DISABILITY RIGHTS MAINE

March 6, 2019

Department of Health and Human Services
Division of Policy/MaineCare Services,
242 State St.
11 State House Station,
Augusta, Maine 04333-0011

RE: Comments on the Draft Section 1115 Waiver Application

Dear Department of Health and Human Services:

Disability Rights Maine (DRM), Maine's federally funded protection and advocacy agency for people with disabilities, and the class counsel in the class action lawsuit against the Department of Health and Human Services ("Department") that resulted in a class Settlement Agreement ("Settlement Agreement)[1] offers the following comments on the Department's draft 1115 Demonstration Waiver Application.

DRM strongly opposes the waiver request. The focus of this comment will be on the waiver's application for adults with serious mental illness (SMI).[2]

Section 1115 of the Social Security Act gives the Health and Human Services Secretary authority to waive Maine's compliance with certain requirements of the Medicaid Act, but only for an "experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). This waiver request would do the exact opposite.

The express purpose of the Medicaid Act is to enable each State "to furnish medical assistance on behalf of [individuals] whose income and resources are insufficient to meet the costs of necessary medical services" and *to provide*

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[1] The lawsuit was brought to correct problems at the Augusta Mental Health Institute (AMHI) one of Maine's two state hospitals and problems in the community mental health service system after a number of patients died at AMHI during the summer of 1988. The terms of the agreement are part of a judicially approved consent decree which remain in force to this day. For a general overview please see DRM's website publication: "The AMHI Consent Decree" https://drme.org/assets/brochures/CD-Presentation.pdf

[2] DRM is also submitting separate comments regarding objections to the waiver's reference to SED (Serious and Emotional Disturbance) for children.

"rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Id. § 1396-1. (emphasis added)

The Medicaid statute further requires that in order for these waivers to be granted they are "likely to assist in promoting Medicaid's objectives." Id.

Maine's waiver application would not comply with promoting Medicaid's objective to provide services to help individuals with mental illness retain the capability for independence or self-care due to its failure to address the faults in how mental health services are being delivered in the community under the terms of the Settlement Agreement. The Department's seeking such a waiver against this backdrop would lead to inappropriate institutionalization prohibited by the Americans' with Disabilities Act, particularly the integration mandate[3], the United States Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999)[4] and the terms of the Settlement Agreement.

Finally, the waiver application's assertion that Maine's participation in a waiver demonstration project from 2012-2015 should be seen as supporting such a waiver is in error.

I. The 1115 waiver is "not likely to assist in promoting" Medicaid's objectives" 42 U.S.C. §1315(a).

As outlined above the community mental health system of Maine is currently being operated under judicial oversight of the terms of a now almost 30 year old Settlement Agreement in the case of Bates v. Lambrew, Commissioner of DHHS, et als. [5] The guiding principle of this agreement can be found at paragraph 23 which reads:

> This settlement agreement requires that "[a]ll services within the comprehensive mental health system shall be oriented to supporting

[3]Title II of the ADA regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (the "integration mandate").

[4] The Court held that people with disabilities have an enforceable ADA right to receive services in the most integrated setting appropriate to their needs. When a state designs and implements a system that unnecessarily relies (even implicitly) on institutional facilities, that state is responsible for segregation.

[5] The original complaint filed 30 years ago last month was entitled Bates v. Glover, as Paul Glover was the Commissioner of the Department at the time. The current Commissioner is Ms. Lambrew.

> class members *to continue to live in the community and to avoid hospitalization."*[6] (emphasis added).

This agreement gives the Department the option of providing the services directly or through contracts with private providers:

> Defendants, Commissioner and Department of Mental Health and Mental Retardation [now Health and Human Serviced] shall establish, either within the Department or through contracts with private agencies, community support services.

See Settlement Agreement at ¶50.

The Department has chosen to contract with independent mental health providers in order to meet almost all of its obligations under the terms of the agreement instead of providing these mental health services directly to individuals in need of these services.

Notwithstanding these contracts, private mental health providers can refuse to provide mental health services to the individuals they are tasked with serving with almost no risk of losing their state contracts.

This is due to the effect that the termination of the entire contract would have on other individuals who are receiving treatment from that same provider. It is unlikely the Department would terminate a provider contract that would not have a ripple effect on all of the other clients of the provider.

