NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

UNDER THE MICROSCOPE

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MEDICAID IMD EXCLUSION: TIME FOR CHANGE

ISSUE.

Last month's *Under the Microscope* identified six specific topics of particular importance to NACBHDD members as well as to the behavioral health and ID/DD consumers and providers in the communities we serve. Among those issues is the Medicaid "IMD exclusion," a longstanding provision of the 1965 Medicaid law that bars federal Medicaid funds from paying for medically necessary inpatient care provided by licensed health professionals to Medicaid beneficiaries in "institutions for mental diseases" (IMDs). (Operationally, an IMD is any inpatient facility in which 50% or more of the patients have a mental illness diagnosis.) While initially conceived as a means of promoting deinstitutionalization, the federal funding exclusion, today, precludes access to a range of services and settings that can benefit the people we serve. Moreover, it stands as a unique barrier to care for the behavioral health and ID/DD communities, despite the Affordable Care Act of 2010 and the Mental Health Parity and Addiction Equity Act of 2008.

This issue of *Under the Microscope* examines the future of the IMD exclusion, posing and answering questions about whether the time is right to delete the exclusion from the Medicaid statute altogether, or whether to continue the incremental approach that has whittled away at the IMD exclusion over the past 40 years. It is an issue that may well be susceptible to change and one on which we most certainly should work.

ANALYSIS.

A BIT OF HISTORY. Under Medicaid statute and regulation, IMDs—institutions for mental diseases—include inpatient treatment facilities, not only including state-run and other public and private large hospitals, but also community-based facilities, including, by definition, those for people with significant mental or substance use problems, and those with co-occurring ID/DDs. Under a provision unique in Medicaid law, the IMD exclusion specifically limits *who* may get Medicaid-covered care in these facilities and the *kinds of facilities* to which the exclusion applies.

Readers will remember in 1965 when Medicaid was created state and local psychiatric hospitals housed large numbers of persons with severe mental illness primarily at state and county expense. Thus, when crafting the Medicaid statute, Congress made two points clear:

- IMD care was only to be augmented with federal Medicaid funds for adults ages 65 and older; and
- Federal Medicaid dollars were *not* intended to supplant the resources from state and local governments that historically supported care in IMDs.

Over the years, the treatment system has not been static. It has changed radically in the nearly 50 years since Congress forbade cost-shifting to federal Medicaid coffers of what then was a state and county responsibility. In response to the changing health care climate, some piecemeal changes have been made to the near-absolute IMD exclusion in the original Medicaid statute.

- In 1972, Medicaid law was amended to make coverage in psychiatric hospitals a coverage option for children under age 21 and to mandate coverage for children with a mental disorder diagnosed through EPSDT screening. Remember, treatment in an IMD for older adults, age 65 and up, was covered under the 1965 Act itself.

- Medicaid amendments in 1988 brought facilities with 16 or fewer beds out from under the IMD exclusion. While not necessarily the most cost-effective type of facility, the small size was specified in statute primarily in response to the growing movement toward community-based care instead of large-scale institutions. It also reflected a legislative branch response to a Supreme Court decision supporting deinstitutionalization. The same amendments and subsequent regulations clarified that federal Medicaid funding is available for partial hospital and day programs that do not institutionalize participants.

Thus, after almost 50 years and piecemeal amendments, today, care for individuals between ages 21 and 64 in IMDs with more than 16 beds remains *excluded* from federal Medicaid coverage, and remains the financial province and responsibility of states and counties.

In contrast, for over 40 years, Medicaid has covered residential treatment for *adults* (ages from 21 to 64) with ID/DDs in *intermediate care facilities for the mentally retarded* (ICF/MRs). Further, following discharge from an ICF/MR to the community, eligibility for Medicaid wrap-around services continues for these individuals through a "community options" waiver that "swaps" a Medicaid-covered inpatient bed for a similarly covered, community-based slot. No such waiver exists for persons leaving an IMD. That's because the IMD exclusion prohibits federal coverage for adults. The absence of Medicaid-covered IMD inpatient beds means nothing is available to trade for a "community option" slot.

IMD EXCLUSION TODAY. As the foregoing discussion suggests, a number of factors continue to make the IMD exclusion a problem today for states and counties and millions of individuals for whom this type of necessary care continues to be barred from federal Medicaid support.

