Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate—Argument to Retain the IMD Rule

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Recent years have brought increasing calls for the repeal of Medicaid's long-standing IMD exclusion rule, accompanied by the refrain that deinstitutionalization has "gone too far" and by the contention that dramatic downsizing of psychiatric hospital capacity over the past half century reflects a crisis. Although our mental health systems *are* in crisis, neither the IMD rule nor insufficient hospital beds are the primary problem. The primary problem is the failure to implement an effective system of intensive community-based services, which have been shown to prevent or shorten hospitalizations. Repealing the IMD rule would do little to alleviate the true crises in our public mental health systems and would likely deepen those crises.

The IMD Rule Has Been an Important Driver of the Shift Toward Community Services

The IMD exclusion rule, which has been in place since the beginning of the Medicaid program in 1965, bars the use of federal Medicaid funds to finance services for individuals ages 22 to 64 residing in "institutions for mental diseases" or IMDs—hospitals, nursing homes, or other institutions with more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with "mental diseases" other than dementia or intellectual disabilities (1). Congress's adoption of the rule reflected its view that serving individuals in mental institutions was a state responsibility. Lawmakers did not want federal payments to replace state financial commitments.

The rule's enactment, coming two years after Congress passed the Community Mental Health Centers Act, also reflected congressional intent to promote a shift toward community-based services. In adopting the IMD rule, Congress explained that community mental health centers were "being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963," that "often the care in [psychiatric hospitals] is purely custodial," and that Medicaid would provide for "the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals" (1).

Because states can draw down federal Medicaid reimbursement for community services but generally not for care in psychiatric hospitals, the IMD rule has been an important driver of state systems shifting toward community services. That has been good policy.

Complaints about the loss of psychiatric hospital beds often give short shrift to the important reasons why public systems deliberately reduced investment in hospital capacity and shifted resources to community capacity: to promote better and less costly treatment in the community and in particular new approaches and improved services that enable even people with challenging conditions to regain their independence, dignity, and autonomy. This shift reflects a dramatic, albeit insufficient, reinvestment in more modern, effective community services, which has resulted in thousands of people once warehoused in state hospitals thriving in community settings. Furthermore, Medicaid does cover inpatient services in general hospitals, including those provided in specialized psychiatric units. In contrast to 1963, when state systems provided state hospital services and little else, the vast majority of public service system dollars now support individuals in community settings (2). That is a benefit, not a loss. And although much of the savings from hospital closures was never reinvested in community services, that failure suggests the remedy of making good on the promise to expand community services, not rebuilding hospitals.

Inpatient Bed Shortages Reflect Gaps in Community Services

As the state mental health program directors themselves have emphasized, pressure to increase psychiatric inpatient capacity "often actually stems from an underfunded community mental health system, exemplified by emergency department overcrowding and boarding, visible chronic homelessness, increased police encounters and jail census, stigma, or a high-profile incident" (3).

Accordingly, "When determining psychiatric inpatient capacity, system leaders should first assess the capacity of evidence-based community programs and services to reduce the need for inpatient care" (3). Community services such as assertive community treatment, crisis services, supportive housing, and other services have proven successful in reducing inpatient admissions and bed-days, as well as incarceration in jails and prisons (3). Yet calls for more psychiatric hospital beds almost never take into account what additional community capacity is needed and how much reduction in inpatient beds—or arrests and incarceration—could be expected if that capacity were developed. Dr. Jess Jamieson, former Director of State Hospitals in Washington State, observed (4): "When I was running the State hospitals in Washington, we were right in the middle of this controversy . . . boarding patients in the ERs waiting for a bed. My hospitals were full, so the prevailing attitude was we needed more beds. This is not the solution!! What I needed was a stronger community-based system to divert patients from inpatient hospitalizations and the community resources to discharge my patients who were ready for community placement, thus opening up a bed for those patients who needed hospitalization. The problem was the community system was under funded and lacked resources."

Not only is the expansion of community services frequently overlooked as a solution, so too is the fact that the number of *private* psychiatric hospital beds has actually *increased* in recent decades (2), and it is these beds, not state hospital beds, that are especially suited for crisis care. Moreover, the significant decreases in state hospital beds occurred years ago. As the state mental health program directors observed: "The shortage of bed capacity is often attributed to the closure of state psychiatric hospitals. But . . . most of the state psychiatric hospital bed capacity that has been closed was actually closed decades ago, with the rate of downsizing drastically slowed in recent years" (2).

Federal Reimbursement for IMDs Is Not a Guarantee of Increased Access to Care—in Fact, It Would Likely Decrease Access

Allowing federal reimbursement to states for providing inpatient psychiatric care does not guarantee expansion of such care. Repeal of the IMD rule would make each hospital bed less expensive for the state to operate or rely on but would not require an expansion of this form of care. Indeed, the long history of states' underinvestment in mental health services strongly suggests that states would not use the savings they realize from repeal of the IMD rule to expand mental health services.

