



October 2017

**Blueprint for Recovery:**  
***Increasing Access to Inpatient and Residential Behavioral Health Treatment***

The National Association of Psychiatric Health Systems (NAPHS)—on behalf of our more than 800 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care—thanks President Donald Trump’s Commission on Combating Drug Addiction and the Opioid Crisis for its work and preliminary recommendations in the commission’s interim report released in late July.

NAPHS represents the entire behavioral health continuum of care. Behavioral health encompasses both mental health and substance use disorders, and the care continuum includes inpatient care, partial hospitalization services, residential treatment and outpatient services. Our diverse membership positions us well to help the commission and the administration solve our nation’s deadly and pervasive opioid problem.

In its recommendations, the commission calls on President Trump to declare the opioid crisis a national emergency. While it is unprecedented to declare a national emergency in behavioral health, we believe it is the right course of action. A recent analysis estimated that more than 59,000 people in the United States died of a drug overdose in 2016.<sup>i</sup> That means the number of Americans who died in a single year by drug overdoses was greater than the total number of Americans killed in action during the entire Vietnam War.

Simply put, the opioid crisis is the worst behavioral health challenge the United States has faced. And to address it, we need an approach that is as comprehensive, tenacious, and effective as any we would apply to confront a physical health crisis.

We believe the commission’s most important recommendation is to “rapidly increase treatment capacity” by providing states relief from the antiquated Institutions for Mental Diseases (IMD) exclusion. Doing so would expand low-income Americans’ access to inpatient and residential treatment. This is a vital need, given that more than 46 percent of all patients cared for in NAPHS inpatient settings are Medicaid and Medicare beneficiaries, and one out of every four patients treated in NAPHS residential settings is on Medicaid.<sup>ii</sup>

In this blueprint, we explain why the IMD exclusion needs to be eliminated. For more than 80 years, our member facilities have advocated and cared for the many Americans who are often forgotten or have been cast aside because of their addiction or mental illness. Because we understand this patient population and what it needs, we have drafted this blueprint that includes detailed, practical, and applicable actions that the commission and administration can take to solve our nation's opioid crisis—and help millions of Americans recover.

### **Background**

Since 1965, the IMD exclusion has prohibited federal payments to states for services to adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds, and that provide inpatient or residential behavioral health (substance use disorders and mental illness) treatment. Half of all inpatient and residential substance use disorder treatment facilities meet this definition, meaning that Medicaid will not pay for beneficiaries treated in 50 percent of substance use treatment facilities in the United States.<sup>iii</sup>

This is a huge barrier for people with behavioral health problems to receive care, given that Medicaid—the nation's largest behavioral health payer—covers 26 percent of all behavioral health treatment in the United States.<sup>iv</sup> This is partly because Medicaid beneficiaries typically have higher rates of behavioral health diagnoses than privately insured patients. Also, Medicaid beneficiaries between the ages of 18 and 64 are twice as likely to have an opioid use disorder than those with private insurance.<sup>v</sup>

Meanwhile, there is a treatment gap between Medicaid beneficiaries and patients with private insurance. According to the non-partisan Medicaid and CHIP Payment and Access Commission (MACPAC), "... many Medicaid enrollees with an opioid use disorder are still not receiving treatment" and only one in every three Medicaid enrollees with an opioid use disorder receives treatment.<sup>vi</sup> The commission identified the IMD exclusion as a contributing factor to this treatment gap.

In recent decades, the IMD exclusion has been a contributing factor in the decrease in inpatient and residential treatment availability. From 1990 to 2008, the number of adult inpatient and residential behavioral health treatment beds decreased by 35 percent.<sup>vii</sup> The decline has had a negative effect on access: more than 26 percent of adults on Medicaid (between the ages of 22 and 64, the population that the IMD exclusion affects) with a behavioral health condition reported unmet need for treatment, while fewer than 20 percent with other insurance reported an unmet need.<sup>viii</sup> Also, during and directly after the number of available beds declined (between 1999-2014), the number of drug overdose deaths in the United States nearly tripled. Compounding the problem is that this increase was highest among individuals between the ages of 25 and 54, an age bracket directly in the middle of the IMD exclusion.<sup>ix</sup>

The good news is that opioid use disorder can be treated effectively and managed. Recurrence rates or "relapses" are no higher among those with substance use disorders than they are for individuals with other chronic illnesses, such as type 2 diabetes, hypertension or asthma.<sup>x</sup> The difference is that many people with an opioid use disorder need access to treatment—and they

cannot get it. The Medicaid IMD exclusion, one of the few instances in the Medicaid program in which federal funds cannot be used for medically necessary services, is the largest barrier to effective behavioral health treatment. The following steps are actions that the commission and the Trump administration can take immediately to address the crisis.

