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November 16, 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: New Hampshire SUD/SMI/SED Treatment and Recovery
Access 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 provide these comments on New Hampshire's Substance Use Disorder (SUD), Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Treatment and Recovery Access Demonstration Extension Request.¹

Below, please find comments on New Hampshire's request for continued authority to obtain federal financial participation (FFP) for services provided to adults with SUD, children with SED, and adults with SMI in institutions for mental diseases (IMDs). We also comment on New Hampshire's new request to obtain FFP for services provided to individuals in prisons for up to 45 days prior to reentry.

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.² 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.”³ Thus, the “central objective” of the Medicaid Act is “to provide medical assistance,” that is to provide health coverage.⁴

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-6.⁵

¹ New Hampshire’s Pending Application – Extension Request (October 14, 2022), <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82561> [hereinafter “Extension Request”].

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

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

⁴ *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).

⁵ *See* 42 U.S.C. § 1315(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.⁶ 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.⁷ 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 projects that are consistent with Medicaid’s objectives and that waive only provisions set forth in section 1396a.⁸

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

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

II. Mental Health IMD Exclusion Waiver for Adults

New Hampshire requests that the Centers for Medicare and Medicaid Services (CMS) continue to permit FFP for services provided to enrollees who are residents of mental health IMDs. This

⁶ *Id.* § 1315(a)(2).

⁷ *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.”).

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

⁹ 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)).



authority was first requested on September 3, 2021, as an amendment to New Hampshire’s section 1115 demonstration.¹⁰ CMS approved this amendment on June 2, 2022, and now New Hampshire seeks a five year extension.¹¹ As we have noted in numerous other comments on section 1115 applications requesting FFP for services provided in IMDs, such projects do not comply with the requirements of section 1115.¹² Our objections remain.

We oppose New Hampshire’s request regarding FFP for services provided to adults in IMDs for three specific reasons. First, the IMD exclusion lies outside of 42 U.S.C. § 1396a and thus, 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, providing FFP for services in IMDs risks undermining health equity and community integration for people with disabilities.

A. The Secretary Does Not Have Authority to Waive Compliance With Provisions Outside of Section 1396a

Because the IMD exclusion lies outside of 42 U.S.C. § 1396a, it cannot be waived.¹³ 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...”¹⁴ Moreover, as noted above, section 1115(a)(2) does not create an independent “expenditure

¹⁰ New Hampshire SUD/SMI/SED Treatment and Recovery Access Demonstration, Amendment #2 Request (Sept. 3, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mnh-sud-trtmnt-recovry-amendment-pa.zip> [hereinafter “Amendment #2 Request”].

¹¹ See Extension Request at 2.

¹² See, e.g., 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 Mental Illness (Apr. 24, 2021), https://gov1.qualtrics.com/ControlPanel/File.php?F=F_r2oyBsIWQfN45IT.

¹³ Social Security Act § 1115(a)(1).

¹⁴ 42 U.S.C. § 1396d(a)(31)(B).



authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a.

B. New Hampshire Has Not Proposed a Genuine Experiment

New Hampshire is not proposing a genuine experiment. Providing FFP for mental health services in IMDs is not an experiment, and it certainly is not a new idea or approach to addressing the 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.¹⁵ Some of these states only covered individuals at certain hospitals or for a set number of 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.”¹⁶

Although over the past several years CMS has encouraged states to apply for mental health-related section 1115 waivers that would allow for FFP for services provided in IMDs, CMS has not provided any justification for its change in position.¹⁷ 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.

A primary goal of New Hampshire’s amendment request is to address psychiatric emergency department boarding by creating more inpatient psychiatric bed capacity.¹⁸ As New Hampshire wrote in the amendment submitted September 3, 2021, which it now seeks to extend: “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

¹⁵ 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>.

¹⁶ *Id.*

¹⁷ See 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> (hereinafter “SMD #18-011”).

