LEGAL ACTION CENTER

RECENT DEVELOPMENTS AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES RELATED TO THE MEDICAID INSTITUTION FOR MENTAL DISEASE (IMD) EXCLUSION FOR PEOPLE WITH SUBSTANCE USE DISORDERS

Background:

The Medicaid Institution for Mental Disease ("IMD") exclusion prohibits federal Medicaid financing for any services provided to otherwise eligible individuals between the ages of 21 and 64 who are patients in facilities that are determined to be IMDs. The exclusion has been interpreted to include inpatient mental health and substance use disorder treatment facilities. It is one of very few examples of Medicaid law prohibiting the use of federal financial participation for medically necessary care provided by licensed medical professionals to enrollees based on the setting where those services are provided.

Section 1905(a)(B) of the Social Security Act prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." The law then defines IMDs as any "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, or related services."

The IMD exclusion has its roots in the Social Security Amendments of 1950 and has been part of the Medicaid program since it was created in 1965. It has only been amended by Congress a few times in its long history, including changes to apply it only to certain patients based on their ages and to certain facilities based on size. Previously, Congress significantly modified the IMD exclusion in 1988.

Recently, largely in response to the nation's opioid crisis and the need to improve access to substance use disorder ("SUD") care, there have been important developments at the federal level that are aimed at improving access to residential SUD care. It is important to understand the various options states have as they work to improve access to SUD care, including to criminal justice system-involved individuals.

Why is the Medicaid IMD exclusion important to the criminal justice system?

Untreated mental health and substance use disorders are extremely prevalent among the criminal justice population and have been shown to contribute to criminal justice involvement and recidivism. The justice-involved population has disproportionately lacked health insurance coverage to address their health care needs, including mental health ("MH") and SUD treatment. Before the Affordable Care Act, most justice-involved people were not eligible for Medicaid or other public coverage no matter how low their income. In addition,

even individuals who had health insurance often had difficulty accessing quality mental health and SUD services and medications.

Medicaid beneficiaries have higher rates of opioid use disorder than the general population; however, only about 32 percent of Medicaid beneficiaries with opioid use disorder received treatment in 2015. The IMD exclusion has historically been a considerable barrier to accessing quality SUD care. In addition, Medicaid beneficiaries with SUD have high rates of co-morbid physical and mental health conditions.

What's new on the Medicaid IMD Exclusion at the federal level?

1. Action by CMS: State Medicaid Director Letter # 17-003 on Strategies to Address the Opioid Epidemic

On November 1st, 2017, the Centers for Medicare & Medicaid Services ("CMS") released a State Medicaid Directors' letter (SMD #17-003) that expressed the agency's willingness to work with states on section 1115 waivers to improve access to and quality of SUD care for Medicaid beneficiaries in the midst of the nation's opioid crisis. Under the authority of section 1115 of the Social Security Act, CMS can waiver certain federal requirements so that states can test new or existing ways to deliver and pay for health care services in Medicaid, consistent with the goals of the Medicaid program.

SMD #17-003 made clear that the policy guidance it contains replaces previous guidance released during the Obama administration on the same topic. Four states (California, Maryland, Massachusetts and Virginia) received section 1115 waiver approval to improve access to SUD care under the previously issued guidance. In October 2017, CMS approved West Virginia's 1115 waiver application. Details about those CMS-approved section 1115 waivers follows below.

According to SMD #17-003, through the new policy guidance, CMS sought to offer a more flexible, streamlined approach to enable states to more quickly respond to the national opioid crisis. Under the guidance, CMS will work with states to develop five-year demonstration projects to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, while incorporating metrics to measure and evaluate outcomes.

Through section 1115 waivers approved by CMS, under the approach described in the SMD letter, states will be able to receive federal financial participation ("FFP") for Medicaid-coverable services provided to individuals in residential SUD treatment facilities. Those Medicaid-coverable services are not ordinarily matchable because those facilities qualify as IMDs. However, the SMD letter states that room and board payments in those facilities will continue to be disallowed unless they qualify as inpatient facilities under section 1905(a) of the Social Security Act.

