Medicaid Reimbursement for Health Services in Institutions for Mental Disease

An Analysis of the IMD Exclusion and Proposals for Change

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SUMMARY

Federal Medicaid law prohibits federal financial participation (FFP) for health services provided to individuals age 21 to 64 who are patients of an institution for mental disease (IMD). This rule, known as the IMD exclusion, applies to *all* medical and behavioral services received by these patients, regardless of whether they are related to the patients' mental illness and regardless of whether they are provided in the IMD or in another health care setting. For individuals under age 21, an exception to the rule allows FFP for inpatient psychiatric services, but denies FFP for all other services.

This policy brief describes the history of the IMD exclusion, its impact on the treatment of mentally ill Medicaid enrollees, and several proposals for repealing or relaxing the exclusion, including:

- Total repeal;
- Demonstration projects for partial repeal;
- Increasing the allowable number of beds that classify an institution as an IMD; and
- Other avenues for change arising from a potential conflict between the exclusion and the 2008 Mental Health Parity Act.

WHAT IS THE IMD EXCLUSION?

Federal law defines an IMD 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] "Primarily engaged" has been taken to mean that if mental illness is the principal cause of over 50 percent of patient admissions in an institution, that institution is an IMD.[3]

When Medicaid was enacted in 1965, Congress specified that the exclusion did not apply to patients age 65 or older. In 1972, Congress passed an additional exemption for patients under age 21, allowing FFP *only* for inpatient psychiatric services, but not any other services they might need.[4]

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[2] 42 U.S.C. §1369d(i)
[3] Rosenbaum, S., et al. "An Analysis of the Medicaid IMD Exclusion." Dec. 19, 2002. Available online at: http://gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/behavioral_health/reports/IMD%20Report%201202.pdf
[4] Geller, J. "Excluding Institutions for Mental Diseases from Federal Reimbursement for Services: Strategy or Tragedy?" *Psychiatric Services* 51.11 (2000): 1397-1403. Available online at: http://psychservices.psychiatryonline.org/cgi/reprint/51/11/1397

Any Medicaid enrollee who is admitted to an IMD immediately becomes ineligible for federal Medicaid assistance and remains ineligible for the duration of his or her admission to the institution (with the exception of youth under age 21, who may still receive FFP for inpatient psychiatric services).[5] Federal Medicaid reimbursement is denied for all health services provided by the IMD. The exclusion applies even if the patient needs emergency medical care or sustains an injury or illness that requires treatment in another facility while he is still a patient of the IMD. In such a case, in order to receive federal Medicaid assistance, he would have to be discharged from the IMD and re-enrolled in Medicaid before receiving treatment.

Some states that have implemented Medicaid managed care programs have been granted waivers to receive FFP for limited coverage of treatment in an IMD. These waivers require that the coverage be restricted to acute episodes only and include controls on the length of stay in the IMD. In addition, the state must ensure that the program remains budget neutral, meaning it must find other areas of savings to make up for the cost of providing this limited IMD coverage.[6]

History of the IMD Exclusion and Trends in the Treatment of the Mentally Ill

In the first half of the 20th century, large state-run psychiatric hospitals were the primary source of care for the mentally ill.[7] Because the care of these patients was considered to be the exclusive responsibility of the states, federal law throughout this time period consistently denied federal financial assistance for the cost of their treatment and other public benefits, such as old-age assistance.[8]

With the enactment of Medicaid in 1965, states for the first time could utilize federal assistance for mentally ill patients over the age of 65. However, Congress specified that the medical treatment of other institutionalized mentally ill patients would not be covered by Medicaid except in a general hospital setting.[9] Congress later modified this exclusion to exempt facilities of 16 or fewer beds, reflecting its desire to promote small community-based programs as an alternative to institutionalization.[10] In 1972, and exception was enacted for individuals under the age of 21, allowing FFP for inpatient psychiatric services.[11]

Along with other public policies in the later decades of the 20th century, the IMD exclusion played a role in the trend of deinstitutionalization of the mentally ill by creating financial incentives for states to remove patients from large psychiatric institutions.[12] The exclusion of IMDs from FFP encouraged states to admit those patients to a setting where they would eligible for federal Medicaid reimbursement.[13] By the 1990s, the number of patients in state psychiatric hospitals was only 5 percent of its peak in 1955.[14]

As fewer patients were served in state hospitals, many states began diverting money away from hospitals and into community-based treatment services.[15] Despite some advocates' hopes that inpatient psychiatric institutions would eventually be eliminated altogether in favor of an entirely community-based treatment system, this has not happened. Although the number of patients in state hospitals sharply decreased over the last part of the 20th century, in recent years the decline has halted.[16] States now spend about $7.7 billion, or 28 percent of state mental health agency (SMHA) budgets, on state hospitals,

