

Changes to Medicaid's Institutions for Mental Disease (IMD) Exclusion

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Issue

Summarize the recent changes to Medicaid's institutions for mental disease (IMD) exclusion contained in the SUPPORT (Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment) for Patients and Communities Act ([P.L. 115-271](#)).

Summary

The SUPPORT for Patients and Communities Act of 2018 is a comprehensive set of reforms designed to prevent and combat substance use disorders. It combined House bill 6 of the same name with the Senate's recent [Opioid Crisis Response Act of 2018](#). Among its many provisions, the SUPPORT act modifies Medicaid's IMD exclusion to lift some of the restrictions on using Medicaid funds to pay for addiction treatment. Specifically, for federal fiscal years 2019 through 2023, the act suspends Medicaid's IMD exclusion for treatment of substance use disorders, but places a 30-day limit on residential treatment length of stay. States must meet specific criteria to receive federal payments (i.e., federal financial participation (FFP)), including outlining their plans to improve access to outpatient care. The act also clarifies that the exclusion for pregnant and postpartum patients receiving care in an IMD does not extend to other Medicaid-covered care provided outside of an IMD. Finally, it requires the Medicaid and Children's Health Insurance

IMD Exclusion

The IMD exclusion generally prohibits states from receiving FFP for care or services provided by an IMD to any adult aged 21 to 65 (42 U.S.C. § 1396d(a)(29)(B)). States are permitted to receive IMD funding, however, through Section 1115 demonstration waivers, Medicaid managed care "in lieu of" authority, and disproportionate share hospital (DSH) payments.

Program Payment and Access Commission (MACPAC) to report on information relating to services for Medicaid enrollees who are patients in IMDs.

Suspending the IMD Exclusion to Address the Opioid Crisis

Federal law generally prohibits Medicaid payment for services provided in IMDs for individuals under the age of 65 (although states may receive payment through certain mechanisms, such as a Medicaid waiver – see BACKGROUND). The law defines IMDs as any “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.”

The SUPPORT act’s temporary five-year suspension of the IMD exclusion (§ 5052) allows states to apply to receive FFP through a state plan amendment, rather than having to obtain a waiver. For an adult (aged 21 to 64) with any substance use disorder enrolled in the state’s Medicaid plan or a waiver, inpatient addiction treatment services and other medically necessary services provided in eligible IMDs may be covered for a total of up to 30 days (whether consecutive or not) in a 12-month period. The act defines eligible institutions as IMDs that (1) follow reliable, evidence-based practices and (2) offer at least two forms of medication-assisted treatment for substance use disorders on site, including, in the case of opioid use disorder, at least one antagonist and one partial agonist.

Maintenance of Effort (MOE) provisions

As a condition for a state to receive federal payments under the act, state funding levels must be maintained from year to year. Commonly referred to as maintenance of effort (MOE), these provisions are required to show that federal funds do not supplant state and local funding. Specifically, the act requires states to maintain separate level non-federal funding on an annual basis for items and services furnished to eligible individuals who are 1) patients in eligible IMDs and 2) in outpatient and community-based settings. The latter group is defined as those receiving the following services:

1. outpatient and community-based substance use disorder treatment;
2. evidence-based recovery and support services;
3. clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies;
4. outpatient medication-assisted treatment, related therapies, and pharmacology;
5. counseling and clinical monitoring;

6. outpatient withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs;
7. routine monitoring of medication adherence; or
8. other outpatient and community-based services for the treatment of substance use disorders, as designated by the Secretary of Health and Human Services (HHS).

The minimum funding levels are based on the most recently ended fiscal year as of the law's enactment or, if higher, the most recently ended fiscal year as of the date the state submits a state Medicaid plan amendment to provide such medical assistance. The act requires the HHS Secretary, within eight months after enactment, to establish a reporting process for states to report to him such information as he deems necessary to verify a state's compliance with these provisions.

Ensuring a Continuum of Services

Under the act, a state must notify the HHS Secretary of how it will ensure that eligible individuals receive appropriate evidence-based clinical screening prior to being furnished with items and services in an eligible IMD. This includes initial and periodic assessments to determine the appropriate level of care, length of stay, and setting for such care for each individual. The act defines outpatient levels of care, as outlined in Table 1.

