

An Analysis of the Medicaid IMD Exclusion

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Executive Summary

This report examines the Medicaid Institutions for Mental Disease (IMD) exclusion, one of the very few instances in which federal Medicaid law prohibits federal contribution to the cost of medically necessary care furnished by licensed medical care providers to enrolled program beneficiaries. The report begins with a brief overview of Medicaid's role in financing care for conditions and illnesses classified as "mental diseases" under professional medical guidelines and the allocation of state and federal funding responsibilities under Medicaid. The report then reviews the elements of the Medicaid IMD exclusion, as well as key judicial and administrative rulings related to the exclusion. The report concludes with a discussion of certain policy considerations related to the exclusion.

Public spending is approximately 53% of total national expenditures for the treatment of conditions classified as mental diseases under professional medical guidelines¹. When only inpatient care in state and county mental hospitals for mental diseases is considered, the state and local share increases to 74% of total expenditures. In 1997, publicly financed mental hospitals provided just over 50% of inpatient care for persons aged 18-64. The departure from the normal federal/state payment allocation ratios in the case of treatment for conditions classified as mental diseases is in part the result of a special payment exclusion under Medicaid, the nation's largest public insurance program. This exclusion, known as the "Medicaid IMD exclusion" and part of the program since its 1965 enactment, bars federal contributions to the cost of medically necessary inpatient care incurred in treating Medicaid beneficiaries ages 21-64 who receive care in certain institutions that fall within the definition of an "institution for mental disease."² An "institution for mental diseases" is defined as "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."³

¹ The most commonly used reference for classifying mental diseases is the *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV*.

² 42 U.S.C. §1396d.

³ 42 U.S.C. §1396d(i)

A recent report from SAMHSA's Center for Mental Health Services presented evidence suggesting that from 7 to 10 percent of the Medicaid population used mental health-related services and reported furthermore that total Medicaid spending for MH/SA users amounted to between 21 to 24 percent of all Medicaid expenditures.⁴ Thus, services for the diagnosis, treatment and management of mental illness comprise a substantial proportion of total Medicaid spending, and expenditures on persons with mental illness represent an even more significant overall portion of total Medicaid expenditures.

The IMD exclusion is limited to persons ages 21-64. Federal law exempts two populations from the IMD exclusion. The first exemption, which has existed since Medicaid's enactment, applies to adults ages 65 and older who receive services in institutions for mental diseases.⁵ The second exemption, added in 1972, applies to children under age 21 (or in certain circumstances, under age 22).⁶ In the case of children, inpatient psychiatric hospital care is a coverage option but is mandatory when a child's condition is diagnosed through an EPSDT screen.⁷

Beyond the population exemptions to the IMD exclusion, there are two other notable limits on the exclusion. The first is an exemption under 1988 amendments in the case of institutions with fewer than 17 beds.⁸ The history of this exemption indicates that Congress was particularly concerned that Medicaid be used to promote small, community based group living arrangements as an alternative to large institutions. The second limitation focuses on the inpatient status of the patients; that is, the exclusion applies only in the case of health providers that are *institutions* for mental diseases with 17 beds or more. Services furnished by partial hospitalization and day treatment programs that do not institutionalize their patients are not excluded.

The IMD exclusion raises numerous policy considerations, although numerous attempts to narrow its scope or eliminate the exclusion entirely have been rejected (other than the 16-bed exemption and amendments excluding children under 21 and the elderly). Some of the most important issues are as follows:

- As researchers gain an increasing understanding of the biological basis of many forms of mental illness, does the exclusion continue to have meaning other than as a financial penalty? If conditions classified as "mental diseases" in fact increasingly are treated through medical therapies and treatments that require limited to no traditional psychiatric intervention, is there still a justification for the exclusion?
- Does the presence of the exclusion encourage state efforts to evade it? The exclusion obviously has costly implications for state health budgets, even where states make efforts to minimize its impact through the use of smaller facilities and general treatment facilities.

⁴ *Id.*

⁵ 42 U.S.C. §1396d(a)(14). This coverage was permitted as an optional Medicaid benefit in the original Act, paralleling the exclusion of such services under Medicare. CRS notes that these services were precluded from the predecessor Kerr Mills Program. Medicaid Source Book, op. cit. p. 917.

⁶ Coverage can continue until the earlier of the child's 22d birthday or an unconditional release. 42 C.F.R. §440.160; SMM §4390.1.

⁷ 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a)(); 1396d(r)(5). This provision was added by the Social Security Act amendments of 1972, P.L. 92-603. The Senate added the provision, noting that helping children with mental illness become productive members of society was a clear Medicaid goal. Medicaid Source Book, op. cit., p. 918.

⁸ 42 U.S.C. §1905(a)(B).

State's use of Medicaid's disproportionate share hospital and upper payment limit standards have frequently been connected to efforts by state officials to support institutional services for persons with mental illness. Would it be preferable to revise Medicaid contribution rules to permit coverage of IMD services in order to lessen the potential for aggressive state efforts to avoid the exclusion?⁹

- How does the financial impact of the exclusion affect Medicaid managed care premiums related to behavioral health care? Does the reduction in federal funding result in premiums that are under-financed in relation to need, at least in states in which the federally matched portion of the state's premium is not supplemented with state funds?
- How is the quality of care affected by the IMD exclusion? Does it matter that in order to avoid the exclusion, states must place patients with mental diseases in larger general purpose institutions? Are these institutions capable of health care quality as good as that furnished by more specialized facilities? Are there particularly promising treatment arrangements that cannot be developed or disseminated and replicated because of the impact of restrictions on Medicaid funding?
- Given the attention to mental health parity, can the exclusion be justified? Indeed, a common rationale given by commercial health insurers for their failure to cover mental illness was that responsibility for payment for mental illness traditionally lay with state governments.⁹ Is the rationale for the Medicaid exclusion any different? In the Medicaid context is there sufficient justification for the continued withholding of financing?¹⁰
- *Children and the IMD exclusion:* How does the IMD exclusion apply to unborn children of pregnant women who are receiving treatment in an IMD? If a pregnant woman being treated for addiction in an IMD to go into labor and need maternity care, is the care furnished to her or to the infant? Recent regulations issued by HHS on the subject of coverage of unborn children under the State Children's Health Insurance Program¹¹ suggest a willingness on the part of HHS to recognize this eligibility classification under certain circumstances. Were the case to be viewed as one involving a child in a "non-treatment bed" who simply accompanied its mother, then it would appear that Medicaid coverage could be approved for the baby's delivery and certainly for its follow-up care.¹²
- *IMDs and substance abuse:* What has been the impact of the IMD exclusion on the use of Medicaid to develop residential treatment programs for persons with substance abuse problems? Would lifting the exemption spur greater investment?

