LEGAL ACTION CENTER

The Medicaid IMD Exclusion: An Overview and Opportunities for Reform

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

What is in the law?

The IMD exclusion is found in section 1905(a)(B) of the Social Security Act, which prohibits "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" except for "inpatient psychiatric hospital services for individuals under age 21." The law goes on to define "institutions for mental diseases" 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, including medical attention, nursing care, and related services." The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.

The IMD exclusion has been part of the Medicaid program since Medicaid's enactment in 1965, and while Congress has had the opportunity on numerous occasions to amend or repeal the exclusion, it has remained largely intact. In addition, the regulations governing the IMD exclusion have not been updated since 1988.

What makes a facility an IMD?

In the State Medicaid Manual, the federal Department of Health and Human Services (HHS) interprets the IMD exclusion to include any institution that, by its *overall character* is a facility established and maintained primarily for the care and treatment of individuals with mental diseases. The guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility:

- Is licensed or accredited as a psychiatric facility;
- Is under the jurisdiction of the state's mental health authority;

- Specializes in providing psychiatric/psychological care and treatment, which may be ascertained if indicated by a review of patients' records, if an unusually large proportion of the staff has specialized psychiatric/psychological training, or if a facility is established and/or maintained primarily for the care and treatment of individuals with mental diseases; or
- Has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases.

If any of these criteria is met, a thorough IMD assessment will be made. Therefore, a facility is determined to be an IMD based on the character of the institution, including its governance, staffing, and patient population.

How do the regulations define "mental disease?"

In interpreting whether an individual's admission to an institution is a result of a "mental disease" for the purpose of applying the "50 percent test," reviewers will consult the International Classification of Diseases (ICD-9-CM), of which the Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subclass. Because the ICD-9-CM system classifies substance use disorders (SUD) as mental disorders, facilities providing inpatient SUD treatment may be considered IMDs under the law. In its discussion of SUD treatment facilities, the State Medicaid Manual says:

> There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

The State Medicaid Manual also clarifies that facilities that rely on peer counseling and meetings to promote group support and encouragement, and primarily use lay persons as counselors, are not considered IMDs and the services they provide are not eligible for Medicaid reimbursement because they do not provide medical assistance.

What options might be available to improve the IMD exclusion?

The IMD exclusion is included in federal Medicaid statute so significant changes to the IMD exclusion would require an act of Congress, and while Congress has had opportunities to change the IMD exclusion it has largely not done so. There are also certain limited administrative options available to HHS to make it easier for facilities to use Medicaid to finance inpatient mental health and/or SUD services. Specifically, the following options are among those that are frequently discussed:

- Congress could fully repeal the IMD exclusion,
- Congress could raise the bed limit above 16 to a number that would allow larger facilities to fall outside of the scope of the IMD exclusion,
- HHS could exclude SUD from the definition of mental disease for the purposes of determining if a treatment facility is an IMD, or
- HHS could allow states to use section 1115 waivers to drawdown FFP for services provided in IMDs.

There are potential downsides to each approach that would need to be considered by policymakers. For example, potential risks associated with a full or partial repeal by Congress could be to encourage inpatient treatment when outpatient treatment is preferable. Repeal would also be quite expensive for the federal government.

If HHS were to exclude SUD from the definition of mental disease for the purpose of determining if a facility was an IMD, states could draw down federal funds for SUD treatment provided in inpatient settings with more than 16 beds if less than 50 percent of patients had co-occurring mental illnesses that required an inpatient level of care. However, this approach could promote a separate service delivery system and financing limitations for patients with co-occurring mental health and SUD conditions.

HHS could also allow states to use waivers to cover services provided in IMDs in some circumstances, which would improve access to inpatient behavioral health services for Medicaid beneficiaries. Waivers must be cost-neutral to the federal government and are time-limited. In addition, waivers are state specific, which would limit the impact of increasing access to residential treatment services using this approach.

Other considerations

Finally, while the IMD exclusion has remained essentially stagnant for decades, the health care system and disability law in the United States has changed dramatically in that time. These changes must be considered as context for the IMD exclusion and its continued role in the Medicaid program.

For example, the Affordable Care Act significantly expands Medicaid coverage to low-income adults, and while states have flexibility to determine the benefits that are available to the expansion population, it is likely that beneficiaries in many states will have coverage for inpatient behavioral health services that they will be unable to access because they are only available in IMDs. In addition, as states have continued to move to managed care delivery systems for their Medicaid programs beneficiaries often are covered by the same provider networks as individuals enrolled in commercial coverage that includes facilities that Medicaid considers IMDs, leaving Medicaid enrollees unable to access certain services and leading to disparities.

The IMD exclusion also raises parity issues after the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, since for no other conditions are Medicaid services in certain medical institutions excluded. The requirements of MHPAEA apply to Medicaid managed care coverage and will apply to fee-for-service and managed care coverage provided to those adults gaining Medicaid eligibility under the Affordable Care Act.

Finally, federal law and several key court decisions since the implementation of the IMD exclusion have afforded individuals with disabilities the right to community-based care when appropriate. The expansion of protections to individuals with disabilities may potentially mitigate some of the concerns Congress had when it established the IMD exclusion.