Goals of the initiative are to:

- Increase rates of identification, initiation and engagement in treatment;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;

- Reduce utilization of emergency departments and inpatient hospital settings for treatment;
- Reduce readmissions to the same or higher levels of care; and
- Improve access to care for physical health conditions among beneficiaries.

Milestones states should be committed to meet are:

- Access to critical levels of care for SUD, including opioid use disorder ("OUD");
- Widespread use of evidence-based, SUD-specific patient placement criteria;
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
- Sufficient provider capacity at each level of care;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Improved care coordination and transitions between levels of care.

States wishing to participate in the initiative should submit a demonstration application to CMS outlining the state's strategy for achieving the goals of the demonstration, including a commitment to meeting the above-listed milestones. States will also be required to develop implementation plans describing the various timelines and activities the state will undertake to achieve the above-listed milestones.

The SMD letter makes clear that the Medicaid Innovation Accelerator Program ("IAP") will continue to be available to states to support national learning opportunities and technical expert resources, including strategic design support to states that are planning targeted addiction treatment delivery system reforms and developing 1115 proposals.

Additional information on Medicaid's 1115 waiver initiative to improve access to SUD care can be found here.

2. Action by CMS: Provisions on the IMD in the Medicaid and CHIP Managed Care Final Rule

In May of 2016, CMS released the Medicaid and Children's Health Insurance Program ("CHIP") Managed Care Final Rule, the first significant update to Medicaid and CHIP managed care regulations in many years. The Final Managed Care Rule, which became effective on July 5th, 2016, includes two important provisions aimed at improving care delivery for people with SUD and mental health needs:

- crisis stabilization services in IMDs, and
- the "in lieu of" flexibility to use substitute providers and settings.

Federal Medicaid Payments for Crisis Residential Services in IMDs

The Final Managed Care Rule allows states to make a monthly capitation payment to managed care entities for an enrollee, aged 21 to 64, who is a patient in an IMD, if:

- the facility is a hospital providing psychiatric or SUD inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services, and

- the length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.

Therefore, there could be federal Medicaid reimbursement for up to 15 days in a month for psychiatric or SUD crisis residential services in a hospital or a sub-acute facility that is an IMD. Length of stay could be more than 15 days if it covers two consecutive calendar months. The level of care refers to medically managed, American Society of Addiction Medicine ("ASAM") Level 4 detoxification/stabilization services.

"In Lieu of" Flexibility for Substitute Services and Settings, including IMDs

The Final Managed Care Rule also includes provisions to allow managed care organizations ("MCOs") to use substitute services or settings "in lieu of" covered services or settings. "In lieu of" settings and services are settings and services that are medically appropriate, cost-effective substitutes to those included in the managed care contract.

The Final Rule clarifies that MCOs have a responsibility to ensure access and availability of services that are covered under the managed care contract that are not prohibited, even if the managed care entity must provide an alternative service or use an alternative setting "in lieu of" what is covered under the Medicaid state plan. Accordingly, MCOs have the flexibility to use IMDs as a means to ensure that appropriate care is provided. The Final Rule clarifies that states cannot include "in lieu of" requirements in their MCO contracts. However, states can include the benefits and the MCO then has the flexibility to use residential facilities when appropriate. Under the "in lieu of" flexibility, if a residential SUD treatment benefit is included in the state plan and MCO contract, the MCO has the ability to use IMDs to provide those services if doing so is cost-effective and medically appropriate.

Additional information about implementing these provisions of the Final Managed Care Rule can be found in a Frequently Asked Questions document CMS released in August of 2017.

What's new in the states?

In recent years, a number of states have secured CMS approval for section 1115 waivers of the IMD exclusion. This includes:

- **West Virginia** received CMS approval for the state's section 1115 waiver, "Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders," in October 2017.