⁹ *Metropolitan Life Ins. Co. v Massachusetts* 421 U.S. 724 (1985).

¹⁰ For a discussion of these and other policy considerations as well as an extensive legislative and judicial history, see, for example: Edwards, JF. (1997). "The Outdated Institution for Mental Diseases Exclusion: A Call to Re-examine and Repeal the Medicaid IMD Exclusion." Published by the Treatment Advocacy Center. Available at <http://www.psychlaws.org/HospitalClosure/Index.htm>.

¹¹ "States May Provide SCHIP Coverage For Prenatal Care: New Rule to Expand Health Care Coverage for Babies, Mothers." HHS Press Release, September 27, 2002. Available at: <http://www.hhs.gov/news/press/2002pres/20020927a.html>.

¹² *Id.*

Finally we believe that a more extensive study of the 16-bed exception to the exclusion would be warranted. The absence of information was striking and it became clear to us that in light of the Administration's initiative to achieve community integration, carefully examining both how states use this exception as well as the barriers to its greater use is of tremendous important both for mental illness and substance abuse. Because the "16 bed or fewer" rule is not an optional benefit class per se but simply an exception to an exclusion, tracking state use of these types of facilities would require detailed descriptive analysis work. But the option is of such potential value that in our view, its use as well as practical and policy barriers to expanding the use of these arrangements should be thoroughly studied.

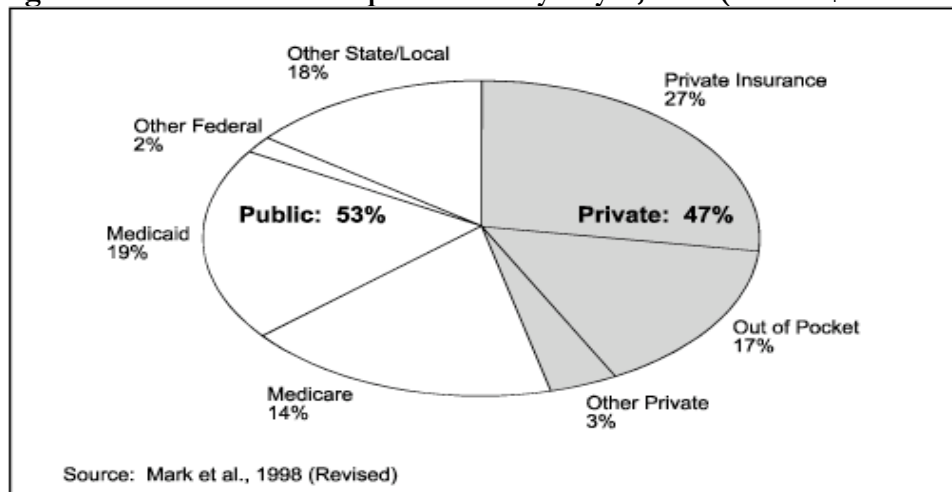
Introduction

This report examines the Medicaid Institutions for Mental Disease (IMD) exclusion, one of the very few instances in which federal Medicaid law prohibits federal contribution to the cost of medically necessary care furnished by licensed medical care providers to enrolled program beneficiaries. The report begins with a brief overview of Medicaid's role in financing care for conditions and illnesses classified as "mental diseases" under professional medical guidelines and the allocation of state and federal funding responsibilities under Medicaid. The report then reviews the elements of the Medicaid IMD exclusion, as well as key judicial and administrative rulings related to the exclusion. The report concludes with a discussion of certain policy considerations related to the exclusion.

Public Expenditures for "Mental Diseases": A Brief Overview and Assessment of the Financial Impact of the Medicaid IMD Exclusion

In 1999, direct expenditures by federal and state governments accounted for approximately 50% of total personal health care spending in the U.S. Of this public expenditure amount, 70% was accounted for by federal expenditures.¹³ However, in the case of expenditures for the treatment of conditions classified as mental diseases under professional medical guidelines,¹⁴ public spending rises to approximately 53% of total national expenditures. (Figure 1). Furthermore, when only inpatient care in state and county mental hospitals for mental diseases is considered, the state and local share increases to 74% of total expenditures (Figure 2). In 1997, publicly financed mental hospitals provided just over 50% of inpatient care for persons aged 18-64 (Figure 3).

Figure 1: Mental Health Expenditures by Payer, 1996 (total = \$69 billion)

