Policy Implications of Repealing the IMD Exclusion

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INTRODUCTION

Major barriers exist to accessing mental health and substance use disorder (SUD) services (collectively referred to as "behavioral health" services), and many people are seeking new ways to address immediate needs for treatment. Some have proposed rewriting the provision of the Medicaid Act that excludes federal financial reimbursement for mental health and SUD inpatient facilities (called Institutions for Mental Diseases, or "IMDs") with more than sixteen beds. However, repealing the "IMD exclusion" is an inappropriate solution and would be a stark reversal of decades of federal law and policy.

Investment in inpatient beds creates more inpatient beds, but investment in community-based services can reduce the need for inpatient beds. Federal Medicaid reimbursement for services for adults under age 65 provided in IMDs could result in large numbers of individuals being served needlessly in these facilities, opening the door to potentially billions of dollars in federal spending on institutions at the expense of community-based services. Thus, using Medicaid to increase bed capacity may harm the very people this change is intended to help.

States already have many options to expand behavioral health services under Medicaid's current mechanisms, and these options are underutilized. Legislative policy approaches should encourage states to maximize Medicaid's tremendous existing potential and flexibility to provide robust behavioral health services and promote community integration.

BACKGROUND ON THE IMD EXCLUSION

The IMD exclusion prohibits states from using federal funds to pay for "care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases."[1] An institution for mental diseases is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or

care of persons with mental diseases, including medical attention, nursing care, and related services."[2]

The exclusion has existed since 1965. Enacted as part the original Medicaid Act against the backdrop of an unprecedented rise in the rate of individuals confined to institutions with horrendous conditions, it reflected a Congressional determination that these institutions were a state responsibility.[3] In 1988, the law was amended to state that services could be provided in facilities with 16 or fewer beds, to allow states to move towards smaller placements and away from institutional warehousing of individuals.[4] While the statutory definition of IMDs only prohibits federal funding of services for residents of institutions "primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases," HHS has interpreted this exclusion to include facilities that provide SUD treatment.[5]

The IMD exclusion pushes states to focus on community-based alternatives in integrated environments as opposed to institutional care. Because Medicaid reimbursement is available for mental health and SUD services in the community rather than institutions, the IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated environments.

Further, repealing the IMD exclusion would reverse decades of federal policy initiatives stressing the importance of increasing community integration. This could happen because evidence exists that the need for psychiatric beds, at least, is "elastic." That is, if the beds are available, they are filled, siphoning resources from community-based services. But when beds are not available, other options adequately meet individuals' needs. While a state could theoretically increase both in-patient and out-patient resources, the reality is states continually try to limit their Medicaid spending. Spending money on more costly institutional settings would very likely result in less funding available for more cost-effective community based programs that provide better outcomes. [6] Therefore, repealing the IMD exclusion could encourage states to promote institutional placement to the detriment of community-based care, seriously undercutting Congress's intent when enacting the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act, and particularly the Integration Mandate articulated by the Supreme Court's decision in Olmstead v. L.C.

LEVERAGING MEDICAID TO BETTER ADDRESS UNMET NEED FOR BEHAVIORAL HEALTH SERVICES

Most people who need mental health or SUD services are not getting them. According to the 2016 National Survey on Drug Use and Health, less than half of adults with mental illness received *any* kind of mental health treatment. Even worse, only one out of five individuals over age twelve identified as needing SUD treatment received it. Coupled with the fact that more

than 63,600 individuals died due to a drug overdose in 2016 – more than any year on record – the fact that so few individuals are receiving needed treatment is inexcusable.

It is because the need is so great that Congress should focus on funding proven, cost-effective solutions. Below are eight concrete steps federal and state governments can take to expand access to treatment through Medicaid that do not necessitate repealing the IMD exclusion.

1. **Treat pain as a serious societal, economic, and public health issue.**

   Much of the increase in SUD has been driven by an increase in prescriptions for opioids to treat pain. One way to address the increase in opioid use disorder (OUD) is to ensure that Medicaid state plans provide quality pain management services, including patient-centered care management, psychological therapies, rehabilitative and physical therapy, medications, surgery, and complementary and alternative therapies (which few states cover).

2. **Expand provider capacity and access to treatment by addressing provider shortages.**

   In most areas of the United States, psychiatrists and other behavioral health specialists are in extremely short supply, and the problem is worse in rural areas. If individuals cannot access care in the community due to provider shortages, it is appropriate to remedy that community-based shortage, not to fund facility-based services. Strategies to increase access to care include: an enhanced Medicaid match to incentivize more providers, Medicaid reimbursement of peer supports (*see below* No. 5(h)), encouraging states to include provisions in managed care contracts that require comprehensive and adequately staffed behavioral health networks, and addressing barriers to telemedicine in Medicaid.

