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Repealing Medicaid Exclusion for Institutional Care Risks Worsening Services for People With Substance Use Disorders

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Opioid use caused over 42,000 deaths in 2016, and drug overdose deaths rose by statistically significant amounts in 27 states that year, according to the Centers for Disease Control and Prevention.¹ The opioid crisis has led to increased calls for repealing Medicaid's Institutions for Mental Disease (IMD) exclusion, which prohibits federal Medicaid funds from paying for substance use disorder (SUD) treatment provided by treatment facilities with more than 16 beds to patients ages 21 through 64.² But proposals to repeal or partially repeal the IMD exclusion for SUD treatment, such as a draft proposal now before the House Energy and Commerce Committee, risk doing more harm than good.³

Guidance issued by the Obama and Trump Administrations provides an alternative approach to relaxing the IMD exclusion for SUD treatment that makes repeal unnecessary and likely counterproductive. The guidance allows states to obtain limited waivers from the exclusion, provided that they also take steps to ensure that people with SUDs have access to other care they need, including preventive, treatment, and recovery services, all provided in accordance with evidence-based standards. Ten states have SUD waivers, and 11 others have proposals pending; the Trump Administration has encouraged other states to apply.

Repealing the exclusion would eliminate the incentive for states to implement current waivers or propose new ones, likely leading to overreliance on residential treatment and underinvestment in other services and in community-based alternatives that are often more appropriate and cost effective.

¹ Centers for Disease Control and Prevention, "Drug Overdose Death Data: 2015-2016 Death Increases," <https://www.cdc.gov/drugoverdose/data/statedeaths.html>.

² MaryBeth Musumeci, "Key Questions about Medicaid Payment for Services in "Institutions for Mental Disease," Kaiser Family Foundation, April 12, 2018.

³ "Discussion Draft: A bill to amend title XIX of the Social Security Act to allow states to provide under Medicaid services certain individuals with substance use disorders in institutions for mental diseases," April 5, 2018, <http://docs.house.gov/meetings/IF/IF14/20180411/108092/BILLS-115pih-ProvideIMDServicesUpto90DaysforMedicaidBeneficiarieswithSUD.pdf>.

Repeal of the IMD exclusion — even partial repeal as under the draft proposal — would also be costly, requiring harmful offsets or crowding out other badly needed investments in SUD treatment. Instead of IMD repeal, policymakers should consider measures to help more states take advantage of existing waiver flexibilities and expand access to a full range of SUD services, including community-based care.

Targeted SUD Waivers Preferable to IMD Repeal

The IMD exclusion has been part of Medicaid since the program's creation in 1965.⁴ Congress excluded IMDs from federal Medicaid payments largely to ensure that states continued paying for inpatient behavioral health services, rather than shifting these costs to the federal government.⁵ The exclusion applies to hospitals, nursing facilities, or other institutions of more than 16 beds that primarily diagnose, treat, or care for persons with “mental disorders.”⁶ Residential SUD treatment facilities that otherwise meet the IMD definition are considered IMDs, because SUDs are included in the definition of mental disorders.⁷

In 1993, the federal Centers for Medicare & Medicaid Services (CMS) began approving state demonstrations that provide limited waivers of the exclusion.⁸ In 2015, the Obama Administration announced a new opportunity for waivers of the exclusion as part of state proposals to provide the full continuum of services needed to address SUDs.⁹ The Trump Administration reaffirmed its support for these “SUD waivers” in 2017.¹⁰

SUD waivers ensure that Medicaid beneficiaries with SUDs have access to an array of community-based and residential SUD services. To secure an SUD waiver:

- States must meet specific goals and milestones. Among other things, they must use evidence-based patient placement criteria to ensure that individuals who are best served in the community are not unnecessarily placed in residential facilities, and must establish evidence-

⁴ The original definition included a state option to pay for IMD care for individuals over age 64; in 1972, Congress added a state option to pay for IMD care for individuals under age 21.

⁵ GAO-17-652, fn. 2.

⁶ Section 1905(a)(B) of the Social Security Act.

⁷ Centers for Medicare & Medicaid Services, “State Medicaid Manual,” accessed March 16, 2018, <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

⁸ Government Accountability Office, “States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies,” August 9, 2017, <https://www.gao.gov/products/GAO-17-652>.