For example, if a group home provider refuses to engage with a psychiatric hospital for the return of a resident they are contractually bound to serve, but instead take the position that the resident has been discharged, the Department terminating the contract in response to this breach would lead to the other residents of the group home losing their services.

The contracts the providers sign with the Department are the model of unambiguity. For example, Rider A in the residential contracts reads:

> Note: Section 277 of the Bates v. Department Consent Decree (Consent Decree) does not allow for the denial of a Referral. Any such denial is a

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[6] Although the Settlement Agreement refers to "class members" the Department is required to provide these services to non-class members as well. In 2004 the Maine Supreme Judicial Court ruled that "[O]ur interpretation of the settlement agreement, consistent with the ADA, supports the plaintiffs' arguments and the trial court's determination that compliance with the settlement agreement requires the State to provide the same community mental health services to qualifying non-class members as are required for class members." Bates v. DBDS et. al., 2004 ME 154¶68, 863 A.2d. 890, 907.

> violation of this Agreement, and may result in termination of this Agreement.[7] Rider A pg. 3 Section IV(C)(1).

The argument that there is a "lack of beds" ignores the above dynamic. The problem may not be so much a lack of beds, but instead, a lack of effective contract enforcement necessary to get a person who does not belong in that hospital bed to be able to go back home without the enforcement mechanism being one that causes others to lose their services.

A Governor's bill was submitted at the end of last session to address this issue. The bill was entitled LD 1911 An Act to Improve Access to Services for Adults with Serious and Persistent Mental Illness.[8] The bill summary was as follows:

> This bill establishes the right of an adult with serious and persistent mental illness who is denied access to services by a provider contrary to the terms of the provider's contract with the Department of Health and Human Services to seek Department review of that action. If Department review does not resolve the matter the consumer may bring a private right of action in the District Court for injunctive relief.

This issue of individual enforcement of rights to mental health services along with this bill was referenced in the most recent Court Master's Report that was filed with the Kennebec County Superior Court on August 29, 2018 which commented that:

> Many of the service delivery issues identified in this report would be easily resolved with prompt departmental review and the availability of a private right of action by the person in need of services.

Pg. 7 ¶3 Court Master's Progress Report Pursuant to Paragraph 299, August 29, 2018[9].

Until there is an effective contract enforcement mechanism in place for the community mental health system it would be impossible to determine whether the perceived need for additional beds is due to an actual need or rather the fact that beds are being inappropriately used due to a lack of community resources and/or how those services are delivered. Making such a premature

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[7] In the almost 30 years of contracting for these services it does not appear that the Department of Health and Human Services has completely terminated any of these contracts as a result of a provider's refusal to accept placement of an individual from a hospital and/or emergency room that the Department has authorized for placement in that residence.

[8] This bill did not receive Legislative consideration due to it being submitted late in the session.

[9] The Settlement Agreement provides for a Court Master who submits a written report to the Court and the parties every six months detailing the progress achieved with implementing the terms of the Agreement. Settlement Agreement at ¶299.

assessment and then acting upon it by applying for an IMD waiver comes at the cost of risking inappropriate institutionalization in violation of the ADA, Olmstead and the Settlement Agreement.

There is also an argument that this waiver would not increase the risk of institutionalization because hospitals could only be paid for individuals who meet hospital level care. This misses the underlying principles of the Settlement Agreement, the ADA and Olmstead. The issue is about people not spending one more day in an institution than necessary, not funding streams for those people in the institutions.

And, in many cases, these individuals will likely meet hospital level of care as a result of the system that was described above. Hospitals begin discharge planning very shortly after the individual arrives. If the person meets hospital level of care the discharge planning is still taking place. If a community mental health provider informs the hospital they are refusing to take the person back then the individual's discharge planning goal of a return home ends. This would certainly increase the length of time that the individual would unnecessarily stay in the hospital, while presumably still meeting hospital level of care. The planning would have to shift from substantive work on returning the person back home to the hospital social worker trying to find another community placement that is willing to engage in the discharge planning process.

In fact, in some cases it would not be surprising for this to contribute to why the person continues to meet this level of care. Obviously mental health is adversely effected when someone is taken out of his or her home and told that he can't go back, and that he needs to be prepared to live in a totally different community located miles away with different people that he has never met.

