National Association for Behavioral Healthcare

Access. Care. Recovery.

Response to Center on Budget and Policy Priorities (CBPP) Paper on the IMD Exclusion

Hospital and residential treatment for substance use disorders (SUD) should not be a privilege limited to the wealthy or those who are fortunate to have commercial insurance. The sad reality is low-income Americans with SUDs face significant difficulties accessing hospital or residential care if they are on Medicaid. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), lack of "residential SUD treatment" is one of the "largest gaps in coverage" for Medicaid beneficiaries with SUDs.

States in recent years have recognized SUDs as medical conditions and made important advances in covering all three medications— buprenorphine, naltrexone and methadone— that the Food and Drug Administration (FDA) has approved for the treatment of opioid use disorders (OUD). Every state covers buprenorphine in its Medicaid program; 49 states cover naltrexone; and 38 states cover methadone. But only 17 states cover the American Society of Addiction Medicine's (ASAM)[1] levels of residential care for SUDs. As a result, less than half of SUD residential treatment providers in the United States accept Medicaid. This is constricting 50% of residential treatment capacity for individuals with severe SUDs at a time when 67,000 people die each year from drug overdoses.

Many people are quick to blame states for not covering all FDA-approved medications for OUDs, and that is a fair criticism because those are state-level decisions. However, states are not to blame for the lack of residential treatment coverage. The federal government has prohibited this since 1965 through the Institutions for Mental Diseases (IMD) exclusion, which prevents adult Medicaid beneficiaries (ages 21-64) from accessing residential or hospital care for mental health or SUDs. The discriminatory IMD policy was written at a time when SUDs were not considered as medical conditions on the same level as other physical health conditions. This was an early instance of a lack in behavioral health parity. Today we know that SUDs are brain diseases and that their treatment requires access to the full continuum of care—namely, inpatient care, partial hospitalization, residential treatment and outpatient services.

As MACPAC states, "an effective Medicaid response to the opioid epidemic requires payment for the full continuum of care." This would allow individuals to enter SUD treatment at their clinically appropriate level of care and adjust to other levels of care as needed. However, the IMD exclusion excludes one half of the treatment continuum that ASAM identifies. The states need relief from the IMD exclusion and the Energy and Commerce Committee's legislative language provides that relief for SUD treatment.

Some advocates have expressed concern that providing states with much-needed relief from the IMD exclusion will draw attention and funding away from community-based treatment, services and supports. But, this is not an "either/or" scenario. As the ASAM criteria suggest, there is an ongoing need for the full spectrum of services. Moreover, the nation's federally declared opioid public health emergency requires investments across this continuum of care. Pitting different parts of the system against each other and perceiving different services as interchangeable parts mischaracterizes the clinical needs of individuals and the behavioral healthcare continuum. It also hurts the people who need help.

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[1] *The ASAM guide is a widely accepted resource to evidence-based levels of treatment for individuals with SUDs that account for the full continuum of necessary care, including residential settings.*

Different types of patients require different clinical services from the care continuum. For example, ASAM recommends some patients need to start treatment at the residential level. Specifically, ASAM identifies adolescents, pregnant women, individuals with unstable housing, persons with high relapse potential and individuals who have OUDs or other substance use disorders with co-occurring alcohol or benzodiazepines addictions as the patient populations that typically need residential or hospital level of care. Therefore, investing only in outpatient care and not providing states relief from the IMD exclusion would continue to block these patients from the most clinically appropriate care that they need.

Recent reports have asserted that the existing 1115 SUD waiver option provides sufficient relief from the IMD and that repeal is not necessary. But while SUD waivers are helpful, they are far from perfect. Too often advocates against repealing the IMD fail to consider the following important points:

- According to MACPAC, "section 1115 waivers are not a viable option for all states."
- It can take years for the Centers for Medicare & Medicaid Services (CMS) to approve 1115 waivers. And it may require additional time for new state laws to enact the waiver, and longer still for a new state regulatory structure to implement the waiver.
- 1115 waivers can be terminated, and future administrations can take away or refuse to extend waivers.
- Waivers do not address the underlying statutory discrimination of the IMD, which blocks access to critical levels of care for certain patient populations. Waivers are not a solution to a bad law.

