

January 27, 2018

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

The Bazelon Center for Mental Health Law submits these comments in response to the Kansas KanCare 2.0 Section 1115 Demonstration Renewal Application. The Bazelon Center is a national non-profit legal advocacy organization that promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, community living, housing, education, employment, voting, and other areas. Our comments focus on what we believe are the three most concerning aspects of Kansas’ waiver application—a requested waiver of the IMD rule, proposed work requirements resulting coverage lockouts, and lifetime limits on Medicaid coverage. None of these proposals, as drafted, are permitted by the Medicaid statute and all would have damaging effects on the state’s system of services for people with disabilities.

1. *Proposal to Waive the Medicaid Institutions for Mental Disease (IMD) Rule Entirely for Acute Mental Health Services*

CMS Lacks Authority to Grant the Proposed Waiver of the IMD Rule

Kansas asks CMS to waive the IMD rule beyond the parameters established by CMS’ July 2016 regulation (Federal Rule 42 C.F.R. 438.6(e) as amended) and “provide coverage under KanCare 2.0 for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.”¹ Such payments would clearly be impermissible under the Medicaid statute and CMS has no authority to allow them, including under a Section 1115 waiver.

CMS has specified in its regulations that, for the limited exception to the IMD rule to apply, several specific requirements must be met: (1) the person’s stay in the IMD must not exceed 15 days in a month, (2) the person must have a choice about whether to receive the IMD services, (3) the IMD must be providing the person with crisis services, and (4) the IMD services must be shown to be cost-effective. 42 C.F.R. § 438.3(u); 80 Fed. Reg. 31098, 31118 (June 1, 2015). Kansas’ proposal ignores these limitations and requests and asks for a complete waiver of the IMD exclusion for individuals enrolled in an MCO and receiving services in an IMD. While Section 1115 permits waiver of particular listed provisions of the Medicaid statute, the IMD rule is not among them. Accordingly, CMS has no authority to grant Kansas’ request.

¹ KANSAS WAIVER APPLICATION 25-6 (Dec. 28, 2017).

While we continue to believe that CMS does not have authority to allow any coverage for IMD stays for individuals 22-64,² it is beyond dispute that CMS' own regulations do not permit the waiver of the IMD exclusion that Kansas has proposed.

Evidence Does Not Support Policy of Permitting Federal Funding Percentage for Individuals in IMDs to Ensure Access to Appropriate Mental Health Care

In addition, such a policy change would allow the state to invest in the most expensive, ineffective, and discriminatory form of mental health services. The past fifty years have seen a clear and deliberate public policy shift away from the historic *overreliance* on psychiatric institutions and increase investment in the community mental health services that reduce the need for psychiatric hospitalization and are more cost-effective.

States have shifted resources away from psychiatric hospitals and toward community-based services for two important reasons: (1) a recognition that many individuals served in psychiatric hospitals would receive better care and achieve recovery in home and community-based settings, and (2) an effort to come into compliance with the Americans with Disabilities Act's (ADA's) integration mandate and the Supreme Court's *Olmstead* decision, which require states to offer individuals with disabilities the opportunity to receive services in the most integrated setting appropriate.

Indeed, numerous federal government commissions and reports over several decades have urged that mental health systems shift toward greater investment in community services, including President Carter's Commission on Mental Health, the Surgeon General's Report on Mental Health under President Clinton, and President Bush's New Freedom Commission on Mental Health. The U.S. Justice reached numerous settlement agreements with states requiring an expansion of states' community mental health systems and downsizing of their psychiatric hospitals. In the State of New Jersey, for example, a recent settlement resulted in thousands of individuals with serious mental illness receiving services in the community instead of institutions.³ Even after the close of the settlement period, New Jersey has continued to expand community-based mental health services because of the clear "win-win" entailed in shifting

² When CMS proposed the limited exception to the IMD rule in 2015, we commented that the exception was inconsistent with the Medicaid statute. As CMS acknowledged in its proposed Medicaid Managed Care rule, Title XIX's statutory IMD exclusion prohibiting federal financial participation (FFP) for services provided to individuals 21-64 in IMDs is a "broad exclusion" and it is "applicable to the managed care context." While 42 U.S.C. § 1396(n)(b)(3) permits states to offer Medicaid beneficiaries "additional services" not covered under the state plan if they realize cost savings through managed care, the capitation payments for such "additional services" include FFP and thus cannot pay for services for individuals 22-64 who reside in an IMD, as the statute explicitly forbids FFP for such services. The statute does not say that FFP for individuals staying short times in IMDs is permitted; it *prohibits* FFP for individuals 21-64 residing in IMDs. CMS disagreed and included the exception in its final rule. Regardless, what Kansas proposes goes far beyond the limited exception that CMS has read into the statutory IMD rule.