### **Expedite the 1115 Waiver Process**

In their March 14, 2017 letter to state governors, former HHS Secretary Tom Price and CMS Administrator Seema Verma discussed the IMD exclusion and developing “a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities.”<sup>xi</sup> This should be the Trump administration’s top priority to address the crisis.

As of September 2017, HHS had not approved half of all 1115 waivers related to behavioral health. Meanwhile, the states waiting for approval are those the opioid crisis has hit hardest: Arizona and Indiana. In addition, 75 percent of the 1115 waiver requests—including requests from Arizona and Indiana—seek relief from the IMD exclusion.<sup>xii</sup>

The simplest and easiest way to increase access to inpatient and residential treatment for opioids is to approve the pending 1115 waivers for behavioral health immediately. Given the current crisis, HHS should place all other 1115 waivers on hold and direct its resources to concentrating on behavioral health waivers.

### **Expand the Existing 1115 Waiver for Substance Use Disorders**

On July 27, 2015 the Centers for Medicare and Medicaid Services (CMS) issued a letter detailing new service delivery reform opportunities for Medicaid beneficiaries with substance use disorders.<sup>xiii</sup> The letter provided states with information about how they can use 1115 waivers to cover substance use disorder treatment not otherwise covered under Medicaid, including in IMDs.

This letter and the use of the 1115 waivers were good initial steps. Now we urge the administration to build on those actions by expanding the waivers to include treatment in an IMD for beneficiaries who have a diagnosis of substance use disorder and a co-occurring diagnosis of mental illness.

The data and the science on the connection between mental health and substance use disorders makes it a clinical necessity to address the two together. The commission’s interim report rightly notes that in many cases opioid-based prescription painkillers are a gateway to heroin use. Of the people who have used both prescription opioids for non-medical purposes and heroin, 77.4 percent started using prescription opioids before they shifted to heroin.<sup>xiv</sup> This pathway from prescription opioids to street drugs is an enormous problem for Medicaid beneficiaries and people with mental health conditions.

Meanwhile, Medicaid beneficiaries are prescribed pain relievers at higher rates than those with other sources of insurance.<sup>xv</sup> In 2015, nearly one in every four Medicaid beneficiaries was prescribed an opioid in 2015.<sup>xvi</sup> In addition, Medicaid beneficiaries are also more likely than privately insured adults to report having misused a prescription pain reliever.<sup>xvii</sup> Both of these

statistics increase the likelihood that Medicaid beneficiaries will develop a substance use disorder.

More than 40 percent of people who have a substance use disorder have a mental health condition.<sup>xviii</sup> And of that 40 percent, 48.1 percent receive no treatment for either condition.<sup>xix</sup> There is also a higher prevalence of opioid use disorder among individuals with anxiety or mood disorders, such as major depressive disorder or bipolar disorder, than in individuals without these conditions.<sup>xx</sup> There are several reasons for this, including that individuals with mental health conditions are also more likely to be prescribed opioid painkillers, which increases their chances of developing a substance use disorder.<sup>xxi</sup>

People with mental health conditions make up approximately 18 percent of the population, but they are the recipients of nearly 52 percent of the 115 million opioid prescriptions written each year in the United States.<sup>xxii</sup> According to the National Institute of Health (NIH), this is because “both drug use disorders and other mental illnesses are caused by overlapping factors such as underlying brain deficits, genetic vulnerabilities, and/or early exposure to stress or trauma.”<sup>xxiii</sup> This explains why it is essential to consider substance use disorders and mental health conditions in tandem.

Although the 1115 waiver was meant to expand beneficiary access to inpatient and residential substance use disorder treatment facilities (half of which are IMDs where treatment for Medicaid beneficiaries is not covered), the nearly 600,000 Medicaid beneficiaries who have substance use disorders as a co-occurring diagnosis still cannot access inpatient or residential treatment.<sup>xxiv</sup> We suggest HHS clarify that 1115 waivers for substance use disorders can apply to treatment for patients who have substance use disorder and a co-occurring diagnosis of mental illness.

