August 31, 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: Washington Medicaid Transformation Project Demonstration Extension 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 Washington's requested extension to its section 1115 demonstration, "Washington Medicaid Transformation Project" (MTP 2.0). Below, please find comments regarding the proposed new initiative 1.2: "Re-entry coverage for continuity of care" and for the continuing initiative 1.4: "SUD and mental health IMD."

1444 I Street NW, Suite 1105 · Washington, DC 20005 · (202) 289-7661
3701 Wilshire Boulevard, Suite 750 · Los Angeles, CA 90010 · (310) 204-6010
200 N. Greensboro Street, Suite D-13 · Carrboro, NC 27510 · (919) 968-6308
www.healthlaw.org

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]

---

[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).

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 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.

II. Re-Entry Coverage for Continuity of Care

We support demonstrations designed to increase access to care for historically marginalized populations, particularly those involved in the criminal justice system, and agree that preparing incarcerated individuals for re-entry is an important step in achieving that goal. We also support the focus on continuity of care, improving physical and behavioral health care outcomes, and reducing health disparities and advancing health equity, both for individuals exiting prisons and jails and for those leaving "institutions for mental diseases" (IMDs) –

---

[5] *Id.* § 1115(a)(2).

[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). 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).

particularly IMDs that are state hospitals where individuals are likely to be hospitalized for extended periods of time.

However, an 1115 demonstration is not the appropriate vehicle for allowing such demonstrations. As discussed above, section 1115 only permits the waiver of requirements found in 42 U.S.C. § 1396a, but the Medicaid Act's prohibition on obtaining federal financial participation (FFP) for services provides to "inmates[s] of a public institution" is in 42 U.S.C. § 1396d, as is the prohibition on obtaining FFP for services provided to residents of IMDs. Therefore, the Secretary does not have authority to waive it. And, there is no freestanding expenditure authority that authorizes use of FFP for this purpose.

If CMS does choose to approve MTP 2.0, however, it must ensure that there are appropriate guardrails in place to ensure that Medicaid funding is used strictly for services that aid in re-entry and that is primarily used for home and community based services. This includes requiring detailed descriptions of and commitments to providing specific services for those being released.

- First, CMS must require the state agency to ensure that the coverage of pre-release services is not merely a shifting of costs of correctional services or services provided in IMDs to the federal government. CMS should require specific descriptions of the new or expanded services that will be provided and how coverage will support the stated goal of enhancing continuity of care.
- Second, CMS should require the state agency to ensure that case management services are covered for each person leaving incarceration or an IMD, and that a voluntary meeting be scheduled with a case manager before the person is released. The person should also be given the opportunity to be assigned to a health home.
- Third, to the greatest extent possible, CMS should require use of community based organizations and providers. These organizations are most likely to have the cultural competence and connections necessary to forge connections with the formerly incarcerated population and those individuals leaving IMDs. They are also the most likely to be able to connect patients to other community resources, such as housing or nutrition assistance.
- Fourth, when individuals re-entering from prisons, jails, or IMDs are enrolled in managed care, CMS should ensure that the state impose obligations on MCOs to take all necessary steps to ensure that they are connected to care. The plans have the legal and contractual obligation to manage and coordinate care for enrollees and are compensated to do so. Active participation of responsible MCOs is key to ensuring that

this effort is successful. The State must hold MCOs accountable for coordination of care, including development of the re-entry care plan, coordinating transfer of health records from penal settings to providers, and performing in-reach for potential members who may not have been connected to Medicaid before incarceration. MCOs should also be required to include community health workers in their networks.

- Fifth, CMS should require development of comprehensive evaluation plan with detailed monitoring and oversight, including provider criteria that meet or exceed the state licensure or Medicaid provider requirements, a plan for state oversight including site visits, and reports on progress disaggregated by demographics. In particular, the state should monitor the performance of MCOs in performing their obligations related to this population. Health outcomes should be monitored, including use of community based services following release, rates of hospital and ED use following release, self-reported wellbeing, and whether social needs are met.

III. SUD and SMI IMDs

Washington requests an extension of authority to obtain FFP for residential and inpatient treatment for individuals with serious mental illness (SMI) and substance use disorders (SUD). Washington is currently permitted to obtain FFP for services provided in IMDs for up to 60 days for individuals with SMI, as long as it maintains a 30-day average length of stay. For individuals with SUD, Washington is required to "aim for a statewide average length of stay of 30 days in residential treatment settings." It appears that Washington is seeking an extension of these terms.

As we have noted in numerous other comments on section 1115 demonstrations requesting FFP for services provided in IMDs, such demonstrations do not comply with the requirements of section 1115.[7] Our objections remain. Specifically, the IMD exclusion lives outside of §

[7] See, for example, Comments on Louisiana's Section 1115 Waiver Renewal Application (June 24, 2022), https://1115publiccomments.medicaid.gov/jfe/file/F_1Ov6i4itJALWZY9; Comments on New Hampshire Section 1115 Demonstration, Amendment #2 Request (Oct. 20, 2022), https://1115publiccomments.medicaid.gov/jfe/file/F_2c7ot76ZZe5t2MY; Comments on Pennsylvania Medicaid Coverage for Former Foster Youth From a Different State and SUD Demonstration Extension Request (May 12, 2022), https://1115publiccomments.medicaid.gov/ControlPanel/File.php?F=F_2aLVZVDxZo8N518; Comments on Alabama's Section 1115 Institutions for Mental Disease Waiver for Serious

1396a, and thus cannot be waived; Washington has failed to propose a genuine experiment, demonstration or novel approach when requesting federal financial participation for stays in IMDs; and the proposed waiver and extension is not limited to the extent and for the period necessary.

There are several policy reasons why we oppose a general waiver of the IMD exclusion for SUD and SMI services that is not directly and narrowly tied to discharge planning. 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.[8] This incentive is particularly important due to "bed elasticity," where supply drives demand.[9] 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.[10] When states have limited resources, spending money on increasing access to costlier institutional settings results in less available funding for more cost-effective community-based programs, making community-based services harder to access.

Mental Illness (Apr. 24, 2021), https://gov1.qualtrics.com/ControlPanel/File.php?F=F_r2oyBsIWQfN45lT.

[8] 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.

[9] 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.

[10] *Id.*

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.[11] 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."[12] Providing FFP for large institutional settings could reinforce 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.*

Likewise, for individuals with SUD, community-based services are more effective, less restrictive and less coercive alternatives for SUD treatment compared to inpatient services.[13] Thus, it is important that states continue to invest and build their community-based systems. Unfortunately, the way current SUD IMD exclusion waivers are designed provides no guarantee or commitment that states will continue investing in and reinforcing availability of community-based services. Regardless of where individuals start their treatment—in the community or in a facility—there must be sufficient resources in the community to support individuals upon discharge and ensure continuity of care.

IV. Conclusion

For the above legal and policy reasons, we ask the Secretary to reject Washington's request to waive the IMD exclusion. We further note that section 1115 is not an appropriate vehicle for the demonstrations regarding reentry and discharge planning. However, to the extent that HHS approves these requests, we ask that CMS consider including the guardrails and

---

[11] 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.
[12] 42 U.S.C. § 12101.
[13] Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorders*, 3 JAMA Network 2 (2020).

limitations suggested in these comments. We appreciate your consideration of our comments. If you have questions about these comments, please contact Jennifer Lav (lav@healthlaw.org) or Sarah Somers (somers@healthlaw.org).

Sincerely,

Jennifer Lav
Senior Attorney