Recently, the Center on Budget and Policy Priorities (CBPP) published a paper titled *Repealing Medicaid Exclusion for Institutional Care Risks Worsening Services for People with Substance Use Disorders*, which makes several arguments against providing states relief from the IMD. This paper included numerous misleading statements and opinions masquerading as research. The authors make many assertions, but they do not support those assertions with facts. And, not all members of the behavioral healthcare community agree with the authors' opinions. Below are several quotes from this paper, followed by explanations of why the quotes are misleading or inaccurate.

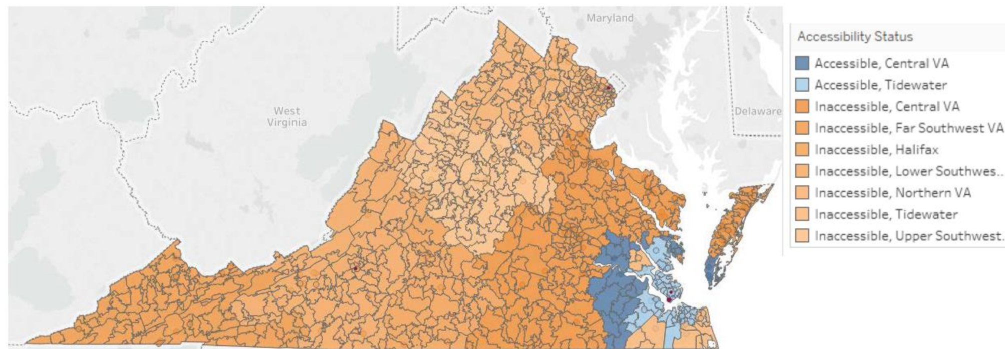
<u>**General Concerns**</u>

1. **The CBPP paper is titled: *"Repealing Medicaid exclusion for institutional care risks worsening services for people with substance use disorders."***

The title itself is misleading and is written in a way to conjure images of old state psychiatric hospitals. Most state psychiatric institutions have closed, and the remaining institutions do not provide SUD treatment. If the IMD is lifted, the majority of new SUD treatment would be provided in residential care settings. The minimal amount of care that would be provided in hospital settings would be limited to detoxification, which lasts a few days. "Institutional" care for SUDs simply does not exist, and repealing the IMD would not create this type of care. Instead, if Congress repeals the IMD, states would start to reimburse providers for residential care, and those providers who have excess capacity but take only patients with commercial insurance would begin accepting Medicaid patients.

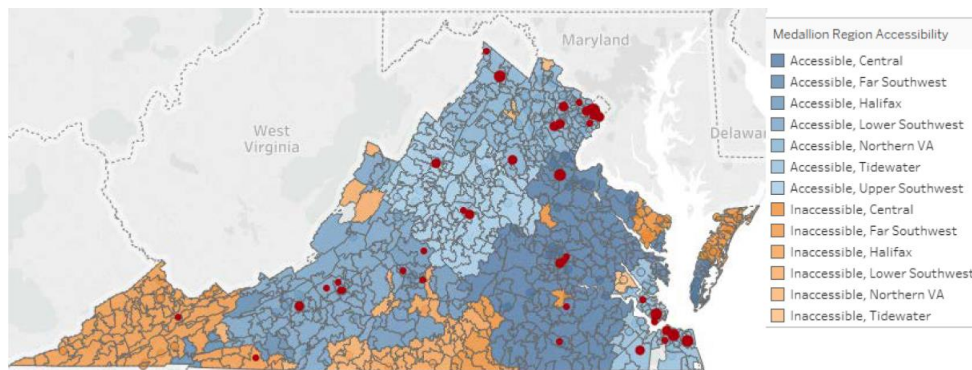
Below are images of Virginia's Medicaid SUD residential provider network before and after the Commonwealth received a waiver from the IMD exclusion. It is clear from these images that Virginia had providers with capacity to treat more patients with SUDs but did not provide that treatment to Medicaid patients because the Commonwealth could not reimburse providers for that treatment. And the reason why Virginia could not reimburse these providers for that treatment is because the IMD prohibited it.

