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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. (See CRS Report R43357, *Medicaid: An Overview*.)

Medicaid's IMD exclusion limits the circumstances under which federal Medicaid matching funds are available for inpatient mental health care. Policymakers have concerns about access to mental health care, and in recent years some have introduced bills to amend or eliminate the IMD exclusion. The scope of the unmet need for inpatient mental health care for individuals with mental illness on Medicaid is unknown, as is the extent to which the need might be met by increasing community-based care or inpatient care in facilities that are not IMDs.

What Is the IMD Exclusion?

The IMD exclusion is a long-standing policy under Medicaid that prohibits the federal government from providing federal Medicaid matching funds to states for services rendered to certain Medicaid-eligible individuals who are patients in IMDs. (§1905(a)(29)(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, *State Medicaid Manual*, Part 4, §4390.) Under this definition, substance use disorders 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 older than 65 in IMDs. In 2012, 45 states and the District of Columbia (DC) 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 (Section 1905(a)(14) of the Social Security Act)
2. Inpatient psychiatric hospital services for individuals under age 21 (Section 1905(a)(16) of the Social Security Act)

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 large institutions.

Inpatient Mental Health Services for Persons Aged 21 Through 64

Taking into consideration all the exceptions, the IMD exclusion prevents the federal government from providing

federal Medicaid matching funds for any service delivered to individuals aged 21 through 64 in an IMD. However, even with an IMD exclusion, states can receive federal Medicaid matching 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.

In addition, Section 2707 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included a demonstration project in which participating states can reimburse certain IMDs that are not publicly owned or operated for services provided to Medicaid enrollees, aged 21 through 64, who require medical assistance to stabilize a psychiatric emergency medical condition. Eleven states and DC are participating in this Medicaid Emergency Psychiatric Demonstration, which ends in December 2015.

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. Most states focus their Medicaid DSH funding on general hospitals, but some states use this funding for IMDs, with one state spending all of its Medicaid DSH funding on IMDs. (See CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.)

Problem: Access to Needed Care

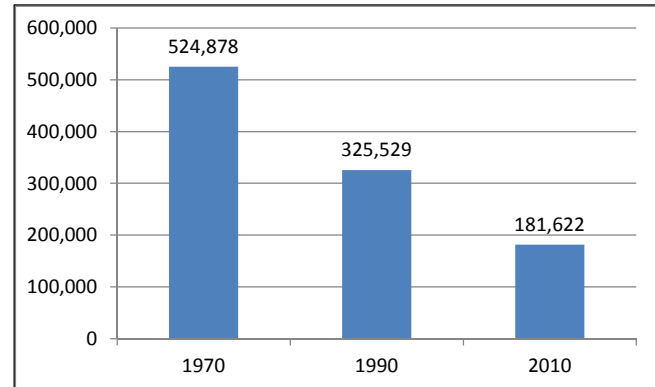
The current paradigm for psychiatric care relies primarily on community-based care and often reserves institutional care for short-term treatment of individuals experiencing severe episodes. Historically, institutional care was far more common until the deinstitutionalization movement reduced the number of psychiatric beds and shifted care to community-based settings.

For roughly a century leading up to the 1950s, psychiatric care relied increasingly on institutional care in state psychiatric hospitals that were growing in both number and size, at state expense. The psychiatric deinstitutionalization movement responded to concerns about the living conditions and civil rights of institutionalized individuals and was facilitated by advances in psychiatric medications and new federal funding for community-based mental health services. The number of psychiatric beds, which reportedly peaked in 1955, declined between 1970 and 2010 (as illustrated in **Figure 1**) and has continued to decline since then.

Medicaid was established at about the time psychiatric deinstitutionalization began and may have contributed to the shift by providing a new source of federal funding for outpatient psychiatric care while continuing the tradition of making inpatient psychiatric care primarily a state responsibility. At present, there is general agreement that

many people with mental illness do not have access to needed care, including institutional care.

Figure 1. U.S. Psychiatric Beds in 1970, 1990, and 2010 (includes both hospital inpatient and residential beds)



Source: CRS, using data from the Substance Abuse and Mental Health Services Administration.

Note: Changes in study methods limit comparability of the numbers.

According to the National Association of State Mental Health Program Directors, during FY2010-FY2013, a decrease of almost 4,500 hospital inpatient psychiatric beds and many community mental health centers coincided with a 28% increase in emergency department use for mental illness (including substance use disorders). Hospital emergency departments sometimes “board” patients for hours or days while waiting for an available psychiatric bed. (See CRS Report R43812, *Hospital-Based Emergency Departments: Background and Policy Considerations*.) In addition, the Medicaid IMD exclusion may result in certain IMDs providing uncompensated care to Medicaid-eligible individuals with emergency medical conditions.

Proposed Solutions

Despite general agreement on the problem, disagreement exists regarding the potential solutions. Some see eliminating or revising the Medicaid IMD exclusion as a means to increase the availability of psychiatric beds. They argue that increased Medicaid funding for IMDs not only would help non-elderly adults on Medicaid have access to institutional mental health care but also would help others (not on Medicaid) by creating an incentive to increase the number of beds in IMDs.

Others oppose eliminating the IMD exclusion or creating more exceptions out of concern that doing so will lead to unnecessary institutionalization. They argue for more access to and increased quality of community-based care, which they believe can reduce the demand for institutional care by preventing many of the crises that precipitate emergency department visits and institutionalization.

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