JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

January 5, 2018

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 North Carolina Medicaid and NC Health Choice Amended Section 1115 Demonstration Waiver 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 two most concerning aspects of North Carolina's waiver application—a requested waiver of the IMD rule and proposed work requirements. Neither of these proposals, as drafted, is permitted by the Medicaid statute and both 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

North Carolina proposes "to make [Medicaid] payments to IMDs for all Medicaid enrollees, either through PHPs or local management entities-managed care organizations (LME/MCOs), or directly to IMDs for fee-for-service enrollees, regardless of whether enrollees are enrolled in managed care or through other delivery systems."[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.

First, the proposal would violate the Medicaid statute by allowing federal financial participation (FFP) for services provided to fee-for-service enrollees who reside in IMDs. Yet the limited exception to the IMD rule that CMS has carved out applies only to managed care enrollees; indeed, the entire rationale for why FFP could be allowed on a limited basis for individuals 22-64 in IMDs is based on the statute's provision allowing managed care savings to be used to pay for alternative services not otherwise covered under the state plan. 42 U.S.C. § 1396(n)(b)(3).

Second, the proposal would violate the Medicaid statute by allowing FFP for services provided to any individuals residing in an IMD, regardless of whether CMS's regulatory requirements for

[1] NORTH CAROLINA WAIVER APPLICATION 16 (Nov. 20, 2017).

the limited exception to the IMD rule are met, as long as the IMD services the person receives can be labelled as acute care. 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). North Carolina's proposal contains none of these limitations.

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 North Carolina's request.

While we continue to believe that CMS does not have authority to allow coverage for IMD stays for individuals 22-64,[2] it is beyond dispute that the statute does not permit the sweeping waiver of the IMD exclusion that North Carolina proposes.

We note that the state's request of a 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 individuals in IMDs providing SUD services. For mental health services, the statutory language is clear. The Administration's Commission on the Opioid Crisis report recognizes this, stating that "legislation would be necessary to repeal the exclusion in its entirety."[3] CMS cannot approve North Carolina's proposed waiver.

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

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[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 North Carolina proposes goes far beyond the limited exception that CMS has read into the statutory IMD rule.

[3] 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.

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.[4] 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 resources away from state psychiatric hospitals and into community services.[5] In addition, other states like Indiana,[6] Ohio,[7] and Virginia[8] 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

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

[5] 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.

[6] 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.

[7] 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

[8] 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.

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.*[9]

Moreover, North Carolina's proposal would not only incentivize increased admissions to psychiatric hospitals at the expense of developing appropriate community-based services; it would also undermine the ongoing settlement agreement between the state and the federal government, which involves thousands of individuals with serious mental illness warehoused in large, for-profit IMD board and care homes providing substandard services. These homes are poor care settings for people with serious mental illness, and would be particularly inappropriate settings for providing acute care. Yet North Carolina's proposal would permit FFP to subsidize acute care in these settings.

CMS should instead encourage North Carolina to continue the work that the state has already done under the *Olmstead* settlement and continue to expand the community-based intensive mental health services that are a better use of federal dollars. We note the state's own statements about the importance of access to Young Adult Peer Support Services[10] and other services that are not currently available.[11] Also, given the Administration's recent action to enforce North Carolina's *Olmstead* settlement, we are surprised to see no mention in the waiver of supported housing and only general references to supported employment. The state has legal obligations to meet regarding access to both of these services for class members and since the state is so focused on behavioral health, it is surprising that the expansion of these services is not a priority.

2. Work or Work-Like Requirements for Adult Enrollees

We believe HHS lacks the authority to approve the proposal to condition Medicaid eligibility for Section 1115 waiver participants on these individuals engaging in 20-30 hours/week of employment or work-related activities. 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

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[9] 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.

[10] NORTH CAROLINA WAIVER APPLICATION 98 (Nov. 20, 2017).

[11] NORTH CAROLINA WAIVER APPLICATION 107 (Nov. 20, 2017).

program]."[12] The North Carolina 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.

North Carolina's 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.[13]

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 [. . .][14]

North Carolina's proposed work requirements 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, they would have the *opposite* effect of reducing access to needed services, including those that enable people with disabilities to work.

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

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

13 42 U.S.C. 1396-1.

14 *About Section 1115 Demonstrations*, *supra* note 15.

poor, and some became poorer.[15] 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."[16]

These outcomes—together with the lack of any commitment in the waiver modification application to expand the availability of employment services, training programs, and other services that would enable participants to meet the work requirements—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."[17] 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.[18]

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[15] *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/.

[16] *Work Requirements Don't Cut Poverty*, *supra* note 18.

[17] *Medicaid Enrollees and Work Requirements*, *supra* note 18.

[18] *Id.*

North Carolina's proposal is not an experiment, pilot, or demonstration of the sort contemplated by the Medicaid statute

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

North Carolina offers no justification for this waiver. It does not identify how the current design of the program is failing to provide work opportunities or provide any data suggesting that individuals who are or will become eligible for Medicaid are not currently working. In fact, a federal court recently found that North Carolina was failing to meet its obligations to provide supported employment services to individuals with serious mental illness under its *Olmstead* settlement with the federal government.[19]

In addition, there is no indication from the application that North Carolina has considered how this work requirement proposal will impact people with disabilities. The overwhelming majority of people with 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.

Consequently, the employment rate of people with disabilities has remained far lower than that of any other group tracked by the Bureau of Labor Statistics. Among working age adults, the employment rate of people with disabilities is less than half of that for people without disabilities.[20]

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.[21] 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 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.[22]

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[19] https://www.ada.gov/olmstead/documents/us_reply_nc_opp.pdf

[20] U.S. Department of Labor, Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics Summary* (June 21, 2017) (among persons age 16 to 64, the employment-population ratio in 2016 for people with disabilities was 27.7 percent, in contrast to 72.8 percent for people without disabilities), https://www.bls.gov/news.release/disabl.nr0.htm.

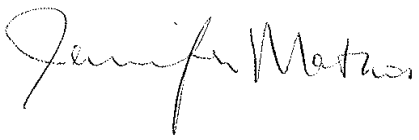
[21] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, Federal Financing of Supported Employment and Customized Employment for People with Mental Illness: Final Report vii (Feb., 2011), http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf.

[22] 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.

In North Carolina, as in most states, evidence-based supported employment services are not available for many people with disabilities who need them. The state committed to expand these services for certain individuals under a settlement agreement with the Justice Department. Unfortunately, North Carolina is currently failing to provide those services: "the State's supported employment program operated at 61 percent of its expected capacity, which constitutes a failure to comply substantially."[23]

For all of these reasons, work requirements that cut off access to Medicaid if an individual does not work a sufficient number of hours or cannot obtain a job quickly will disproportionately harm people with disabilities. North Carolina's requested waiver modification should be denied.

Respectfully submitted,



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[23] https://www.ada.gov/olmstead/documents/us_reply_nc_opp.pdf