¹⁸ Extension Request at 6.



primary motivation for requesting this amendment to its authority granted under the SUD-TRA demonstration waiver.”¹⁹

The hypothesis that increasing federal funding for inpatient and residential beds will reduce ED boarding is the very same hypothesis that 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.²⁰

New Hampshire 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 the question that New Hampshire poses. The first report, published in 2016, concluded that in those states that had sufficient data to draw conclusions, “[t]he results do not support our hypothesis that ER visits would decrease as a result of MEPD.”²¹ 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].”²² In 2019, an additional report was commissioned by HHS and submitted to Congress, pursuant to requirements in the 21st Century Cures Act.²³ 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.”²⁴ Because Congress has already thoroughly tested the primary IMD-related hypothesis New Hampshire now seeks to test, New Hampshire has not proposed a genuine experiment, pilot, or demonstration.

¹⁹ Amendment #2 Request at 8.

²⁰ Crystal Blyer et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report*, MATHEMATICA POLY RESEARCH (Aug. 18, 2016), <https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf>.

²¹ *Id.* at 49.

²² *Id.* at 49-50.

²³ HHS, *Medicaid Emergency Psychiatric Demonstration: Response to the 21st 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>.

²⁴ *Id.* at 67.



New Hampshire's request to waive the IMD exclusion does not propose a genuine experiment. 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 primary hypothesis is not reasonable, because the same hypothesis was already tested by a national demonstration, and found to be unsupported. Therefore, the Secretary should not approve this demonstration request.

C. The Proposed Project Risks Undermining Health Equity and Community-Integration for People with Disabilities

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. Repeated investments in institutional settings with the goal of creating additional capacity risks increasing the unjustified segregation of people with disabilities, particularly if community-based services are underfunded and not reliably available for those who need them.

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."²⁵ In *L.C. v. Olmstead*, the Supreme Court held that this kind of unjustified segregation is a form of discrimination:

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. . . . Second, confinement in an institution severely diminished the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."²⁶

²⁵ 42 U.S.C. § 12101.

²⁶ 527 U.S. 581, 600-601 (1999).



This is why the National Council on Disability (NCD), an independent federal agency, recently called on CMS to “[s]top issuing waivers of the Medicaid Institute for Mental Disease (IMD) rule that allow states to receive federal Medicaid reimbursement for services in mental health institutions” as part of its Health Equity Framework for People with Disabilities.²⁷ Allowing FFP for IMDs risks undermining hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.

Disability Rights Center-NH (DRC-NH) has supplied evidence that the State has inadequate community-based services to meet the current need, and that unnecessary segregation in hospitals of people that could benefit from community-based services is ongoing. Thus, DRC-NH argues that no additional federal funding is necessary for institutional placements. New Hampshire counters by arguing that the fact that ED boarding exists indicates a need for more inpatient beds, because individuals who are currently in the ED have been clinically certified as needing inpatient services, and thus there is no unjustified segregation.²⁸

We agree that ED boarding is a serious problem, but disagree with the State’s assertion that ED boarding automatically means there is insufficient inpatient capacity. ED boarding can be caused by a lack of inpatient services, but it can also be caused by a lack of community-based services, delays in discharge for those ready to leave inpatient facilities, or even simply administrative delays in processing individuals through the ED. For example, if there is an inadequate supply of high quality community-based services, it is predictable that individuals will seek care at EDs and the demand for inpatient services will grow. Building additional inpatient capacity will never address the root of the problem.

The evidence submitted during the state-level comment period suggests that ED boarding is being caused by both a lack of community based services and delays in discharge for those that can benefit from community-based services. As DRC-NH explained, New Hampshire is facing a community mental health worker crisis.²⁹ Their comments cite evidence from the New Hampshire Community Behavioral Health Association noting an increase in vacancies at

²⁷ Nat’l Council on Disability, *Health Equity Framework for People with Disabilities* at 11 (Aug. 2022), https://ncd.gov/sites/default/files/NCD_Health_Equity_Framework.pdf.

²⁸ Extension Request at 40.

²⁹ Extension Request at 176 (Disability Rights Center-NH Comments on SUD-SMI-SED-TRA Demonstration Extension (Sept. 6, 2022)).



community mental health centers since 2016, with vacancies almost doubling between 2021 and 2022.³⁰ While the state recently launched statewide access to mobile crisis teams, other community based services that are crucial to preventing hospitalization and institutionalization, such as Assertive Community Treatment teams, are insufficient in supply.³¹ Furthermore, DRC-NH noted that the Chief Executive Officer of the New Hampshire Hospital—one of the two IMDs participating in the demonstration--stated to the House of Representatives Finance Committee that half the patients at New Hampshire Hospital could be better served in a less restrictive environment, and that the current inpatient census is made up of many who could and should be treated in other environments.³² There will never be enough inpatient capacity if individuals get “stuck” in facilities once they are admitted. Thus, we remain concerned that additional funding for institutional settings will undermine decades of federal policy initiatives to promote community integration for people with disabilities.