BEFORE (March 2017):



Source: Department of Medical Assistance Services - Provider Network data (March 20, 2017).
Circles # of Medicaid providers included in network adequacy access calculation.
For a zip code to be considered accessible, there must be at least two providers within 30 miles (urban) or 60 miles (rural) driving distance.
Driving distance is calculated by Google services based on the centroid of each zip code.

AFTER (July 2017):



Source: Department of Medical Assistance Services - Provider Network data (July 15 2017).
Circles # of Medicaid providers included in network adequacy access calculation.
For a zip code to be considered accessible, there must be at least two providers within 30 miles (urban) or 60 miles (rural) driving distance.
Driving distance is calculated by Google services based on the centroid of each zip code.

<u>1115 Waivers and Reforming the IMD</u>

1. ***"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."*** **(CBPP paper, page 1)**

As noted earlier, the 1115 waivers might be a good approach for many states to expand treatment. However, MACPAC has noted rightly that "section 1115 waivers are not a viable option for all states." (April 19, 2018 MACPAC presentation "Access to Substance Use Disorder Treatment in Medicaid"). Additionally, it can take years for CMS to approve 1115 waivers. And it takes time for states to make changes to laws and implement them. Finally, future administrations can overturn waivers.

2. ***"CMS can approve them [1115 waivers] expeditiously."* (CBPP paper, page 4)**

According to MACPAC, "… while the approval process is more flexible for 1115 waivers than state plan amendments—there is no 90-day clock—the negotiation process can take several months or years." Also, there is wide variation in how state legislatures manage the waiver process.

Community-Based Care and Residential Treatment

1. ***"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."*** **(CBPP paper, page 1)**

Some policymakers are concerned that repealing the IMD would disincentivize the use of current waivers; overuse residential treatment; and siphon financing from other community-based levels of care. However, this has not happened. According to a March 2018 report from the Kaiser Family Foundation, 40% of the states with approved 1115 waivers for SUD services did not include a request for relief from the IMD. In addition, in three of the eight pending waivers, states also seek to expand community-based benefits without changes to the IMD. Therefore, concluding that repealing the IMD exclusion will put a freeze on 1115 SUD waivers or stop state efforts to expand their community-based services is inconsistent with what is happening in the field.

Moreover, several states are now using the "in lieu of" exception in the most recent managed care rule* to provide treatment in IMDs. There is no evidence that these states have trimmed community-based services to finance residential treatment or that it disincentivizes states to apply for 1115 waivers.

**In April 2016 CMS finalized an update to the Medicaid managed care regulation, which included a clarification that allow Medicaid reimbursement IMDs for treating patients for up to 15 days per month under the in lieu of" exception.*

2. ***"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." (*****CBPP paper, page 2)**

When Medicaid was created in in 1965 as a joint state-federal program, the goal was to provide health insurance to low-income Americans and persons with disabilities. That health insurance covers inpatient medical treatment for every healthcare condition except for SUD and mental health treatment. SUD was excluded at the time because this condition was not considered a medical condition in the same way other physical health conditions were. A half century later, we know—and scientific data are unequivocal on this point—that addiction is a disease and requires treatment. To uphold the IMD would be to uphold the idea that SUDs are not medical conditions. That idea is wrong; inconsistent with the overwhelming scientific evidence; antithetical to behavioral health parity; and perpetuates the stigma against individuals with SUDs.

3. ***"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." (*****CBPP paper, page 3)**

This quote suggests that:

- States only apply for 1115 waivers to work around the IMD exclusion; therefore, if you repeal the IMD exclusion, there will be no need for states to apply for 1115 waivers.

- States should not receive relief from the IMD exclusion unless they agree to expand community-based services.

As noted earlier, this is inconsistent with the fact that several states have applied for 1115 SUD waivers for reasons unrelated to the IMD exclusion. Furthermore, the idea of providing states relief from the IMD only if they expand community-based services, is ridiculous and misguided. Different levels of care are not

clinically interchangeable. And when patients cannot access the appropriate level of care, they will be less likely to recover. This is why the federal government should not dictate specific types of healthcare levels and procedures. Consider that in the general healthcare setting, the federal government would never deny coverage for open-heart surgery if a state Medicaid program chose not to cover cardiac catheterization. We would expect policymakers to apply the same logic when they create behavioral healthcare policy.