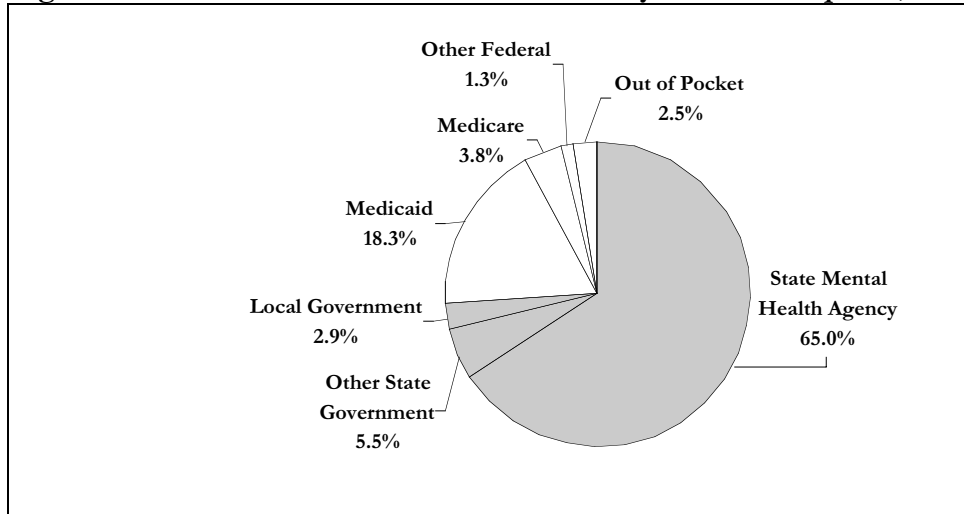


Source: Figure 6.6. *Mental Health: A Report of the Surgeon General*, 1999. Available at <http://www.surgeongeneral.gov/library/mentalhealth/toc.html>. (Note: Medicaid includes both Federal and state expenditures.)

¹³ HHS, Health United States, 2001.

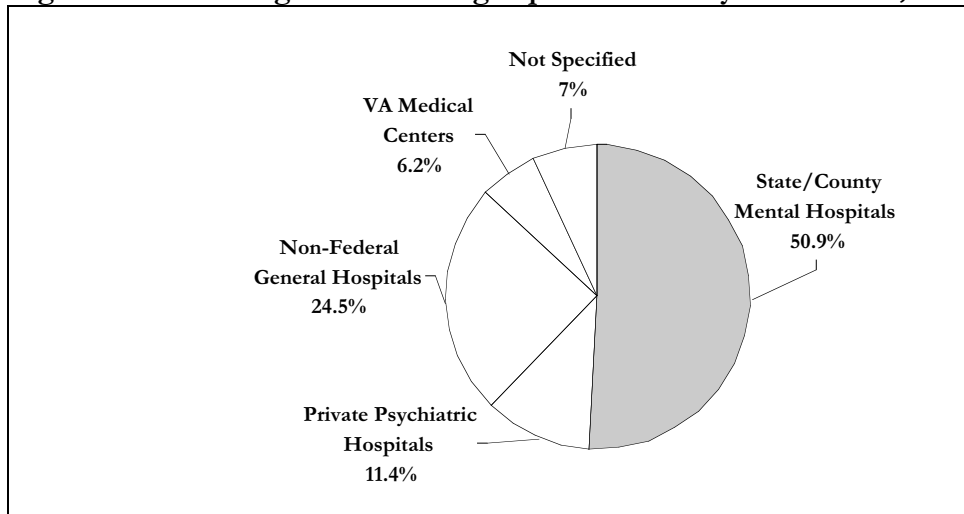
¹⁴ The most commonly used reference for classifying mental diseases is the *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV*.

Figure 2: Revenue Sources for State and County Mental Hospitals, 1994



Source: *Mental Health, United States, 2000*: Chapter 14, Table 9. Center for Mental Health Services, SAMHSA. Available at <http://www.mentalhealth.org/publications>.

Figure 3: Persons Aged 18-64 Using Inpatient Care by Site of Care, 1997



Source: *Mental Health, United States, 2000*: Chapter 15, Table 4. Center for Mental Health Services, SAMHSA. Available at <http://www.mentalhealth.org/publications>. Total = 87,914 persons.

The departure from the normal federal/state payment allocation ratios in the case of treatment for conditions classified as mental diseases is in part the result of a special payment exclusion under Medicaid, the nation’s largest public insurance program. This exclusion, known as the “Medicaid IMD exclusion” and part of the program since its 1965 enactment, bars federal contributions to the cost of medically necessary inpatient care incurred in treating Medicaid beneficiaries ages 21-64 who receive care in certain institutions that fall within the definition of an “institution for mental disease.”¹⁵ An “institution for mental diseases” is defined as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing

¹⁵ 42 U.S.C. §1396d.

diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.”¹⁶

The IMD exclusion represents a significant coverage and financial issue in federal Medicaid policy, particularly in recent years in the wake of the United State’s Supreme Court decision in *Olmstead v L.C.*¹⁷ which held that the medically inappropriate institutionalization of adults with mental diseases violated the Americans with Disabilities Act when reasonable modifications in state programs could achieve community integration.¹⁸ An important follow-up question is what is the potential impact of a federal prohibition against states reporting a portion of their total state spending as a type of expenditure that qualifies for federal financial assistance.

The IMD question is not a small one. The literature regarding estimates of the prevalence of mental illness conditions among Medicaid enrollees is limited because the Centers for Medicare and Medicaid Services does not compile Medicaid program statistics by diagnosis and because of the complexity and cost associated with analyzing state Medicaid data.¹⁹ At the same time, there is evidence that the use of mental health and substance abuse (MH/SA) services by Medicaid enrollees is significant. A recent report from SAMHSA’s Center for Mental Health Services presented evidence suggesting that from 7 to 10 percent of the Medicaid population used mental health-related services and reported furthermore that total Medicaid spending for MH/SA users amounted to between 21 to 24 percent of all Medicaid expenditures.²⁰ Thus, services for the diagnosis, treatment and management of mental illness comprise a substantial proportion of total Medicaid spending, and expenditures on persons with mental illness represent an even more significant overall portion of total Medicaid expenditures.

In order to be able to consider the possible impact of the IMD exclusion on beneficiary access to appropriate level care and health care quality, it is important to understand the exclusion and its limits, as well as the federal guidelines and judicial decisions that have addressed the exclusion.

The Medicaid IMD Exclusion in the Context of Overall Medicaid Policy Related to Mental Diseases

In its 1993 review of Medicaid,²¹ the Congressional Research Service characterized Medicaid mental health policy as falling into several distinct issue categories, two of which are immediately relevant to this analysis. The first issue category focuses on *coverage*. What is the range of mental health treatments that fall within classes of covered services and benefits recognized under Medicaid law, and what are the limits on states’ discretion to make medical necessity decisions related to coverage? The second category focuses on *who provides the services*: that is, are there situations in which no matter how necessary or appropriate the service, there can be no federal contribution

¹⁶ 42 U.S.C. §1396d(i)

¹⁷ 119 S. Ct. 2176 (1999).

