them to play a part in recovery.”[25]

Because Montana’s request risk diverting resources from community-based services and undermining the civil rights of people with disabilities, the Secretary should not approve this demonstration request.

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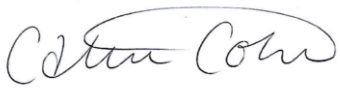
[22] Application at 80.
[23] President's New Freedom Comm’n on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.
[24] 42 U.S.C. § 12101(a)(2).
[25] Application at 79.

V. Conclusion

For the above stated reasons, we urge the Secretary to reject Montana's request to permit FFP for services provided in IMDs. We appreciate your consideration of our comments. If you have any questions, please contact Cathren Cohen (cohen@healthlaw.org).

Sincerely,



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