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A little known 50-year-old federal law, the Medicaid Institutions for Mental Diseases (IMD) exclusion, has come under increased scrutiny as the death toll associated with the opioid epidemic continues to climb. The rule has been blamed for limiting treatment options for persons with substance use disorders (SUD). A report released by the U.S. Centers for Disease Control at the end of last year said that Ohio ranked second in the nation in heroin overdose deaths in 2014. They stated that deaths had climbed by 18.3 percent in just one year. This followed an earlier Ohio Department of Health report that found unintentional drug overdoses had killed 2,482 Ohioans in 2014.[1] Now multiple efforts are underway to either repeal the law, modify it, or work around it to expand access to treatment.

There appears to be a general consensus by policy makers that expanding education, prevention, and treatment is the preferred approach to ending the opioid epidemic. Ohio Attorney General DeWine said recently that "we're not going to arrest our way out of this problem …we have to do a better job with education and prevention, and we have to do a better job with treatment and make that treatment available."[2] According to the National Survey on Drug Use and Health (NSDUH) 238,000 Ohioans abuse or are dependent on an illegal drug. But the same survey found that less than 10 percent of Ohioans who are abusing or dependent on an illicit drug are receiving treatment.[3]

Increasingly state and federal policy makers have identified the Medicaid IMD exclusion as a barrier to developing increased treatment options for those suffering from substance use disorders (SUD). The IMD exclusion is in Section 1905(a)(B) of the Social Security Act and it prohibits Medicaid payments for care or services for any Medicaid beneficiary under the age of 21 or over the age of 65 who is a patient in an institution for mental

[1] 2014 Ohio Drug Overdose Preliminary Data: General Findings, The Ohio Department of Health, September, 2015
[2] DeWine: Heroin kills 4 to 5 people daily in Ohio, Shane Hoover, The Canton Repository, March 23, 2016
[3] By the Numbers 3: Analysis of Alcohol and Other Drug Treatment in Ohio, The Center for Community Solutions and the Mental Health and Addiction Advocacy Coalition, July 27, 2015

diseases. The exclusion was put in place when Medicaid was enacted by Congress, and although Congress has had many opportunities to amend or repeal the exclusion they have chosen not to. The U.S. Centers for Medicare and Medicaid Services (CMS) has not updated the IMD exclusion regulations in 28 years. The exclusion provision reflected both a long history of federal policy makers viewing the care of persons with mental illness as a state responsibility, and a preference for community-based care over large institutions. In fact, some argue that repealing the rule would allow the federal government to inappropriately take over mental health policy from the states.[4]

A significant barrier to full repeal of the IMD exclusion would be the cost to the federal government, which the Congressional Budget Office has estimated to be anywhere between $40 and $80 billion annually.[5] Recently the U.S. Senate Health, Energy, Labor, and Pensions Committee unanimously passed major mental health and substance abuse legislation that didn't address the IMD exclusion. One reason was the cost and the other was because the rule falls under the jurisdiction of the U.S. Senate Finance Committee.

Ohio Senator Rob Portman sponsored and helped pass legislation in the U.S. Senate, the Comprehensive Addiction and Recovery Act of 2015, which requires the U.S. General Accounting Office to examine the IMD exclusion and to report back on how certain policy changes to the rule, including repeal, would improve treatment options for persons with a substance use disorder. The legislation now heads to the U.S. House of Representatives where companion legislation has been introduced. Its prospects for final passage in an election year are unclear, although it has enjoyed bipartisan support.

Another approach has been taken by Ohio Congresswoman Marcia Fudge who introduced legislation, the Breaking the Addiction Act, in both 2014 and 2015. Her legislation requires the Secretary of Health and Human Services to accept 1115 (a) Medicaid waiver applications from states proposing to lift the IMD exclusion on facilities with fewer than 60 beds that are serving persons with a substance use disorder. The legislation has been referred to the U.S. House Committee on Energy and Commerce, but no hearings have been held. Because an 1115 (a) Medicaid waiver must be budget neutral, meaning it cannot cost the federal government any more than what they would have spent without the waiver, and it sidesteps the full repeal cost obstacle. But waivers are time-limited and state-specific which could limit their long term effectiveness in addressing the overall problem.