Table 1: Outpatient Levels of Care Defined in Act

I.	Early intervention for individuals who, for a known reason, are at risk of developing substance-related problems and for individuals for whom there is not yet sufficient information to document a diagnosable substance use disorder
II.	Outpatient services for less than 9 hours per week for adults, and for less than 6 hours per week for adolescents, for recovery or motivational enhancement therapies and strategies
III.	Intensive outpatient services for 9 hours or more per week for adults, and for 6 hours or more per week for adolescents, to treat multidimensional instability
IV.	Partial hospitalization services for 20 hours or more per week for adults and adolescents to treat multidimensional instability that does not require 24-hour care

The act also requires states to provide services consistent with at least two of the following defined inpatient and residential levels of care, as described in Table 2.

Table 2: Inpatient and Residential Levels of Care Defined in Act

I.	Clinically managed, low-intensity residential services that provide adults and adolescents with 24-hour living support and structure with trained personnel and at least 5 hours of clinical service per week, per individual
II.	Clinically managed, population-specific, high-intensity residential services that provide adults with 24-hour care with trained counselors to stabilize multidimensional imminent danger along with less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
III.	Clinically managed, medium-intensity residential services for adolescents, and clinically managed high-intensity residential services for adults, that provide 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment
IV.	Medically monitored, high-intensity inpatient services for adolescents, and medically monitored, intensive inpatient services withdrawal management for adults, that provide 24-hour nursing care, make physicians available for significant problems in Dimensions 1, 2, or 3 (defined in American Society of Addiction Medicine 2013 treatment criteria), and provide counseling services 16 hours per day
V.	Medically managed, intensive inpatient services for adolescents and adults that provide 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3

Transition of Care

The act requires an eligible individual to appropriately transition from receiving care in an eligible IMD to a lower level of clinical intensity within the continuum of care (including outpatient services). As a result, the state must ensure that (1) a placement in such institution would allow for the individual's successful transition to the community, considering such factors as proximity to his or her support network, and (2) all eligible IMDs that furnish items and services to individuals under the state plan are able to provide care at such lower level of clinical intensity, or have an established relationship with another facility or provider under which the individuals can receive such care.

Other Related Provisions

Help for Moms and Babies

The act clarifies that pregnant and postpartum women (covered through the end of the month in the 60-day period following the end of the pregnancy) receiving care for substance use disorders in an IMD can continue to receive other Medicaid-covered care, such as prenatal care, outside of the IMD (§ 1012)([42 U.S.C. 1396d\(a\)](#)).

Managed Care and Other Medical Assistance

The act clarifies that it does not limit or supersede the ability of states to receive FFP for monthly capitation (i.e., per member, per month) payments to contracted managed care organizations or prepaid inpatient health plans for individuals receiving alternative inpatient treatment in IMDs in lieu of other services that are permitted under the state plan. Current regulations, unchanged by the act, require the facility to be a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is limited to no more than 15 days during the period in a month in lieu of other services (42 C.F.R. § 438.3(e)(2)(i-iii)). The act also specifies that it does not prohibit federal Medicaid funds for items or services provided to such eligible individuals in or away from the eligible IMD during any period in which the eligible individual is receiving items or services in accordance with the act (§§ 1013 and 5052).

Exploratory Study

The act requires MACPAC, by January 1, 2020, to conduct an exploratory study using data from a representative sample of at least two states. The commission must submit a report to Congress with respect to services provided to individuals enrolled under state Medicaid plans or waivers who are patients in IMDs and for which payment is made through fee-for-service or managed care arrangements on at least the following information:

