March 29, 2024

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: Arkansas Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease Section 1115 Demonstration Project

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 Arkansas' proposed "Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease Section 1115 Demonstration Project."[1]

NHeLP recommends that the Centers for Medicare and Medicaid Services (CMS) reject Arkansas' request to obtain federal financial participation (FFP) for expenditures for Medicaid services in institutions for mental disease (IMDs) and in prisons, jails, and youth correctional facilities.

Arkansas' proposed demonstration is substantially different from any demonstration that CMS has previously approved, either for prison and jail reentry or for IMDs. Arkansas' request conflates SMI/SED demonstrations with Reentry

demonstrations, falls far outside of CMS's own articulated parameters for such demonstrations, and fails to comply with the requirements of section 1115.

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]

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[1] Arkansas Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease Section 1115 Demonstration Project (Feb. 28, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-opport-transi-stratg-supp-comm-incar-instit-mentl-diseas-pa-02282024.pdf [hereinafter "Arkansas Reentry Application"].
[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

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 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.

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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).

[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).

As explained below, Arkansas's proposed project exceeds these limitations. Arkansas' request for FFP for services in prison, jails and correctional facilities is incompatible with section 1115 authority because it seeks to waive provisions of the Medicaid Act the Secretary cannot waive. In doing so, Arkansas proposes timeframes for coverage and a package of services that are not targeted towards reentry, and proposes use of "success coaches" in a way that does not promote the objectives of Medicaid. The request for FFP for IMDs similarly exceeds the limitations of section 1115 by failing to propose a legitimate experiment and by requesting waiver of a provision the Secretary does not have authority to waive.

II. Arkansas' Request for FFP for Services Provided in Prisons, Jails, and Youth Correctional Facilities is Incompatible with Section 1115 Authority.

Arkansas has one of the highest incarceration rates in the United States. It ranks third in the number of per capita individuals in prisons, lagging behind only Mississippi and Louisiana.[10] As the state notes in its proposal, the number of incarcerated individuals increased by almost five percent in fiscal year 2022.[11] Furthermore, there has recently been strong interest from the state's leadership in *increasing* the number of prison beds, after the state passed new, tougher sentencing laws that are expected to increase the rate of incarceration.[12]

In the context of a state that is actively seeking to increase the size of its carceral system, we have specific concerns about the extremely broad authority Arkansas requests, particularly when compared to other reentry waivers that CMS has approved.[13] Arkansas' proposal falls far

[10] THE SENTENCING PROJECT, U.S. CRIMINAL JUSTICE DATA, https://www.sentencingproject.org/research/us-criminal-justice-data/ (last visited Mar. 27, 2024).
[11] Arkansas Reentry Application, *supra* note 1, at 13.
[12] Andrew DeMillo, *Arkansas Governer Proposes $470M for 3,000 New Prison Beds*, Associated Press, March 27, 2023, https://apnews.com/article/huckabee-sanders-arkansas-prisons-mental-health-e2f66bfaecc14875574cddb32ab98c6e; Protect Arkansas Act, 2023 Arkansas Laws Act 659 (S.B. 495).
[13] See CMS, California Reentry Demonstration Initiative Amendment Approval, Attachment W (Jan. 26, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf; CMS, Washington Medicaid Transformation Project, Demonstration Extension Approval (June 30, 2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-ca-06302023.pdf; CMS, Montana Healing and Ending Addiction through Recovery and Treatment (HEART), CMS Amendment Approval (Feb. 23, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-heart-cms-amendment-approval-20240226.pdf.

outside the parameters of CMS guidance for reentry demonstrations. Section 1115 does not provide the Secretary authority to ignore 42 U.S.C. § 1396d's prohibition on funding services in carceral settings, and it certainly does not provide a mechanism to use federal Medicaid funds to increase overall carceral funding.

1. Section 1115 Demonstrations Are Not the Appropriate Vehicles for Federal Funding for "Inmates of Public Institutions."

