JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

January 30, 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 New Mexico's Centennial Care 1115 Demonstration Waiver 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 New Mexico's requested waiver of the Institutions for Mental Disease (IMD) rule. This proposal, as drafted, is not permitted by the Medicaid statute and would have damaging effects on the state's system of services for people with psychiatric disabilities.

New Mexico's Proposal to Waive the Medicaid Institutions for Mental Disease (IMD) Rule

New Mexico asks the Centers for Medicare & Medicaid Services (CMS) for two waivers of the IMD rule: First, "to allow 30 day use of an IMD for members who have a non-SUD diagnosis,"[1] specifically requesting "expenditure authority for members in managed care and FFS to receive inpatient services in an IMD so long as the cost of care is the same as, or more cost effective, than a setting that is not an IMD."[2] Second, to "[a]dd services for substance abuse disorders including waiver from limitations on the use of IMD for members with SUD."[3] We have serious concerns about the requested mental health waiver, including that CMS is statutorily prohibited from granting such a waiver and that such a change is not supported by evidence-based policy.

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 from the requested mental health waiver, since it is CMS' own policy and not statutory language that has prohibited use of FFP for individuals in IMDs providing SUD services.

CMS Lacks Authority to Grant the Proposed Waiver of the IMD Rule for Acute Mental Health Services

First, the proposal would violate the Medicaid statute by allowing federal financial participation

[1] NEW MEXICO WAIVER APPLICATION 22 (Dec. 6, 2017).
[2] *Id.* at 34.
[3] *Id*. at 22.

(FFP) for services provided to fee-for-service enrollees who reside in IMDs.[4] 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.[5]

Second, the proposal would violate the Medicaid statute by allowing FFP for mental health services provided to any individuals residing in an IMD, regardless of whether CMS's regulatory requirements for the limited exception to the IMD rule are met. CMS' July 2016 regulation established specific requirements for any waiver of the IMD rule that do include cost effectiveness, but also several other criteria: (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.[6] New Mexico's request acknowledges the cost effectiveness criteria,[7] but also requests 30-day reimbursement and of coverage all "inpatient services" in direct contradiction with CMS' other criteria.[8] The waiver application says nothing about ensuring that an individual has a choice to receive IMD services. Since these clear regulatory criteria have not been met, CMS would need another basis on which to approve this 1115 waiver. 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 New Mexico's request.

For these reasons, it is beyond dispute that CMS' own regulations do not permit the waiver of the IMD exclusion that New Mexico has proposed. We also note that we continue to believe that CMS does not have authority to allow any coverage for IMD stays for individuals 22-64,[9]

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[4] 42 U.S.C. § 1396(n)(b)(3).
[5] *Id*.
[6] 42 C.F.R. § 438.3(u); 80 Fed. Reg. 31098, 31118 (June 1, 2015).
[7] NEW MEXICO WAIVER APPLICATION 34 (Dec. 6, 2017).
[8] *Id*.
[9] 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 New Mexico proposes goes beyond the limited exception that CMS has read into the statutory IMD rule.

Evidence Does Not Support Expanding Federal Funding for Individuals in IMDs to Ensure Access to Appropriate Mental Health Care

In addition, such a policy change would encourage overreliance on expensive and ineffective mental health services, particularly in New Mexico, where community mental health services have experienced unprecedented turmoil in recent years and the state's Medicaid behavioral health services are the subject of an investigation by the U.S. Department of Health and Human Services Inspector General.[10] It would be particularly damaging to New Mexico's ability to rebuild the community capacity needed in its behavioral health system for the state to invest in increasing institutional services rather than community 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.[11] 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.[12] In addition, other

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[10] DEPT. OF HEALTH AND HUMAN SERV., OFFICE OF THE INSPECTOR GENERAL, LETTER TO SENATORS UDALL AND HEINRICH AND REP. LUJAN AND LUJAN GRISHAM (Jun. 28, 2017) https://lujangrisham.house.gov/sites/lujangrisham.house.gov/files/HHS%20OIG%20Response%20re%20NM%20Congressional%20Request%20-%2006.28.2017.pdf.

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

[12] 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%202%20Plan%20-%20January%202017.pdf.

states like Indiana,[13] Ohio,[14] and Virginia[15] 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.*[16]

CMS should instead encourage New Mexico to rebuild and expand the community-based intensive mental health services that are a better use of federal dollars. New Mexico's Benefit and Delivery System Proposal #9 proposes to "expand the availability of basic housing supports."[17] But it is unfortunate that beyond that, New Mexico offers no other proposals to expand access to community services.

New Mexico's requested waiver of the Medicaid statute's IMD provisions should be rejected.

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[13] 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.

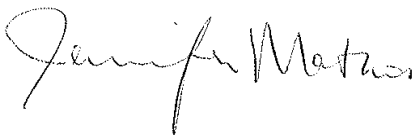
[14] OHIO, DEPARTMENT OF MEDICAID, TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL (July 1, 2016) http://www.medicaid.ohio.gov/Portals/0/Resources/PublicNotices/1915i/1915i-StatePlan.pdf

[15] 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.

[16] 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.

[17] Waiver app. P. 30.

Respectfully submitted,



Jennifer Mathis
Director of Policy and Legal Advocacy
jenniferm@bazelon.org

Bethany Lilly
Deputy Director of Policy and Legal Advocacy
bethanyl@bazelon.org