III. FFP for Qualified Residential Treatment Programs (QRTPs) that are IMDs

It is unclear whether New Hampshire is requesting FFP for children with serious emotional disturbance (SED) in IMDs. To the extent that New Hampshire is seeking this authority, NHeLP strongly objects for three specific reasons. First, we object to the lack of transparency and public notice regarding FFP for children residing in IMDs. New Hampshire requests an extension of all of its current authorities, which includes FFP for children in IMDs that are QRTPs, but neither the extension application nor the state public notice makes this request explicit, thus depriving the public of a meaningful opportunity to comment on it. Second, the Secretary lacks the authority to create new exceptions to the IMD exclusion for child-serving settings outside of the formal rulemaking process. 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.³³ Section 1115 is not the appropriate vehicle. And third, as a policy matter, New Hampshire’s request for an extension of an STC that eliminates *any* average length of stay or maximum length of stay requirements for the next two years is unreasonable and risks subjecting youth to long-term institutionalization.

³⁰ *Id.* at 181.

³¹ *Id.*

³² *Id.* at 178.

³³ 42 U.S.C. §§ 1396d(a)(16); 1396d(h).



A. New Hampshire Did Not Comply With Public Notice and Comment Provisions Regarding its Request for FFP for Children in IMDs

New Hampshire first obtained federal authority to collect FFP for services provided in IMDs via an amendment to its SUD demonstration. Notably, while the amendment application did not mention that the State was seeking FFP for children in mental health IMDs, CMS' approval provided FFP for youth under age 21 who have SED and are receiving services in QRTPs that are IMDs.³⁴ Specifically, Special Terms and Conditions (STC) 16 states that Medicaid recipients under age 21 will be able to receive coverage for treatment services in QRTPs, and STC 24 allows for FFP in QRTPs over 16 beds and states that that stays in QRTPs will not be subject to the 30-day average length of stay requirement or the 60-day length of stay requirement for the first two years.³⁵

It is unclear if New Hampshire is currently asking for FFP for youth under age 21 in IMDs. The State asks for a complete extension of the current STCs approved on June 2, 2022, which would include STC 16 and 24 that permit FFP for youth with SED in IMDs.³⁶ However, in numerous places in the extension proposal, the State appears to limit its request to adults. The extension request states that the "State's goal is to increase access to treatment options for Medicaid eligible adults ages 21-64 with SMI ..."³⁷ Additionally, the state-level public notice for the extension request states it will apply to beneficiaries with SMI in IMDs who are "ages 21-64."³⁸ Similarly, in public forums hosted by the New Hampshire Department of Health and Human Services, the State portrays the waiver as only applying to Medicaid beneficiaries age 21-64 with SMI . . .³⁹ Thus, one cannot discern exactly what New Hampshire is requesting by reading its extension request.

Federal regulations require states seeking an extension of a demonstration project to provide a state public notice process, and the public notice must include "a comprehensive description of the demonstration . . . that contains a sufficient level of detail to ensure meaningful input from

³⁴ Amendment #2 Approval.

³⁵ *Id.* at 10, 20.

³⁶ Extension Request at 24.

³⁷ Extension Request at 6.

³⁸ *Id.* at 133.

³⁹ *Id.* at 141.



the public, including . . . The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.”⁴⁰

New Hampshire’s state level notice failed to identify that children under age 21 with SED may be impacted by the demonstration, thereby denying the public the opportunity to engage in meaningful comment and feedback.⁴¹ This is all the more troubling given that the public did not have any opportunity to comment on this aspect of the project before it was initially approved in June.

Because New Hampshire did not explain the impact on children and youth in its summaries and public notice, we request that CMS require a new state-level notice and comment period. If New Hampshire wants to include a major new population in its demonstration, it should clearly say so, and CMS should require a new state-level notice and comment period, to allow for appropriate transparency and stakeholder participation. If New Hampshire is not requesting extension of this part of its current waiver, this should be clarified, and STC 16 and 24 should be removed.

