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September 30, 2022

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: Missouri Section 1115 Institutions for Mental Disease  
Waiver for Serious Mental Illness

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 provide these comments on Missouri's request to obtain federal financial participation (FFP) for institutions for mental disease (IMDs) for both children and adults.<sup>1</sup>

For the reasons below, NHeLP recommends that the Department of Health and Human Services (HHS) deny Missouri's request.

## **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.<sup>2</sup> 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. According to Congress, 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.”<sup>3</sup> Thus, the “central objective” of the Medicaid Act is “to provide medical assistance,” that is to provide health coverage.<sup>4</sup>

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 through 1396w-6.<sup>5</sup> 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.<sup>6</sup> 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). To be clear, as worded, section 1115 does not include an independent, freestanding expenditure authority.<sup>7</sup> As the Supreme Court’s recent opinion involving the EPA illustrates, the words of statutes must control—and limit—the actions of the federal agency, in this case limiting HHS to using federal Medicaid funding only for experimental

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<sup>1</sup> Missouri Application for Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness (2022), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mo-smi-demo-pa.pdf> [hereinafter “Application”].

<sup>2</sup> *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

<sup>3</sup> 42 U.S.C. § 1396-1; *id.* § 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services).

<sup>4</sup> *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).

<sup>5</sup> See 42 U.S.C. § 1315(a)(1).

<sup>6</sup> *Id.* § 1315(a)(2).

<sup>7</sup> See, e.g., *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1097 (9th Cir. 2005) (“Section 1115 does not establish a new, independent funding source. It authorizes the Secretary to ‘waive compliance with any of the requirements of’ a series of provisions of the Social Security Act in approving demonstration projects.”).

projects that are consistent with Medicaid’s objectives and that waive only provisions set forth in section 1396a.<sup>8</sup>

Fourth, section 1115 allows approvals only “to the extent and for the period . . . necessary” to carry out the experiment.<sup>9</sup> The Secretary cannot use section 1115 to permit states to make long-term policy changes.

As explained below, Missouri’s proposed project exceeds these limitations.

## **II. Waivers to Obtain FFP in IMDs**

Missouri requests permission to obtain FFP for residential and inpatient treatment for individuals ages 21-64 with serious mental illness (SMI) and in Qualified Residential Treatment Programs (QRTPs) for children under age 21. As we have noted in numerous other comments on section 1115 applications requesting FFP for services provided in IMDs, such demonstrations do not comply with the requirements of section 1115.<sup>10</sup> Our objections remain.

We oppose Missouri’s request for five specific reasons. First, the IMD exclusion lies outside of section 1396a and thus cannot be waived. Second, Missouri’s request is not a genuine experiment. Third, the project risks undermining health equity for people with disabilities and community integration. Fourth, the Secretary lacks the authority to create new exceptions to the IMD exclusion for child-serving settings outside of the formal rulemaking process. And fifth, we object to Missouri’s request to eliminate the length of stay limitation for children in Qualified Residential Treatment Programs (QRTPs) for up to two years.

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

The IMD exclusion lies outside of 42 U.S.C. § 1396a, and it cannot be waived.<sup>11</sup> 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

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<sup>8</sup> See *West Virginia v. EPA*, 142 S. Ct. 2587 (2022).

<sup>9</sup> 42 U.S.C. § 1315(a); see also *id.* §§ 1315(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>10</sup> See, for example, Comments on Louisiana’s Section 1115 Waiver Renewal Application (June 24, 2022), [https://1115publiccomments.medicaid.gov/jfe/file/F\\_1Ov6i4itJALWZY9](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](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](https://1115publiccomments.medicaid.gov/ControlPanel/File.php?F=F_2aLVZVDxZo8N518); Comments on Alabama’s Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness (Apr. 24, 2021), [https://gov1.qualtrics.com/ControlPanel/File.php?F=F\\_r2oyBsIWQfN45IT](https://gov1.qualtrics.com/ControlPanel/File.php?F=F_r2oyBsIWQfN45IT).

<sup>11</sup> See 42 U.S.C. § 1115(a)(1).

individual who has not attained 65 years of age and who is a patient in an institution for mental diseases...”<sup>12</sup> 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.