³ *Disability Rights New Jersey v. Velez* (Jul. 29, 2009) http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf.

resources away from state psychiatric hospitals and into community services.⁴ In addition, other states like Indiana,⁵ Ohio,⁶ and Virginia⁷ have obtained state plan amendments and waivers to expand a core set of intensive mental health services, including peer support services, supported employment, mobile crisis services, and other intensive services that are eligible for FFP under current Medicaid law. A waiver of the IMD exclusion is not required to expand these evidence-based and cost-effective services.

To the extent that is difficult for individuals to access psychiatric hospital beds, building a well-functioning community system that has the capacity to resolve crises without hospitalization, that addresses mental health needs early to prevent needless hospitalizations, and that enables the earlier discharge of individuals from psychiatric hospitals, is widely recognized as an important solution. As noted by Dr. Jess Jamieson, former Director of State Hospitals in Washington State:

When I was running the State hospitals in Washington, we were right in the middle of this controversy...boarding patients in the ERs waiting for a bed. My hospitals were full, so the prevailing attitude was we needed more beds. This is not the solution!! What I needed was a stronger community-based system to divert patients from inpatient hospitalizations and the community resources to discharge my patients who were ready for community placement, thus opening up a bed for those patients who needed hospitalization. The problem was, the community system was under funded and lacked resources.⁸

CMS should instead encourage Kansas to expand the community-based intensive mental health services that are a better use of federal dollars.

Kansas' request for a waiver of the IMD rule also conflicts with Kansas' proposed hypothesis for the KanCare 2.0 Section 1115 demonstration that "[i]ncreasing employment and independent living supports for members with behavioral health needs . . . will increase independence and improve health outcomes."⁹ Dramatically decreasing the cost to states of serving individuals in

⁴ NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES, HOME TO RECOVERY 2017 TO 2020: A VISION FOR THE NEXT THREE YEARS (January 2017) <http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/Home%20to%20Recovery%202%20Plan%20-%20January%202017.pdf>.

⁵ INDIANA MEDICAID, 1915(i) HOME AND COMMUNITY-BASED SERVICES PROGRAMS (2014) [http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/1915\(i\)-home-and-community-based-services-programs.aspx](http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/1915(i)-home-and-community-based-services-programs.aspx).

⁶ OHIO, DEPARTMENT OF MEDICAID, TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL (July 1, 2016) <http://www.medicare.ohio.gov/Portals/0/Resources/PublicNotices/1915i/1915i-StatePlan.pdf>

⁷ COMMONWEALTH OF VIRGINIA, VIRGINIA GAP PROGRAM FOR THE SERIOUSLY MENTALLY ILL §1115 DEMONSTRATION APPLICATION (October 2014) http://www.dmas.virginia.gov/Content_atchs/1115/Virginia%20Section%201115%20Application%20GAP%20Waiver%20for%20the%20Seriously%20Mentally%20Ill.pdf.

⁸ Monica E. Oss, Executive Briefing, Open Minds, *You Have to Take Something Out, to Put Something In*, <http://www.openminds.com/market-intelligence/executive-briefings/take-something-put-something.htm>.

⁹ KANSAS WAIVER APPLICATION *supra* note 1, 4 (Dec. 28, 2017).

IMDs will eliminate important incentives to ensure that people with mental illnesses live independently and have employment opportunities. The IMD exclusion has incentivized expansion of community services due to the federal reimbursement for community services. In addition, living in an institution makes it far more difficult for individuals to secure and maintain employment for a variety of reasons, including the very limited personal needs allowance that institutional residents can retain and not remit to the institution.

Kansas has already recognized the need for better community services following hospital discharge, given that the performance improvement project for UnitedHealthcare is “to improve follow-up after hospitalization for mental illness.”¹⁰ Kansas reports that only 0.2% of KanCare members utilize inpatient mental health services.¹¹ Yet the follow up rate after an inpatient hospitalization is only 62.2%.¹² Kansas’ own reporting suggests that the problem is not the unavailability of inpatient services, but insufficient community mental health services. Kansas’ requested waiver of the IMD provisions should be rejected.

