National Association for Behavioral Healthcare

Access. Care. Recovery.

SUMMER 2024

# *Repeal the Medicaid Program's IMD Exclusion*

## LEGISLATIVE REQUEST

***NABH urges Congress to build on improvements enacted in March 2024[1] and fully repeal the Medicaid program's Institutions for Mental Diseases (IMD) exclusion by passing H.R. 1201 – the Increasing Behavioral Health Treatment Act. Current access to care still falls short of the country's crisis-level needs, especially for the patients with more intensive needs who require inpatient care.***

## ISSUE OVERVIEW

America's behavioral health crisis persists following the COVID-19 pandemic as current rates of deaths by suicide and/or opioid/fentanyl overdoses, as well as other behavioral health-related trauma, continue at unacceptable rates.

To help address the crisis, we must expand the number of healthcare providers to meet the wide range of behavioral healthcare patient needs, which, for individuals with either mental health (MH) or substance use disorder (SUD), range from telehealth to hospital-level care. In short, the IMD exclusion policy acts as an obstacle for individuals with complex and time-sensitive clinical needs.

Under Medicaid's IMD exclusion policy – as updated earlier this year – *federal* Medicaid funds cannot be used to pay for *mental health* services provided to Medicaid enrollees ages 21 to 64 who use IMD inpatient or outpatient services. IMDs are defined in statute as healthcare facilities with more than 16 beds that primarily engaged in diagnosing, treating, or caring for people with mental diseases, including SUDs.

Earlier this year, Congress authorized states to permanently allow federal matching dollars for up to 30 days of SUD services per year. NABH advocated for and strongly supports this gain in access to SUD care in IMDs.

[1] H.R.2882, the *Further Consolidated Appropriations Act of 2024*, enacted in March 2024, lowered the restrictions of the IMD exclusion policy by allowing federal Medicaid dollars to apply to SUD services. The bill also requires that, beginning in October 2025, states with an IMD state plan amendment must use evidence-based SUD-specific individual placement criteria and utilization management approaches to guide patient placements, including related state oversight.

Congress should build upon improvements enacted in March 2024 by fully repealing the IMD exclusion. Even with these recent adjustments, access to care still falls short of demand, especially for patients with more intensive needs who require specialized care.

Coverage of IMD and all other behavioral healthcare services should be based on the expert judgment of treating physicians and other practitioners who examine the patient to determine the level of clinical and wrap-around services that are necessary.

***The outdated IMD exclusion does the opposite: it continues to arbitrarily block access to medically needed behavioral healthcare treatment, rather than relying on an evidence-based approach.***

## HISTORY & BACKGROUND

Congress created the IMD exclusion when Medicaid was established in 1965. The policy does not apply to inpatient psychiatric units. Today, the policy is a strong financial deterrent against opening and maintaining IMD-level services.

### IMD Providers and Services Fill a Critical Need

IMDs – including hospitals, nursing homes, and other facilities – play an essential role in the behavioral healthcare continuum by providing a wide range of behavioral healthcare services, including SUD treatments (65% of all IMDs), outpatient psychiatric services (27%), adolescent care (23%), and geriatric care (31%).[2] IMDs also provide more structured and medically oriented inpatient care for people experiencing severe behavioral health symptoms who require continuous care. In addition, residential services in IMDs treat patients with serious behavioral health conditions who have not improved in outpatient settings or whose work or living arrangements are not stable and who have limited or no support from their social network.

### Medicaid Managed Care Plans Cover Services in IMDs

Medicaid managed-care plans in at least 32 states have covered services in IMDs for many years, and doing so has not resulted in excessive institutionalization. Rather, the average length of stay in IMDs in these states is fewer than 10 days per episode even though Medicaid managed care rules allow for coverage of services in IMDs for up to 15 days per month. These relatively short lengths of stay mirror the average lengths of stay for IMD services that commercial and Medicare managed care plans – neither of which is subjected to the IMD exclusion – cover.[3]

### Section 1115 Waivers Help Fund Behavioral Healthcare Service Expansions

Many states use Section 1115 waivers for SUD services provided in IMDs. However, these waivers rarely have been granted for mental health services. According to the Kaiser Family Foundation, as of September 2023, 35 states had Section 1115 waivers for SUD services and 11 states had waivers for mental health services. For mental health, the section 1115 waivers limit federal reimbursement to stays of no more than 60 days.[4]

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[2] National Library of Medicine. November 2022: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8574225/.
[3] Musumeci M, Chidambaram P, Orgera K. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. Kaiser Family Foundation. Nov. 2019
[4] Congressional Budget Office. April 2023: https://www.cbo.gov/system/files/2023-04/58962-Medicaid-IMD-Exclusion.pdf.