¹⁸ *Id.*

¹⁹ Buck, JA and Miller, K. (2002) *Mental Health and Substance Abuse and Medicaid, 1995*. Publication SMA02-3713. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Available at <http://www.mentalhealth.org>. Accessed September 30, 2002.

²⁰ *Id.*

²¹ CRS, Medicaid Source Book: Background Data and Analysis (A 1993 Update) (GPO, Washington D.C.)

because of the *specific type of medical care provider* (e.g., an “institutions for mental disease”) that furnishes the service?

In the case of the IMD exclusion, one encounters a highly unusual situation in federal Medicaid policy: instances in which federal medical assistance payments are denied no matter how medically necessary the service and regardless of the qualifications of the provider and the patient’s eligibility simply because the provider’s characteristics place it within a classification known as an institution for mental diseases. This policy has its roots in Social Security Act legislation that existed at the time of enactment of Medicaid and which excluded federal contributions under Medicaid’s predecessor program to the cost of caring for persons residing in “public or private [IMDs].”²² The exclusion was codified in the original Medicaid statute and with limited exceptions reviewed below, has remained relatively untouched since 1965.

In general: In general, Medicaid coverage policies as they apply to persons with mental diseases are more expansive than either commercial coverage or Medicare. For example, unlike private health insurance, Medicaid contains no pre-existing condition exclusions and no waiting periods prior to the commencement of coverage. Coverage for all persons who fall within one of the “categorically needy” coverage groups must be comparable, regardless of diagnosis. Moreover, unlike private health insurers, Medicaid programs must satisfy certain tests of reasonableness in coverage and are prohibited in the case of required benefits from discriminating in coverage for required services based on an individual’s condition. This anti-discrimination provision can be thought of as a form of parity mandate. Cost-sharing is nominal for adults and entirely prohibited for nearly all children. Furthermore, in the case of children with mental illness, coverage is particularly broad as a result of the EPSDT coverage mandate as well as the elimination of the IMD exclusion in the case of individuals under age 21.

The IMD exclusion: The IMD exclusion is limited to persons ages 21-64. Federal law exempts two populations from the IMD exclusion. The first exemption, which has existed since Medicaid’s enactment, applies to adults ages 65 and older who receive services in institutions for mental diseases.²³ The second exemption, added in 1972, applies to children under age 21 (or in certain circumstances, under age 22).²⁴ In the case of children, inpatient psychiatric hospital care is a coverage option but is mandatory when a child’s condition is diagnosed through an EPSDT screen.²⁵

Beyond the population exemptions to the IMD exclusion, there are two other notable limits on the exclusion. The first is an exemption under 1988 amendments in the case of institutions with fewer than 17 beds.²⁶ The history of this exemption indicates that Congress was particularly concerned that Medicaid be used to promote small, community based group living arrangements as an alternative to large institutions. The second limitation focuses on the inpatient status of the

²² HHS, Report to Congress (1992): Medicaid and Institutions for Mental Diseases, p. II-2.

²³ 42 U.S.C. §1396d(a)(14). This coverage was permitted as an optional Medicaid benefit in the original Act, paralleling the exclusion of such services under Medicare. CRS notes that these services were precluded from the predecessor Kerr Mills Program. Medicaid Source Book, op. cit. p. 917.

²⁴ Coverage can continue until the earlier of the child’s 22d birthday or an unconditional release. 42 C.F.R. §440.160; SMM §4390.1.

²⁵ 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a)(); 1396d(r)(5). This provision was added by the Social Security Act amendments of 1972, P.L. 92-603. The Senate added the provision, noting that helping children with mental illness become productive members of society was a clear Medicaid goal. Medicaid Source Book, op. cit., p. 918.

²⁶ 42 U.S.C. §1905(a)(B).

patients; that is, the exclusion applies only in the case of health providers that are *institutions* for mental diseases with 17 beds or more. Services furnished by partial hospitalization and day treatment programs that do not institutionalize their patients are not excluded.

As a practical matter therefore, the IMD exclusion only affects federal Medicaid payments to certain types of institutions, and then only in the case of certain beneficiaries (i.e., eligible adults ages 21-64). To the extent that a state furnishes treatment in outpatient or small facility settings, the IMD exclusion has no impact. At the same time however, the IMD exclusion is significant because of its scope and application well beyond the range of large state mental hospitals to virtually any form of long-term institutional placement in a facility with more than 16 beds that is skilled in the acute or long-term management of mental diseases and to which patients with mental diseases therefore would be admitted.²⁷

The Medicaid IMD exclusion also is notable because, unlike conventional insurance, Medicaid contains so very few coverage and payment exclusions, especially in the case of medically necessary care.²⁸ In this sense, the IMD exclusion is akin to the types of provider/service setting exclusions found in commercial insurance plans (e.g., exclusions of school-based health services or services of public institutions). The exclusion also raises parity issues, since for no other condition in Medicaid are the services of certain medical institutions excluded.

HHS policy guidance related to the IMD exclusion can be found in the State Medicaid Manual, Part 4, §4390.²⁹ HHS notes that the exclusion “was designed to assure that States, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services.”³⁰ Under HHS policy, the IMD exclusion has been interpreted broadly to apply not to specific defined categories of institutions but instead to any institution which, by its *overall character* is transformed into an IMD; as a result, the determination of whether an institution is an IMD is intensely fact-specific.

Two common justifications are offered for the exclusion. CRS notes that there is no evidence in the original Act of a broad policy decision regarding appropriate federal/state roles in the case of services furnished by IMDs and ascribes the continued exclusion to federal concerns about the growth of Medicaid costs. However, in *Minnesota v Heckler* 718 F. 2d 852 (8th Cir., 1983), which focused on the legality of applying the IMD exclusion to private chemical dependency treatment facilities, the court of appeals noted that the basis for the exclusion lay in a 1963 House of Representatives report finding that state mental institutions were simply warehouses and furnished no treatment and thus were inappropriate facilities for Medicaid coverage purposes.

