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Medicaid's Institutions for Mental Disease (IMD) Exclusion

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, for a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.

Medicaid's IMD exclusion limits the circumstances under which federal Medicaid funding to states is available for inpatient mental health care. Policymakers have concerns about access to mental health care, and, in recent years, federal guidance and the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) have amended the IMD exclusion.

What Is the IMD Exclusion?

The IMD exclusion is a long-standing policy under Medicaid that prohibits the federal government from providing federal Medicaid funds to states for services rendered to certain Medicaid-eligible individuals who are patients in IMDs (§1905(a)(30)(B) of the Social Security Act [SSA]). When a Medicaid-eligible individual is a patient in an IMD, he or she cannot receive Medicaid coverage for services provided inside or outside the IMD. Due to the exceptions explained in the "Legislative History" section, the IMD exclusion applies to individuals aged 21 through 64.

> "The term 'institution for mental diseases' means a 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." (SSA §1905(i).)

Determination of whether a facility is an IMD depends on whether its overall character is that of a facility established and maintained primarily to care for and treat individuals with mental diseases. Examples include a facility that is licensed or accredited as a psychiatric facility or one in which mental disease is the current reason for institutionalization for more than 50% of the patients.

For the definition of IMDs, the term *mental disease* includes diseases listed as mental disorders in the International Classification of Diseases, with a few exceptions (e.g., mental retardation). (See Centers for Medicare & Medicaid Services [CMS], *State Medicaid Manual*, Part 4, §4390.) Under this definition, substance use disorders (SUDs) are included as mental diseases. If the substance abuse treatment follows a psychiatric model and is performed by medical personnel, it is considered medical treatment of a mental disease.

Legislative History

The IMD exclusion was part of the Medicaid program as enacted in 1965 as part of the Social Security Amendments (P.L. 89-97). The exclusion was designed to assure that states rather than the federal government maintained primary responsibility for funding inpatient psychiatric services.

As originally enacted, federal Medicaid law included an exception to the IMD exclusion for individuals aged 65 and older. Therefore, since the beginning of Medicaid, states have had the option to provide Medicaid coverage of services provided to individuals aged 65 and older in IMDs. In 2018, 42 states provided this optional coverage.

Exceptions to the IMD Exclusion

1. Inpatient hospital services and nursing facility services for individuals 65 years of age or older in an IMD (SSA § 1905(a)(14))
2. Inpatient psychiatric hospital services for individuals under age 21 (SSA § 1905(a)(16))

The Social Security Amendments of 1972 (P.L. 92-603) provided an exception to the IMD exclusion for children under the age of 21, or in certain circumstances under the age of 22. (This exception is commonly referred to as the "Psych Under 21" benefit.) With this exception, states have the option to provide inpatient psychiatric hospital services to children. However, these services are mandatory for states to cover if an early and periodic screening, diagnosis, and treatment (EPSDT) screen of a child determines inpatient psychiatric services are medically necessary. As a result, all states provide Medicaid coverage of inpatient psychiatric services for individuals under the age of 21.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) created the statutory definition of an IMD, which followed the regulatory definition with one addition: the exception for facilities with 16 beds or fewer. Thus, small facilities can receive Medicaid funding, which indicates Congress supported the use of smaller facilities rather than larger institutions.

The SUPPORT Act included a number of provisions that provide additional exceptions to the IMD exclusion in certain situations. See "The SUPPORT Act" section for more detail on these provisions.

Inpatient Mental Health Services for Persons Aged 21 Through 64

Taking into consideration all the statutory exceptions, the IMD exclusion prevents the federal government from providing federal Medicaid funds to states for any service delivered to individuals aged 21 through 64 in an IMD.

However, even with the IMD exclusion, states can receive federal Medicaid funding for inpatient mental health services for individuals aged 21 through 64 outside of an IMD. States can provide Medicaid coverage for services rendered in facilities that do not meet the definition of an IMD, such as facilities with 16 or fewer beds and facilities that are not primarily engaged in providing care to individuals with mental diseases.