2. Work or Work-Like Requirements for Some Adult Enrollees

Kansas also requests a waiver so that the state can “institute work requirements for only some able-bodied adults.”¹³ We believe HHS lacks the authority to approve this proposal. As HHS has repeatedly stated, Section 1115 Waivers may only be approved for “any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid program].”¹⁴ Even if CMS believes that some work requirements would be permissible,¹⁵ the Kansas work requirement does not promote the objectives of the Medicaid program nor is it an experiment, pilot, or demonstration of the sort contemplated by the Medicaid statute.

Kansas’ work requirement proposal does not promote the objectives of Medicaid.

The statutory objectives of the Medicaid program are to furnish (1) “medical assistance” to people with disabilities, seniors, and families with dependent children, whose income and resources are insufficient to secure needed medical services, and (2) services to help such individuals and families attain or retain independence and self-care.¹⁶

¹⁰ *Id.* at 28.

¹¹ *Id.* at 108.

¹² *Id.* at 96.

¹³ *Id.* at 9.

¹⁴ Centers for Medicare & Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicare.gov/medicaid/section-1115-demo/about-1115/index.html>.

¹⁵ We respectfully disagree. See BAZELON CENTER FOR MENTAL HEALTH LAW, COMMENTS ON THE NORTH CAROLINA MEDICAID AND NC HEALTH CHOICE AMENDED SECTION 1115 DEMONSTRATION WAIVER APPLICATION (Jan 5, 2018) http://www.bazelon.org/wp-content/uploads/2018/01/Bazelon_NC-Comments_1-5-17.pdf, BAZELON CENTER FOR MENTAL HEALTH LAW, COMMENTS ON THE NEW HAMPSHIRE 1115 DEMONSTRATION WAIVER APPLICATION (Jan 5, 2018) http://www.bazelon.org/wp-content/uploads/2018/01/Final-Comments_12-2-17.pdf.

¹⁶ 42 U.S.C. 1396-1.

HHS’s criteria for determining whether a proposed demonstration would promote Medicaid’s objectives include whether the demonstration would:

Improve access to high-quality, person-centered services that produce positive health outcomes for individuals; [. . .] Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals; Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making [. . .]¹⁷

Kansas’ proposed work requirement would neither promote the goals of furnishing medical assistance and services, nor improve access to high quality services, support strategies to address health determinants promoting upward mobility and independence, or strengthen engagement in individuals’ healthcare and decision-making. In fact, it would have the opposite effect of reducing access to needed services, including those that enable people with disabilities to work.

Kansas states that it will align these new work requirements with the Temporary Assistance for Needy Families (TANF) work requirements.¹⁸ Years of experience with work requirements in the TANF program—another program where participants receive benefits critical to their subsistence—have consistently shown that work requirements do not assist individuals in obtaining full employment or lift them and their families out of poverty. Studies of these requirements have shown that: (1) increases in employment among recipients subject to work requirements were modest and diminished over time, (2) stable employment among recipients subject to work requirements was the exception rather than the norm, (3) most recipients who had significant barriers to employment never found employment, and (4) the vast majority of individuals subject to work requirements remained poor, and some became poorer.¹⁹ Indeed, within five years, “employment among recipients not subject to work requirements was the same as or higher than employment among recipients subject to work requirements in nearly all of the programs evaluated.”²⁰

In addition, the “Studies consistently show that TANF recipients who are sanctioned because they have not complied with work requirements report higher rates of disability than those who are not sanctioned.”²¹ Kansas’ own TANF program, which is cited approvingly by the waiver application, has not resulted in increased employment: “analysis of state-collected data on the

¹⁷ *About Section 1115 Demonstrations*, *supra* note 14.

¹⁸ KANSAS WAIVER APPLICATION, *supra* note 1, at 11.

¹⁹ See, e.g., LaDonna Pavetti, Center on Budget and Policy Priorities, *Work Requirements Don’t Cut Poverty, Evidence Shows* (June 2016), <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>. See also Marybeth Musumeci, Kaiser Family Foundation, *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>.

²⁰ *Work Requirements Don’t Cut Poverty*, *supra* note 19.

²¹ Mathematica, LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, *Assisting TANF Recipients Living With Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments* (Feb. 2008) https://www.acf.hhs.gov/sites/default/files/opre/conducting_in_depth.pdf/.

employment and earnings of Kansas parents leaving TANF cash assistance between October 2011 and March 2015 indicates that the vast majority of these families worked before and after exiting TANF, but most found it difficult to find steady work and secure family-sustaining earnings.”²² These outcomes strongly suggest that many participants will not succeed in meeting the work requirements and hence will lose the critical coverage of health care that they receive through the Section 1115 waiver.