²⁷ The Supreme Court explicitly recognized the medical necessity of such care arrangements in *L.C. v Olmstead* 119 S. Ct. 2176 (1999).

²⁸ Sara Rosenbaum, Health Policy 2002: Medicaid. *NEJM* (Feb. 21, 2002).

²⁹ The State Medicaid Manual can be found in its entirety at the CMS website, <http://www.cms.gov/medicaid>.

³⁰ CRS notes that there is no evidence in the original Act of a broad policy decision regarding appropriate federal/state roles in the case of services furnished by IMDs and ascribes the continued exclusion to federal concerns about the growth of Medicaid costs. However, in *Minnesota v Heckler*, 718 F. 2d 852 (8th Cir., 1983) which focused on the legality of applying the IMD exclusion to private chemical dependency treatment facilities, the court of appeals noted that the basis for the exclusion lay in a 1963 House of Representatives report finding that state mental institutions were simply warehouses and furnished no treatment and thus were inappropriate facilities for Medicaid coverage purposes. This case is discussed below.

The scope of the exclusion: HHS interprets the exclusion to cover not only services furnished by IMDs but also services that are furnished to IMD patients either inside or outside the facility.³¹ Whether or not a facility is an IMD covered by the prohibition depends on whether it is larger than 16 beds and “if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.”³² Institutions of fewer than 17 beds are essentially excluded from the definition of an IMD rather than being considered IMDs that are exempt from the exclusion.

Defining what constitutes an IMD: Federal guidelines specify the attributes of an entity that is considered an IMD and also provide guidance regarding how to recognize which entity is to be assessed as an IMD. In determining whether an entity is appropriate for consideration as an IMD (as opposed to simply a portion of a larger entity to which the exclusion would not apply), HHS will examine the following matters:

- governance (e.g., all components controlled by one owner or governing body);
- medical direction (one chief medical officer in control of medical staff in all components of the entity)
- administrative control (one CEO in control of all administrative activities in all components of the entity);
- licensure (is there a separate entity license)
- organizational operation as a single entity
- an ability of several operating components within a larger unit to independently meet the conditions of participation under the applicable provider category (e.g., nursing facilities)³³

Where it is determined that a component of an entity is actually its own independent entity, the separate component (such as the psychiatric ward of a general acute care hospital) will be examined for its status as an IMD if it is over 16 beds.

Once an entity is identified for IMD evaluation purposes, CMS applies certain criteria to determine if the entity is an IMD. These criteria are designed to consider the overall character of the facility; most importantly, they can have the effect of re-classifying as an excluded IMD a facility that is licensed as a SNF or ICF and a participating Medicaid provider. CMS guidelines notes a number of relevant factors that come into play when deciding whether a nursing facility takes on the attributes of an IMD (for example a nursing facility in which the residents are decisively younger than the average age of Medicaid nursing home residents, suggesting that they are working age adults with mental illness rather than elderly adults for whom federal financial participation is not barred.) CMS notes that:

A final determination of a facility’s IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established or maintained primarily for the care and treatment of individuals with mental diseases.³⁴

³¹ SMM §4930(a)(2).

³² 42 C.F.R. §435.1009; SMM 4390(A)(3).

³³ SMM §4390(3)(B).

³⁴ SMM §4390(3)(C).

The criteria of key importance to the CMS determination reflect two essential measures: the services that the facility provides, and the prevalence of patients with “mental diseases:”

- whether the facility in question is licensed or accredited as a psychiatric facility,
- whether the facility is under the jurisdiction of the state’s mental health authority, specializes in providing psychiatric or psychological care (as determined by patient records, prescription drug patterns, and staff training and credentialing); and
- whether “the current need for institutionalization for more than 50% of all the patients in the facility results from mental diseases.”³⁵

Thus, the determination is heavily fact driven and turns on both the character of the institution itself – its status, governance, staffing, services and treatments – as well as the current needs of the individuals who are receiving treatment. If the institution takes on the characteristics of an IMD and/or if the cause of institutional placement among current residents relates to a mental disease, then the institution is likely to be considered an IMD.

It is clear that on the basis of admissions alone, a facility can be transformed from a covered Medicaid entity to an excluded IMD. CMS notes that in applying the 50% test, it is *not necessary* to determine whether mental disease treatment currently is being furnished; the only relevant matter is whether the current need for institutional care results from a mental disease either currently or at the time of admission within the past year. In interpreting whether admission ties to a mental disease, CMS instructs staff to consult the International Classification of Diseases (ICD-9-CM) of which the Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subclass. If patient record review is not possible, surveyors are authorized to rely on their professional observations, discussion with staff, and the specialty of the attending physician.

Specific Examples of Facilities that Can be Designated as IMDs: Nursing Facilities and Chemical Dependency Treatment Facilities

Chemical dependency treatment facilities

Private chemical dependency treatment facilities appear to have an even more difficult time avoiding exclusion as IMDs. Because the ICD-9-CM system classified alcoholism and other chemical dependency syndromes as mental disorders, the assumption is that a chemical dependency facility is an IMD if it is a separate entity or a distinct component with more than 16 beds. Furthermore, CMS guidelines clarify that certain forms of chemical dependency treatment facilities would not under any circumstances qualify for coverage. CMS guidelines attempt to distinguish excluded chemical dependency treatment facilities from those that do not qualify for coverage simply because they do not furnish services that are considered “medical assistance”:

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50% guideline.

³⁵ Id.

Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum * * * are facilities that are limited to services based on the AA model, i.e., they rely on peer counseling and meetings to promote group support and encouragement and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment.³⁶ (See 42 C.F.R. §440.2(b)). Do not count patients admitted to a facility only for lay counseling or services based on the AA model as mentally ill under the 50% guideline. If psychological support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.³⁷

Because FFP cannot be claimed when the primary reason for an institutional stay is to receive lay counseling, CMS notes that such facilities cannot claim Medicaid reimbursement for these services regardless of the characteristics of their patients. Because these types of facilities are not considered Medicaid providers, they cannot claim Medicaid funding for the covered services they do furnish. In short, facilities that admit over 50% of their patients for medical chemical dependency treatment become IMDs, and their services are excluded. On the other hand, facilities that admit more than 50% of their patients for lay counseling in effect furnish a service that is not medical assistance; because they are not Medicaid providers, they cannot claim Medicaid for the covered services they do provide.

Nursing Facilities

Because of the potential for a covered provider to be transformed into an IMD based on patient characteristics, the types of services furnished by the facility are less relevant. Thus, it is possible that a private nursing facility not dedicated to the treatment of mental illness may in fact be classified as an IMD based upon the characteristics of its patients. CMS guidelines instruct that when the 50% guideline is used to identify the facility as an IMD, “the guideline is met if more than 50% of the NF patients require specialized services for treatment of serious mental illnesses,” as defined in federal rules.³⁸ CMS notes that since mental health services are common in both skilled and intermediate nursing facilities, the critical issue is whether the mental health services being furnished amount to “specialized services” for patients admitted on the basis of a mental disease, as described in federal regulations.

The potential for a nursing facility to lapse into IMD status is of particular significance to the management of elderly and disabled patients with long term care needs. Under the Medicaid nursing home reform enacted as part of OBRA 1987, the Preadmission Screening and Annual Resident Review (PASSAR) process is required to include an assessment of mental illness in order to ensure that inpatient treatment includes mental illness treatment and management when appropriate.³⁹ If mental illness treatment is required, the nursing facility must ensure its provision even if in doing so

³⁶ Note: FFP cannot be claimed for institutional services when lay counseling is the primary reason for the stay.

³⁷ SMM §4390(3)(E).

³⁸ SMM §4390(3)(D).

³⁹ HCFA Report to Congress III-3.

the facility risks effective conversion into an IMD by virtue of its services and patient mix. The federal government has rejected the position advanced by some that PASSAR essentially modified the IMD exclusion to exempt nursing facilities complying with the law's treatment requirements.⁴⁰

Trial Leave, Conditional Release, and Counting the Number of Beds

Counting the number of beds: When counting beds, CMS notes that surveyors should exclude from the bed count beds that are being used “solely to accommodate the children of the individuals who are being treated.”⁴¹ Children in beds that are not certified or used as treatment beds are not considered patients of the IMD. Thus, the covered services they receive *outside the facility* would be considered Medicaid covered if they are Medicaid eligible.

Impact on Medicaid coverage of being a patient in an IMD: When a beneficiary or Medicaid eligible person is a patient in an IMD, all FFP is denied for covered benefits whether furnished inside or outside the IMD. However, federal regulations on conditional release or convalescent leave from an IMD are not considered to be patients of the institution.⁴² Trial home visits are convalescent leave and as a result, health services received in the community during a trial leave would qualify for federal payments. Similarly, and release on condition of continuing to receive outpatient treatment in ambulatory settings is considered conditional leave and thus the outpatient treatment would be recognized as qualifying for federal assistance, even if the individual continues to be classified as a resident of the IMD.

Emergencies that arise during a conditional or convalescent leave are covered; but if a patient experiences a medical emergency while an IMD patient and not on conditional or convalescent leave, then the exclusion travels with the patient and medical emergency and follow-up treatment would be denied because of the individual's IMD patient status.

The 16-Bed Exception to the IMD Exclusion.

An important exception to the IMD exclusion is the exception drawn for 16 bed facilities. These facilities are permitted to include room and board in their rates and they can specifically house and specially treat adults with mental illness without losing their eligibility for federal medical assistance contributions to state expenditures.

Despite the importance of this exception and its potential relevance to both chemical dependency treatment and efforts to achieve community integration of individuals with serious mental illness who could live in community settings with reasonable modifications in state programs, very little is known about actual practices in this area. Further study would be needed to ascertain how many states actually make payments to group residences of 16 or fewer that specialize in mental illness treatment.

Administrative and Judicial Rulings Regarding the IMD Exclusion

⁴⁰ Id., p. III-4.

⁴¹ SMM §4390.1.

⁴² 42 C.F.R. §435.1008(c); SMM §4390.1.

As with virtually all provisions of the federal Medicaid statute, the IMD exclusion, as well as HHS interpretation and application of its scope and application, have raised numerous legal issues that have received considerable judicial attention over the years.

The legislative authority for the Secretary’s broad “overall character” regulatory approach

The seminal case in this area is *Connecticut Department of Income Maintenance v Heckler*,⁴³ in which the United States Supreme Court upheld as a valid exercise of administrative authority the Secretary’s policy that a licensed SNF or ICF could lose its Medicaid coverage characteristic and be excluded as an IMD solely on the basis of the characteristics of its patients.

In the *Connecticut Department* case, the state of Connecticut appealed a decision excluding a private ICF from program coverage following a review and audit. The review and audit found that the facility, a private, 180-bed entity, was licensed as a “rest home with nursing supervision” that also was authorized to care for persons with certain psychiatric conditions. Over half of all patients were transferees from state mental hospitals, and the professional staff of the facility included three psychiatrists. On the basis of these findings, the HHS Grant Appeals Board excluded the facility’s treatments from FFP because it was determined to be “primarily engaged in providing diagnostic treatment and care for persons with mental diseases within the meaning of the applicable regulations.”⁴⁴ Connecticut appealed and its appeals were consolidated with similar claims from Minnesota,⁴⁵ California, and Illinois.

The state argued that HHS was without the legal authority to de-classify a participating private ICF or SNF as an IMD and that the Department had misinterpreted Congressional intent underlying the exclusion. In the state’s view, Congress meant only to exclude from Medicaid coverage state mental hospitals and did not intend to exclude private long term treatment facilities. As evidence of this intent, the state pointed to the fact that SNFs and ICFs constituted separate categories of treatment services and that in their definitions themselves, Congress recognized that they would treat patients with both physical and mental conditions.