### **Maximize the Authorities Provided in the 21st Century Cures Law**

The NIH reports that “mental illnesses can lead to drug abuse. Individuals with overt, mild, or even subclinical mental disorders may abuse drugs as a form of self-medication.”<sup>xxv</sup> Despite the research that highlights this direct link, access to mental health treatment for Medicaid beneficiaries remains limited. Each year, 2.5 million Medicaid beneficiaries report an unmet need for mental health treatment.<sup>xxvi</sup>

A codicil to the reforms of the *21st Century Cures Act*<sup>xxvii</sup> requires CMS to issue a letter (similar to the agency’s July 2015 substance use disorders letter noted above) about “opportunities for demonstration projects under section 1115” and for innovative service delivery systems reforms for “adults with a serious mental illness or children with a serious emotional disturbance.” We urge CMS to allow funds to be used for providing services to low-income individuals with mental health disorders in IMDs for short-term acute care.

In its July 2015 letter about 1115 waivers for substance use disorders, CMS said the IMD exclusion challenges “states’ abilities to offer a full continuum of care and effectively treat individuals with substance use disorders.” The same problem that CMS identified in the

substance use disorder treatment system exists in the mental health delivery system. The number of inpatient and residential behavioral health treatment beds decreased by more a third between 1990-2008, but there was also a separate decline in inpatient adult mental health treatment beds between 2010-2015.<sup>xxviii</sup> This shortage of beds has a system-wide effect that significantly and adversely affects those with behavioral health conditions. The IMD exclusion is an important source of that shortage.

The administration needs to increase access to mental health treatment and allow IMDs to treat patients with mental health disorders. CMS can do this by ensuring that short-term acute care can be provided in an IMD to Medicaid beneficiaries with mental health conditions. This will expand access to mental health services; complement broader delivery system transformation efforts; and have a positive effect on substance use disorders.

Given the national emergency, CMS should send a letter to the nation's governors related to IMD prior to the *21<sup>st</sup> Century Cures Act* deadline. Then the agency should follow with a second letter that provides more detail about other policies in the mental health 1115 waiver. To maximize the impact of the second letter, CMS should include language about improving care delivery, integrating behavioral and physical care, expanding electronic health record adoption among behavioral health providers, and increasing provider capacity.

#### **Modify and Clarify the Managed Care Rule as it Relates to Treatment in an IMD**

In its interim report, the commission also recommends enforcing the *Mental Health Parity and Addiction Equity Act* (MHPAEA) with the goal of ensuring "health plans cannot impose less favorable benefits for mental health and substance use diagnoses versus physical health diagnoses." The report is clear when it notes: "at this point, the largest outstanding issue is treatment limits." The Medicaid managed care rule finalized in 2016 offers another way to increase access to inpatient and residential behavioral health treatment and meet the commission's goal of enforcing parity.

Under the new regulations, CMS clarified that Medicaid managed care plans contracting with state Medicaid agencies may provide care in an IMD to beneficiaries "in lieu" of other covered services, if specific conditions are met, including that the length of stay is not more than 15 days during a given month. CMS' rationale for this policy cites the growing need for short-term mental health and substance use disorder services and a decline in the number of beds in freestanding psychiatric facilities and in psychiatric units within general hospitals. This CMS clarification is an example of parity and is a significant improvement to treat those with behavioral health conditions. The commission should build on that improvement by increasing the number of days to 25 and changing to a facility-wide average length-of-stay cap from a per-beneficiary cap.

While the 2016 clarification moved managed care closer to full parity, it did not achieve it. The commission's first change to the Medicaid managed care rule should be to make the managed care rule compliant with parity as the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) defines it.

To be clear: parity does not mean unlimited coverage. It means that limitations placed on coverage for mental health and substance use disorders benefits should be no more restrictive than the “predominant” limitations as applied to “substantially all” medical and surgical benefits. In other words, if a Medicaid managed care plan has no treatment limitations on inpatient medical and surgical benefits, then parity prevents that plan from placing any treatment limits on inpatient mental health or substance use services.

The 2016 managed care rule sets a quantitative treatment limit of 15 days of payment for stays in IMDs for short-term inpatient treatment. However, federal law defines long-term care hospitals (medical and surgical) as having lengths of stay of greater than 25 days and short-term care as 25 or fewer days. This is a stricter treatment limitation (15 days versus 25 days) on mental health and substance use disorder benefits than the treatment limitations applied to medical and surgical hospital benefits. Therefore, the rule violates parity. Because the commission’s interim report identified this type of treatment limitation as the “largest outstanding issue” in parity, the commission and the administration should adjust the managed care definition of short-term hospitalization related to IMDs in the 2016 rule with existing federal definitions of short-term hospitalization, changing the period to 25 days from 15 days. This would both bring Medicaid managed care closer to full parity and provide additional access to inpatient and residential behavioral health treatment for those who need it.

