February 3, 2023

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 York State Medicaid Section 1115 Demonstration
Medicaid Redesign Team (MRT) Waiver Amendment

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 York's proposed waiver amendment.[1]

Below, please find comments objecting to New York's proposed amendment.

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] 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

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[1] New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team (MRT) Waiver (11-W-00114/2) amendment proposal (Dec. 12, 2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-pa-12212022.pdf [hereinafter "SUD and SMI Transformation Waiver Amendment"].
[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).
[6] *Id.* § 1315(a)(2).

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 York's proposed amendment exceeds these limitations.

II. Mental Health IMD Exclusion Waiver for Adults

New York requests that the Centers for Medicare and Medicaid Services (CMS) permit FFP for services provided to enrollees who are residents of mental health IMDs. 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.[10] For the

[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)).
[10] *See*, *e.g.*, Comments on New Hampshire SUD/SMI/SED Treatment and Recovery Access Demonstration Extension Request (Nov. 2022), https://healthlaw.org/resource/nhelp-comments-on-new-hampshire-sud-smi-sed-treatment-and-recovery-access-demonstration-extension-request/; Comments on Missouri Section 1115 Request for Federal Funding for Institutions for Mental Disease (IMDs) for Children and Adults (Oct. 2022), https://healthlaw.org/resource/comments-on-missouri-section-1115-request-for-federal-funding-for-institutions-for-mental-disease-imds-for-children-and-adults/; Comments: Washington Medicaid Transformation Project Demonstration Extension Request

purposes of brevity, we have not reiterated every argument and all of the evidence contained in previous comments. However, our objections very much remain.

We oppose New York's request for FFP for services provided to adults in IMDs for three specific reasons. First, the IMD exclusion lies outside of section 1396a and thus, cannot be waived. Second, New York has not explained how obtaining FFP for services rendered at IMDs constitutes a valid experiment under section 1115. 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 section 1396a, it cannot be waived.[11] The IMD exclusion is contained in section 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…"[12] Moreover, as noted above, section 1115(a)(2) does not create an independent "expenditure

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(Aug 2022), https://healthlaw.org/resource/comments-on-missouri-section-1115-request-for-federal-funding-for-institutions-for-mental-disease-imds-for-children-and-adults/;
Comments: NHeLP Comments on West Virginia Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (SUD) Demonstration Extension Request (July 2022), https://healthlaw.org/resource/nhelp-comments-on-west-virginia-creating-a-continuum-of-care-for-medicaid-enrollees-with-substance-use-disorders-sud-demonstration-extension-request/; Comments on 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 California Section 1115 Demonstration Five-Year Renewal and Amendment Request: CalAIM Demonstration (Aug. 2021), https://healthlaw.org/resource/nhelp-comments-on-california-section-1115-demonstration-five-year-renewal-and-amendment-request-calaim-demonstration/; 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_r2oyBsIWQfN45lT.

[11] 42 U.S.C. § 1315(a)(1).

[12] *Id.* § 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 York Has Not Proposed a Genuine Experiment

New York 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. As we have noted in our previous comments on such waivers, 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 as of 2009, CMS phased out all but one of these projects, precisely because they were no longer "innovative or experimental."[13]

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.[14] 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.

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.

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[13] 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.

[14] *See* CMS, Dear State Medicaid Director Letter, SMD #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf [hereinafter "SMD #18-011"].

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."[15] 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."[16]

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.[17] 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.

We are particularly concerned with New York's proposal to "transition" select campuses to offer enhanced services, such as transitional housing, employment and education supports, and integrated care. It is unclear exactly what New York is proposing. If New York intends to fund these enhanced services via community-based funding, they must meet the home and community-based services rules. The State is obligated to have any section 1115 project used for community-based services follow these rules, which include only using Medicaid HCBS funds (including behavioral health home and community based services) in settings that meet the definition of community.[18] A community-based setting must be

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[15] 42 U.S.C. § 12101.
[16] 527 U.S. 581, 600-601 (1999).
[17] 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.
[18] *See, e.g.,* 42 C.F.R. §§ 441.301(c)(4); 441.302(5); CMS, *Questions and Answers – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting*

integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to engage in community life and receive services in the community, to the same degree as individuals not receiving Medicaid HCBS.[19] Services located on the grounds of an IMD are presumptively institutional settings.[20] CMS has previously asked states to carefully consider creating new presumptively institutional settings to be funded by HCBS funds. It is important to know whether such settings are funded as HCBS and whether the settings could meet the HCBS criteria under heightened scrutiny.

III. SUD-Specific IMD Exclusion Waiver

New York also requests 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 section 1396a and thus, cannot be waived.[21]

Second, we question whether New York'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 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

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Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers – CMS 2249-F and 2296-F 2 (Dec. 2019), https://www.medicaid.gov/sites/default/files/2019-12/final-q-and-a.pdf; *see also* CMS, New York State Medicaid Redesign Team Special Terms and Conditions 31 (April 29, 2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-04292022.pdf.

[19] *See, e.g.,* 42 C.F.R. §§ 441.301(c)(4); 441.302(5).

[20] *Id.* § 441.301(c)(5).

[21] 42 U.S.C. § 1315(a)(1).

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.[22] 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.[23] 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 explicit maintenance of effort requirement to ensure resources are not diverted from community-based services.

We are particularly troubled by CMS's refusal to establish any maximum length-of-stay in IMDs providing SUD services, particularly for demonstrations like New York's that potentially allow children to obtain SUD services in inpatient settings. While New York states that it will achieve an average length of stay of 30 days, nothing in New York's proposal appears to set a maximum stay for any individual. 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

[22] 42 U.S.C. § 1396n(l).
[23] Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorders*, 3 JAMA Network 2 (2020).

has consistently limited SMI-related IMD waivers for adults to a 30-day average 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.[24] We recommend that CMS both ensure MAT is available and track increased MAT intake among IMD residents with SUD.

IV. Conclusion

For the above legal and policy reasons, we ask the Secretary to reject New York's proposed amendment. If you have questions about these comments, please contact Jennifer Lav (lav@healthlaw.org).

Sincerely,

Jennifer Lav
Senior Attorney

[24] 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 AFFS. 326 (2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00404.