IMD Exclusion: Its History, Effects, and Future Policy Implications

Mental Health America
Regional Policy Council

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Presenters

Debbie Plotnick, MSS, MLSP
VP of Mental Health Systems Advocacy
Mental Health America

Rusty Selix, JD
Executive Director of Policy & Advocacy
Mental Health America of California

Dr. John O'Brien
Senior Policy Advisor
Centers for Medicare & Medicaid Services

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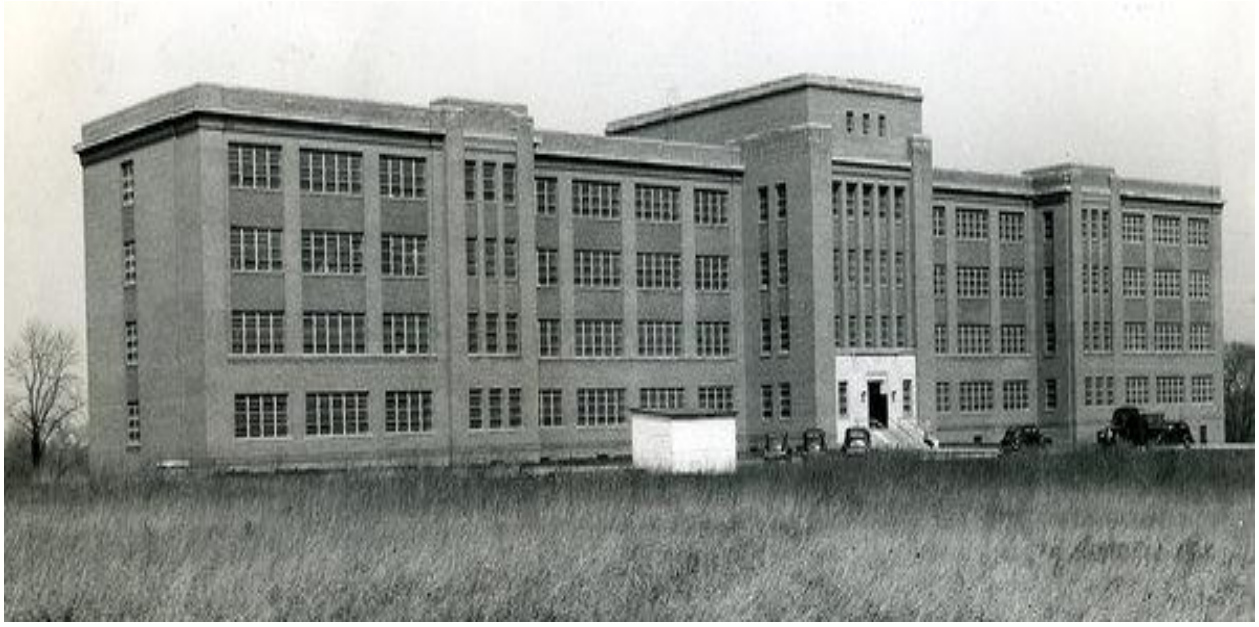
Philadelphia State Hospital: also known as Byberry



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IMD exclusion represented lives of men

Special Philadelphia State Hospital work detail, 1946.

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IMD exclusion represented the lives of women

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IMD exclusion represented lives of young people

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Glossary

IMD: institution of mental disease

ACA: Affordable Care Act, Obamacare

CMS: Center for Medicare and Medicaid Services

EMTALA: Emergency Medical Treatment and Labor Act

MEPD: Medicaid Emergency Psychiatric Demonstration

NPRM: Notice of Proposed Rulemaking

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1115 Waivers

Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. In September 2014, the Centers for Medicare & Medicaid Services initiated a national, cross-state evaluation of four types of Medicaid section 1115 demonstrations. See the evaluation design.

Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.

(http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html)

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IMD in recent proposed legislation

S. 599: Improving Access to Emergency Psychiatric Care Act
https://www.govtrack.us/congress/bills/114/s599

H.R. 2646: Helping Families in Mental Health Crisis Act of 2015
https://www.govtrack.us/congress/bills/114/hr2646

S. 1945: Mental Health Reform Act of 2015
https://www.govtrack.us/congress/bills/114/s1945/text

H.R. 953: Comprehensive Addiction and Recovery Act of 2015
https://www.govtrack.us/congress/bills/114/hr953

H.R. 1988: Breaking Addiction Act of 2015
https://www.govtrack.us/congress/bills/114/hr1988/text

