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Medicaid Coverage For Residential Substance Use Disorder Treatment: Addressing The Institution For Mental Disease Exclusion Policy

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On August 10, 2017, President Donald Trump announced that the opioid crisis will be declared “a national emergency.” This announcement was in line with one of the nine recommendations made by the President’s Commission on Combating Drug Addiction and the Opioid Crisis (the Commission) from its July 31, 2017, interim report. Commission members created the report through discussions with all 50 state governors and governors’ offices; reviewing more than 8,000 public comments; conducting “listening sessions” with bipartisan congressional representatives, key presidential cabinet members, health care professionals, treatment experts, and scientists in the addiction field; and convening a public meeting where addiction-related nonprofits provided testimony.

In addition to asking for the national emergency declaration, other recommendations in the interim report included, but were not limited to, expanding access to residential treatment services and increasing the availability of medication assisted treatment at federally qualified health centers, drug treatment facilities, and in correctional settings. The report explicitly

recommended that the Department of Health and Human Services grant Medicaid waiver approval for all 50 states to eliminate restrictions from the federal Institutions for Mental Diseases (IMD) exclusion policy.

What Is The IMD Exclusion?

Sixty-seven years ago, an amendment to the Social Security Act precluded federal payment for services rendered to a patient residing in an IMD facility (see Exhibit 1). An IMD facility, statutorily defined in Section 1905 42 U.S.C. 1396d, has more than 16 beds and primarily provides services to individuals with mental diseases, including alcohol and drug use disorders. Because of the IMD exclusion policy, state Medicaid programs cannot use federal match dollars to pay for any beneficiary services affiliated with an IMD facility, including residential services for substance use disorders. Two recently enacted federal laws create tension with the long-standing IMD exclusion policy: the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) and the 2010 Affordable Care Act (ACA). The MHPAEA prevents health insurers from imposing inequitable benefit design for mental health and substance use disorders as compared with medical and surgical benefits. Additionally, for states participating in ACA Medicaid expansion, substance use disorder services are now one of ten essential health benefits (EHBs). EHBs are the minimum standard of coverage required for Medicaid expansion benefit plans; thus, states must include coverage policies for the treatment of substance use disorders.

Exhibit 1: IMD Exclusion Policy Historical Highlights From The 1992 Report To Congress

Show 10 entries Search:

Date	Event
1950	The Institutions of Mental Diseases (IMD) exclusion policy is created.
1965	The IMD exclusion policy is applied to the Medicaid program.
1969	The formal regulations for the IMD exclusion are published.
1972	The IMD exclusion policy is amended, and elderly people may receive care in an IMD facility. Individuals ages 21 years and younger may receive care in an IMD (inpatient psychiatric) facility.
1985	The US Supreme Court ruled unanimously that the IMD exclusion was reasonable and applied to both public and private facilities.
1987	The definition of an IMD facility as having more than 16 beds was a part of OBRA 87 adding section 1905(i) to the act.

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Sources: 1992 Report to Congress; US Supreme Court, State of Connecticut Department of Income Maintenance v. Heckler, 471 U.S. 524

Data from the 2015 National Survey of Substance Abuse Treatment Services (NSSATS) published in March 2017, depicts a substance use disorder treatment system that is at capacity —in the census of publicly funded substance use treatment facilities, 105 percent of residential

(non-hospital) beds and 109 percent of hospital inpatient beds designated for substance use disorder treatment were occupied (numbers above 100 percent mean non-designated beds were also occupied). Moreover, Saloner and Le Cook observed disparities in access to publically funded treatment services, including residential services, among black and Hispanic people as compared with white people and advocated for increased Medicaid coverage for residential substance use disorder treatment services. The IMD exclusion policy, however, stands in the way. In addition to the evidence of capacity and disparity issues, the ongoing opioid use disorder epidemic has inspired action by government officials and policy makers to address the IMD exclusion policy through changes to federal Medicaid policy and proposed legislation, specifically:

- **July 2015:** The Centers for Medicare and Medicaid Services (CMS) encouraged Medicaid agencies to apply for a Section 1115 waiver opportunity, allowing states to apply for authority to use federal funds to pay for substance use disorder treatment in an IMD facility;
- **May 2016:** CMS changed the managed care rules to allow Medicaid managed care organizations to pay for substance use disorder treatment in an IMD facility under certain conditions;
- **March 2017**: The new secretary of Health and Human Services, Tom Price, in a letter sent to governors, indicated that CMS will continue to support the Section 1115 waiver applications and changes to the managed care rules related to the substance use disorder treatment in IMDs; and
- **May 2017:** Congressional lawmakers proposed legislation in the US Senate and US House of Representatives to allow Medicaid beneficiaries to receive up to 60 days of residential services in an IMD facility, extending the IMD number of beds to 40 or more, and allowing federal financial participation for services rendered inside or outside of an IMD facility.

