JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

October 20, 2017

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

Dear Acting Secretary Hargan:

The Bazelon Center for Mental Health Law submits these comments in response to the MassHealth - September 2017 Amendment 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.

1. *#1, Proposal to Enroll Non-Disabled Adults over 100% FPL in Commercial Insurance*

We share the concerns of many other advocates that this proposal will not reduce churn and will instead result in individuals losing coverage and believe that it would not promote the objectives of the Medicaid program. However, we are also concerned that the protections for people with disabilities in this proposal are completely insufficient. MassHealth has sufficient data to determine at the state level which individuals have disabilities and would qualify as medically frail. Placing the onus of "asking for a determination"[1] on individuals with disabilities who might need additional assistance to understand the process or who might, due to their disability, be unable to ask for such a determination is insufficient when Massachusetts already has the relevant data to make that determination.

In addition, we are concerned that formal disability determinations might overlook individuals with disabilities. It is unclear from this proposal how Massachusetts intends to identify all individuals with disabilities. Medically frail individuals who are afforded extra protections under the Affordable Care Act are partially listed at 42 CFR 440.315. As that limited list suggests, people with disabilities are incredibly diverse and many people with mental health needs require Long Term Services and Supports, but might not qualify for SSI or other "formal" programs. Proposals that define the disability population narrowly will be drastically under-inclusive and Massachusetts has not explained with sufficient clarity how the state plans to ensure that all individuals with disabilities are protected.

2. *#7, Proposal to Waive Institutions for Mental Disease (IMD) Rule*

[1] COMMONWEALTH OF MASSACHUSETTS, EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, OFFICE OF MEDICAID, MASSHEALTH SECTION 1115 DEMONSTRATION AMENDMENT REQUEST 6 (Sept. 8, 2017) available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf

CMS Lacks Authority to Waive the Statute's IMD Rule

As we commented when CMS proposed the now existing 2016 Medicaid Managed Care regulation, we believe CMS lacks authority to waive the Institutions for Mental Disease (IMD) exclusion as it did in the regulation. As CMS acknowledged in the proposed Medicaid Managed Care rule back in 2015, 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."[2] 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,[3] the capitation payments for such "additional services" include FFP and thus cannot pay for services for individuals 21-64 who reside in an IMD. 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.

In addition, while managed care permits flexibilities in the Medicaid program, these flexibilities are not unlimited. They are specifically described in the statute. The Title XIX statutory authorities under which states can implement a managed care delivery system identify the particular provisions of the statute that may be waived under such a system; the IMD rule is not among those provisions.[4] If Congress had intended to authorize HHS to waive additional statutory provisions besides those identified, it would have said so. The specific authorization to waive certain provisions makes clear that provisions not listed, including the IMD rule, cannot be waived.

Massachusetts' request goes far beyond the very limited exception that CMS attempted to create in the 2016 Medicaid Managed Care and Massachusetts acknowledges that.[5] Even if CMS had the authority to create that limited exception, it cannot waive "all IMD payment restrictions" as Massachusetts requests. We point out that the same commission report cited by Massachusetts recognizes this, stating that "legislation would be necessary to repeal the exclusion in its entirety."[6] Massachusetts' current waiver of the IMD rule for Substance Use Disorder (SUD) services provisions is a different question, since it is CMS' own policy and not statutory language that has prohibited use of FFP for SUD services for the past.

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[2] 80 Fed. Reg. 31116, 31118 (June 1, 2015). The IMD rule provides that "medical assistance," including FFP, does not include any "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 [IMD]." 42 U.S.C. § 1396d(a)(29)(B).

[3] *See also* 42 C.F.R. § 436.3(e).

[4] *See* 42 U.S.C. 1396n(b) (Secretary "may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a (a)(15), 1396a (bb), and 1396a (a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d (a)(2)(C) of this title"); 42 U.S.C. 1315(a) ("the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title . . . ."). *See also* 42 U.S.C. §§ 1396n(a), 1396u-2.

[5] COMMONWEALTH OF MASSACHUSETTS, *supra* note 1 at 12 ("we are requesting a broader waiver for IMD, including of the 15-day limit in CMS' 2016 managed care rule").

[6] PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, DRAFT INTERIM REPORT (2017) https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf.

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

The waiver of the IMD rule that Massachusetts is requesting would allow the state to invest in the most expensive, ineffective, and discriminatory form of mental health services. It is unsurprising that Massachusetts is facing a budgetary challenge within its Medicaid program if the state believes that "most cost-effective care for members with significant behavioral health needs" is psychiatric hospitalization.[7] 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 Department has made enforcement of *Olmstead* a priority, reaching numerous settlement agreements requiring an expansion of states' community mental health systems and downsizing of their psychiatric hospitals. This includes in the State of New Jersey, where a recent settlement resulted in thousands of individuals with serious mental illness receiving services in the community instead of institutions.[8] The settlement is now over, but New Jersey has continued to expand community-based mental health services because of this clear policy win-win.[9] In addition, other states like Indiana,[10] Ohio,[11] and Virginia[12] have

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[7] COMMONWEALTH OF MASSACHUSETTS, s*upra* note 1 at 12.
[8] *Disability Rights New Jersey v. Velez* (Jul. 29, 2009) http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf.
[9] NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES, HOME TO RECOVERY 2 2017 TO 2020: A VISION FOR THE NEXT THREE YEARS (January 2017) http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/Home%20to%20Recovery%20 2%20Plan%20-%20January%202017.pdf.
[10] 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.
[11] OHIO, DEPARTMENT OF MEDICAID, TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL (July 1, 2016) http://www.medicaid.ohio.gov/Portals/0/Resources/PublicNotices/1915i/1915i-StatePlan.pdf
[12] COMMONWEALTH OF VIRGINIA, VIRGINIA GAP PROGRAM FOR THE SERIOUSLY MENTALLY ILL §1115 DEMONSTRATION APPLICATION (October 2014)

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.*[13]

CMS should not incentivize increased admissions to psychiatric hospitals at the expense of developing appropriate community-based services. Doing so would simply drive mental health systems backward and encourage needless spending. CMS should instead encourage Massachusetts to pursue an expansion of community-based intensive mental health services that would be a better use of federal dollars.

Thank you for the opportunity to comment.

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http://www.dmas.virginia.gov/Content_atchs/1115/Virginia%20Section%201115%20Application%20GAP%20Waiver%20for%20the%20Seriously%20Mentally%20Ill.pdf.

[13] 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.