B. 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. First, New Hampshire has not proposed a valid experiment. The potential evaluation questions included in the Extension Request are not targeted towards youth under age 21, nor does New Hampshire explain its justification for proposing unlimited lengths of stay for youth in QRTPs for the next two years.⁴² Second, 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

⁴⁰ 42 C.F.R. § 431.408(a)(1)(i)(A).

⁴¹ Notably, there was robust participation in the state-level comment period for the New Hampshire extension. Fourteen unique organizations and individuals provided state-level comments, either verbally or in written form. Not one of these organizations or individuals mentioned youth with SED, either in support of the proposal or in opposition. *See* Extension Request at 33.

⁴² Extension Request at 14.



“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 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).⁴³ 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.

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

New Hampshire’s current project includes an exemption for children in QRTPs from the 30-day average length of stay (ALOS) requirement that CMS has applied to every adult mental health IMD approval in recent history.⁴⁴ New Hampshire does not suggest any alternative ALOS or maximum length of stay in its stead, and CMS has not imposed one. 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. Children do best in family-like settings, and the harm from ongoing institutionalization of children has been well-documented.⁴⁵ 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.

⁴³ 42 C.F.R. § 441.151.

⁴⁴ Amendment #2 Approval at 20.

⁴⁵ 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.



In October 2021, CMS issued guidance 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.”⁴⁶ If CMS intended 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 receiving mental health services in IMDs, as well as from the 2018 CMS guidance on QRTPs.⁴⁷

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. SUD-Specific IMD Exclusion Waiver

New Hampshire requests a renewal of its current authority to receive FFP for services provided to individuals with SUD who are residents of an IMD. We continue to oppose the continuous reliance on section 1115 waivers to fund IMDs.

First, as with mental health-related waivers of the IMD exclusion, we object because the IMD exclusion lies outside of 42 U.S.C. § 1396a and thus, cannot be waived.⁴⁸

Second, we question whether New Hampshire’s extension proposal meets the experimental requirement of section 1115. A section 1115 demonstration request must propose a genuine

⁴⁶ 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>.

⁴⁷ See CMS, *Qualified Residential Treatment Programs and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers 4* (Sept. 20, 2019), <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.”).

⁴⁸ 42 U.S.C. § 1315(a)(1).



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 considered experimental.

Section 1115 is not intended to provide opportunities to states to waive Medicaid requirements in perpetuity and, in so doing, bypass congressional intent and 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 2023.⁴⁹ 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. If proponents of these waivers believe that a certain activity has been effective, they should push for adoption of that policy through congressional action, instead of requesting continuous approval of section 1115 waivers.

Third, there are also several policy reasons why we oppose waiving the IMD exclusion for SUD services. Because of the risks that institutionalization presents, residential treatment in IMDs should be used only for patients with more serious SUDs, and only on a short-term basis. Community-based services are more effective, less restrictive and less coercive alternatives for SUD treatment.⁵⁰ 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. Thus, it is important that states continue to invest and build their community-based systems. 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. This reality contrasts with the state plan option that Congress authorized, which contains an

⁴⁹ 42 U.S.C. § 1396n(l).

⁵⁰ Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorders*, 3 JAMA Network 2 (2020).



explicit maintenance of effort requirement to ensure resources are not diverted from community-based services.

We are particularly troubled by CMS' refusal to establish a maximum length-of-stay of 30 days in IMDs providing SUD services, particularly for demonstrations like New Hampshire's that potentially allow children to obtain SUD services in inpatient settings. While the early SUD IMD exclusion waivers incorporated requirements regarding assessments of a statewide maximum average length of stay of 30 days, this language has been omitted from more recent CMS guidelines and approvals, and nothing in New Hampshire's STCs appears to mandate specific length of stay limits for SUD treatment. The lack of a maximum length of stay is also specific to SUD section 1115 waivers, since the temporary state option to provide SUD services for IMD residents is limited to 30 days in a calendar year, and CMS has consistently limited SMI-related IMD waivers for adults to a 30-day ALOS and a 60-day maximum.