⁹ Centers for Medicare & Medicaid Services, “New Service Delivery Opportunities for Individuals with a Substance Use Disorder,” July 27, 2015, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>.

¹⁰ Centers for Medicare & Medicaid Services, “Strategies to Address the Opioid Epidemic,” November 1, 2017, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. States can also draw down federal funding for SUD services provided in IMDs in two other ways. Medicaid managed care organizations can provide IMD care “in lieu of” covered services or settings if they are medically appropriate and budget-neutral. Of the 39 states that operate managed care programs, 26 report that they provide or plan to provide IMD services through this pathway. States can also make limited Disproportionate Share Hospital payments to IMDs. 42 CFR 438.6(e); Government Accountability Office, “States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies.”

based qualifications for residential treatment providers. They also must ensure sufficient capacity at each level of care.

- States must “indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state.” CMS notes, “this initiative should not reduce or divert state spending on mental health and addiction treatment services as a result of available federal funding.”
- States must closely monitor the outcomes of the waivers and conduct rigorous evaluations, which will be publicly reported.

The first waiver approved by the Trump Administration, for West Virginia, is typical in that it expands access to a broad set of services in addition to residential treatment. The waiver expands coverage for medication-assisted treatment (which combines medication with therapy) and adds coverage for peer recovery support services.¹¹ The continuum of care provided under the waiver is consistent with the American Society of Addiction Medicine Criteria, the nationally accepted treatment criteria for SUDs.

SUD waivers give states an incentive to improve and expand community-based SUD services for Medicaid beneficiaries, because doing so allows them to receive federal payment for inpatient care. This feature of the waivers is critical for two reasons. First, community-based services are a more appropriate and cost-effective approach to treatment for some people with SUDs. Second, regardless of whether they begin their treatment in residential or community-based treatment, people with SUDs need access to a full array of community-based treatment options tailored to their individual needs, which will change as they progress in their recovery.¹² For example, they often need ongoing community-based services such as case management, medication-assisted treatment, and peer support services to maintain their recovery, prevent relapse, and quickly return to treatment if relapses occur. Expanding access to residential treatment *without* providing access to community-based services could undermine efforts to ensure the availability of SUD treatment that meets patients’ needs.

Moreover, the evaluations required as part of SUD waivers will inform future policymaking by improving understanding of what works, including the appropriate role of residential treatment in the continuum of care.

As of April 2018, ten states have obtained SUD waivers, and 11 states have waivers pending.¹³ Health and Human Services Secretary Alex Azar recently encouraged more states to apply, urging

¹¹ The waiver defines peer recovery support as services “designed and delivered by individuals in recovery from substance use disorder (peer recovery coach) to provide counseling support to help prevent relapse and promote recovery.”

¹² “What Are the ASAM Levels of Care?,” Continuum, May 13, 2015, <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>.

¹³ The ten states with waivers are California, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah, Virginia, and West Virginia. The 11 states with pending waivers are Alaska, Arizona, Illinois, Kansas, Michigan, North Carolina, New Mexico, Pennsylvania, Vermont, Washington, and Wisconsin.

them to submit SUD waivers separately from other waiver proposals so that CMS can approve them expeditiously. “[W]e can handle those [discrete SUD waivers] quite quickly,” he told governors.¹⁴

IMD Repeal Would Be Expensive

While Congressional Budget Office estimates are not yet available, even the limited repeal of the IMD exclusion in the House Energy and Commerce draft would likely be expensive. The cost of inpatient care typically ranges from \$6,000 for a 30-day program to \$60,000 for 90-day programs, while community-based outpatient services cost around \$5,000 for three months of services.¹⁵

That means that any repeal of the IMD would require significant offsets. This could threaten other important Medicaid policies. (And, because the House Energy and Commerce draft proposes only a five-year repeal, Congress might look for additional Medicaid offsets to pay for extending the repeal in a few years.) Alternatively, the need for offsets could crowd out other federal investments badly needed to address the opioid crisis, such as funding to help SUD providers meet the requirements to participate in Medicaid and funding for community-based treatments and supports.¹⁶

Energy and Commerce Proposal Could Impede Needed Investments in Community-Based Care