**Waiver Approvals Face Major Delays in 2024**
We note the material problem of the stymied approval process for state waivers for valuable, permanent coverage expansions. As the National Association of Medicaid Directors reported recently, the average wait for approval for an 1115 waiver has increased in recent years from 17 to 450 days – mostly due to agency staffing challenges acknowledged by the Centers for Medicare & Medicaid Services. As examples of this backlog, Kentucky, Utah and West Virginia waiver applications have waited two years for permission to use Medicaid to pay for addiction treatment.[5]

**The IMD Exclusion's Harmful Effects on Patients**
Serious thought and mood disorders account for more than 1 million hospital emergency department visits every year.[6] This population includes patients facing opioid and other addictions who require more than a phone call, mobile crisis visit, or 23-hour stay in a crisis receiving facility. To understand more about this population, we use as a proxy the inpatient psychiatric update that the Medicare Payment Advisory Commissions published in October 2022, which reported that Medicare beneficiaries receiving inpatient services tend to have higher risk scores, higher rates of chronic conditions, and more than three times more likely to be dually enrolled in Medicare and Medicaid or have low-income status. Most of these patients suffer from psychosis including affective mood disorders and schizophrenia.

**State Waivers Support Behavioral Healthcare Service Expansion**
These waivers have freed up funds to improve transitions between inpatient and outpatient settings, discharge planning, and follow-ups for individuals with SUD. Some states implemented performance incentives and infrastructure improvements, as well as increased reimbursements for outpatient and partial hospitalization services. Virginia allowed same-day billing to incentivize immediate SUD treatment, and California funded peer counselors and social workers in emergency rooms. Evaluations of the waivers show increased treatment utilization, expanded provider participation, fewer emergency room visits, and fewer hospitalizations.[7] In 2023, California also asked to use federal Medicaid funds to connect behavioral healthcare patients with housing and employment resources and have been approved for providing contingency management for stimulant use disorder. CMS also notes waiver requests submitted to expand care for incarcerated persons.

**Lack of Behavioral Healthcare Options Make Jails and Prisons the Default Provider**
Due to access limitations in the existing system and other factors, people who need behavioral healthcare services often end up in jails and prisons in the United States. According to an April 2020 report from the State Justice Institute, jails are the largest providers of mental health services across the country, with evidence that in 44 states, a jail or prison holds more mentally ill individuals than the largest remaining state psychiatric hospital. [8]

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[5] State Waivers Hit Snag at CMS. June 2004. *Politico Pulse*: https://www.politico.com/newsletters/politico-pulse/2024/06/07/state-waivers-hit-snag-at-cms-00162232

[6] National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables," Table 12. National Center for Health Statistics.

[7] *Behavioral Health Business*. Jan. 20, 2023. "Why One State is Pushing Back Against Medicaid's IMD Exclusion. Chris Larson.

[8] Mental Health and Criminal Justice. April 20, 2020. https://www.ncsc.org/__data/assets/pdf_file/0017/38024/MH_and_Criminal_Justice_Fact_Sheet.pdf

Unfortunately, despite the prevalence of mental illness and SUDs in jails and prisons -- three to four times more common than that of the general population[9] – the criminal justice system is not equipped to handle this critical need. Instead, the nation should expand other behavioral healthcare resources to improve overall health status and reduce incarcerations.

An analysis of mental healthcare spending by 44 states found that increased spending on inpatient mental health treatment reduces incarceration, with investments in inpatient care driving down state spending on jails and prisons.[10] NABH also notes that the inpatient psychiatric hospital population already includes many people officially connected to the criminal justice system, such as those arrested for a crime who were not mentally competent to stand trial, which further emphasizes the value of proactive behavioral healthcare investments to reduce the potential for future incarceration.

**COVID-19 Expanded the Demand for Inpatient and Residential Psychiatric Care**
Even before the COVID-19 pandemic, Medicaid beneficiaries with behavioral health conditions reported high levels of unmet need— on par with uninsured population. The pandemic exacerbated the decades-long shortage of inpatient psychiatric services, rendering the IMD exclusion even more harmful.

One telling indicator of this shortage is the waitlist facing patients who need a transfer from emergency departments to practitioners in specialized inpatient or other treatment settings.[11] Research shows six in 10 practitioners reported they no longer have openings for new patients; nearly half (46%) said they have been unable to meet the demand for treatment; and nearly three-quarters (72%) have longer waitlists than before the pandemic.[12] Also, on average, psychologists reported being contacted by more than 15 potential new patients seeking care a month. For the three state-run psychiatric hospitals in North Carolina, the average wait of six days before the pandemic increased to 16 days in December 2021.[13]

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[9] Balfour ME, Stephenson AH, Winsky J, et al. Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Alexandria, VA, National Association of State Mental Health Program Directors, August 2020. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf.
[10] Yoon J, Luck J: Intersystem return on investment in public mental health: positive externality of public mental health expenditure for the jail system in the U.S. Social Science & Medicine 170: 133-142. 2016.

[11] Ramachandran S. (2020, Oct. 9). “A Hidden Cost of Covid: Shrinking Mental-Health Services”: *The Wall Street Journal*.
[12] American Psychological Society, 2022 COVID-19 Practitioner Impact Survey
[13] “New Mental Health Data Show ‘Unsustainable’ Burden on NC Hospitals”: *North Carolina Health News.* T. Knopf. Aug. 22, 2022.