While we support efforts 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 crucial, a section 1115 demonstration is not the appropriate vehicle to obtain FFP for incarcerated individuals. As discussed above, section 1115 only permits the waiver of requirements found in 42 U.S.C. § 1396a, but the Medicaid Act's prohibition on obtaining federal financial participation (FFP) for services provides to "inmates[s] of a public institution" is in 42 U.S.C. § 1396d. Therefore, the Secretary does not have authority to waive it. As noted above, there is no freestanding expenditure authority that authorizes use of FFP for this purpose.

2. The Proposed Timeframe for Coverage is Not Targeted to Reentry.

Arkansas' application asks for coverage for both 90 days upon entry to the prison or jail system, and also for 90 days' coverage pre-release, for a potential total of 180 days.[14] These two 90 day periods could run consecutively for people whose projected length of incarceration is 180 days or less. CMS' guidance, however, only permits states to request one 90 day period, immediately prior to release.[15]

Reentry demonstrations only allow states to obtain FFP for up to 90 days prior to release because the demonstrations are intended to focus "improv[in]g care transitions and increase[ing] the likelihood that individuals participating in the demonstration will access needed care upon release from incarceration."[16] However, Arkansas' request for coverage

[14] Arkansas Reentry Application at 34.
[15] CMS, Dear State Medicaid Director 27 (April 17, 2023) (SMD # 23-003) (Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated), https://www.medicaid.gov/media/154971.
[16] *Id.* at 2.

upon entry to the prison or jail system is not specifically targeted to individuals who are soon to be released. Instead, they seek blanket coverage for 90 days upon admission.

Arkansas claims that this additional "flexibility [is] to provide more equitable services by reaching individuals with unknown release dates . . . "[17] We are sensitive to the difficulty of assisting with reentry in jails, where release dates are often uncertain, but the answer cannot be to simply cover everyone without regard to whether the individual may or may not be released soon.[18] Because the request is not tailored to a "pre-release" timeframe, Arkansas' request risks shifting large amounts of federal funds to county jails without tying such funding to improved transitions.

Furthermore, Arkansas' legal argument for how CMS can allow FFP during the first 90 days relies on a misunderstanding of 42 C.F.R. § 435.1010(b). Arkansas cites the definition of inmate of a public institution, which excludes people from the definition of inmate if they "are in a public institution for a temporary period pending other arrangements appropriate to his needs."[19] Arkansas asks the Secretary to define "temporary" as 90 days, but just for the purposes of this demonstration. Not only does the Secretary not have the authority to use section 1115 to redefine regulatory terms to circumvent the "inmate exclusion" contained in 42 U.S.C. § 1396d, but Arkansas asks HHS to read the phrase "temporary period" out of context.[20] The temporary period must be temporary *because,* by the very language of the regulation, the individual is "pending other arrangements." Longstanding CMS policy has been

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[17] Arkansas Reentry Application, *supra* note 1, at 21.

[18] In contrast to Arkansas' proposal, California has created a set of policy guidelines to provide Medicaid-funded pre-release services to individuals in county jails, while still taking steps to limit the pre-release timeframe to 90 days. While California's operational guide recognizes that there may be circumstances where an individual receives 90 days of pre-release services in a jail, and then receives another 90 days of pre-release services in a prison, California limits pre-release services to 90 days per facility, per incarceration. California's policy also requires the 90 days to be paused if a release date is unexpectedly extended. *See* California Department of Health Care Services, Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative at 62, Oct. 20, 2023, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf.

[19] 42 C.F.R. § 435.1010(b).

[20] 42 U.S.C. § 1315(a)(1) authorizes the Secretary to waive compliance with the requirements of 42 U.S.C. § 1396a, but it does not authorize him to define the meaning of a word in a regulation differently for just one state.

clear that the length of time the person is in the institution is not dispositive, instead it is the voluntariness of that stay. As CMS has explained:

> It is important to note that the exception to inmate status based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is resident in the public institution awaiting these arrangements does not determine status.[21]

We ask CMS to reject Arkansas' request to reinterpret longstanding CMS practice and guidance, and thus decline to approve Arkansas' request for up to 180 days of FFP in prisons, jails, and youth correctional facilities.