The Court rejected the state’s position based on the “plain language of the statute, the Secretary’s reasonable and long-standing interpretation of the Act, and by the Act’s legislative history.”⁴⁶ The Court noted that in the case of all three categories of services – hospital, SNF and ICF – the statute expressly provides that coverage is not available if the facility is an IMD.⁴⁷ The Court also determined that services could be furnished in each setting for persons with mental illness “provided the services are performed in a hospital, skilled nursing facility or an ICF that is not an IMD.”⁴⁸

⁴³ 471 U.S. 524 (1985).

⁴⁴ 471 U.S. 526-527.

⁴⁵ Minnesota separately litigated a series of cases, *Minnesota v Heckler* 718 F. 2d 852(8th Cir., 1983) and *Granville House v Department of HHS* 715 F. 2d 1292 (8th Cir., 1983), challenging HHS’ decision to classify private chemical treatment programs as IMDs on the basis of the ICD-9 Code. The Court of Appeals concluded that the federal government had no legal basis for treating chemical dependency as a mental illness and that the Secretary had exceeded his authority by re-classifying a Medicaid participating ICF as an IMD because of its treatment of patients with addictions.

⁴⁶ 471 U.S. 528.

⁴⁷ E.g., “inpatient hospital services (other than in an institution for mental diseases)”; skilled nursing facility services (other than in an institution for mental diseases); intermediate care facility services (other than in an institution for mental diseases).” 42 U.S.C. §1396d(a)(1)(4) and (15).

⁴⁸ Id.

The thrice-repeated exclusion demonstrates that Congress did not intend the ICF and IMD categories to be mutually exclusive.⁴⁹

In reaching this conclusion regarding the potential for dual status as both an ICF and an IMD, the Court referenced but did not discuss the ICF definition which in the statute specifically was defined as “an institution licensed * * * to provide * * * health care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who *because of their mental or physical condition* require care and services which can be made available to them only through institutional facilities.”⁵⁰ The Court did not perceive a need to explain this apparent contradiction, because it determined that since 1965, and without Congressional objection, the Secretary had interpreted the IMD exclusion to cover private Medicaid providers whose overall characteristics “tipped” them into the realm of IMDs. Noting the failure on Congress’ part to object to this “overall character” approach, the Court found the Secretary’s interpretation to be reasonable. Indeed, the Court cited the exemption of the over-65 population in the original Medicaid law as evidence of Congressional support for this dual status approach. The exemption reflected Congressional intent that Medicaid policy support removal of elderly mental institution residents and relocation in less restrictive care settings that could participate in Medicaid without jeopardizing their status as Medicaid providers. In other words, the over-65 amendments were in the Court’s view evidence that in the absence of the age exemption, an ICF or SNF would be converted into an IMD were more than half its patient population to be comprised of persons whose mental diseases led to their institutional status.

Since the statute itself did not ever use the term “public” in describing an IMD, the Court rejected the state’s efforts to place a gloss on the definition, even though Medicaid law makes clear that the treatment of persons with mental illness is assumed throughout the statute:

The [legislative history] * * * does clearly establish that an individual is not ineligible for Medicaid simply because his need for care is based on a diagnosis of mental illness. Moreover, it is perfectly clear that hospitals, skilled nursing facilities, and intermediate care facilities are not ineligible simply because they provide care and treatment for mentally ill patients. However, the legislative history demonstrates that Congress has thrice since 1965 not accepted proposals to lift the IMD exclusion for persons under age 65. But most damaging to the State’s position is a statement by Congress from the legislative history of the 1972 amendments, which *authorized Medicaid funding for ICF services for the elderly in IMDs*. * * * This [amendment] is consistent with the plain language of the statute and with the Secretary’s longstanding administrative interpretation: hospitals, skilled nursing facilities and ICFs can be IMDs and the terms are not mutually exclusive.⁵¹

The net result of *Connecticut Department* has been to sustain the Secretary’s broad powers to interpret the exclusion broadly based on both the structure and services of the participating facility and the characteristics of its patients.

⁴⁹ Id.

⁵⁰ 471 U.S. Note 14.

⁵¹ 471 U.S. 538.

When does the exclusion begin?

Because the IMD exclusion is tied to an institution and not the residential status of the patients, it begins at the time of admission and continues to the date of discharge (complete or conditional). Therefore, states cannot receive federal payments for partial month coverage for what might be an acute episode of need and prior to the establishment of long term institutional status. In other words, if the admission is to an IMD, the exclusion is immediate.⁵²

When is a program in a facility considered a sufficiently distinct component to be an IMD?

The determination of when a portion of an institution is in fact sufficiently distinct in character and operation to be classified as an IMD is a factual one and therefore, disputes over classification would be common. In *In re NY State Department of Social Services*⁵³ two Westchester psychiatric facilities were determined to be sufficiently distinct from St. Vincent's, a New York City general acute care hospital of which they were a part, to be considered IMDs. The state attempted to prove that because the facilities were under a common ownership and common medical direction and shared a common CEO and board of trustees did not satisfy the HHS Departmental Appeals Board. Of great importance was the fact that the facilities were separately licensed and accredited, were certified as psychiatric hospitals for Medicare purposes, filed separate Medicare and Medicaid cost reports, and were paid at different rates from the parent corporation. The Board held that even putting aside the operation of state licensure law, the overall character of the Westchester branches of St. Vincent's was such that for Medicaid purposes they would be considered distinct IMDs rather than branches of a parent entity.

Similar results were reached in *California Dept. of Health Services*⁵⁴ and *New York State Department of Social Services (II)*,⁵⁵ in which the Appeals Board rejected arguments by the state regarding ownership and management because of evidence of separate locations, licensure and accreditation, scope of services, specialized management, and payment rates. In *New York State II* the Board made clear that an entity could be an IMD even if it is merely a portion of a larger institution that is not primarily for the care and treatment of persons with mental diseases. If the primary use of branch facilities is for the care and treatment of persons with mental diseases, then the overall character is that of an IMD. Administrative relationship alone is basically irrelevant.