In fact, a large federal demonstration project recently examined whether allowing federal reimbursement for *private* IMD beds for adults ages 21 to 64 would improve access to inpatient care. The demonstration project, authorized by the Affordable Care Act, required the Centers for Medicare and Medicaid Services to assess the effects of providing Medicaid reimbursements to private psychiatric hospitals for individuals ages 21–64. The Medicaid Emergency Psychiatric Services Demonstration Evaluation ran from 2012 through 2015. Through this project, 11 states and the District of Columbia received federal Medicaid matching funds for inpatient treatment in participating private IMDs for beneficiaries with psychiatric emergency medical conditions, which were defined as being suicidal, homicidal, or dangerous to oneself or others. As mandated by the ACA, the evaluation addressed the following areas: Medicaid inpatient access, length of stay, and emergency room visits; discharge planning by participating hospitals; impact on costs of the full range of mental health services, including inpatient, emergency, and ambulatory care; and the percentage of individuals admitted to participating IMDs as a result of the demonstration, compared with those admitted to the same facilities through other means.

The final evaluation report indicated that federal reimbursement for private IMD beds did not increase access to inpatient care for adults ages 21–64 (5). The evaluation found no increase in the number of inpatient admissions or the length of stays in IMDs, no decrease in the number of emergency room visits or the length of emergency department boarding, and no decrease in the number of admissions to or lengths of stay in nonpsychiatric units in general hospitals (5). The report did note, however, that "one of the most consistent findings from our interviews was the existence of significant shortages of community-based outpatient services. Both beneficiaries and facility staff almost universally reported difficulties in obtaining needed aftercare services from community providers."

Whether repeal of the IMD rule would expand psychiatric hospital services or not, the enormous sum that it would cost the federal government would almost certainly bring similar-sized federal cuts to other parts of the Medicaid program, likely resulting in reduced funding for community services and generating new pressures on inpatient capacity. It is naïve to assume that the $40 billion to $60 billion federal price tag estimated for repeal of the IMD rule (6) would be adopted by any Congress without offsetting cuts, particularly in light of pay-go rules—but especially now, with federal commitment to the Medicaid program at a historic low, as evidenced by the near passage of legislation that would have cut the program to the bone.

The IMD Rule Does Not Promote Discrimination—It Helps Prevent It

Arguments that the IMD rule discriminates against people with mental illness miss the mark and ignore the discrimination that comes from needless institutionalization. The IMD rule does not bar Medicaid from covering inpatient psychiatric hospital services. Medicaid covers these services and always has, if they are provided in a general hospital setting rather than in a freestanding psychiatric hospital. Congress's decision to provide Medicaid coverage for

inpatient psychiatric care in a general hospital setting, where people *without* mental illnesses also receive care, rather than in a segregated setting does not amount to discrimination. If anything, the opposite is true.

Moreover, Congress's choice promotes the integration of mental health care and medical care, the importance of which has been widely recognized. People with serious mental illnesses have high rates of diabetes, heart disease, cancer, stroke, and pulmonary disease and tend to die at a much earlier age than the general population. These physical health problems may be exacerbated by obesity, smoking, substance use, and side effects of psychiatric medications. General hospitals with psychiatric units are well positioned not only to address a mental health crisis but also to treat the "whole person," including co-occurring and interrelated physical health issues.

Not only does the IMD rule not discriminate, it helps prevent discrimination by promoting compliance with the Americans with Disabilities Act (ADA). The ADA's "integration mandate" and the 1999 *Olmstead* decision prohibit institutionalization of people with disabilities who could be served in community settings if providing community services can be reasonably accommodated. Although the worst abuses of psychiatric institutions may be in the past, institutionalization of individuals who could be served in community settings is *itself* harmful, regardless of whether abuse occurs. As the Supreme Court observed in its *Olmstead* decision, needless institutionalization is a form of discrimination because "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life . . . and institutional confinement severely diminishes the everyday life activities of individuals" (7).

Enforcement by the U.S. Department of Justice and private plaintiffs has resulted in *Olmstead* settlement agreements across the country that require states to offer sufficient assertive community treatment, supported housing, mobile crisis services, supported employment, and peer support services to avoid needless institutionalization in state psychiatric hospitals, psychiatric nursing facilities, adult homes, and other institutional settings. These settlements show that even today, there is significant overreliance on hospitals and other institutions that could be avoided with the development of community services. As the Senate HELP Committee observed several years ago, needless institutionalization remains widespread, including for people with mental illnesses (8).

The Federal Government Has Already Enacted a Partial Repeal of the IMD Rule

The federal government has already modified its interpretation of the IMD exclusion rule in 2016 to allow federal reimbursement of short stays (15 days or fewer) in IMDs in Medicaid managed care systems (9). Federal Medicaid reimbursement is now available for stays in an IMD of up to 15 days in a month for individuals ages 21–64 enrolled in Medicaid managed care plans, provided that the services are medically appropriate and cost-effective compared with covered inpatient psychiatric services in a general hospital (9).

Conclusions

It makes little sense to forge ahead with a full repeal of the IMD rule, given the harmful consequences that may occur, without first examining the impact of the partial repeal of the rule that was recently enacted. And more significantly, it makes little sense to do so without first building the community service system that everyone agrees is lacking and that would significantly ease pressure on inpatient capacity as well as reduce incarceration of people with serious mental illness. That is where we should start.

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