Without Medicaid coverage of needed health care services, individuals’ employment opportunities will decrease rather than increase. As the Kaiser Family Foundation has observed, “[h]ealth coverage through Medicaid is an important precursor to and support for work.”²³ The Foundation’s surveys concerning the impact of health coverage on employment of Medicaid beneficiaries are instructive:

*Without health insurance, individuals may forgo needed services, and their health may deteriorate to a point that interferes with their ability to work. An analysis of Ohio’s Medicaid expansion found that over half of enrollees who are working (without being required to do so) reported that having Medicaid made it easier for them to continue working. In addition, most Ohio expansion enrollees who were unemployed but looking for work reported that having Medicaid made it easier for them to seek employment. A study examining Michigan’s Medicaid expansion found that nearly seven in 10 (69%) enrollees who were working said they performed better at work once they got Medicaid coverage. Over half (55%) of Michigan expansion enrollees who were not working indicated that having Medicaid coverage made them better able to look for work. Having access to regular preventive health care to manage chronic conditions and address health issues as early as possible before they worsen is important so that individuals are healthy enough to work. In addition, an unmet need for mental health or addiction treatment results in greater difficulty with obtaining and maintaining employment, and Medicaid is an important source of coverage for mental health and addiction treatment services, such as opioid addiction.*²⁴

Kansas’ proposal is not an experiment, pilot, or demonstration of the sort contemplated by the Medicaid statute.

1115 Waiver and Demonstration programs are not intended to serve as blind experiments with individuals’ lives. They are supposed to contain clearly defined goals, identify a specific problem that is being addressed, have a reasonable basis to believe that the demonstration is

²² Tazra Mitchell and LaDonna Pavetti, Center on Budget and Policy Priorities, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (Jan. 23 2018) <https://www.cbpp.org/research/life-after-tanf-in-kansas-for-most-unsteady-work-and-earnings-below-half-the-poverty-line>. We also note that Kansas’ own citation of its TANF requirements fails to offer any comparative information, simply stating reporting how many TANF participants obtained jobs without any contextual information about how those rates differ from individuals not on TANF or compared to individuals who were sanctioned.

²³ *Medicaid Enrollees and Work Requirements*, *supra* note 19.

²⁴ *Id.*

likely to address the problem effectively and without harming individuals, and put measures in place to ensure that individuals are not harmed.

Kansas' justification for this waiver is that it will "promote highest level of member independence."²⁵ 68% percent of enrollees in Kansas work full time and 18% work part time; in total, 84% of Kansas' enrollees already work.²⁶ Kansas has offered no evidence showing that the work requirements will increase employment. Kansas acknowledges that:

Unemployed Americans face numerous health challenges beyond loss of income. Workers who are laid-off are "54 percent more likely than those continuously employed to have fair or poor health, and 83 percent more likely to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis." With respect to behavioral health, a 2013 Gallup Poll found that "the longer Americans are unemployed, the more likely they are to report signs of poor psychological wellbeing." Employment plays a major role in adult life, frequently bringing with it a sense of accomplishment, personal satisfaction, self-reliance, social interaction, and integration into the community, which can ultimately impact an individual's social determinants of health and independence. Steady employment can provide the income, benefits, and stability necessary for good health.²⁷

We agree with this statement, but it runs counter to the course of action Kansas has proposed. Losing health care will make it harder, not easier, for people with mental health needs who are unemployed and facing challenges securing work to get and keep a job.

Indeed, Kansas' proposed "*Voluntary Work Opportunities*"--for individuals on MediKan who are waiting for determinations from the Social Security Administration²⁸ and individuals who have disabilities or behavioral health conditions and who are at risk for institutionalization²⁹--recognizes that for some people with mental illness or other health problems, there is a "need for vocational supports and other interventions."³⁰

We strongly support providing individuals with intensive employment supports, but we oppose Kansas' 18 month time limit on MediKan members who opt into this new program. People who have been unable to find jobs with "a broader array of health care and social support services" will not cease to need access to health care services after 18 months, and given the time that it

²⁵ KANSAS WAIVER APPLICATION, *supra* note 1, at 4.