The first problem is the very definition. Intended in 1965 to address the institutionalization of millions of people with behavioral disorders and ID/DDs, in today's era of community-based care, the definition stands between many people and federal coverage for the care they need that is available in their communities. By definition today, an IMD 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*." HHS regulation interprets the statute to mean that the prohibition against federal Medicaid coverage depends on whether a facility has more than 16 beds *and*, critically, "if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases."

From a practical perspective, states are not prohibited from providing these services using their own Medicaid funds; and if states provide treatment in outpatient or small facility settings, the IMD exclusion does not come into play. States simply cannot receive their usual federal Medicaid match if beneficiaries are between 21 and 64 and are being treated in a facility with more than 16 beds, where 50% or more of the patients have a mental illness diagnosis. Just as facilities are unable to be reimbursed for IMD care by Medicaid, also individuals' Medicaid eligibility is switched off while in an IMD. As a result, to receive treatment for medical disorders unrelated to their behavioral disorder, they must be discharged from the IMD, be reinstated under Medicaid, receive treatment in a medical/surgical setting, and then be readmitted to the IMD.

Perhaps most critical from a county and state perspective, the scope and application of the IMD exclusion extends far beyond the traditional large state mental hospital. The exclusion applies to any and all types of mid- to long-term placement in residential facilities over 16 beds providing acute or long-term management of mental disorders. Critically, because alcoholism and other substance use disorders are considered forms of mental disorder by both the DSM and ICD classification, the assumption is that residential facilities with more than 16 beds that treat chemical dependency are, by definition, considered to IMDs.

Thus, notwithstanding the changes that have already been made, the remaining elements of the IMD exclusion continue to have pernicious effects for adults, ages 21 to 64, with behavioral disorders, particularly those with substance use problems. It also affects the availability of care for many people with ID/DDs who have co-occurring behavioral diagnoses. Remember, in addition to the roughly 17.5 million people with behavioral disorders covered by traditional Medicaid, as many as another 6.6 million are eligible for or already are covered under the expanded Medicaid provisions of the ACA. And, since the IMD exclusion applies to community residential programs, not just large inpatient facilities, the exclusion still keeps millions who would benefit from inpatient or residential care from getting the services that could lead to recovery. Ironically, in an era of the ACA, and of both community and integrated care, the exclusion also raises the specter of stigma and the tenacity of rules that threaten parity, since nowhere else in Medicaid are the services of certain medical institutions excluded.

So what can be done?

TODAY'S IMD CONUNDRUM. Community-based care—in the form of residential community programs for people with behavioral disorders—is part of the continuum of local services that can help people move from dependence to independence and from illness to recovery. But, the IMD exclusion has thwarted many efforts to take all the steps necessary to make community-based care a reality for Medicaid-eligible individuals with severe behavioral disorders, including those with co-occurring acute or chronic physical disorders.

According to a recent report by Frank, Goldman and Hogan, the IMD exclusion "… [e]ncourages care in general hospitals and discourages use of state mental hospitals. The IMD rule also means that states have difficulty qualifying for home and community-based waivers that depend on budget-neutrality. Savings on institutional care in IMDs cannot be counted in the budget-neutrality formula when estimating the cost impact of alternative home and community-based mental health services."

Clearly the answer is not to build more large public or private hospitals and make Medicaid funds available to those large facilities. Similarly, the answer is not for states to circumvent the IMD exclusion by placing people with behavioral disorders in large, general purpose hospitals. Neither localities nor states can guarantee to the federal government that small-scale community facilities of 16 or fewer beds can be operated with optimal cost effectiveness or a full range of care capacity. And what does this mean about the quality of care in these smaller facilities or in the larger facilities that lack behavioral health specialized services? Indeed, little research has been undertaken to assess the impact of the 16-bed IMD exception on the quality or scope or cost of care. Similarly, the impact of the ACA's provision regarding Medicaid coverage for adult inpatient crisis services is entirely unknown. And from a public health policy perspective, can the exclusion continue to be justified when held up against the backdrop of the Parity Act, and the ACA's mandate for behavioral coverage as an essential health benefit for private insurers?

These and other questions beg answers, and the best way to begin to answer them is to begin to change the playing field, to keep chipping away at the IMD exclusion, even in these challenging financial times on Capitol Hill.