## **B. Missouri Has Not Proposed a Genuine Experiment**

Missouri is not proposing a genuine experiment. 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. Missouri has not provided this information. Instead, it has provided a cookie-cutter list of potential evaluation questions, only some of which are related to the authority it requests, and none of which are targeted towards youth under age 21 or address Missouri’s request to allow unlimited lengths of stay for youth in QRTPs for up to two years.<sup>13</sup>

One rationale Missouri puts forth for this request is that the state seeks to “regain and sustain the benefits achieved under the State’s previous participation in the Medicaid Emergency Psychiatric Demonstration (MEPD).”<sup>14</sup> Missouri asserts the MEPD showed that from 2012 to 2014 there were fewer patients overall that were boarded in emergency departments (EDs), that the number of patients in EDs declined throughout the demonstration, and that the demonstration was associated with a reduction in psychiatric emergency room visits and psychiatric admissions.<sup>15</sup>

First, a project designed to “regain and sustain” benefits from a federal demonstration that Congress included in the Affordable Care Act and specifically chose to discontinue is not an experiment, pilot, or demonstration. Between 2012 and 2015, Missouri received FFP for IMDs via the MEPD program, a three-year IMD demonstration authorized by Section 2707 of the Affordable Care Act.<sup>16</sup> At the end of the MEPD demonstration, Congress enacted the Improving Access to Emergency Psychiatric Care Act, which would have continued the MEPD and expanded it to new states if the Secretary and CMS actuaries certified the program as cost neutral to the federal government.<sup>17</sup> The program ended because CMS actuaries could not certify it as such.<sup>18</sup> Congress set the conditions under which such a demonstration could continue, and thus it was Congress that decided the demonstration

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<sup>12</sup> 42 U.S.C. § 1396d(a)(30)(B).

<sup>13</sup> Application at 14.

<sup>14</sup> Application at 4.

<sup>15</sup> Application at 9. Missouri does not explain how it came to the conclusion that Missouri made gains under the MEPD. The application only cites “Missouri Hospital Association survey data,” but does not include the actual data or a link to the survey. As noted below, two reports to Congress came to a different conclusion. Without additional information on the survey Missouri relies upon, Missouri has not provided sufficient information to allow the public to comment on this data.

<sup>16</sup> 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>.

<sup>17</sup> Improving Access to Emergency Psychiatric Demonstration Project, Pub. Law No. 114-97, 129 Stat. 2194 (Dec. 11, 2015).

<sup>18</sup> U.S. GOV’T ACCT. OFF., *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* at 35 (2017), <https://www.gao.gov/assets/690/686456.pdf>.

should end. Section 1115 should not be used as an end-run around Congress, which has declined to provide long-term funding for IMD settings.

Second, Missouri has not explained why it needs to re-test a hypothesis that was already tested via the MEPD. Two independent reports to Congress on the MEPD have already analyzed questions that Missouri poses. The first report, in 2016, concluded that in those states that had sufficient data to draw conclusions (including Missouri), “[t]he results do not support our hypothesis that ER visits would decrease as a result of MEPD.”<sup>19</sup> The 2016 study also concluded that there was “no statistically significant difference in boarding time or length of stay for MEPD-eligible patients relative to non-MEPD-eligible patients with psychiatric EMCs [emergency medical conditions].”<sup>20</sup> In 2019, an additional report was commissioned by HHS and submitted to Congress, pursuant to requirements in the 21st Century Cures Act. This report contains more state-level analysis and concluded that in Missouri, MEPD participants were actually *more likely* to visit the ED during the MEPD than before it began.<sup>21</sup> Furthermore, in Missouri, MEPD-eligible beneficiaries with psychiatric emergency medical conditions actually stayed longer in EDs during the MEPD than prior to the start of the demonstration (8.3 hours during vs. 7.8 hours before).<sup>22</sup> Both MEPD reports concluded that there is little evidence that the MEPD reduced Medicaid and Medicare costs . . . [n]or was it associated with reduced hospital emergency department use.”<sup>23</sup> Because Congress has already thoroughly tested a primary IMD-related hypothesis Missouri now proposes to test, Missouri has not proposed a genuine experiment, pilot, or demonstration.