3. The Proposed Package of Services is Not Targeted to Reentry.

Arkansas' proposal is also overly broad in the services it seeks to cover, rather than narrowly tailored to time-limited transition services related to reentry. Arkansas seeks funding for *all* Medicaid services for individuals in this 180-day period.[22] The application states that in addition to case management MAT, and a 30-day supply of prescription drugs, "all medically necessary Medicaid covered services will be available to an individual during the pre-release period. . . . "[23] Arkansas does not explain how its proposed service package is targeted towards improving reentry.

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[21] HCFA, Program Issuance Transmittal Notice, Region IV (March 6, 1998) (on file with NHeLP); *see also* HCFA, Clarification of Medicaid Coverage Policy for Inmates of a Public Institution, Dec. 12, 1997 (on file with NHeLP); CMS, Dear State Health Official Letter (Apr. 28, 2016) (SHO #16-007) (Re: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities), , https://www.medicaid.gov/media/40096 (noting that "[t]he voluntary nature of the residence is critical; an individual would be considered an inmate during temporary involuntary residence in a public institution imposed by the justice system (for example when confined pending trial) but the individual is not free to leave).

[22] Arkansas Reentry Application, *supra* note 1, at 20-21.

[23] *Id.* at 21.

CMS has never approved a reentry demonstration that requests coverage for all Medicaid services. Instead, states have been required to define a specific package of services, designed to aid reentry. For example, California limits pre-release services to: case management, physical and behavioral health clinical consultation services; laboratory and radiology services; medications, Medication Assisted Treatment (MAT), and services provided by community health workers with lived experience.[24] Washington likewise provides only a targeted set of pre-release services, similar to the services covered by California.[25] Montana provides even more narrowly targeted pre-release services.[26]

Further demonstrating how Arkansas' package is not targeted towards reentry, Arkansas requests coverage of the same service package for the first 90 days of incarceration and the last 90 days of incarceration. This means that those individuals with longer lengths of incarceration will receive Medicaid-funded services for the first 90 days of incarceration, then will not be eligible for Medicaid-funded services for some time period, and then will receive Medicaid-funded services again during their last 90 days of incarceration. Arkansas does not explain how it will address continuity of care issues between these two 90-day periods of coverage. If Arkansas covers medication for opioid use disorder (MOUD) during the first 90 days of incarceration, as the state proposes, but the individual remains incarcerated after that time period, will the state continue to provide access to MOUD?[27] The requested

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[24] CMS, California Reentry Demonstration Initiative Amendment Approval, Attachment W (Jan. 26, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf.

[25] CMS, Washington Medicaid Transformation Project, Demonstration Extension Approval 71 (June 30, 2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-ca-06302023.pdf.

[26] CMS, Montana Healing and Ending Addiction through Recovery and Treatment (HEART), CMS Amendment Approval (Feb. 23, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-heart-cms-amendment-approval-20240226.pdf (pre-release services include limited clinical consultations, case management, MAT, a 30-day supply of all prescription medications, but exclude radiology and laboratory services).

[27] We note that states and counties have separate obligations to provide MOUD, even if FFP is not available for such services. *See* Settlement Agreement Between the United States of America and Allegheny County, DJ No. 204-64-172 (Dec. 1, 2023), https://www.justice.gov/opa/media/1326786/dl?inline (settlement of investigation into violation of Title II of the Americans with Disabilities Act (ADA) due to county refusal to provide methadone to

demonstration does not address continuity of care issues raised by the state's failure to target covered services towards improving reentry. The objective of Medicaid is to provide health care coverage. Schemes that by design will create disruptions in care for significant portions of the covered population do not further that objective.

While CMS' guidance gives states some flexibility to cover additional services beyond the three basic services that must be included in every reentry demonstration, such services should further the goal of reentry.[28] Arkansas' proposal is not targeted towards reentry, and therefore should not be approved.