Similarly, in these types of cases it is not the lack of beds that is causing the system problem but rather that the mental health provider is refusing to honor their contracts and work with the hospital to bring people home.[10] While paying the hospitals eases their financial pain while this scenario unfolds again and again, it does nothing to address the real problem of why those beds are being taken up unnecessarily in the first place.

Given that there has been no systems review of this process, there is simply no foundational evidence to jump to the conclusion that it is a lack of beds in

[10] It's important to note that many of these residential providers are contracting to provide high intensity services to meet the needs of individuals specifically coming out of the hospital with daily rates for services ranging from $173.97 per day to $948.53 per day. See State of Maine DHHS Section 97 PNMI-Apppendix E Mental Health Rates/Fee Schedule Effective July 1, 2018 to June 30, 2019.

Maine that is causing any problems rather than how the current model of community services, *and how they are delivered*, may actually be the source of the problem.

And this is not limited to residential services. The Court Master observed in his last report, commenting on Maine's crisis system as follows:

> As of April 1, the crisis system, which includes crisis stabilization units and crisis workers in the community to serve persons requiring mental health services, has been placed on a fee-for-service basis. The service has been underutilized in the past, particularly in the use of crisis units, *and its lack of success in diverting persons in crisis from the emergency rooms of community hospitals.* SAMHS's rationale for the change was to increase utilization. *It is too early at this stage to determine the overall impact of this change.* (emphasis added)

Pg. 5 ¶3 Court Master's Progress Report Pursuant to Paragraph 299, August 29, 2018.

The way crisis services are delivered in the community is another cause that contributes to individuals not receiving the services they need in the community and instead landing in the emergency department.

It's important to note that CMS seems to be interested in ensuring that state waiver applicants have sufficient crisis services. The November 13, 2018 letter of CMS inviting states to apply for this waiver, states as follows:

> Furthermore, CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, *particularly crisis stabilization services.*

See November 13, 2018 letter of Mary C. Mayhew Deputy Administrator and Director Center for Medicaid Service to State Medicaid Directors RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Pg. 14 ¶1.

Notwithstanding CMS's interest, nowhere in the Department's application does it disclose that there was a concern that Maine's crisis system may lack success in diverting persons in crisis from the emergency rooms of community hospitals or that the crisis system went through fundamental change eleven months ago and there has been no assessment of how that change is or is not working.

The Department's waiver application is built on an unfounded premise, that there is a need for more beds in institutional settings. This then leads them to the conclusion that they need to obtain a waiver from Medicaid in order to pay for these beds. This faulty logic, which defaults to increasing the risk of unnecessary institutionalization, rather than assessing and addressing the problems in the community mental health system would do the opposite of promoting the objectives of Medicaid to provide services to individuals to "attain or retain capability for independence or self-care."

As this waiver application does not promote the objectives of Medicaid it should be denied.

2. The Waiver Applications goal of "funding streams" for facilities over 16 beds violates the Department's obligations to only develop homes with a capacity of eight beds or fewer.

The Department is very transparent in its application for the waiver that they want this money to be leveraged in order to fund and build more institutions. They state:

> Maine has several enrolled IMDs (primarily in-state and out-of-state psychiatric facilities) that would immediately participate in this proposed demonstration; it is possible that, *with this funding stream available, additional facilities would begin providing these services or expand their current services to the point of reaching the definition of an IMD* (e.g. residential treatment facilities may expand capacity to above sixteen beds), when allowable under state law. (emphasis added)

The Settlement Agreement however provides as follows:

> The housing to be developed, recruited, newly funded or supported under this Agreement shall be located where the other community services described in this Agreement are reasonably available. Except for hospices, shelters and nursing homes, no homes which exceed an *eight person capacity* may be used or developed. (emphasis added)[11]

Settlement Agreement at ¶ 96.

The rationale behind this eight bed provision is to ensure that appropriate community housing is developed instead of housing that resembles institutional settings. The Department's draft waiver's stated purpose is to incentivize the *exact opposite* of the type of housing that is envisioned under

[11] This paragraph was later amended to give the Department the authority to seek a waiver of this provision.

the terms of the Settlement Agreement. This waiver application runs afoul of promoting the objectives of Medicaid to attain or retain the capability for independence or self-care also given the terms of the Settlement Agreement the community mental health system is currently operating under.

3. The state already has a vehicle to "unlock" funds for community services without a waiver. The Settlement Agreement directs them to seek these funds from the Legislature.