4. ***"First, community-based services are a more appropriate and cost-effective approach to treatment for some people with SUDs." (*****CBPP paper, page 3)**

The paper includes no analysis or comprehensive data to support this assertion, which makes this assertion nothing more than conjecture. This argument that community-based services are more appropriate and cost-effective is a common misconception because it is true for *some* patients, but it is not true for *all* patients. And, the opposite is true for some patients: residential or inpatient services are often a more appropriate and cost-effective approach to treatment. ASAM makes clear there are certain patient populations that require residential or inpatient treatment: adolescents, pregnant women, individuals with unstable housing, persons with high relapse potential, and individuals who have opioid use disorders or other substance use disorders with co-occurring alcohol or benzodiazepines addictions.

If patients do not receive the level of care they need, they will likely drop out of community-based services, relapse, overdose, or even die. All of this can be avoided by allowing patients to access the medically correct level of care that their clinicians determine. Patients who are not clinically appropriate for community-based services and forced into these settings are likely to drop out and cycle through the healthcare system. There is little room for error in this opioid epidemic. Simply put: bad policies can result in death. A better approach would be to send patients to settings where they can receive the appropriate level of care, which includes a variety of settings.

5. ***"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."*** **(CBPP paper, page 3)**

Patients do need access to "a full array" of SUD treatment services. That includes, according to ASAM, residential- and hospital-based treatment. As MACPAC states:

- "…an effective Medicaid response to the opioid epidemic requires payment for the full continuum of care."
- "…ensuring access to treatment across [the] continuum allows individuals to enter SUD treatment at clinically appropriate level of care and step up or down as needed."

To claim that patients need access only to a full array of community-based services and supports to reach recovery is inconsistent with the scientific understanding of SUD treatment.

6. ***"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."*** **(CBPP paper, page 3)**

Expanding residential treatment will not hurt *community-based* care. We know this because states with 1115 waivers for the IMD and states using their authority under the managed care rule* to provide inpatient treatment have not cut their community-based services. See response #1 in this section for more details on this.

**In April 2016 CMS finalized an update to the Medicaid managed care regulation, which included a clarification that allow Medicaid reimbursement IMDs for treating patients for up to 15 days per month under the in lieu of" exception.*

Cost Concerns

1. ***"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."*** **(CBPP paper, page 2)**

The CBPP paper states that full or partial IMD repeal will require expensive offsets and crowd out other services and investments. However, the Energy and Commerce Committee's proposal is capped at 90 days, limited to five years, and covers only SUDs. This inherently limits the cost of the provision. Additional costs will be offset by significant reductions in emergency room visits that nearly doubled between 2005 and 2014 due to opioid admissions. For example, when Virginia received partial relief from the IMD exclusion under an 1115 waiver, it saw significant declines in emergency department visits for all SUDs:

- All Substance Use Disorder related ED visits declined by 31%;
- Opioid Use Disorder related ED visits decreased by 39%;
- Alcohol Use Disorder related ED visits were down 36%.

Furthermore, there is no evidence that repealing the IMD will force out any other services. As mentioned previously, several states have used the managed care rule to provide behavioral health treatment in IMD settings, and there is no evidence to indicate that these new services have pushed out existing services or inhibited creating new services.

2. ***"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."*** **(CBPP paper, page 4)**

A recent report indicated that inpatient costs compare poorly with outpatient costs. However, many studies have demonstrated over time and across patient populations that there is a large return on investment when individuals with severe SUDs receive the right type of treatment for the right amount of time. Without appropriate treatment, these individuals become high users of emergency department care, emergency medical services, and other social services that often increase Medicaid, Medicare, and other federally funded services.

While the CBPP paper acknowledges this broader truth, it fails to integrate longer-term cost savings into cost-of-care data. These authors chose the higher-end number from the documents that provided the data. The primary source reads: "Some inpatient rehabs…the total average of costs could range anywhere from $12,000 to $60,000." This also misrepresents the cost of treatment because it does not include reductions in other services that we know will occur when inpatient and residential treatment is provided.

For example, when Virginia received partial relief from the IMD exclusion under an 1115 waiver, the Commonwealth saw declines in emergency department visits for all SUDs: 31% declined in all SUD related ED visits, 39% for OUD related ED visits, and 36% for Alcohol Use Disorder related emergency department visits.