²⁶ Rachel Garfield, Robin Rudowitz, and Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* (Dec. 7, 2017) <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

²⁷ KANSAS WAIVER APPLICATION, *supra* note 1, at 9.

²⁸ *Id.* at 13.

²⁹ *Id.* at 14.

³⁰ *Id.* at 13.

often takes to find employment, access to employment services.³¹ Likewise, the pilot program for people with disabilities that the state is considering,³² which includes providing enhanced services, is also more likely to yield the results that Kansas purports to want. Cutting off health coverage will do nothing to help people become or remain employed.

Moreover, Kansas does not propose to exempt from work requirements medically frail individuals—including individuals with serious mental illness—as required by CMS’s Dear State Medicaid Director letter concerning work requirements.³³ Instead, Kansas merely says that it “may” consider an exceptions process for people with mental health disabilities.³⁴ This is not consistent with CMS’s guidance.

In addition, Kansas does not identify how it will comply with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, including the provision of reasonable modifications in work or community engagement requirements, as mandated by CMS’s Dear State Medicaid Director letter.³⁵ In that letter, CMS specified that reasonable modifications “must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports.”³⁶

Kansas’ employment rate for people with serious mental illnesses reflects a serious problem—people with serious mental illnesses are employed at less than a fifth of the rate for all Medicaid enrollees: 15.9%.³⁷ As discussed above, having access to health care promotes independence. The overwhelming majority of people with mental health disabilities want to and can work, but many are not working as a result of attitudinal barriers among employers, the need for reasonable accommodations that have not been provided, or the need for supported employment services that are scarcely available. For people with serious mental illness, the employment rate is even lower; it has been estimated over time at about 22%, with approximately 12% working full-time.³⁸ Dr. Gary Bond, then Professor of Psychiatry at Dartmouth Psychiatric Research Center, testified that the reason for the dramatic gap between the desire of people with serious mental

³¹ See, e.g. The Independent, *Disabled People Have to Apply for 60% More Jobs than Non-Disabled People Before Finding One* (Sept. 27, 2017) <https://www.independent.co.uk/news/uk/home-news/disabled-people-jobs-applications-more-able-bodied-stats-before-employment-a7970701.html>.

³² KANSAS WAIVER APPLICATION, *supra* note 1, at 11. We note that the lack of commitment on the part of the state to this pilot is confusing, given the extensive evidence that such programs help people with disabilities work.

³³ Centers for Medicare & Medicaid Services, SMD: 18-002, *Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries* (Jan. 11, 2018), at 5, <https://www.medicare.gov/federal-policy-guidance/downloads/smd18002.pdf>.

³⁴ *Id.*

³⁵ See *supra* note 33, at 6.

³⁶ *Id.*

³⁷ *Id.* at 107.

³⁸ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY, FEDERAL FINANCING OF SUPPORTED EMPLOYMENT AND CUSTOMIZED EMPLOYMENT FOR PEOPLE WITH MENTAL ILLNESS: FINAL REPORT vii (Feb., 2011), <http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf>.

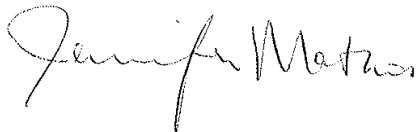
illness to work and their low employment rates is not an inability to work, but rather “attitudinal, service, and system barriers” such as stigma and discrimination, inadequate treatment, and lack of employment services.³⁹ Kansas could instead expand the work opportunity programs and attempt to address these fundamental problems rather than institute work requirements that will, instead, discourage work.

For all of these reasons, Kansas’ requested waiver modification should be denied.

3. Lifetime Limits on Eligibility for Adult Enrollees

Kansas is also proposing a lifetime limit on Medicaid eligibility of three years for individuals subject to the work requirements, even if the individual complies with the work requirement. CMS has rejected time limits on coverage because such limits “undermine access to care and do not support the objectives of the program.”⁴⁰ We concur with this legal analysis. CMS should reject, as it has before, this aspect of the proposal.

Respectfully submitted,



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³⁹ WRITTEN TESTIMONY OF DR. GARY BOND, U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION PUBLIC MEETING ON EMPLOYMENT OF PEOPLE WITH MENTAL DISABILITIES (March 15, 2011), <https://www.eeoc.gov/eeoc/meetings/3-15-11/bond.cfm>.

⁴⁰ Arizona Approval Letter, (Sept. 30, 2016) <https://ccf.georgetown.edu/wp-content/uploads/pdfs/az-hccc-ca.pdf>