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IMD in proposed regulation

Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

A Proposed Rule by the Centers for Medicare & Medicaid Services on 06/01/2015

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IMD Exclusion: Generates Savings for Federal Budget Costly and Opposed by States Incentives and Disincentives that Divides Mental Health Community

Rusty Selix
Executive Director for Policy and Advocacy
Mental Health Association/America of California (MHAC)

What It is – Exclusion from Medicaid

- Institutes for Mental Disease
- 16 or more Beds
- Residential or Inpatient
- Locked or Unlocked
- Acute or long term care
- Only applies if facility is primarily for people with mental illnesses- does not apply if it is a wing of a general hospital

Why it was created

- Federal government did not want to have to pay for care of people in state hospitals- or other long term institutional care for people with mental illnesses
- Dates back before Deinstitutionalization

Acute Hospitalizations

- Most acute hospitalizations are not subject to IMD in most states because they take place at general hospitals which are not IMDs
- Does apply if people are placed in a “psychiatric hospital”
- Pilot program as part of ACA to have a few facilities in a few states exempt for a few years to see how it impacts placements
- Pilot ended???- results???

Psych Hospitals/States want end

- For the entire 30 years that I have been doing mental health advocacy states and psychiatric hospitals have tried to find ways to end the IMD exclusion
  - States argue that it simply reduces FFP
  - Say Olmstead takes care of policy incentive to use least restrictive placement critieria
  - Psych hospitals say it discriminates against them as compared to general hospitals

Mental health community divided

- Generally along philosophical lines
- NAMI and Psychiatrists want end
- Consumer and disability advocates like it
- Providers divided – generally like financial incentive and support keeping it but recognize the loss of overall federal funds and seek exemption for unlocked residential facilities currently restricted to 15 beds

Broad change unlikely

- Congressional proposals estimate cost of complete end of exclusion as tens of billions of added federal costs annually
- Action has been on narrow changes-
  - Acute hospitalizations pilot
  - Unlocked residential facilities that have limited medical care – seems doable through CMS waivers without statutory changes- California SUD Organized Delivery System

Substance Use Residential

- Residential Care is an essential element in almost all cases in recovery from chemical dependency while it is only occasionally needed in recovery from severe mental illness
- California has a newly approved federal waiver for Substance Use providers to eliminate the 15 bed limit for such unlocked facilities with federal guidance making this available to other states

No controversy in California

- All groups are supportive of this change
- It was recognized that this level of care is broadly needed and that the 15 bed limit made it infeasible for facilities to operate
- It is not the same as for mental health where there are often alternatives to residential care but this could set a precedent that may be extended to mental health unlocked residential care placements-especially for short term crisis facilities.

Questions or Comments?

- Rusty Selix
- rselix@mhac.org
- 916-205-7777

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid and Acute Care Behavioral Health Services

November, 2015

Areas of Activity

- Section 2707 of the Affordable Care Act—Medicaid Emergency Psychiatric Demonstration
- State Medicaid Director on Substance Use Disorders
- Managed Care Notice of Proposed Rule Making

Overview of Medicaid Emergency Psychiatric Demonstration (MEPD)

- Section 2707 of the Affordable Care Act authorizes the Secretary to conduct and evaluate a demonstration that:
  - Provides Medicaid reimbursements to private psychiatric hospitals (IMDs)
  - Treat beneficiaries ages 21 to 64 with psychiatric emergency medical conditions (EMCs).
  - Provided Federal financial participation according to the current Federal share of Medicaid paid by the Federal government in each of the participating States.

Participating States

- Washington
- California
- Missouri
- Alabama
- District of Columbia
- Illinois
- North Carolina
- West Virginia
- Rhode Island
- Maryland
- Connecticut
- Delaware
- Maine

MEPD Preliminary Results

- 11,552 admissions (average of 438 per month):
  - -75 percent expressed suicidal thoughts or gestures;
  - -20 percent were judged to be a danger to self or others without expressing suicidal or homicidal thoughts or gestures;
  - -11 percent expressed homicidal thoughts or gestures (some overlapping between categories)

- 62 percent were admitted with diagnoses of mood disorders, and 32 percent with schizophrenia or psychosis. The remaining 6% include anxiety disorders, substance-related disorders and “other mental health diagnoses”.

- 20 percent had a primary or secondary discharge diagnosis of substance-related disorders.

MEPD Preliminary Results

- Average length of stay: 8.5 days (range: 0 to 147 days);
- 92 percent discharged to home or self-care;
- The remaining 8 percent were discharged/transferred to another facility, left against medical advice, were in hospice, expired, were still patients, or discharge information was not available
- 21 percent readmitted to a participating IMD during the MEPD;
- Total expenditures (combined federal and state): just under $78 million, with an average of $6,724 per admission.

