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May 12, 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: Pennsylvania Medicaid Coverage for Former Foster
Care Youth From a Different State and SUD
Demonstration Extension Request**

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 Pennsylvania's requested extension to its section 1115 demonstration, "Medicaid Coverage for Former Foster Care Youth from a Different State and SUD Demonstration." For the reasons below, we ask HHS to reject Pennsylvania's request for waiver-based substance use disorder (SUD) services.

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

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. SUD-Specific IMD Exclusion 1115 Waiver Request

While NHeLP supports efforts to improve access to treatment for Medicaid beneficiaries with SUD, we oppose the continuous reliance on section 1115 waivers to funnel federal dollars to institutional care, including IMDs. First, we question whether Pennsylvania’s proposal meets the experimental requirement of section 1115. A section 1115 demonstration request must propose a genuine experiment of some kind. While these SUD-specific IMD exclusion waivers (now in place in over thirty states) may have represented a novel approach to addressing SUDs when they were first approved, we see no reason why they should continue to be

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).



considered experimental after all these years. Moreover, Pennsylvania has not presented a valid hypothesis that would justify approval of the waiver for the purpose of testing such hypothesis, other than a general assumption that the waiver will improve access to SUD care.

Section 1115 is not intended to provide opportunities to states to waive Medicaid requirements in perpetuity and, in so doing, bypass congressional intent and/or approval. Rather, Congress envisioned section 1115 waivers as a tool for states to test novel approaches to health coverage that would then presumably inform congressional action. After seven years of SUD-specific IMD exclusion waivers, Congress could have amended the Medicaid statute to permanently allow states to use federal dollars for SUD treatment in IMDs. In fact, Congress has spoken on this very question as it has specifically enacted a more limited Medicaid state plan option to treat SUD conditions in IMDs that is set to expire in 2023.⁷ Failure to extend this state plan option or otherwise amend the IMD exclusion provision indicates that Congress intends the IMD exclusion to remain the law of the land.

In addition to considerations regarding the requirement that a state present an actual experiment or demonstration, the IMD exclusion is not waivable under section 1115. By its terms, section 1115 authorizes the Secretary to waive only those Medicaid requirements contained in 42 U.S.C. § 1396a. And, as explained above, section 1115 does not give the Secretary an independent “expenditure authority” to allow a state to ignore requirements outside of § 1396a. Because the IMD exclusion is found outside of § 1396a (in § 1396d(a)(31)(B)), the Secretary does not have the authority to allow states to receive federal Medicaid funding for services provided in IMDs.

There are also several policy reasons why we oppose waiving the IMD exclusion for SUD services. First, because of the risks that institutionalization presents, residential treatment in IMDs should be used only for patients with more serious SUDs. Unfortunately, the way current IMD exclusion waivers are designed provides no guarantee or commitment that states will continue investing in and reinforcing availability of community-based services, which are more effective and less restrictive alternatives for SUD treatment. We are particularly troubled by CMS’s refusal to establish a maximum length-of-stay in IMDs, which will likely result in longer average stays in the institution even for beneficiaries who do not need that level of care for such an extended period of time. While the early IMD exclusion waivers incorporated

⁷ 42 U.S.C. § 1396n(l).



requirements regarding a statewide maximum average length-of-stay of 30 days, this language has been omitted from more recent CMS guidelines and approvals. In contrast, in the state plan option to treat SUD in IMDs, Congress imposed an absolute maximum of 30 days per person (whether or not consecutive) during a 12-month period. Similarly, CMS has included a requirement of a 30-day average length of stay for section 1115s that allow for federal funding for services in IMDs for individuals with serious mental illness. There is no reason why CMS should not impose similar lengths of stay requirements for SUD treatment.

In addition, while we commend CMS for implementing a requirement that IMDs connect individuals to medication-assisted treatment (MAT), we caution that IMD patients are less likely to receive MAT than patients in the community, and approval of IMD exclusion waivers for SUD has not changed this reality.⁸ Until CMS properly enforces this requirement, the treatment Medicaid beneficiaries receive in these institutions remains questionable at best and harmful at worst. There is no evidence to date that demonstrates that IMD waivers specific to SUD have resulted increased MAT availability or referral at these facilities. Furthermore, to better increase MAT uptake, CMS should not only require that MAT be available at the facility or that a referral for treatment be made, but rather CMS should require states to ensure and demonstrate increased MAT intake among IMD residents with SUD.

Finally, we are concerned that Pennsylvania's proposal does not address the specific applicability of this request to children and adolescents under age 21. IMD waivers are an improper avenue to provide residential behavioral health services to children and adolescents. As CMS has explained, Congress created a state Medicaid plan option to provide inpatient behavioral health care, including SUD, under the inpatient psychiatric services for beneficiaries under 21 benefit. As part of this benefit, states must provide residential SUD services to minors in Psychiatric Residential Treatment Facilities (PRTFs) if necessary, pursuant to the Medicaid Act's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.

By seeking approval of a section 1115 IMD waiver that extends to beneficiaries under 21, Pennsylvania is effectively seeking to circumvent the avenue that Congress established for

⁸ Tamara Beetham et al., *Therapies Offered at Residential Addiction Treatment Programs in the United States*, 324 JAMA 804 (2020), <https://jamanetwork.com/journals/jama/article-abstract/2769709>; Johanna Catherine Maclean et al., *Institutions for Mental Diseases Medicaid Waivers: Impact on Payments for Substance Use Treatment Facilities*, 40 HEALTH AFF. 326 (2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00404>.



these service settings. As long recognized by CMS, children and adolescents are not small adults.⁹

III. Conclusion

For the above legal and policy reasons, we ask the Secretary to reject Pennsylvania's request to waive the IMD exclusion for SUD services.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Hector Hernandez-Delgado (Hernandez-delgado@healthlaw.org)

Sincerely,



Héctor Hernández -Delgado
Staff Attorney

⁹ CMS, EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (2014), https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