Last, while we commend CMS for implementing a requirement that IMDs connect individuals to MAT, we caution that the majority of residential treatment facilities do not offer opioid agonist treatment as maintenance therapy, even though this is considered the standard of care.⁵¹ Thus, while the demonstration requires that residential treatment providers either offer MAT on-site or facilitate access to MAT off-site within 12-24 months of the SUD demonstration approval, it does not appear that New Hampshire is tracking whether the IMD waiver results in increased MAT availability and initiation in these institutions.⁵² We recommend that CMS should not only require IMDs to ensure that MAT is available, but CMS should also track increased MAT intake among IMD residents with SUD.

V. Reentry from Prisons

New Hampshire is also seeking federal funding to provide care coordination services to certain individuals who are incarcerated in a state prison during the 45-day period prior to their

⁵¹ 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>.

⁵² Amendment #2 Approval at 23 (STC 19).



release.⁵³ 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 New Hampshire's focus on increasing continuity of care and improving behavioral health care outcomes for individuals exiting prisons. However, an 1115 demonstration is not the appropriate vehicle for accomplishing these aims.

As discussed above, section 1115 only permits the waiver of requirements found in 42 U.S.C. § 1396a, but, like the prohibition on obtaining FFP for services provided to residents of IMDs, the Medicaid Act's prohibition on obtaining FFP for services provided to "inmates[s] of a public institution" is in 42 U.S.C. § 1396d.⁵⁴ Therefore, the Secretary does not have authority to waive it. And, as described above, there is no freestanding expenditure authority that authorizes use of FFP for this purpose.

Furthermore, we are unable to fully comment on New Hampshire's request for authority to provide FFP for enrollment in managed care organizations (MCOs) prior to release because New Hampshire has not explained why it is seeking this authority. States can already require managed care organizations to provide in-reach to prisons as part of their contracts.⁵⁵ To the extent that New Hampshire is asking for permission to make capitated payments to MCOs prior to release, the State has not explained what services the MCOs would provide and how that service would further the objectives of Medicaid.

If CMS does approve this portion of the request, 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 from the State to the federal government. CMS should require specific descriptions of the new or expanded

⁵³ Extension Request at 10.

⁵⁴ 42 U.S.C. § 1396d(a)(31)(A).

⁵⁵ State Health & Values Strategies, *Leveraging Medicaid to Establish Meaningful Health Care Connections for Justice-Involved Populations Q&A* (Sept. 2019), <https://www.shvs.org/wp-content/uploads/2019/09/Justice-Involved-Populations-QA-Updated-9-12.pdf>



services that will be provided and how coverage will support the stated goal of enhancing continuity of care. We appreciate that the application states that the “program is not meant to replace in any way the health care services the State is responsible for providing to all incarcerated individuals but rather to supplement pre-release treatment activities.”⁵⁶ It is essential that CMS require the State to track this, especially since some of the services that New Hampshire proposes to add, such as peer support services, already appear to be provided to some extent via the Well Units.⁵⁷ CMS should ensure that any new funding for peer support is only for new services provided by community-based providers.

- Second, CMS should require the New Hampshire Department of Health and Human Services to ensure that case management services are covered for each person included in the proposed project, and that a voluntary meeting be scheduled with a case manager before the person is released. We are unclear from this proposal whether additional case management services will be available for individuals leaving prison, and if so, whether those services will be provided by a community-based organization.
- Third, to the greatest extent possible, CMS should require use of community-based organizations and providers for all services included in the project, including peer support services. These organizations are most likely to have the cultural competence and connections necessary to forge connections with individuals leaving prison. 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 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. As noted above, while New Hampshire

⁵⁶ Extension Request at 10.

⁵⁷ Extension Request at 17, 19.



states that it is seeking authority for FFP for MCOs during periods of incarceration, the State has not explained why it is requesting authority via Section 1115, and why the state cannot enforce active MCO provision without approval of the proposed project.

- Fifth, CMS should require development of a 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.

IV. Conclusion

For the above legal and policy reasons, we ask the Secretary to reject New Hampshire's request to waive the IMD exclusion. We specifically emphasize our request that CMS reject any request to obtain FFP for children in QRTPs that are IMDs. We further note that section 1115 is not an appropriate vehicle for demonstrations regarding reentry. However, to the extent that CMS approves these requests, we ask that CMS consider including the guardrails and 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).

Sincerely,



Jennifer Lav
Senior Attorney