LEGISLATIVE AND OTHER OPTIONS. Clearly, the time is not right for wholesale elimination of the IMD exclusion. The ability to find a way to make the necessary changes and concomitantly achieve budget neutrality is an extreme challenge. The potential a protracted debate about Medicaid has for opening up wholesale changes to the ACA may be too great a chance to take in the current political climate. And, the time remaining in this particular session of Congress is diminishing rapidly, with only a few weeks this month and, depending on the November election results, perhaps a brief lame-duck session.

Nonetheless, a number of options and activities on which we can focus do exist. Legislation is already in the offing in this area. For example, Rep. Murphy's *Helping Families in Mental Health Crisis Act* (HR 3717), while a seriously flawed measure as a whole, does include a provision that would partially remove the Medicaid IMD exclusion, allowing Medicaid to pay for care in state hospitals and private psychiatric hospitals for people between ages 21 and 64, but only if an average length of stay of less than 30 days is demonstrated.

At the same time, we have been working with Congress to develop an amendment to the Medicaid statute to enable people with severe substance use problems to be covered by Medicaid for community-based facilities of sufficient size to provide all necessary services at a reasonable price. This effort is based on the central tenet that facilities of 16 or fewer beds may not be able to provide the full range of needed services and supports, or to achieve a sufficient economy of scale. And a measure has been introduced recently in the House of Representatives that moves in just that direction.

Representatives Tim Ryan (D-OH) and Marcia Fudge (D-OH) have introduced the *Breaking Addiction Act* (H.R. 5136) that would create a demonstration program in 8-10 states under which up to $300 million in Medicaid funds over 5 years could be used to fund residential substance use disorder treatment services in facilities larger than 16 beds. It would also require the Department of Health and Human Services to evaluate the results of the demonstration and report to Congress on the need to modify or repeal the IMD exclusion to improve access to residential services for individuals enrolled in the Medicaid program.

This last legislation dovetails nicely with some of our other efforts to champion a change in the IMD exclusion for people with serious substance use disorders. We have been working with CMS to urge a regulatory change that would provide Section 1115 demonstrations for this expansion, notwithstanding the above-noted difficulty in achieving a statement of budget neutrality. And we are looking at the possibility of pressing for a White House Executive Order to achieve a similar end, perhaps facilitated through the new head of the White House Office on the National Drug Control Policy. Through such demonstrations, it might be possible to identify how best to limit institutional care, improve transitions between facility and community, and support community-based services and recovery support.

With these steps as a springboard to further discussion, we hope that still other steps can be taken leading, ultimately, to deletion of any remaining elements of the IMD exclusion from the Medicaid statue altogether.

ACTION.

We recognize that the political will *does not exist to* take such a large step. Moreover, in the current climate, the ability to accomplish budget neutrality at the same time as eliminating the IMD exclusion seems unlikely. However, the good news is that political support *does* exist for one or more incremental changes to the IMD exclusion, specifically expansion of the IMD exception that would provide community-based residential care for people with severe substance abuse problems.

Thus, at the local level, while we ultimately hope to change the IMD law, we know the time is not right. What we can do now is to advocate for change, to give representatives and senators the information and materials they need to make change happen early in the coming Congress.

We can explain—

- That the IMD exclusion is an anachronism in today's health care environment that flies in the face of the Parity Law and the growing movement toward integrated care.
- How the IMD exclusion costs more than it saves by forcing people with behavioral disorders to move in and out of Medicaid to seek care for comorbid physical problems, and doing so most often when severely ill.
- The likely cost inefficiencies and service gaps resulting from making only small-size behavioral health facilities eligible for federal Medicaid matching funds.
- How, by withholding federal dollars for care provided in IMDs, requiring states and localities to bear the cost, the IMD exclusion makes it virtually impossible for states to successfully apply for and receive home- and community-based waivers that require budget neutrality. They become unable to test potentially better, more effective and efficient means of providing services now not eligible for federal Medicaid coverage.

These are just some of the topics on which we can educate our federal legislators. We also need to share the bottom line—in local terms and in dollars and cents—with them. We can and must gather data about how the IMD exclusion affects people in our communities, and what it costs individuals, counties, states and the Nation. And we need to encourage our county and state officials to get educated and to do the same. There are actions that can be taken now with our Representatives and Senators. Now is the time to educate our federal Representatives and Senators about the adverse impact of the IMD exclusion as a whole. And now is the time to get ready to advocate for specific, incremental change with those legislators, with CMS and with the White House. It's just months before an election, and our issues—and votes—count.

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