Medicaid DSH Payments

States also can provide Medicaid disproportionate share hospital (DSH) payments to IMDs, but these are lump-sum payments provided to the facilities rather than payments for services rendered. (See CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.) Most states focus their Medicaid DSH funding on hospitals, but some states use this funding for IMDs. In FY2018, 32 states provided Medicaid DSH payments to IMDs, and 2 of these states spent all of their Medicaid DSH funding on IMDs.

Section 1115 Waivers

States may request a Section 1115 waiver to receive federal Medicaid funds for services provided to individuals who are patients in IMDs. Between 1993 and 2009, nine states had approved Section 1115 waivers allowing the states to receive federal Medicaid funds for behavioral health services in IMDs. All except one of these waivers were phased out.

Then, in July 2015, CMS issued guidance notifying states that certain Section 1115 waivers would be approved for short-term stays in IMDs for individuals receiving SUD treatment. The CMS guidance for these waivers was amended in November 2017.

In November 2018, CMS issued guidance, as mandated by Section 12003 of the 21st Century Cures Act (P.L. 114-255), about opportunities to design innovative systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). This guidance allows states to provide Medicaid coverage through Section 1115 waivers for short-term stays in IMDs for individuals with SMI and SED.

According to the Kaiser Family Foundation, as of July 16, 2019, 24 states had approved Section 1115 waivers allowing states to receive federal Medicaid funds for SUD services in IMDs and 1 state had an approved waiver for mental health services. At that time, 5 states had pending waivers for SUD services, and 1 state had a pending waiver for mental health services.

Medicaid Managed Care

Under Medicaid managed care coverage, states may make monthly payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD. In May 2016, CMS added this policy to regulations and specified that states may make payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD as long as the length of stay in the IMD is no more than 15 days during the month of the payment. According to the Kaiser Family Foundation's State Medicaid Budget Survey, 28 states reported providing this IMD coverage through their managed care programs in state fiscal year 2018.

The SUPPORT Act

The SUPPORT Act, enacted on October 24, 2018, includes the following provisions that affect the IMD exclusion.

IMD State Option for SUD Services

Section 5052 adds a new state plan option, beginning October 1, 2019, and ending September 30, 2023, to provide Medicaid coverage of Medicaid enrollees aged 21 through 64 with at least one SUD who are patients in an eligible IMD for no more than a period of 30 days (whether or not consecutive) during a 12-month period.

An eligible IMD is defined as an IMD that (1) follows reliable, evidence-based practices and (2) offers at least two forms of medication-assisted treatment for substance use disorders on site.

As a condition of the state plan option, states would have to maintain the annual level of state expenditures for items and services furnished to Medicaid enrollees aged 21 through 64 with at least one SUD in (1) eligible IMDs and (2) outpatient and community-based settings.

Also, as a condition of the state plan option, states are required to ensure that a continuum of services is available by (1) notifying the Secretary of Health and Human Services of how individuals receive evidence-based clinical screening before receiving services in an eligible IMD; (2) providing coverage of certain outpatient, inpatient, and residential services; and (3) ensuring appropriate transition from an eligible IMD to receiving care at a lower level of clinical intensity.

Under the state option, individuals receiving IMD SUD services also must receive Medicaid coverage of services provided outside the IMD.

Services Outside of IMD for Pregnant Women

Section 1012 permits states to receive federal Medicaid funds for Medicaid services provided only outside of an IMD for patients in IMDs receiving SUD treatment who are eligible for Medicaid on the basis of being pregnant (through 60 days postpartum).

Managed Care Coverage

Section 1013 codifies the regulation discussed above allowing states to make monthly payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD as long as the length of stay in the IMD is no more than 15 days during the month of the payment.

MACPAC Report

Section 5012 requires the Medicaid and CHIP Payment and Access Commission to submit a report to Congress, not later than January 1, 2020, that discusses Medicaid-funded services provided to individuals who are patients in IMDs.

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