Policy Considerations

The IMD exclusion raises numerous policy considerations although as noted, numerous attempts to narrow its scope or eliminate the exclusion entirely have been rejected (other than the 16-bed exemption and amendments excluding children under 21 and the elderly). Some of the most important issues are as follows:

⁵² *Illinois v Heckler*, 609 F. Supp. 1421 (N.D. Ill., 1985).

⁵³ DAB No. 91-48 (1992); reprinted at CCH Medicare/Medicaid Guide para 40,343.

⁵⁴ DAB No. 1495 (1994).

⁵⁵ DAB No. A-95-34 (1995); reprinted at CCH Medicare/Medicaid Guide para. 45886.

- As researchers gain an increasing understanding of the biological basis of many forms of mental illness, does the exclusion continue to have meaning other than as a financial penalty? If conditions classified as “mental diseases” in fact increasingly are treated through medical therapies and treatments that require limited to no traditional psychiatric intervention, is there still a justification for the exclusion?
- Does the presence of the exclusion encourage state efforts to evade it? The exclusion obviously has costly implications for state health budgets, even where states make efforts to minimize its impact through the use of smaller facilities and general treatment facilities that do not fall into the same “box” as the New York State and California arrangements discussed above. State’s use of Medicaid’s disproportionate share hospital and upper payment limit standards have frequently been connected to efforts by state officials to support institutional services for persons with mental illness. Would it be preferable to revise Medicaid contribution rules to permit coverage of IMD services in order to lessen the potential for aggressive state efforts to avoid the exclusion? Recent articles in the New York Times examining New York State’s allegedly substandard treatment of seriously mentally ill residents suggest that before a state will forego federal financial payment for services it will ignore evidence of serious mental illness and will permit patients to be scattered into nursing facilities that are incapable of furnishing appropriate level care simply as a strategy for avoiding the risk of having the nursing facility classified as a form of IMD.⁵⁶
- How does the financial impact of the exclusion affect Medicaid managed care premiums related to behavioral health care? Does the reduction in federal funding result in premiums that are under-financed in relation to need, at least in states in which the federally matched portion of the state’s premium is not supplemented with state funds?
- How is the quality of care affected by the IMD exclusion? Does it matter that in order to avoid the exclusion, states must place patients with mental diseases in larger general purpose institutions? Are these institutions capable of health care quality as good as that furnished by more specialized facilities? Are there particularly promising treatment arrangements that cannot be developed or disseminated and replicated because of the impact of restrictions on Medicaid funding?
- Given the attention to mental health parity, can the exclusion be justified? Indeed, a common rationale given by commercial health insurers for their failure to cover mental illness was that responsibility for payment for mental illness traditionally lay with state governments.⁵⁷ Is the rationale for the Medicaid exclusion any different? In the Medicaid context is there sufficient justification for the continued withholding of financing?⁵⁸
- *Children and the IMD exclusion:* How does the IMD exclusion apply to unborn children of pregnant women who are receiving treatment in an IMD? If a pregnant woman being

⁵⁶ Clifford Levy, “Mentally Ill and Locked Away in Nursing Homes” NYT (Oct. 6, 2002) www.nytimes.com/2002...034942835.

⁵⁷ *Metropolitan Life Ins. Co. v Massachusetts* 421 U.S. 724 (1985).

⁵⁸ For a discussion of these and other policy considerations as well as an extensive legislative and judicial history, see, for example: Edwards, JF. (1997). “The Outdated Institution for Mental Diseases Exclusion: A Call to Re-examine and Repeal the Medicaid IMD Exclusion.” Published by the Treatment Advocacy Center. Available at <http://www.psychlaws.org/HospitalClosure/Index.htm>.

treated for addiction in an IMD to go into labor and need maternity care, is the care furnished to her or to the infant? Recent regulations issued by HHS on the subject of coverage of unborn children under the State Children's Health Insurance Program⁵⁹ suggest a willingness on the part of HHS to recognize this eligibility classification under certain circumstances. While the Secretary's authority to recognize unborn children as a separate group of eligible persons was eliminated by Congress in 1986 in the case of non-legal residents who are pregnant women, the bar was not absolute. No such barrier to the Secretary's authority exists in the case of unborn children of Medicaid eligible women who are patients in IMDs for whatever reason. Viewed as an adult patient, a woman who is a Medicaid beneficiary and a patient in an IMD could not get coverage for a pregnancy-related emergency. But were the case to be viewed as one involving a child in a "non-treatment bed" who simply accompanied its mother, then it would appear that Medicaid coverage could be approved for the baby's delivery and certainly for its follow-up care.⁶⁰

- *IMDs and administrative costs:* Even if federal medical assistance payments are denied in cases of medical care and treatment furnished in IMDs, should a different policy be adopted where administrative costs related to utilization and patient management are concerned? Would health care quality and continuity be improved if state Medicaid programs could claim FFP for the cost of managing the care of patients who between IMDs and more community-based settings?
- *IMDs and substance abuse:* What has been the impact of the IMD exclusion on the use of Medicaid to develop residential treatment programs for persons with substance abuse problems? Would lifting the exemption spur greater investment?

Finally we believe that a more extensive study of the 16-bed exception to the exclusion would be warranted. The absence of information was striking and it became clear to us that in light of the Administration's initiative to achieve community integration, carefully examining both how states use this exception as well as the barriers to its greater use is of tremendous important both for mental illness and substance abuse. Because the "16 bed or fewer" rule is not an optional benefit class per se but simply an exception to an exclusion, tracking state use of these types of facilities would require detailed descriptive analysis work. But the option is of such potential value that in our view, its use as well as practical and policy barriers to expanding the use of these arrangements should be thoroughly studied.

⁵⁹ "States May Provide SCHIP Coverage For Prenatal Care: New Rule to Expand Health Care Coverage for Babies, Mothers." HHS Press Release, September 27, 2002. Available at: <http://www.hhs.gov/news/press/2002pres/20020927a.html>.

⁶⁰ *Id.*