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[4] The Feds Are Trying To Take Over Mental Health Policy From States, Kate Murphy, The Federalist, December 29, 2015

[5] Lawmakers Confront an $80 Billion Problem for Fixing Mental Health, Morning Consult, Caitlin Owens, March 16, 2016

Most of the current attempts to repeal or modify the IMD exclusion rule have focused on addressing it from the perspective of persons suffering from a substance use disorder. If Congress were to repeal or modify the rule, following this approach it could leave out those individuals who are dual diagnosed with both a substance use disorder and a severe and persistent mental illness. For example, a state Medicaid program might only be able to draw down funds for SUD treatment provided in facilities where less than 50 percent of the patients had co-occurring mental illnesses.[6] According to the National Alliance for the Mentally Ill, about half of people living with severe mental illness also experience substance abuse.

Another avenue for addressing the issue comes through pending Medicaid managed care rules that have been drafted by CMS. Under the proposal, state Medicaid programs would be allowed to include in their health plan capitation payments the cost of short-term stays in hospitals or sub-acute facilities providing psychiatric or SUD care for less than 15 days a month or up to 28 consecutive days if spread over two-months. In addition CMS is proposing to allow Medicaid managed care plans to provide alternate services or services in alternate settings if it is cost effective. This could provide a way for Medicaid managed care plans to circumvent the IMD exclusion rules.[7]

The Medicaid and CHIP Payment and Access Commission (MACPAC), a legislative branch agency established in 2010, will be hosting a presentation on the IMD Exclusion rule at their March meeting. It's clear then that the IMD exclusion rule is getting a lot of renewed attention driven in large part by the opiate epidemic, but at this point, the law remains unchanged. Nearly all of the paths forward are long and complicated.

One option would be for the state and local governments to decide to cover the costs of the treatment provided by some portion of these IMD facilities. This would be expensive to provide and to administer, but it could simultaneously reduce costs in other areas of government like the criminal justice and/or corrections systems. As compared to pending federal options, it might also be operationalized faster.

The Ohio Department of Medicaid (ODM) could seek an 1115 (a) waiver from the Secretary of Health and Human Services to allow them greater flexibility around the IMD exclusion. CMS issued a State Medicaid Director Letter in 2015 saying states could submit

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[6] The Medicaid IMD Exclusion: An Overview and Opportunities for Reform, Legal Action Center, July 2014

[7] Game Changer: CMS' Proposed Medicaid Managed Care Regulation, Sara Rosenbaum, Health Affairs Blog, June 10, 2015

1115 waivers that included "coverage for (SUD) services in inpatient and or residential settings that are within the definition of IMDS". The letter specifically mentions "short-term acute SUD treatment".[8] Such a waiver would still need to meet budget neutrality requirements, meaning the state would need to demonstrate that any additional Medicaid funds being spent in these IMD facilities would have to be offset by savings in other areas of the Medicaid program. In addition, the letter outlines a series of other SUD specific waiver requirements that state would need to meet The Ohio Department of Medicaid is already engaged in massive behavioral health re-design so it's not clear if the department would have the resources needed to design and negotiate such a complex waiver. It's easy to imagine the design, approval and implementation of such waiver taking one to two years. Finally, since waivers are typically time-limited, a waiver might only offer only a temporary solution.

The pending changes in Medicaid managed care rules may represent the fastest federal path to relief. These rules have the advantage of not requiring any action by Congress. Although they aren't final, it might be worthwhile for ODM to begin thinking about how they might operationalize them and to consider what they might cost to put in place. Again, these issues will take time to consider and will involve a large number of stakeholders.

Congress could also decide not to tackle full repeal of the IMD exclusion and instead raise the bed limit by some smaller amount, change the definition of what constitutes mental health disease, limit the payment exclusion to long-term stays, or reduce the share of the federal government's cost for these stays.

It seems likely that there will be either regulatory or legislative changes to this 50 plus year old law. We should start thinking now about how we might address these changes in Ohio. But whatever solutions we develop, they shouldn't just address the issues of persons with substance use disorders and ignore the needs of persons with severe and persistent mental illness. Often these health issues co-exist and we shouldn't do anything that would result in a further fragmented treatment system. We also need to be cautious that whatever solutions we develop don't undermine our efforts to create community-based programs that can be very effective in addressing the needs of persons affected by substance use disorders and/or severe and persistent mental illness.

[8] New Service Delivery Opportunities for Individuals with a Substance Use Disorder, Vikki Wachino, Director, U.S. Center for Medicaid and CHIP Services, July 27, 2015

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