Next, in the managed care rule, the commission should change a per-beneficiary cap to a per-facility cap based on average length of stay for the patient. A facility-wide average length of stay is a more appropriate methodology for determining what constitutes a short-term stay. While a per-beneficiary cap covers the majority of IMD stays, it excludes the coverage of a significant number of medically necessary stays when individuals require short-term inpatient psychiatric care that exceeds the arbitrary cap.

A more patient-centric approach would be to adopt a policy that focuses on a facility-wide cap, rather than number of days. Such a policy would remain consistent with the “in lieu” of policy because hospital stays would be provided in a short-term setting. This approach favors patient-centered care versus a one-size-fits-all approach that does not account for a patient’s medical needs.

In addition, a facility-wide length-of-stay approach is more consistent with CMS’ approach in general health care and would align with CMS’ existing standard for what constitutes short-term and long-term hospital care in Medicare (section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as “a hospital which has an **average inpatient length of stay** (as determined by the Secretary of Health and Human Services) of greater than 25 days”).

Under this change, CMS should determine a facility’s average length of stay by calculating all treatment days divided by the number of discharges for that facility. This policy would define eligible hospitals by the services they deliver, rather than by their payer mix. Looking at a facility-wide average length of stay also provides a way of determining a facility’s overall

treatment approach and general emphasis on short-term treatment and crisis stabilization. This would be more accurate than determining a facility's Medicaid specific length of stay.

To better align managed care with the rest of existing CMS policies, improve parity compliance in federal programs, and increase access to mental health and substance use disorder treatment, the commission and the administration should increase the number of days and shift to a facility-wide average length of stay simultaneously.

### **Conclusion**

The commission has identified the central issue of America's opioid crisis: timely access to behavioral health treatment. These are five efficient and effective policy changes that can help provide life-saving behavioral health care:

- Expedite the approval of 1115 waiver for behavioral health;
- Expand the existing 1115 waiver for substance use disorders to individuals with co-occurring mental illness;
- Complete the 1115 waiver for mental health as outlined in the *21<sup>st</sup> Century Cures Act*;
- Change the IMD length of stay in the Medicaid managed care rule to 25 days from 15;
- Move the IMD length of stay in the Medicaid managed care rule to a facility-wide average length-of-stay cap from a per-beneficiary cap.

For too long federal laws and policies have denied Americans with substance use disorders and mental illness the live-saving care they need. The commission has already taken the first step in addressing this issue by recommending increased bed capacity and waivers to eliminate the IMD exclusion in Medicaid. We applaud this effort and hope the commission will consider our recommendations so together we can help the millions of Americans who need care—before it's too late.

### **ABOUT NAPHS**

*Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 800 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient treatment, residential treatment, partial hospitalization, and outpatient services.*

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- <sup>ii</sup> Annual Survey of the National Association of Psychiatric Health Systems, 2017.
- <sup>iii</sup> United States Government Accountability Office Report, *MEDICAID: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, August 2017: <https://www.gao.gov/assets/690/686456.pdf>
- <sup>iv</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2013a. *National expenditures for mental health services and substance abuse treatment, 1986–2009*. HHS Publication no. SMA-13-4740. Rockville, MD: SAMHSA. <https://store.samhsa.gov/shin/content/SMA13-4740/SMA13-4740.pdf>.
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- <sup>vi</sup> Ibid
- <sup>vii</sup> United States Government Accountability Office Report, *MEDICAID: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, August 2017: <https://www.gao.gov/assets/690/686456.pdf>
- <sup>viii</sup> Ibid
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- <sup>xiii</sup> Letter *New Service Delivery Opportunities for Individuals with a Substance Use Disorder* Centers for Medicare & Medicaid Services, July 27, 2015 <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>
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<sup>xxv</sup> Julia Zur, MaryBeth Musumeci, and Rachel Garfield *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals* The Henry J. Kaiser Family Foundation, Jun 29, 2017

<sup>xxvi</sup> Section 12003 of P.L. 114-255

<sup>xxvii</sup> United States Government Accountability Office Report, *MEDICAID: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, August 2017:

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<sup>xxviii</sup> Ibid