NAMD
National Association of Medicaid Directors

To: Congressional staff
From: NAMD staff
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Subject: Medicaid IMD Exclusion – Background and Available Pathways for States

Last month, the Center for Medicare and Medicaid Innovation (CMMI) notified states that it would not extend the Medicaid Emergency Psychiatric Demonstration (MEPD) because it could not establish the budget neutrality of continuing the effort. This decision effectively removed one pathway for states to provide access to specialized inpatient behavioral health services and mitigate the barrier that the Medicaid institutions for mental disease (IMD) exclusion creates to the continuum of appropriate services.

This memorandum provides background information for interested congressional staff on the IMD exclusion in light of this development. Specifically, it provides context on the IMD exclusion; the pathways for states to mitigate the IMD exclusion and the limitations of each; and the questions and issues that CMMI's decision on the MEPD raises from the state perspective.

IMD Exclusion: Background and Context

Federal law prohibits the use of federal Medicaid funds to cover services for adults in an institution for mental disease (IMD). IMDs are hospitals, nursing facilities or other institutions of more than 16 beds that are primarily providing care of persons with mental diseases (Section 1905(a)(29) of the Social Security Act).

States have long identified the IMD payment exclusion as a policy barrier that has impeded access to medically necessary inpatient services for vulnerable populations with mental health and substance use disorders. It also prevents Medicaid programs from achieving parity in coverage for behavioral health services. While Medicaid beneficiaries can receive physical health services in a wide range of inpatient facilities, Medicaid cannot pay for specialized inpatient behavioral health services for individuals with behavioral health conditions, even when such services may be most appropriate to meet the client's needs. The payment exclusion also unnecessarily complicates the care experience for such individuals.

Existing Pathways to Address the IMD Exclusion

While states continue to call for a comprehensive federal solution to the IMD payment exclusion, there are some narrow pathways states have had available to mitigate this barrier to

mental health and substance use disorder services. Each of these pathways and its limitations are discussed below.

"In-Lieu of" Pathway. Under its recently released managed care regulations, CMS clarifies the federal policy for states using capitated managed care to cover short-term IMD stays. These states may permit (but not require) managed care organizations (MCOs) to cover up to 15 days per month in an IMD in lieu of providing such services in a costlier inpatient hospital setting.

Limitations. This policy, while offering more clarity for some states that have not previously used the "in lieu of" pathway, creates a number of operational challenges for states, and it may inappropriately limit medically necessary care that exceeds the 15-day limit. Equally problematic, this pathway does not create a way for the many states that deliver mental health and/or substance use disorder services in a fee-for-service delivery system to cover cost effective IMD services.[1]

Section 1115 Waivers on Substance Use Disorder Services. While states operate their Medicaid programs within broad federal rules, CMS may grant states a waiver of federal rules to try experimental, pilot or demonstration projects in the program. In 2015, CMS announced its willingness to consider Section 1115 waivers that permit Medicaid programs to cover substance use disorder services delivered in an IMD. CMS outlined the criteria the state would have to meet in order for CMS to consider such a waiver. Only one state (California) has received approval for such a waiver to date; as of the issuance of this memo, the state is in the process of implementing the approved program.

Limitations. Through this pathway, CMS is only permitting states to use a waiver to cover IMD services for those with substance use disorders. It does not provide a pathway for the provision of specialized inpatient mental health services.

Medicaid Emergency Psychiatric Demonstration. The Medicaid Emergency Psychiatric Demonstration (MEPD) was authorized by the Affordable Care Act to test over a 3-year period if providing mental health services in IMDs would support higher quality of care

[1] In 2014, 12 states did not contract with MCOs (see Medicaid Moving Forward). These states will not be able to leverage the "in lieu of" pathway. Likewise, many other states carve out behavioral health services from their MCO contracts and deliver them through a separate fee-for-service delivery system. These states will also be prevented from using the "in lieu of" pathway.

and value. Ten states[2] (Alabama, California, Connecticut, Illinois, Maine, Maryland Missouri, North Carolina, Rhode Island and West Virginia) and the District of Columbia participated in the demonstration. In November 2015, Congress passed legislation to extend MEPD for 1-year, with the extension contingent on CMS determining that a state's ongoing participation in it is budget neutral. Last month, CMMI notified states that it could not determine such budget neutrality, and thus, the demonstration would not go forward.

Limitations. Despite the states' expressed interest in continuing the program, CMS' decision to *not* extend the demonstration removes a potential pathway for the original demonstration states to address access to specialized inpatient mental health services. This is particularly problematic for states that do not use a managed care delivery system and may not leverage the "in lieu of" pathway.

As a result of these limitations, many state Medicaid programs are not able to leverage existing pathways to provide access to specialized inpatient mental health services. Thus, while it may not be feasible to advance a comprehensive solution to the IMD exclusion, there may be opportunities for federal policymakers to expand existing pathways to mitigate the IMD exclusion.

CMS's MEPD Decision: Outstanding Issues and Considerations

As mentioned above, for many months states have been actively engaged in conversations – with CMS, elected officials, and stakeholders – about how to continue their work under the MEPD. Therefore, CMS's determination on the MEPD raised a number of questions for state Medicaid programs about how the agency reached this determination. These questions primarily address CMS's process for reaching this determination. They include:

- What guidance did CMS (OACT, CMCS and CMMI) provide to states on its data collection effort to inform the budget neutrality calculation? Did this guidance outline what criteria states should incorporate in its own cost analysis?

- What engagement did CMS have with states to understand the respective analyses that some states submitted? (i.e., individual calls with states, issue follow-up questions, or other means of understanding the analyses)

- Has CMS made available its own cost analysis and methodology to determine that costs went up under the demonstration? Did CMS conduct a separate cost change analysis for

[2] Note: initially 11 states participated in the demonstration, but Washington State withdrew, instead using the "in lieu of" pathway to address the provision of inpatient psychiatric care.

each state or use a uniform approach?

- How does CMS's decision on the MEPD impact CMS's policy on IMD services? For example, will CMS consider 1115 waivers that permit states to deliver mental health and substance use disorders services in IMDs?