4. Arkansas' Proposal to Use "Success Coaches" Should Be Rejected.

Arkansas states that it intends to provide case management services from some individuals through "Success Coaches," once they are twelve-months post release.[29] We object to Arkansas' attempt to tie this demonstration request to the pending ARHOME requested amendment, as such a proposal does not further the objectives of Medicaid.[30] We have attached our previous comments explaining in detail why the ARHOME amendment, including the use of "success coaches," does not comply with the objectives of Medicaid, and incorporate these comments by reference.[31] Namely, the ARHOME amendment inhibits, rather than facilitates, continuity of care by arbitrarily shifting individuals between managed care and fee-for service.[32]

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individuals held in the county jail); *Pesce v. Coppinger*, 355 F.Supp.3d 35 (Nov. 25, 2018) (granting plaintiff's motion preliminary injunction in claim that policy denying methadone to incarcerated individuals violates the ADA and the Eighth Amendment). It is concerning that Arkansas' proposal does not address how it intends to ensure that individuals who are receiving MOUD will continue to receive it after the proposed 90-day post-incarceration period.

[28] CMS, Dear State Medicaid Director 24 (Apr. 17, 2023) (SMD # 23-003) (Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated), https://www.medicaid.gov/media/154971.

[29] Arkansas Reentry Application, *supra* note 1, at 20.

[30] Attachment A, Comments on Arkansas Section 1115 Amendment Request (July 14, 2023).

[31] *Id.*

[32] *Id.*

As we have previously noted, success coaches do not provide any kind of medical or rehabilitative services, and certainly are not what CMS contemplated when requiring case management services for the reentry program.[33] Instead, these success coaches are focused on coordinating work activities as part of Arkansas' continued attempt to mandate a work requirement.[34]

While CMS requires states with reentry demonstrations to provide case management services, such case management services must be person-centered, trauma-informed, and focused on ensuring continuity of care and access to care upon release.[35] The type of case management that CMS envisioned in its guidance looks nothing like the success coaches proposed by ARHOME, and should not be permitted.

III. Arkansas' Request for FFP for Services Provided in IMDs.

Arkansas requests FFP for services provided in IMDs for up to 180 days, through two separate 90 day periods.

We generally object to Arkansas' request for FFP for services in IMDs for the same reasons we have objected to numerous previous SMI/SED demonstrations. Namely, providing FFP for services in IMDs is not a legitimate experiment; the Secretary does not have authority to waive provisions outside of 42 U.S.C. § 1396a; and providing FFP for services in institutions risk diverting resources from community-based services.[36] We object specifically to Arkansas'

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[33] *Id.*
[34] *Id.*
[35] CMS, Dear State Medicaid Director 18-22 (April 17, 2023) (SMD # 23-003) (Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated), https://www.medicaid.gov/media/154971.
[36] *See*, *e.g.*, Comments on New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team (MRT) Waiver Amendment Request (Feb. 3, 2023), https://healthlaw.org/resource/nhelp-comments-on-new-york-state-medicaid-section-1115-demonstration-amendment/; 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-

request to extend the average length of stay permitted by SMI/SED demonstrations to up to 180 days, as such a request risks increasing institutionalization, and makes it difficult for individuals to access community living.

A. Arkansas Has Not Proposed a Legitimate Experiment.

Section 1115 allows HHS to waive some requirements of the federal Medicaid Act so that states can test novel approaches to improving medical assistance for low-income individuals, if such waivers are limited to the extent and time period needed to carry out the experiment or demonstration. This means that a section 1115 demonstration waiver request must propose a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money through a section 1115 demonstration waiver; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.[37]

FFP for 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,

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adults/; Comments: Washington Medicaid Transformation Project Demonstration Extension Request (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.

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

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."[38]

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.[39] 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.

B. 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.[40] 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…"[41] Moreover, 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.

C. Arkansas' Request for 180 days of FFP Risks Increasing Rates of Institutionalization.

Repeated investments in institutional settings with the goal of creating additional capacity risks increasing the unjustified segregation of people with disabilities, particularly if community-

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[38] 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.
[39] *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.
[40] 42 U.S.C. § 1315(a)(1).
[41] *Id.* § 1396d(a)(31)(B).

based services are underfunded and not reliably available for those who need them. These risks are exacerbated by the length of stays that Arkansas proposes. Arkansas requests 180 days of FFP, which is a substantial departure from CMS' current 30-day average length of stay limit.[42]

Historically, the IMD exclusion has encouraged states to rebalance spending towards more integrated settings, because Medicaid reimbursement is available for mental health services in the community rather than institutions, and therefore states have had a financial incentive to focus investments on community-based services.[43] This incentive is particularly important due to "bed elasticity," where supply drives demand.[44] 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.[45] When a state has limited resources, spending money on costlier institutional settings results in less available funding for more cost-effective community-based programs, making community-based services harder to access.