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[5] Rosenbaum op. cit. (3)
[6] Treatment Advocacy Center. "Briefing Paper: Repeal of the Institution for Mental Diseases Exclusion." Nov. 3, 1999. Available online at: http://www.psychlaws.org/HospitalClosure/RepealIMD.pdf
[7] Fischer, W., et al. "The Changing Role of the State Psychiatric Hospital." *Health Affairs* 28.3 (2009): 676-684.
[8] Geller op. cit. (4)
[9] Geller op. cit. (4)
[10] Rosenbaum op. cit. (3)
[11] Geller op. cit. (4)
[12] Geller op. cit. (4); Sharfstein, S. and Dickerson, F. "Hospital Psychiatry for the Twenty-First Century." *Health Affairs* 28.3 (2009): 685-688.
[13] Geller op. cit. (4)
[14] Fischer op. cit. (7)
[15] Fischer op. cit. (7)
[16] Fischer op. cit. (7)

down from 63 percent of SMHA budgets in 1981.[17] The patients remaining in state institutions tend to be the most difficult and problematic patients who cannot be effectively cared for in a general hospital setting.[18]

Despite overall shifts in funding from state-run psychiatric hospitals to general hospitals and community-based services, these programs and facilities still struggle to meet the high need for mental health services. From 7 to 10 percent of Medicaid enrollees use mental health or substance abuse services, and these services account for 21 to 24 percent of all Medicaid expenditures.[19] Today, there is strong evidence of psychiatric bed shortages both in general hospitals and psychiatric hospitals, increased use of emergency departments for the treatment of acute mental health conditions, and lack of sufficient funding for community-based services.[20] With ongoing shortages in treatment capacity causing what has often been termed a "public mental health crisis," community-based programs and smaller residential treatment centers find themselves stretched to meet the need for their services. Some smaller residential treatment programs that are successfully caring for mentally ill Medicaid enrollees have found themselves hindered by the IMD exclusion, which prevents them from expanding their facilities to accommodate more than 16 residents at one time. In family-based treatment settings, the 16-bed limit can prevent children and their parents from being housed together in the same facility. In other cases, it may prevent facilities from providing treatment to youth who turn 21.

PROPOSALS FOR CHANGE

Numerous attempts to repeal or limit the scope of the IMD exclusion have failed over the years since its enactment.[21] Opponents of the IMD exclusion do not universally support a total and immediate repeal of the rule. Other proposals to lessen the impact of the rule include creating demonstration projects to evaluate the success of partial repeal, changing the exclusion so as to allow for a greater number of beds, and pursuing an administrative process for repeal.

Total Repeal of Exclusion: H.R. 619

H.R. 619, introduced by Rep. Eddie Bernice Johnson (D-TX), would entirely repeal the IMD exclusion.

Analysis

This proposal would immediately allow facilities that provide inpatient services to people with mental illnesses to expand the number of beds in their facilities or extend treatment to patients age 21 or over. However, there are also potential downsides: because the 16-bed limit has served to discourage institutionalization of the mentally ill and encourage their treatment in smaller community-based facilities, some advocates for the mentally ill have expressed concern that removing the exclusion could result in money being diverted away from community treatment.[22]

Rep. Johnson has consistently supported a repeal of the IMD exclusion, introducing legislation in the 110th and 111th Congresses. In the 110th Congress, the bill was never reported out of committee.[23] Because Medicaid reform is taking a central role in overall congressional efforts at health reform in 2009, Johnson's bill may have greater support this year. However, part of the difficulty in pushing

[17] Fischer op. cit. (7)
[18] Fischer op. cit. (7)
[19] Rosenbaum op. cit. (3)
[20] Fischer op. cit. (7); Sharfstein op. cit. (11)
[21] Rosenbaum op. cit. (3)
[22] Bazelon Center for Mental Health Law. "Medicaid Inpatient Coverage Would Break the Bank." *Bazelon Center Mental Health Policy Reporter* 4.3 (2005). Available online at: http://www.bazelon.org/newsroom/reporter/2005/10-17-05.htm#medicaid ; Substance Abuse and Mental Health Services Administration. "Barriers to Community Integration for People with Mental Illnesses." Sept. 2001. Available online at: http://www.ahpnet.com/pdfs/OvercomingBarriers.pdf
[23] "Members of Congress Eye Changes to Longstanding IMD Exclusion." *Mental Health Weekly* 19.15 (2009).

forward with a total repeal arises from the lack of information on the fiscal effect of such a move.[24] The unknown cost of a repeal may create difficulties in the current political environment. The Obama administration and fiscally conservative members in the House and Senate have expressed a commitment to ensuring that health care reform is fully paid for within a 10-year budget window.[25] While Obama proposed a budget blueprint that included over $600 billion for health care reform, reform is expected to cost far more than that.[26] Given these financial realities, any proposal with significant new spending will be closely scrutinized by Congress and may not be included in the final health care reform package.