3. **Support the integration of behavioral health services with physical health services.**

   Strengthening coordination between behavioral health and primary care providers can result in improved outcomes. Medicaid can fund the integration of behavioral health services into primary care (Patient Centered Medical Homes) or the integration of primary care into behavioral health services (Medicaid Health Homes). Using the Medicaid Health Home Option, Vermont launched the highly successful "hub and spoke model" to treat OUD using federally qualified health centers (FQHCs), mental health centers, and community clinics to serve as coordination centers (spokes) for narcotic treatment programs (hubs), which provide high intensity medication assisted treatment.

Through this approach, Vermont now has the highest capacity for OUD in the United States.

4. **Improve screening for adolescents.**

   Under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, individuals under age 21 enrolled in Medicaid must be provided with periodic mental health assessments and substance use screening. However, in almost all states, the rate of well-child visits decreases substantially as children enter adolescence, hitting a low at ages 19 and 20. This means states are markedly underutilizing Medicaid's ability to intervene early with youth with emerging substance use and mental health issues. While screening is just the first step to obtaining adequate services, if youth are not screened, they will not be referred to treatment. States should be encouraged to adopt the current Bright Futures periodicity schedules and the Bright Futures Guidelines for Adolescents to ensure that providers implement evidence-based behavioral health screenings. States may also want to consider financial incentives, mandates, and additional reporting requirements to improve adherence to these guidelines.

5. **Support states to provide essential community-based services and supports.**

   Medicaid is a flexible and powerful tool to provide community-based behavioral health services and supports. States can provide these services via their Medicaid state plan, or via various waivers, including Section 1915(i) waivers. Below are examples of services that can currently be covered by Medicaid without any revisions to Medicaid law. Congress should study ways to encourage states to promote these services, via demonstrations, an increased federal match for certain services, and programs that offer technical assistance and support. At the state level, state Medicaid agencies should ensure that the following services are available in sufficient quality and quantity to support individuals with SUD or mental health needs, as appropriate:

   a. **Medication Assisted Treatment (MAT)**: Treatment with the medications methadone and buprenorphine has been proven effective in mitigating the negative effects of OUD by improving treatment retention and reducing risk of relapse, reducing blood borne disease infections, and reducing the risk of opioid related deaths. Currently, all 50 states cover at least one FDA-approved opioid agonist (buprenorphine, methadone, and naltrexone) to treat SUD, but not all states cover all three medications. Many states also require prior authorization, which can create an

additional barrier to accessing services. States should audit their Medicaid state plans and remove these unnecessary barriers to treatment.

b. **Naloxone**: Naloxone is a lifesaving medication that reverses the effects of opioid overdose. All states cover naloxone, although some require prior authorization, an unnecessary barrier to a safe and effective drug that many have argued should be available without a prescription. Medicaid agencies should remove barriers to naloxone by removing prior authorization requirements, and states should encourage layperson access to naloxone.

c. **Behavioral Therapy**: Individual, group, or family therapy can be funded through Medicaid. For individuals with SUD, engaging in such therapies alongside MAT is recommended. For individuals with mental health needs, some forms of therapy in addition to or instead of medication can also be extremely effective.

d. **Assertive Community Treatment (ACT)**: ACT is an evidence-based, highly individualized service designed to support individuals with the most intensive mental health needs, who might otherwise be committed to an IMD. However, it is only offered in 40 states, and it is significantly underutilized in the states where it is available. Nationally, only 2.1% of individuals with serious mental illness receive ACT. Experts estimate the need is much greater, or approximately 4.3% of individuals with serious mental illness.

e. **Supported Housing**: Medicaid cannot pay for room and board, but states can and should use Medicaid to provide flexible and comprehensive services designed to help individuals maintain housing, including but not limited to case management, independent living skills training, SUD treatment, and home health aide services.

f. **Individual Placement and Support (IPS) Supported Employment**: IPS is an evidence-based service that helps individuals with significant mental health needs get and keep jobs. Supports are not time-limited but based on an individual's needs and preferences. Individuals are placed in jobs in the competitive market and provided support services focused on their own vocational goals and preferences. Using a variety of strategies, states can finance components of IPS via Medicaid.

g. **Mobile Crisis Response and Stabilization (“Mobile Crisis”)**: These Medicaid-funded services help individuals experiencing an acute mental health issue to obtain immediate assistance, deescalate difficult situations, and prevent unnecessary hospitalization. They entail rapid deployment of a team of individuals trained in crisis intervention. These services are available 24/7 and can be provided in the home or

anywhere that a crisis occurs. Mobile crisis teams divert individuals from hospitalization or interaction with law enforcement.

h. **Peer Support**: There are services provided by individuals who have received mental health services or SUD treatment and are successful in the recovery process, who then receive training to enable them to use their shared experiences to assist people with serious mental illness or SUD. Peer specialists may perform a variety of tasks, including assisting individuals through the process of transitioning from an institutional setting to the community, developing independent living skills, and helping to increase social supports, and those tasks may be reimbursed by Medicaid.