The draft proposal before the House Energy and Commerce Committee includes a five-year repeal of the IMD exclusion as it applies to treatment for SUDs.¹⁷ States would have the option to receive federal funds for SUD treatment in an IMD for stays up to 90 days. To receive federal funds, they would have to keep their non-Medicaid spending for care in IMDs and for “active psychiatric care and treatment provided on an outpatient basis” at current levels. States would also have to maintain at least the same number of IMD beds.¹⁸

The maintenance of effort (MOE) provision is likely intended to prevent states from using additional federal funding to simply replace state funding for SUD treatment, without increasing the total resources dedicated to helping people with SUDs. But it could also create incentives for states to over-invest in institutional care relative to other services. While the funding requirements of the MOE are ambiguous, they at minimum require states to maintain their current number of IMD beds, irrespective of need. For example, if the number of people in recovery rose and the number

¹⁴ Paige Winfield Cunningham, “The Health 202: HHS chief pushes Trump opioid commission’s top recommendation,” *Washington Post*, March 2, 2018, <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/03/02/the-health-202-hhs-chief-pushes-trump-opioid-commission-s-top-recommendation/>.

¹⁵ Addiction Center, “Cost of Drug and Alcohol Rehab,” <https://www.addictioncenter.com/rehab-questions/cost-of-drug-and-alcohol-treatment/>.

¹⁶ Peggy Bailey, “Better Integration of Medicaid and Federal Grant Funding Would Improve Outcomes for People with Substance Use Disorders,” Center on Budget and Policy Priorities, April 9, 2018, <https://www.cbpp.org/research/health/better-integration-of-medicare-and-federal-grant-funding-would-improve-outcomes-for->

¹⁷ “Discussion Draft.”

¹⁸ The bill would require a state that adopts this option to at least maintain the number of IMD beds and the level of state spending on IMD services as of the date of enactment or the date the state adopts this option, whichever is higher.

needing inpatient care fell over time, the provision could discourage a state from shifting resources away from IMDs and toward community-based care.

Requiring a set number of inpatient beds not tied to need, and the associated incentive for states to over-invest in institutional care, could also have implications for states' community integration obligations under the Supreme Court's *Olmstead* decision if states inappropriately shift people with disabilities into institutions to obtain federal payment for IMD services.¹⁹

Other Measures Can Help Ensure Access to Full Continuum of SUD Services

If policymakers want to encourage more states to take advantage of IMD waivers, they could consider two options.

- To help states achieve the improvements in community-based services that the SUD waivers require, Congress could establish a grant program or direct existing grant funding to allow states with SUD waivers to increase provider capacity. Community-based SUD providers have primarily relied on grant funding and private donations to pay for their services, because few people with SUDs were eligible for Medicaid before the Affordable Care Act's Medicaid expansion. As a result, many providers don't meet the requirements to participate in Medicaid, such as complying with standards for electronic medical records, reviewing utilization of their services, and monitoring and reporting on quality — activities that benefit patients but aren't usually required in grant-funded programs.²⁰
- Congress could direct CMS to create a template SUD waiver that clarifies requirements for the waivers and makes it easier for states to submit readily approvable waivers that allow federal reimbursement for IMDs *and* guarantee access to community-based treatment.

¹⁹ In *Olmstead*, the Supreme Court found that the unjustified institutionalization of people with disabilities violates the Americans with Disabilities Act (ADA). Although the ADA's anti-discrimination provisions do not apply to individuals currently using illegal drugs, the ADA does protect people who previously used illegal drugs and people with mental health-related disabilities. See MaryBeth Musumeci, "Key Themes in Medicaid Section 1115 Behavioral Health Waivers," Kaiser Family Foundation, November 2017, <http://files.kff.org/attachment/Issue-Brief-Key-Themes-in-Medicaid-Section-1115-Behavioral-Health-Waivers>, and MaryBeth Musumeci, "Olmstead's Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's Olmstead Decision," Kaiser Family Foundation, June 2014, <https://www.kff.org/medicaid/issue-brief/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-15-years-after-the-supreme-courts-olmstead-decision/>.

²⁰ Ellen Bouchery, Rebecca Morris, and Jasmine Little, "Examining Substance Use Disorder Treatment Demand and Provider Capacity in a Changing Health Care System: Initial Findings Report," U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, September 2015, pp. 52-53, <https://aspe.hhs.gov/system/files/pdf/203761/ExamSUD.pdf>.