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[42] CMS, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers (Nov. 4, 2019), https://www.medicaid.gov/media/40711.

[43] 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.

[44] 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.

[45] *Id.*

Arkansas does not have sufficient community-based mental health services to meet the needs of its residents.[46] It has one of the lowest percentages of follow-up visits with a mental health practitioner within 30 days of a hospital discharge when compared with other states.[47] Arkansas is also well-below the national average of psychiatrists available for participating Medicaid enrollees.[48] While CMS generally requires states to abide by a "maintenance of effort" (MOE) provision as a condition of receiving demonstration approval, such mechanisms are inadequate when the underlying community-based system is inadequate. An MOE cannot correct for chronic under-funding and shortages of community-based services.

Instead of investing in community based services, Arkansas proposes increasing institutional funding. Arkansas summarizes the requested demonstration as "address[ing] the severe shortage of mental health providers by opening the doors of IMDs on a temporary basis . . ."[49] When the state itself is expressly stating its intent to increase institutional placements to address shortages of services and providers, it is difficult to see how the proposed demonstration will meet some of the state's articulated goals, including "improving care coordination and transitions to community-based care."[50]

We are particularly concerned about Arkansas' request for up to 180 days of FFP for services in IMDs. Arkansas' requested average length of stay (ALOS) is *six times* longer than the ALOS that CMS is currently imposing on states with SMI/SED demonstration. CMS has consistently required states to adhere to a 30-day average length of stay and a 60-day absolute maximum stay.[51] As a practical matter, FFP for longer term stays could make it more difficult to leave. Individuals who spend more than a month or two in a facility may lose housing, either because they have been absent for too long and thus in violation of their lease, or because they can no longer pay their rent. Loss of housing often also means loss of home possessions, including

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[46] Arkansas ranks 45th in Mental Health America's Access to Care State Rankings. Maddy Reinhert et al., Mental Health America, *The State of Mental Health in America: 2023* (Oct. 2022), https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf

[47] Arkansas Reentry Application, *supra* note 1, at 15.

[48] *Id.*.

[49] *Id.* at 51.

[50] *Id.* at 27.

[51] CMS, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers (Nov. 4, 2019), https://www.medicaid.gov/media/40711.

furniture and other basic living items that can be a significant financial barrier to housing post-institutionalization. They may also lose their SSI benefits or have them substantially reduced, particularly for stays over 90 days.[52] If they were working prior to entering the IMD, they may lose their jobs. For these and other reasons, a longer length of stay is also associated with more lost community-connections, which can threaten ongoing community placement and integration with the community generally.

Furthermore, allowing FFP for IMDs, especially for up to 180 days, risks undermining hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration. 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."[53] 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."[54]

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[52] 42 C.F.R. § 416.211 (residents of public institutions, including state operated psychiatric hospitals, are generally not eligible for SSI); 42 C.F.R. § 416.212 (continuation of SSI while in certain medical institutions is limited to 90 days); 42 C.F.R. § 416.414 (benefits reduced to $30 a month in certain private and public medical institutions);
[53] 42 U.S.C. § 12101.
[54] 527 U.S. 581, 600-601 (1999).

This is why the National Council on Disability (NCD), an independent federal agency, 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.[55] We agree, and ask that CMS guard against these harms, and reject Arkansas' request for an 180-day ALOS.

D. CMS Should Reject Requests for FFP for Forensic Commitments.

Arkansas is unclear whether it is requesting FFP for forensic commitments, making it difficult for the public to meaningfully comment on Arkansas' proposal.[56] However, Arkansas does request FFP for services provided in the Arkansas State Hospital (ASH), and many individuals are in ASH due to forensic commitments.[57]

To the extent that Arkansas is requesting FFP for people under forensic commitment, CMS should deny this request. CMS has never permitted FFP for "services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the facility by operation of criminal law."[58] Reversing course on this policy would shift state and local criminal justice expenses to the federal Medicaid system, without providing tangibly improved access to behavioral health services for Medicaid enrollees.