  The waiver, effective from January 1, 2018 through December 21, 2022, seeks to improve care and health care outcomes for West Virginia Medicaid beneficiaries with SUD by expanding SUD coverage and introducing new programs to improve quality of care and care coordination. The waiver specifically aims to combat the opioid epidemic by expanding the SUD benefit package to include coverage of methadone treatment services, peer recovery support services, withdrawal management services, and short-term residential services. The demonstration also aims to increase access to care by expanding the SUD provider networks available to Medicaid populations, and decrease use of emergency and hospital services for enrollees with SUD.

Under the demonstration project, treatment services will be delivered to residents in institutional care settings and IMDs, when determined to be medically necessary and in accordance with individualized services plans. Services can be provided in facilities of any size. Covered services include: therapeutic treatment, addiction pharmacotherapy and drug screening, motivational enhancement, withdrawal management and treatment, monitoring of medication adherence, recovery support services, counseling services involved the beneficiary's family, and education on and referrals to medication assisted treatment. The waiver also includes provisions to increase training for new providers and requires that all MCOs and SUD providers participating in the demonstration comply with industry standards consistent with ASAM criteria.

Within 150 days of approval of the demonstration, West Virginia was required to submit a plan that described data collected, reporting, and analytic methodologies for performance measures, as well as timeframes for reporting progress. The plan must also identify a baseline, a target to achieve by the end of the demonstration, and an annual goal for achieving this target for each performance measure.

- **California**, which received CMS approval for its section 1115 waiver application in August of 2015. Under the substance use disorder-focused demonstration project, the Drug Medi-Cal Organized Delivery System ("DMC-ODS"), the state seeks to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with SUD. According to the state, features of the pilot include providing a continuum of care modeled after the ASAM Criteria for SUD treatment services, increasing local control and accountability, providing greater administrative oversight, creating utilization controls to improve care and efficient use of resources, evidence-based practices in SUD treatment, and increased coordination with other systems of care.

- **Massachusetts** received section 1115 waiver approval from CMS in November 2016. Through the Massachusetts' demonstration project, the state is seeking to strengthen its system of recovery-oriented SUD treatment and supports by covering a more comprehensive array of outpatient, residential inpatient and community SUD services to promote treatment and recovery as part of a statewide opioid action plan.

- **Virginia** received CMS approval for its section 1115 waiver in December 2016. The state's new SUD benefit and delivery system, the Addiction and Recovery Treatment Services Delivery System Transformation, seeks to expand the SUD benefits package to cover the full continuum of care, integrate SUD services into comprehensive managed care and introduce new program, provider and managed care requirements to improve the quality of care consistent with national treatment guidelines established in the ASAM Criteria.

- **Maryland** received CMS approval for its section 1115 waiver in December 2016. The demonstration project created by the waiver seeks to serve individuals with SUD, including an evidence-based benefit design covering the full continuum of care, implementing key benchmarks from industry standards of care, reporting specific quality measures, and embarking on a strategy to integrate physical and behavioral health services to improve health outcomes for beneficiaries with SUD.

What actions on the IMD exclusion are expected next? What steps can criminal justice decision-makers take?

- With the new CMS State Medicaid Directors Letter, which is aimed at streamlining the section 1115 waiver approval process to improve access to SUD care, it is likely that additional states will soon apply for these waivers.
- Additional guidance from CMS is anticipated, including guidance related to managed care provided through Medicaid and CHIP.
- Several bills are pending in Congress that would revise the IMD exclusion: Consideration of these bills could happen as a part of overall efforts to respond to the nation's opioid crisis.

Criminal justice professionals have an essential role in helping to ensure that state Medicaid programs address the MH and SUD care needs of justice-involved Medicaid beneficiaries.

Criminal justice decision-makers should continue engaging with their state Medicaid agencies to share their expertise about the health needs of the criminal justice population, the public safety and public health benefits of justice-involved individuals receiving evidence-based quality health care, and the need to ensure that justice-involved Medicaid beneficiaries have access to the full continuum of SUD services and medications.

For additional information, please contact the Legal Action Center at nationalpolicy@lac.org or 202-544-5478.