Demonstration Projects for Partial Repeal: H.R. 1415

H.R. 1415, introduced by Rep. Bart Gordon (D-TN), would provide $75 million for three-year demonstration projects that would allow selected states to receive FFP to reimburse IMDs for the stabilization of "emergency medical conditions," defined in the bill as "suicidal or homicidal thoughts or gestures… dangerous to self or others."

Analysis

Rep. Gordon's proposal was developed partly in response to the fiscal considerations of the current economic climate (outlined above), and may be more palatable to fiscal conservatives than a total repeal of the rule would be. However, it is very limited in its scope, applying only to the treatment of suicidal or homicidal conditions. Both the Gordon and the Johnson bills have been reported to the House Energy and Commerce Committee, which is taking a central role in writing health care reform legislation, along with the Ways and Means Committee and the Education and Labor Committee.

Increase the Number of Allowable Beds

During the Clinton administration, SAMHSA reportedly recommended increasing the allowable number of beds from 16 to 50.[27] This proposal would have kept the exclusion itself intact, but would have limited its scope to affect only those institutions with more than 50 beds. In the current session of Congress, no legislation on this proposal has been introduced, and SAMHSA has not taken a position on the issue.

Analysis

This proposal would allow residential treatment programs to expand their facilities up to 50 beds (or another number of beds specified). However, it would not address the underlying funding problems and fundamental inequities of the exclusion.

Additionally, this proposal does not seem to have political traction at this time. With many important posts at HHS yet to be filled (including the Director of CMS and Director of SAMHSA), there is currently no prominent champion of this idea in the administration. Although this idea could be pursued through legislative action, no bill on this topic has been introduced in the 111th Congress.

The IMD Exclusion and Mental Health Parity

One significant change in this year's attempts to modify the IMD rule from years past is the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The

[24] The Congressional Budget Office has not yet analyzed the cost impact of a total repeal. One of the obstacles to a final cost estimate is a lack of consensus on current amounts of spending on inpatient mental health services for patients aged 21-64. [*Mental Health Weekly* op. cit. (23)]
[25] Edney, A. "Orszag Sticks To Budget Neutrality For Healthcare Overhaul." *CongressDaily PM,* Mar. 10, 2009.
[26] Obama himself describes the $634 billion as a "down payment" on health reform and has urged lawmakers to find additional revenue to fully offset the rest of the cost. [Connolly, C. "Obama Proposes $634 Billion Fund for Health Care." *The Washington Post* Feb. 26, 2009, p. A1. Available online at: http://www.washingtonpost.com/wp-dyn/content/article/2009/02/25/AR2009022502587.html?nav=rss_business/industries]
[27] National Association on Mental Illness. "IMD Exclusion: Implications of Repeal." Accessed through Treatment Advocacy Center website. Available online at: http://www.psychlaws.org/HospitalClosure/NAMIPolicy.htm

passage of the parity law was a long-sought goal for mental health advocates, prohibiting health plans from covering mental health services to a lesser extent than they cover physical health services. The IMD rule may conflict with the parity law, because it denies services to certain mentally ill patients based exclusively on their condition of being admitted to an institution with a diagnosis of mental illness.[28] For no other condition in Medicaid is there a prohibition on receiving services in a certain category of institution. Nonetheless, because the mental health parity act was so recently enacted and has not yet been fully implemented, states and the federal government have not yet received further guidance on how parity may affect the IMD exclusion. In the case that the two are considered to be in conflict, it is possible that HHS may try to act administratively to modify the IMD exclusion, as some mental health advocates have urged.[29] However, if a large-scale modification of the rules is needed, legislative action may still be necessary.[30]

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About the Alliance for Children and Families and United Neighborhood Centers of America

The Alliance for Children and Families, a nonprofit association, was formed by the 1998 merger of Family Service America and the National Association of Homes and Services for Children. The Alliance represents over 370 nonprofit organizations across the nation that provide services and economic empowerment to children and families. Alliance agencies cover a wide spectrum of providers, including a diversity of faith-based organizations and nonsectarian agencies. Together, these organizations deliver more than $2 billion annually in services to more than 8 million people in nearly 6,700 communities across the United States. More information about the Alliance is available at www.alliance1.org.

United Neighborhood Centers of America (UNCA) is a voluntary, nonprofit, national organization with neighborhood-based member agencies throughout the United States. Formerly known as the National Federation of Settlements and Neighborhood Centers, it was founded in 1911 by Jane Addams and other pioneers of the settlement movement. More information about UNCA is available at www.unca.org.

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[28] Rosenbaum op. cit. (3); *Mental Health Weekly* op. cit. (23)
[29] "Medicaid Rule Change Urged to Allow Funding of Residential Treatment." *Join Together,* Nov. 6, 2000. Available online at: http://www.jointogether.org/news/funding/trends/medicaid-rule-change-urged-to.html
[30] *Join Together* op. cit. (29)