Shifting the costs of the competency to stand trial (CST) process to the federal government will not increase diversion or improve access to behavioral health services. The CST process is often far removed from the provision of meaningful support services and treatment. Instead,

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[55] Nat'l Council on Disability, *Health Equity Framework for People with Disabilities* 11 (Aug. 2022), https://ncd.gov/sites/default/files/NCD_Health_Equity_Framework.pdf.
[56] 42 C.F.R. 431.408(a)(1)(i).
[57] Arkansas Reentry Application at 27 (ASH "has an average length of stay (LOS) of 605 days, as they treat the most acute behavioral health patients in the state as well as all forensic patients.").
[58] CMS, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers (May 17, 2019), https://www.medicaid.gov/media/40731. See also 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 13 (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

"[t[hese services are generally narrowly focused on stabilization, symptom management, and legal education and are not the same as providing access to a fully developed treatment plan and services with the goal of long-term recovery and a positive place in the community."[59] Therefore, we are skeptical that investing more federal funding into the CST evaluation process will achieve the state's stated goals, particularly without more global reform of the entire CST process.[60]

IV. Section 1115 SMI/SED Demonstrations and Reentry Demonstrations Should Not be "Aligned."

We object to Arkansas' attempt to "align this Reentry Waiver with the goals, milestones and objectives stated by CMS in its guidance regarding the reentry and IMD opportunities."[61] In the name of "alignment," Arkansas borrows bits and pieces from each of the listed CMS initiatives, applying timelines from one initiative to authorities articulated in another. For example, as noted above, Arkansas proposes allowing for FFP in IMDs for up to 90 days prior to release, and justifies this request by stating that CMS has allowed states to obtain FFP for 90 days prior to release from prisons or jails.[62]

Alignment for the sake of alignment is bad policy. CMS has designed two very separate demonstration opportunities, for two very different settings, and with two different goals. SMI/SED demonstrations are designed to provide short-term inpatient mental health and substance use disorder services, while reentry demonstrations are designed to help individuals *leave* prison or jail.[63] The guardrails associated with each respective demonstration respond to

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[59] Hallie Fader-Towe and Ethan Kelly, Council of State Governments Justice Center, *Just and Well: Rethinking How States Approach Competency to Stand Trial* 6 (2020), https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf.

[60] *Id.* (suggesting ten strategies states can use to reform the CST process.)

[61] Arkansas Reentry Application, *supra* note 1, at 18.

[62] Undated letter from Kristi Putnam, Secretary, Arkansas Department of Human Services, to Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services 32 (cover letter transmitting the Arkansas Reentry Waiver to CMS), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-opport-transi-stratg-supp-comm-incar-instit-mentl-diseas-pa-02282024.pdf.

[63] Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Pub. Law 115-271, § 5032(b), 132 Stat. 3966 (2018) ("Not later than 1

the different risks involved with each demonstration, and should not be applied interchangeably. For example, because the goal of reentry waivers is to improve reentry, CMS requires states to cover services that are "likely to improve care transitions . . . . . , including . . . at least the minimum set of pre-release services discussed below."[64] Conversely, SMI/SED demonstrations do not limit the scope of benefits covered, because SMI/SED demonstrations are designed to address a wholly different set of problems.[65]

We strongly encourage CMS to reiterate to states that these demonstrations are not interchangeable and to discourage states from seeking combined SMI/SED and reentry demonstrations.

V. Conclusion

For the above legal and policy reasons, we ask the Secretary to reject Arkansas' proposal. If you have questions about these comments, please feel free to contact me at lav@healthlaw.org.

Sincerely,

Jennifer Lav
Senior Attorney

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year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue a State Medicaid Director letter, based on best practices developed under subsection (a)(1), regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX of such Act . . . ")

[64] CMS, Dear State Medicaid Director 16 (Apr. 17, 2023) (SMD # 23-003) (Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated), https://www.medicaid.gov/media/154971.

[65] 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 14 (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.