The argument that the funds the state would save as a result of the federal government paying for certain inpatient care would then be used to improve the community mental health system, does not take into account the Department's obligation to seek this funding under the terms of the Settlement Agreement.[12] The agreement provides the following:

> The defendants shall prepare budget requests which are calculated to meet the terms of this Agreement. The defendants shall additionally take all necessary steps and exert good faith efforts to obtain adequate funding from the Legislature.

While the Settlement Agreement encourages leveraging federal monies where possible[13], such leveraging cannot come at the expense of fulling the terms of one of the Settlement Agreement's overarching purposes which is to ensure that people with serious mental illness "continue to live in the community and to avoid hospitalization."

Due to the waiver's effect of increasing inappropriate institutionalization, the Department's means of saving money is not sufficient justification for violation of the Settlement Agreement, the ADA and Olmstead.

4. The waiver application's assertion that Maine's participation in the Medicaid Emergency Psychiatric Demonstration (MEPD) between 2012-2015 should be seen as supporting such a waiver is in error.

In support of its position that the secretary should grant this waiver, the Department touts its participation in the Medicaid Emergency Psychiatric Demonstration (MEPD). The Department cites to the final report prepared by Mathematica Policy Research entitled: *Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report, August 18, 2016* ("Mathematica Policy

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[12] Although the waiver cites to this type of rational to support its position, nowhere in the application does it affirmatively commit to spending any of the state money that is "unlocked" only on community mental health services. The application would allow them to spend that money on anything *but* the community mental health system if they so choose.
[13] Settlement Agreement ¶34(b).

Report") to bolster its request for the granting of the waiver. The waiver application states:

> Experience with this pilot provides a valuable foundation for the proposed demonstration that expands this to a broader range of individuals and providers to assess the effects of this coverage on health outcomes, quality of care, overall Medicaid costs, and more comprehensive societal impacts. "fn 6 More information about the MEPD including the Final Report can be found at https://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/.

An actual review of the Mathematica Policy Report, however, does not give any support to the notion that this could be a "foundation". In fact, in its conclusion Mathematica states as follows:

> Data limitations prevent us from drawing strong conclusions about the effect of MEPD on access to inpatient care, length of stays, ER visits, and costs.

See Mathematica Policy Report Volume I pg. xxi.

In certain places in the report it particularly cites to problems with data that came from Maine's participation in this project.

For example, regarding admission and cost data from Maine the report states as follows:

> Data quality checks suggested the cost data from both IMD's were incomplete and of questionable quality.

See Mathematica Policy Report Volume 2 pg. 19 (Technical Appendices).

Regarding the emergency department data for one hospital for this metric the report stated as follows:

> Data had fewer than five visits in at least one treatment arm in at least one time period, so sample size too small to include in analyses.

Id.

Regarding data relating to site visits and telephone interviews for one of the two Maine hospitals participating in the demonstration the report observes the following:

> An ED initially agreed to participate in the evaluation but then cancelled just before round one site visit and did not respond to our requests to participate in the evaluation.

See Mathematica Policy Report Volume 2 pg. 2 (Technical Appendices).

It is also important to note what the report *did not* include. The report stated:

> Other potentially important outcomes, such as mortality from suicide and other causes, acts of violence, involvement with and costs to the criminal justice system, homelessness, symptom remission and consumer recovery, and 30-day hospital readmissions were also beyond the scope and resources for this evaluation.

See Mathematica Policy Report Volume 1 pg. 81.

And even with all of its self-admitted data flaws, the report cites to one of the strongest findings it could make was that the IMD waiver *had no effect* on ED boarding times. The report stated:

> ED boarding: Contrary to expectations that access to IMD care would decrease the time beneficiaries spent awaiting inpatient beds, no changes in ED boarding times were observed during MEPD. This analysis included two years of data during the demonstration period and non-Medicaid comparison groups for eight states, and the finding was robust across statistical models, *making it one of our strongest findings...* (emphasis added)

This report can hardly be called a foundation for supporting Maine's arguments that it should be granted this waiver. In fact, given the above, it's puzzling why the Department would cite to it as a foundation for its waiver application.

For the above stated reasons DRM strongly opposes the waiver request.

Very Truly Yours,

Mark C. Joyce
Managing Attorney