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Medicaid considering IMD-exclusion alternatives

By Alison Knopf

Under an Affordable Care Act (ACA)demonstration program, Medicaid is testing payment models for inpatient psychiatric treatment in several states. The mental health treatment community certainly sees it as a step in the right direction. But behavioral health providers' ability to bill Medicaid in larger inpatient facilities is still years ahead.

Providers have never been able to bill Medicaid for treatment in psychiatric facilities with more than 16 beds. And before 1988, they couldn't even bill Medicaid for treatment in smaller facilities.

What's needed is a louder voice among the behavioral health leaders calling for change, including the repeal of or exemptions for the Institutions for Mental Diseases (IMD) exclusion, experts say. Only an act of Congress can change the law.

However, the IMD exclusion is finally being seen by some political leaders as a ridiculously outmoded provision that leaves psychiatric patients with nowhere to go if they need inpatient care.

"The IMD exclusion is creating such a barrier to access to necessary inpatient treatment," Mark J. Covall, president and CEO of the National Association of Psychiatric Health Systems (NAPHS), tells *Behavioral Healthcare*.

Virtually all psychiatric hospitals have more than 16 beds, Covall says, so virtually all are excluded from Medicaid payment for the adult population because of their size. They still treat those Medicaid patients, but the difference is that they can't get paid for it, he says.

"The IMD exclusion is an example of policy gone awry," Jerry Rhodes, CEO of CRC Health Group, says. "It is highly discriminatory and economically absurd."

CRC, the country's largest addiction treatment provider, is working with NAPHS to drive policy change. Rhodes says other associations must invest more in lobbying and education. Politically, it's going to be difficult to make changes, but he says it's worth it because the IMD exclusion issue is as critical as parity.

"Unfortunately, the medical and clinical needs of the exempted population do manifest in significant costs to the judicial system, acute hospital emergency rooms and the latent costs associated with the failure to treat the psychiatric and substance abuse needs of the Medicaid population," he says.

The business case for removing the IMD exclusion is simple: larger facilities have economies of scale. Administrative costs and supporting functions are leveraged in larger programs, which can support clinical and medical innovation, which are both needed to ensure the best care of this population, Rhodes says.

Access issue

When Congress created Medicaid and the IMD exclusion, it did not want to allocate federal dollars for what was long-term, and in many cases, custodial care, says Covall. States responded by shifting patients away from state-funded hospitals and into psychiatric units of general hospitals, where Medicaid picked up the tab.

"That's how things were for decades," Covall says.

During the 1990s, emerging managed care models led to the closure of many private psychiatric hospitals, resulting in a loss of 60 percent of the psychiatric bed capacity in 10 years. More recently, the number of inpatient psychiatric beds in the private sector hospitals have declined precipitously, and many state mental hospitals have closed.

All the ingredients add up to the current, pronounced access problem for inpatient psychiatric care.

With about 7 million new Medicaid beneficiaries as a result of the ACA, there are even more patients who need beds, and that's one reason decisionmakers are looking at the IMD rule seriously. There are possible legislative fixes in the works now. For example, the bill sponsored by Rep. Tim Murphy (R-Pa.) late last year would change the IMD rule for emergency hospital care, and a new bill introduced in July by Rep. Marcia Fudge (D-Ohio) would create a demonstration project in 10 states specific to residential programs for substance use disorders (SUDs).

Some states have crafted workarounds through Medicaid waivers. But the risk of full repeal of the IMD exclusion is that inpatient treatment might be encouraged even in cases in which outpatient care is more appropriate, according to the Legal Action Center. Like most policy decisions, the alternative solutions aren't always clear cut.

NAPHS isn't pushing for full repeal , but is looking for certain exceptions. And there's a reason for the strategy. The language of the IMD exclusion rule isn't specific, naming hospitals but not naming other types of facilities, such as nursing homes. If the IMD exclusion were completely repealed, nursing homes, for example, could become de facto mental health or SUD providers. That's why NAPHS is recommending exemptions only for the organizations that are already specializing in mental illness and SUDs.

CMS grants

The federal Centers for Medicare & Medicaid Services (CMS) is funding the ACA-mandated Medicaid Emergency Psychiatric Demonstration (MEPD) that allows participating states to use Medicaid funds to pay for inpatient emergency psychiatric care in psychiatric hospitals for patients ages 21 to 65 without the 16-bed restriction. Participants will measure access to care and determine Medicaid costs and utilization. The demonstration began two years ago and the evaluation will be completed by 2016.

Dan Belnap, senior health policy analyst with the Legal Action Center in Washington, D.C., says the demonstration – and the Fudge bill – are steps in the right direction. It's also easier to gain support of pilot projects than to overhaul the entire system, he says. When the demonstration grants run out, the case must be made to implement the tested models more broadly.

The momentum building for a change from the demonstration project is a positive sign.

Nevertheless, Rhodes says, it will take the concerted efforts of SUD and mental health advocates and willing political sponsors to find support to allocate Medicaid payments for inpatient care. CRC has no programs with fewer than 16 beds that serve Medicaid, so treating such patients "remains a wholesale opportunity," he says.

Some policy options for the IMD exclusion

- Congress could fully repeal the IMD exclusion
- Congress could raise the bed limit above 16 to allow larger facilities to fall outside of the scope of the IMD exclusion
- SUD could be excluded from the definition of mental disease for the purposes of determining if a treatment facility qualifies as an IMD
- States could be allowed to use Medicaid Section 1115 waivers to draw down reimbursement for services provided in IMDs.

Source: Legal Action Center

States participating in IMD demonstration project

Alabama

California

Connecticut

District of Columbia

Illinois

Maine

Maryland

Missouri

North Carolina

Rhode Island

Washington

West Virginia

Source: Centers for Medicare and Medicaid Services