Another reason Missouri gives for requesting approval for this project is to “ensure comparable access to IMDs for Medicaid enrollees regardless of delivery system.”<sup>24</sup> Missouri goes on to explain that those in managed care can access an IMD via “in lieu of services,” but those in fee for service (FFS) cannot. However, as a practical matter, this proposal does much more than ensure comparability between managed care and FFS. Under “in lieu of services,” managed care plans can only collect capitated payments for months where the enrollee is in an IMD for less than 15 days per month.<sup>25</sup> Although Missouri does not request a specific length of stay for adults, all adult mental health IMD projects approved to date have imposed a 30-day average length of stay and a 60-day maximum length of stay. Therefore, a more accurate way to discuss the effect of the proposal is that, if approved, it would *expand* the length of stay in IMDs available for both managed care and fee for service enrollees. Because Missouri does not explain that this will be the effect of their project, the application does not include an explanation as to why this expansion is necessary, nor does it explain what the expansion of length of stay would test nor why it is likely to promote the objectives of Medicaid. Therefore, Missouri has not

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<sup>19</sup> Blyer et al., *supra* note 3 at 49.

<sup>20</sup> *Id.* at 49-50.

<sup>21</sup> HHS, *Medicaid Emergency Psychiatric Demonstration: Response to the 21<sup>st</sup> Century Cures Act Requirements, Report to Congress* at 65 (Sept. 30, 2019).

<https://www.mathematica.org/publications/medicaid-emergency-psychiatric-demonstration-response-to-21st-century-cures-act-requirements-report>.

<sup>22</sup> *Id.* at 44.

<sup>23</sup> *Id.* at 67.

<sup>24</sup> Application at 3.

<sup>25</sup> 42 C.F.R. § 438.6(e).

included sufficient information to allow the public to meaningfully comment on this portion of the application.

### **C. The Proposed Waiver Risks Undermining the Community-Integration Mandate**

Historically, the IMD exclusion has provided an important financial incentive to states to develop community-based alternatives. 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.<sup>26</sup> This incentive is particularly important due to “bed elasticity,” where supply drives demand.<sup>27</sup> 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.<sup>28</sup> 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.

These waivers risk undermining hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.<sup>29</sup> 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.”<sup>30</sup> Providing FFP for large institutional settings could reinforce discriminatory presumptions about the ability of individuals with disabilities to receive

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<sup>26</sup> 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>.

<sup>27</sup> 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>.

<sup>28</sup> *Id.*

<sup>29</sup> National Council on Disability, *Health Equity Framework for People with Disabilities* at 11 (Aug. 2022) (including in NCD’s health equity framework a call to CMS to stop issuing waivers of the IMD exclusion). 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>.

<sup>30</sup> 42 U.S.C. § 12101.

services in community-based settings, undermining the integration mandate articulated by the Supreme Court in *Olmstead v. L.C.*<sup>31</sup>

### **III. IMD Waiver for Qualified Residential Treatment Programs (QRTPs)**

NHeLP strongly objects to Missouri's request to allow the state to obtain FFP for children placed in IMDs that are QRTPs. The Secretary does not have authority to approve FFP for IMD services for children for all the same reasons he does not have authority to approve FFP for these services for adults. Additionally, while there are some statutory exceptions to the IMD exclusion for youth, Congress has expressly stated that if the Secretary wishes to carve out any additional youth-serving inpatient settings from the IMD exclusion, he must do so via the formal regulatory process.<sup>32</sup> Section 1115 is not the appropriate vehicle. Moreover, as a policy matter, Missouri's request for a waiver without *any* average length of stay or maximum length of stay requirements is unreasonable and risks subjecting youth to long-term institutionalization.