6. **Protect non-emergency medical transportation**.

Medicaid's non-emergency medical transportation (NEMT) service facilitates behavioral health care. Lack of transportation poses a serious barrier to care, especially for low-income individuals who on average have fewer transportation options and more significant health care needs. For behavioral health services, NEMT plays a crucial role. Behavioral health related appointments are the most frequent reason Medicaid recipients use NEMT, accounting for 38% of all trips.[7] While Medicaid requires states to provide NEMT, many states are seeking to waive this requirement. In fact, many of the same states requesting NEMT waivers are also seeking permission to waive the IMD exclusion, increasing barriers to outpatient treatment while incentivizing institutional settings.[8]

7. **Support enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).**

The MHPAEA generally requires most health insurance plans, including Medicaid managed care plans, to treat mental health and SUD benefits on equal footing as medical and surgical benefits. While the act represents an important achievement, enforcement lags. Through the Cures Act, Congress sought to strengthen and increase enforcement of the mental health parity requirements by authorizing the Departments of Health and Human Services, Labor, and Treasury to release compliance guidance and audit health plans to assess compliance. Congress should demonstrate a commitment

to mental health parity by supporting and overseeing these agency activities to increase compliance with the MHPAEA.

8. **Adopt Medicaid Expansion.**

   The best tool for expanding access to treatment is already readily available, and that is Medicaid expansion. As of 2016, 1.2 million individuals with an SUD have gained coverage in states that adopted the expansion and as many as 1.1 million more would get coverage if the remaining states expanded Medicaid. Expanding coverage and access to treatment in the community via Medicaid decreases demand for inpatient beds by providing funding for essential crisis prevention tools and stable aftercare options. (*Supra #5).*

CONCLUSION

Lack of access to quality behavioral health services is a serious problem, but repealing the IMD exclusion is not the right solution. Instead, Congress should be encouraging states to focus on using tools already available to build and maintain a robust system to address mental health needs and substance use disorders. Federal lawmakers and policymakers can support states by providing guidance, oversight, technical assistance, and financial incentives to implement the above-listed strategies to improve behavioral health services.

ENDNOTES

[1] 42 U.S.C. § 1396d(a)(B).
[2] 42 U.S.C. § 1396d(i).
[3] CMS, STATE MEDICAID MANUAL § 4390.
[4] JEFFERY BUCK, DEP'T OF HEALTH & HUMAN SERVS., HCFA PUB. NO. 03339, MEDICAID AND INSTITUTIONS FOR MENTAL DISEASE: REPORT TO CONGRESS II-3 (Dec. 1992), https://babel.hathitrust.org/cgi/pt?id=mdp.39015034439359;view=1up;seq=19. Other limited exceptions exist. For example, federal financial participation is available for services for individuals under age twenty-one in inpatient psychiatric hospitals and other settings designated by HHS, 42 U.S.C. §§ 1396d(a)(16), 1396d(h). Payment is also available to managed care organization (MCO) for enrollees in IMDs for up to 30 days. 42 C.F.R. § 438.6(e) (allowing payments to MCOs for up to 15 days in an IMD in any given month and permitting two consecutive months, meaning payment for an enrollee could be made for up to 30 consecutive days).
[5] CMS, STATE MEDICAID MANUAL § 4390.

[6] While we have serious concerns about repealing the IMD exclusion, we recognize that the American Society of Addiction Medicine continuum of care, often considered an industry standard for determining the level of care necessary for addiction treatment, has four broad levels of care to describe the "continuum of recovery-oriented addiction services." One level corresponds to inpatient and residential treatment, and in some settings, implicates the IMD exclusion. American Society of Addition Medicine, *What Are the ASAM Levels of Care*? (May 13, 2015), https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/. More discussion regarding Medicaid coverage of that level of care is necessary, and should address the following outstanding issues: 1) how to ensure that incentives for community integration are not undermined; 2) any limits necessary on the length of stay; 3) how to establish and require adherence to treatment standards; and 4) staffing, monitoring and ongoing advocacy mechanisms necessary to ensure residents' well-being. Repealing the IMD exclusion without providing additional treatment guidelines, staffing, and monitoring specific to SUD treatment will not ensure provision of SUD treatment that meets the standard of care.

[7] There is no national database that tracks the purpose of NEMT trips. States are not required to report this data. The above-cited statistic is based on reports by one company, providing services in 32 states.

[8] Some states have been granted Section 1115 waivers to make federal Medicaid expenditures for residents of IMDs, but under Section 1115, the Secretary of HHS may waive compliance only with requirements in 42 U.S.C. § 1396a. The prohibition against federal financial participation for services for individuals in IMDs is in 42 U.S.C. § 1396d(a)(B), a provision that the Secretary does not have the authority to ignore.