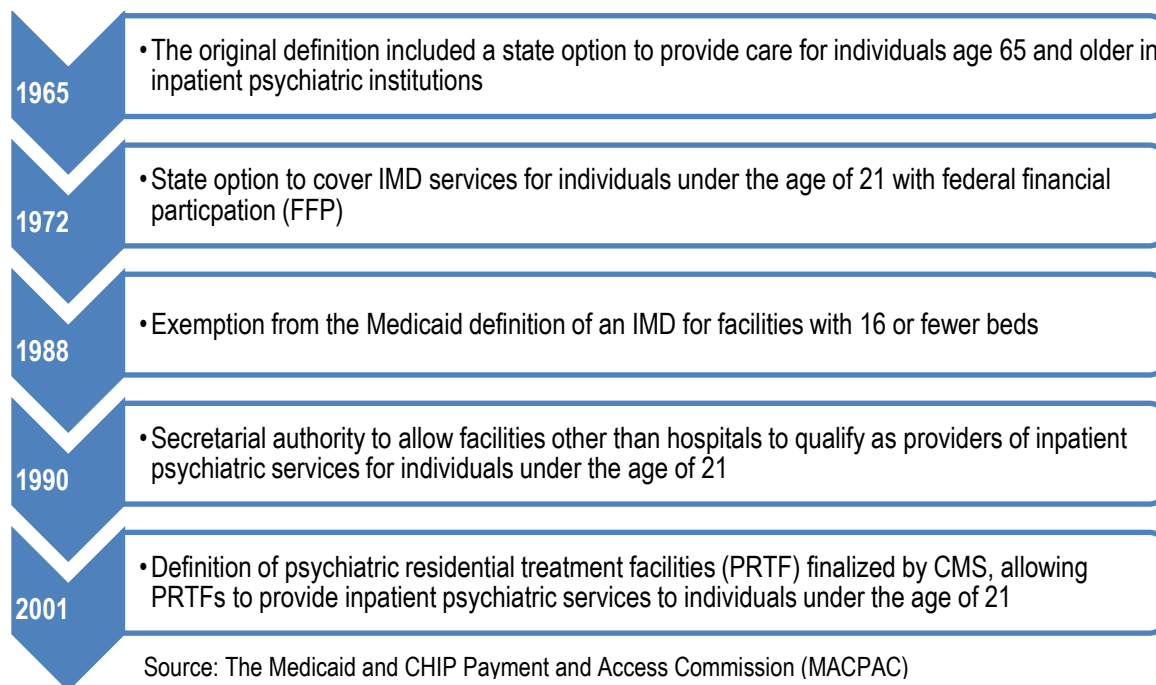
1. a description of such IMDs in each such state, including at a minimum the number, facility type, and any coverage limitations on scope, duration, or frequency of such services under each such state plan (or waiver).
2. for each IMD in each state, a description of the (a) services provided; (b) clinical assessment process, including any timeframe requirements; and (c) discharge process, including any care continuum of relevant services or facilities provided or used.
3. a description of (a) any federal waiver that each state has for IMDs and the federal statutory authority for such waiver and (b) any other Medicaid funding sources used by each state for funding IMDs, such as supplemental payments.
4. a summary of state requirements and standards applied by each state to IMDs in order for such institutions to receive payment under the state plan or waiver and how each such state determines if such requirements and standards have been met.
5. if determined appropriate by the commission, recommendations for policies and actions by Congress and the Centers for Medicare & Medicaid Services.

In carrying out its study, MACPAC must seek input from state Medicaid directors and stakeholders, including at a minimum the Substance Abuse and Mental Health Services Administration, Centers for Medicare & Medicaid Services, state Medicaid officials, state mental health authorities, Medicaid beneficiary advocates, health care providers, and Medicaid managed care organizations (§ 5012).

Background

The IMD exclusion dates back to Medicaid’s inception, when states were the primary payers for inpatient behavioral health services. It generally prohibits states from receiving any federal Medicaid payments “with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases” (42 U.S.C. § 1396d (a)(29)(B)). Individuals age 65 and older have always been excluded from this restriction, and a separate provision enacted in 1972 excludes patients under 21. Figure 1 below outlines the historical changes.

Timeline of Changes to the Medicaid IMD Exclusion



The exclusion was originally intended to encourage states to provide mental health and addiction services in community-based rather than institutional settings. Today’s health providers and policy makers now widely recognize, however, that substance use disorders require a continuum of care, including inpatient care, partial hospitalization, residential treatment, and outpatient services.

Nevertheless, the exclusion remains one of the few instances where Medicaid cannot pay for otherwise medically-necessary covered services for a portion of recipients if such services are received in a specific setting.

States are permitted to receive IMD funding, however, through Section 1115 demonstration waivers, Medicaid managed care “in lieu of” authority, and disproportionate share hospital (DSH) payments. At least 15 states have already received federal waivers to this Medicaid rule, including Massachusetts, New Hampshire, New Jersey, and Vermont in the northeast.

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