#### **A. Congress Has Limited the Secretary's Authority to Create New Carve Outs for Youth in IMDs**

The Secretary does not have authority to approve FFP for individuals under age 21 in QRTPs. Congress has already prescribed the settings that are carved out of the IMD exclusion for youth and articulated the process by which the Secretary can add additional settings. Pursuant to 42 U.S.C. § 1396d(a)(16), states are authorized to obtain FFP for inpatient psychiatric hospital services for individuals under 21 (often referred to as the "psych under 21" or "psych 21" benefit), as defined in 42 U.S.C. § 1396d(h). In turn, 42 U.S.C. § 1396d(h) defines these services as "inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital...or in another inpatient setting *that the Secretary has specified in regulations*" (emphasis added). Through regulation, the Secretary has specified three settings that would normally be considered IMDs as eligible for FFP for provision of inpatient behavioral health treatment for individuals under 21: a psychiatric hospital; a psychiatric unit of a general hospital; and a psychiatric residential treatment facility (PRTF).<sup>33</sup> If the Secretary wishes to authorize additional settings under the psych 21 benefit, the statute requires the Secretary to do so via the formal rulemaking process.

#### **B. A Two-Year Length of Stay is Unreasonable and Will Unnecessarily Segregate Children in Institutional Settings**

Missouri requests an exemption from the 30-day ALOS requirement that CMS has applied to every adult mental health IMD approval in recent history. Missouri does not suggest any alternative ALOS or maximum length of stay in its stead. It simply requests permission to obtain FFP for children for length of stay, up to and including two-year stays. We believe that an exemption to the ALOS or maximum length of stay requirements is bad policy, and sets a dangerous precedent. This is particularly true for children, where two years represents a large portion of their lives.

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<sup>31</sup> 527 U.S. 581 (1997).

<sup>32</sup> 42 U.S.C. §§ 1396d(a)(16); 1396d(h).

<sup>33</sup> 42 C.F.R. § 441.151.

Missouri makes this request based on guidance that CMS issued in October 2021, stating:

For a limited time (not to exceed two years from the effective date of the new demonstration or demonstration amendment), states may propose a SMI/SED 1115 demonstration that also includes an exemption from the foregoing limitations on length of stays for foster care children residing in QRTPs that are IMDs.”<sup>34</sup>

If CMS intends this statement to mean that a state can obtain FFP for stays up to two years, and that no alternative length of stay will be imposed, this is a drastic departure from CMS guardrails that currently exist for adults, as well as from the 2018 CMS guidance on QRTPs.<sup>35</sup>

We strongly object. Children do best in family-like settings, and the harm from ongoing institutionalization of children has been well-documented.<sup>36</sup> If children must be placed in inpatient or residential settings, their length of stay should be measured in days and weeks, not in years. We are unaware of any literature that supports two-year length of stays for inpatient or residential treatment for children.

We encourage CMS to require states to adhere to their current average length of stay of 30 days and a maximum length of 60 days. However, at a bare minimum, if CMS intends to depart from that standard, CMS should impose an alternative ALOS and maximum length of stay for children in QRTPs, so that children are not left in these facilities for up to two years of their lives.

#### **IV. Conclusion**

In summary, NHeLP generally supports Missouri’s efforts to expand access to behavioral health treatment for Medicaid beneficiaries. However, this section 1115 request is not the appropriate vehicle to achieve this goal, and the expansion of FFP for institutional care, particularly for children, risks serious harm. The Medicaid Act does not grant the Secretary the authority to approve this waiver.

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<sup>34</sup> CMS, *Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements Q & A* (Oct. 19, 2021), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf>.

<sup>35</sup> CMS, *Qualified Residential Treatment Programs and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers* (Sept. 20, 2019), at 4, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf> (“States interested in including QRTPs in their section 1115(a) demonstrations will need to determine how best to include stays in QRTPs, recognizing that overall the state will be expected to achieve a statewide average of 30 days as part of these demonstrations.”).

<sup>36</sup> American Academy of Pediatrics, *et al*, *The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care* (Jan. 18, 2022), <https://familyfirstact.org/sites/default/files/QRTP%20and%20IMD%20One%20Pager.pdf>; Think of Us, *Away From Home Youth Experiences of Institutional Placements in Foster Care* (July 2021), [https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96\\_Away%20From%20Home%20-%20Report.pdf](https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf).



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

Sincerely,

A handwritten signature in black ink, appearing to read "Jen Lav", with a stylized flourish at the end.

Jennifer Lav