MEPD Preliminary Results

- Respondents in about half of the participating states reported easier transfer and diversion from EDs to IMDs
- Factors other than time waiting for a bed contribute to increased boarding time
- Some states reported particularly high levels of boarding on weekends
- ED staff in three states reported that IMDs do not accept patients with co-morbid complications

MEPD Preliminary Results

- IMDs in four states stated that they have strengthened linkages to community care during discharge planning
- IMDs in 10 of the 12 participating states reported that lack of available outpatient services, especially psychiatrists, makes discharge planning difficult
- IMDs in five states reported discharging patients to homeless shelters

Medicaid and SUD: Facts and Figures

- Roughly 12% of adult Medicaid beneficiaries has a SUD; 15% of expansion population
- In 2009, Medicaid accounted for 21% of all SUD treatment costs among all payers.
- High costs for Medicaid beneficiaries with SUD and co-morbid medical condition ($3.3 billion for 575,000 people in 2008).
- Rate of fatal overdose in U.S. has quadrupled between 1999 and 2010.

Top 10 dx for Re-hospitalizations, 2011

Medicare	Medicaid
Congestive Heart Failure*	Mood disorders
Septicemia (except labor)*	Schizophrenia, other psychosis
Pneumonia (except TB or STD)	Diabetes mellitus
Chronic Obstructive Pulmonary Disorder (COPD) and bronchiectasis*	Other complications of pregnancy
Cardiac dysrhythmias	Alcohol-related disorders
Urinary tract infections	Early or threatened labor
Acute renal failure	Congestive Heart Failure*
Acute myocardial infarction	Septicemia (except labor)*
Complications of device/implant/graft	COPD and bronchiectasis*
Acute cerebrovascular disease	Substance-related disorders

* Common across Medicaid and Medicare

Source: 2011, Data, Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality (AHRQ). http://www.ahrq.gov/research/data/hcup/index.html

State Medicaid Director Letter

- Released July 2015
- Encourages states to transform their system for individuals with an SUD
- Encourages states to use an 1115 for this transformation
- Interested in gathering information that will be helpful for the field
- Sets forth 13 expectations for states

Expectations in SMD

- States are expected to address the elements of a transformed system of care for individuals with SUD:
  - Enhanced benefit design
  - ASAM Criteria levels of care and placement
  - Network development plan
  - Care coordination design
  - Integration with physical health care
  - Prescription drug abuse strategy
  - Opioid strategy

Expectations in SMD

- Expectations (continued)
  - Program integrity and provider business operations
  - Benefit management
  - Availability of services for adolescents and youth
  - Quality measures, metrics and data analytics
  - Single State Agency (SSA) collaboration
  - Community integration

Enhanced Benefit Design

- Build off of ASAM continuum of care
- Focus on Medication Assisted Treatment (MAT) and Screening, Brief Intervention and Referral to Treatment (SBIRT) evidence
- Short-term residential care consistent with ASAM Criteria
- Aftercare, recovery and support services
- Housing supports

Managed Care NPRM

- Section 1905(a)(29) provides that federal financial participation is not available for any medical assistance under title XIX for services provided to an individual ages 21 to 64 who is a patient in an IMD facility.
- NPRM clarifies that MC plans have had flexibility under risk contracts to provide alternative services or services in alternative settings in lieu of covered services or settings if:
  - cost-effective,
  - Offered on an optional basis; and
  - plan and the enrollee agree that such setting or service would provide medically appropriate care.

Managed Care NPRM

- Facility is an inpatient hospital facility or a sub-acute facility providing crisis residential services;
- 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.

For Further Information

- The SUD SMD Letter is posted here: http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf
- For more information about the 1115 opportunity described in the SUD SMD Letter, please email John.OBrien@cms.hhs.gov or Eliot.Fishman@cms.hhs.gov
- The MC NPRM is posted here: https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

Questions

Thank you for attending today's webinar!

Debbie Plotnick

dplotnick@mentalhealthamerica.net

Rusty Selix

rselix@mhac.org

John O'Brien

John.OBrien@cms.hhs.gov

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Stay tuned for MHA's other webinars:

Medicaid Redesign and Expansion: Can We Have One Without the Other?

Monday, November 16th at 2:00 p.m. EST

https://cc.callinfo.com/r/145ql5edzl1cn&eom

A Peer Driven Solution to Isolation and Social Exclusion: Part III

Tuesday, November 17th at 2:00 p.m. EST

https://cc.callinfo.com/r/z5lcioey4to6&eom

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