Taking A Closer Look At Recent Policy Changes

Section 1115 Waiver

In July 2015, CMS announced and provided guidance on a new Section 1115 waiver application opportunity for Medicaid agencies to redesign state substance use disorder treatment delivery systems to specifically address the opioid use disorder epidemic. CMS expects the wavier proposal to reform statewide systems of care to develop a care continuum to “effectively treat the physical, behavioral and mental dimensions of substance use disorders.” State Medicaid agencies are required to have “comprehensive evidence-based benefit design” including access to residential services. CMS defines the residential service requirements using the American Society of Addiction Medicine (ASAM) Criteria definitions as:

- ASAM Level 4.0: short-term institutional services, a maximum length-of-stay of 15 days;
- ASAM Level 3.1, 3.3, 3.5, and 3.7: short-term residential services, allowed in an IMD facility, with a maximum length-of-stay of 30 days.

A search of the 41 currently approved Section 1115 waivers (as of May 31, 2017), using the keyword “IMD” and “institution for mental disease,” found four state waivers—California, Maryland, Massachusetts, and Virginia—with approval from CMS to allow Medicaid beneficiaries to retain coverage while receiving addiction treatment services in an IMD facility. This policy scan did not include states in active negotiation with CMS, pending waivers, or other waiver

mechanisms (for example, 1915(c)). Exhibit 2 shows further analysis.

Exhibit 2: Section 1115 Approved Waivers

Show 10 entries Search:

State	Waiver name	Effective date	Maximum length-of-stay (days)	Policy details
California	Medi-Cal 2020	1/1/2017	90	• Adult residential services may be authorized for a maximum of 90 continuous days. • Reimbursement is limited to two noncontinuous stays for adults in a 365-day period. • One extension of up to 30 days beyond the maximum length-of-stay of 90 days may be authorized for one continuous length of stay in a 365-day period.
Maryland	HealthChoice	1/1/2017	30	• Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for a substance use disorder and withdrawal management during up to two nonconsecutive stays of 30 days or less annually in IMD facilities.
Massachusetts	MassHealth	11/4/2016	90	• Fee-for-service MassHealth members will receive up to the first 90 days of a medically necessary stay in residential rehabilitation services. • MassHealth members who are enrolled in a managed care organization, accountable care organization, or the primary

				care clinician plan, will receive all medically necessary residential rehabilitation services from a managed care organization or the behavioral health carve-out vendor.
Virginia	The Virginia Governor's Access Plan and Addiction and Recovery Treatment Services Delivery System Transformation	12/15/2016	30	• Expenditures not otherwise eligible for federal financial participation may be claimed for covered services, including services for short-term residents in facilities that meet the definition of an IMD facility for the treatment of substance use disorder and withdrawal management. • Flexibility for extension of stay.

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Sources: California, Maryland, Massachusetts, Virginia

Managed Care Rules

In May 2016, CMS updated the IMD managed care rules. The final rules state that Medicaid enrollees in managed care ages 21–64 receiving care in an IMD facility qualify for a full monthly capitation payment, matched by the federal government, in accordance with the following stipulations:

- The enrollee elects IMD services as an alternative to an otherwise covered settings;
- The IMD is a hospital providing psychiatric care or inpatient care for substance use disorders or a subacute facility providing psychiatric or substance use crisis residential services; and
- The stay in the IMD facility is for no more than 15 days in a calendar month; however, a beneficiary can stay for a total of 30 days as long as it occurs over two calendar months.

Proposed Federal Legislation

On May 17, 2017, seven bipartisan US senators co-sponsored a bill titled, Medicaid Coverage for Addiction Recovery Expansion Act (S.1169). This bill proposes an amendment to the IMD exclusion policy:

- Allowing Medicaid beneficiaries to receive care for up to 60 consecutive days of service in an IMD facility;
- Designating that the IMD residential treatment facility have no more than 40 beds; and

- Allowing federal financial participation for services provided in or outside of the IMD during the patient's stay.

As of August 5, 2017, the Senate bill was with the Committee on Finance. On May 25, 2017, a similar bill, titled Medicaid Coverage for Addiction Recovery Expansion Act (H.R.2687), was introduced in the US House of Representatives, and as of August 5, 2017, the bill was with the Subcommittee on Health.

Moving Forward

The opioid epidemic has resurrected policy maker interest in addressing the IMD exclusion policy. For example, CMS leaders created opportunities and updated policies for Medicaid agencies to expand residential treatment services to include IMD facilities. Members of Congress, moreover, have proposed legislation to amend the IMD exclusion policy. However, simply expanding access to residential treatment services by diminishing the impact of the IMD exclusion policy will not solve the opioid epidemic and the care delivery deficit for individuals with opioid use disorder. CMS leaders emphasize in the Section 1115 waiver opportunity the importance of a whole system redesign that includes residential services as a part of the continuum of care as necessary for providing effective treatment for people with substance use disorders.

Individuals with substance use disorders, like other medical conditions, experience a range in disorder severity (mild, moderate, severe), which necessitates matching disorder severity with appropriate treatment intensity. To achieve this, treatment systems and treatment planners must enhance access to both residential and outpatient treatment services, provide linkages to evidence-based medications, and address substance use disorders as chronic conditions requiring long-term support and treatment in primary care settings.

Authors' Notes

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