Insight

The Problems with the IMD Exclusion

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The Institutes for Mental Disease (IMD) exclusion is a limitation on Medicaid coverage of services provided by institutions that specialize in providing mental health care. The exclusion was created so that federal funds would not end up supplanting state mental health funding, but it has resulted in a number of predictable, yet dangerous consequences.

Background

The IMD exclusion prohibits the use of federal monies through Medicaid for any care (including non-mental health services) provided to patients from 21 to 65 years old, in mental health or substance abuse residential treatment facilities with more than 16 beds. A facility is determined to be an IMD based on its "overall character," or the totality of whether the facility is a licensed psychiatric facility, is under the state's mental health authority's jurisdiction, specializes in providing psychiatric care or treatment (based on the proportion of staff trained in psychiatric care), or whether more than 50 percent of patients are admitted to the facility for mental health care.[1]

The IMD exclusion was included in the Social Security Amendments Act of 1965, which created Medicaid and Medicare. By including this exemption, Congress was attempting to leave the provision and funding of mental health services to state governments. The IMD exclusion has not been significantly changed in over a half of a century. The primary objections to updating the exclusion have been the significant price tag of including inpatient mental health care among the many other services already paid for by Medicaid, and concerns that a repeal or rollback of the IMD exclusion would incentivize the reinstitutionalization of mentally ill or disabled individuals who are currently living (however tenuously) among the general public[BLC1] .

Problems Caused by the Exclusion

Because of the IMD exclusion, many inpatient psychiatric treatment facilities have been closed down, and other facilities have decreased the number of staffers trained to treat mental illness.[2]

As a result, many individuals suffering from mental illness and substance use disorders are unable to access care. Individuals with private insurance or Medicaid managed care plans may even find that though their plans cover mental health care, there may not be any mental health professionals available to provide it. In fact, nearly 43 percent of Americans suffering from mental illness in 2013 did not receive treatment. This is at least partially explained by the fact that 16 states have 5 or fewer operating psychiatric hospitals; six states had two or fewer[3]. Nationally, less than one in five general hospitals have separate psychiatric wards, and these facilities are subject to the IMD exclusion, and are therefore incentivized to keep their bed count below 16 to preserve their Medicaid payment eligibility.[4] These restrictions create significant barriers to patients attempting to access care.

Those who are unable to find appropriate treatment before a mental health crisis occurs may face any number of negative outcomes including job loss, homelessness, imprisonment, emergency room boarding, substance abuse, or vulnerability to violence.

Inpatient psychiatric treatment can be extremely expensive, and attempts to control prices often have unintended consequences that simply shift costs or reduce access. A number of studies by the National Institute of Mental Health and others demonstrate that the average cost for 11 days of treatment for schizophrenia was $8,990, yet 7 days of treatment was $5,707.[5] Similarly, bipolar disorder treatment averages $7,593 for 7 days of treatment, but $4,356 for 5.5 days of treatment—this pattern of uneven treatment costs continues across diagnoses and indicates the difficulties created by payment caps and the resulting inability to accurately estimate the true cost of providing care for severe mental illness.[6]

Reforming the IMD Exclusion

Because a full repeal of the IMD exclusion is neither politically nor fiscally practicable, policymakers should look at ways of reforming the rule to better provide care to those who need it by giving providers an incentive to make mental health care more accessible.

The first option would be to modify the parameters of the exclusion itself. Congress could make the exclusion apply strictly to long-term care institutions by allowing Medicaid payments for IMDs with average inpatient stays that extend to 30, 60, or 90 days, as

opposed to the current limit of 15 days. Similarly, Congress could limit the exclusion by narrowing the definition of IMDs to facilities with more than 30 or more psychiatric beds. These approaches would leave the IMD exclusion itself in place while making access to short-term inpatient care more accessible.

Alternatively, Congress could exclude substance use disorders from the definition of mental diseases only as it applies to the IMD exclusion. Substance use-related hospital admissions make up a large portion of mental health patients who seek care through a general hospital emergency room. By eliminating substance use disorders from this definition, Congress would effectively lower the number of patients eligible for mental health services in the inpatient context, and therefore exempt many general hospitals with psychiatric beds from the threat of losing Medicaid payments through the IMD exclusion.

Another reform approach that is available is for state departments of health to apply to the Department of Health and Human Services for a §1115 innovation waiver. This waiver, if approved by the Department of Health and Human Services (HHS), would enable the state to design its own Medicaid program as long as it provides citizens with equivalent benefits. With such a waiver, a state could design a program that does allow Medicaid payments to IMDs. In the past HHS has approved similar waivers for Arizona, Delaware, Hawaii, Iowa, Maryland, Massachusetts, Oregon, Rhode Island, Tennessee, and Vermont, though with the passage of the Affordable Care Act (ACA) these states were rolled into the Medicaid Emergency Psychiatric Demonstration, which made Medicaid funds available to IMDs for emergency inpatient care.[7] The demonstration will sunset at the end of this year. In response, the House of Representatives has passed the Breaking Addiction Act of 2015, which would compel HHS to accept state §1115 IMD waiver applications if they provide comprehensive addiction treatment; the bill contains no parallel clause for providing treatment for severe mental illness.[8]

This option is the most in line with the original intent of the IMD exclusion – to leave the design of how to provide mental health services to the individual states, and would allow them to function as laboratories of experimentation to find the most effective way to provide care. This approach would also have no cost for the federal government. Most importantly, this approach would create an incentive for psychiatric hospitals to reopen, and for general hospitals to open more beds to patients with mental illness. By better aligning incentives, more appropriate care can be provided in a timely manner, which could help avoid psychiatric crises and the long-term harm they may cause[BLC2] .

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[1] 42 CFR §435.1009; http://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol3/pdf/CFR-2002-title42-vol3-sec435-1009

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