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Statement for the Record

**National Health Law Program,
Autistic Self-Advocacy Network,
Bazelon Center for Mental Health Law
Center for Public Representation, and
National Disability Rights Network**

to the

**House Committee on Energy and Commerce
Subcommittee on Health**

**HEARING ON "COMMUNITIES IN NEED: LEGISLATION TO
SUPPORT MENTAL HEALTH AND WELL-BEING"**

April 5, 2022

The National Health Law Program (NHeLP) is a public interest law firm working to protect and advance the health rights of low income and underserved individuals. Founded in 1969, NHeLP advocates, litigates, and educates at the federal and state levels. Consistent with its mission, NHeLP works to ensure that all people in the United States have access to affordable, quality health care, including comprehensive behavioral health services.

As this committee is well-aware, an unacceptable number of children and adults in the United States struggle with unmet mental health needs. We are gravely concerned by the growth in the proportion of pediatric emergency department visits for mental health conditions during the pandemic, the sharp increases in opioid-related deaths over the past year, and the apparent decline in adolescent mental health.¹

Medicaid, as the largest single payer of behavioral health services, is an integral tool in addressing these challenges. As we shared

with the Senate Finance Committee, we encourage Congress to leverage Medicaid to improve oversight of children’s EPSDT services, increase access to care for justice-involved individuals, and strengthen and enforce parity.²

Many promising proposals have been raised and are being considered by this Committee. However, as an organization committed to advocating for the needs of Medicaid enrollees with disabilities and community living, we are deeply concerned about certain proposals that would alter or weaken Medicaid’s long-standing “institutions for mental disease” (IMD) exclusion.

The IMD Exclusion Is a Prohibition on Settings, not Services

As a preliminary matter, it is essential to clarify that an IMD is not a service, nor is the IMD exclusion a prohibition on payment for any specific kind of service. Instead, it is a limitation on *where* services are provided. As MACPAC previously noted, in the context of the IMD exclusion and substance use disorder (SUD) treatment:

States can cover all of the levels of care described in the ASAM [American Society of Addiction Medication] criteria through their state plan. However, many states do not do so, resulting in gaps in coverage for partial hospitalization and residential treatment in particular. Barriers to care often extend beyond the IMD exclusion.³

The same is true for mental health services. The IMD exclusion only regulates how many **beds** can be in a facility (or a distinct part thereof), not what **services** the state can provide. A bed is a place, not a service. There is no service that has been identified even by those who wish to repeal the IMD exclusion that cannot be provided in settings that do not qualify as IMDs. States can and

¹ CDC, Morbidity and Mortality Weekly Report, *Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the Covid-19 Pandemic—United States, January 1-October 17, 2020* (Nov. 13, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm?s_cid=mm6945a3_w; CDC, Drug Overdose Deaths in the U.S. Top 100,000 Annually (Nov. 17, 2021), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm; CDC, Morbidity and Mortality Weekly Report, *Adolescent Behaviors and Experiences Survey – United States, January-June 2021* (Apr. 1, 2022) https://www.cdc.gov/mmwr/ind2022_su.html.

² National Health Law Prog., *Comments to Senate Finance Committee on Improving Behavioral Health Care* (Nov. 2021), <https://healthlaw.org/resource/comments-to-senate-finance-committee-on-improving-behavioral-health-care/>.

³ Medicaid & CHIP Payment & Access Comm’n, Report to Congress on Medicaid and CHIP, Chapter 4: Access to Substance Use Disorder Treatment in Medicaid, 97 (June 2018), <https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf>.



should provide the full continuum of care for behavioral health services in acute care hospitals, smaller group settings, and in individuals' own homes and communities.

The IMD Exclusion Encourages Investment in Community-Based Services

While the IMD exclusion does not prohibit a state from providing any specific services, it has encouraged states to invest in community-based services and smaller settings. This incentive for community-based settings was a part of Congress' original intent when incorporating the IMD exclusion into the Medicaid Act. Medicaid was established in 1965, just two years after the Community Mental Health Centers Act of 1963 was enacted. In adopting the IMD exclusion, Congress explained that community mental health centers were "being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963," that "[o]ften 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."⁴

Historically, the IMD exclusion provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated settings. Medicaid reimbursement is available for mental health services in the community rather than institutions, creating a financial incentive to rebalance treatment towards community-based services. This incentive is particularly important due to "bed elasticity," where supply can drive demand.⁵ That is, if the beds are available, they will be filled, siphoning resources that could be used to improve and expand community-based services. But when beds are not available, other options adequately meet individuals' needs.⁶

⁴ Comm. on Finance, S. Rep. 404 to accompany H.R. 6675, at 46, 144, 146 (June 30, 1965), <https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%202.pdf>.

⁵ Martha Shumway et al., *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*, 63 PSYCHIATRIC SERVS. 135 (2012), <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201000145>. See also Bradley Watts et al., *Supplier-induced Demand for Psychiatric Admissions in Northern New England*, 11 BMC Psychiatry 146 (2011), <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-11-146>.

⁶ *Id.*



The IMD Exclusion Supports Civil Rights and Community Integration

Changes to the IMD exclusion risk undermining hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.⁷ IMDs are by definition residential settings where individuals with disabilities receive services, and decisions regarding the IMD exclusion will inevitably have an impact on where people with disabilities reside and receive services.⁸ In passing the Americans with Disabilities Act, Congress found that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.”⁹ Many IMDs are quite large, and the size of such facilities increases the risks of segregation and isolation. For example, the average bed capacity of an IMD participating in a three year federal IMD demonstration was over 100 beds, and one had a capacity of over 400 beds.¹⁰ Providing federal funding for large institutional settings could reinforce discriminatory presumptions about the ability of individuals with disabilities to receive services in community based settings, and undermine the integration mandate articulated by the Supreme Court in *Olmstead v. LC*.¹¹

In addition to concerns about IMDs overall, we are particularly concerned that any attempt to repeal or modify the IMD exclusion for youth in foster care is contrary to best practices and current efforts to reform child welfare to encourage more use of family-based care. Children in the foster care do best in family-based care, and to the extent that group homes are used, small (less than 17

⁷ President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm>.

⁸ While the ADA excludes individuals who are currently using illegal substances from the definition of an “individual with a disability,” the definition of disability should include individuals in an IMD, as individuals in IMDs are generally not currently using illegal drugs and are in a supervised rehabilitation program. 42 U.S.C. § 12012; 28 C.F.R. § 35.131 (“(2) A public entity shall not discriminate on the basis of illegal use of drugs against an individual who is not engaging in current illegal use of drugs and who—(i) Has successfully completed a supervised drug rehabilitation program or has otherwise been rehabilitated successfully; (ii) Is participating in a supervised rehabilitation program; or (iii) Is erroneously regarded as engaging in such use.”).

⁹ 42 U.S.C. § 12101.

¹⁰ Crystal Blyer, *et al*, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), <https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf>.

¹¹ 527 U.S. 581 (1999).



beds) is better.¹² Long-standing litigation has established children’s right to community-based services pursuant to both the EPSDT mandate and the Americans with Disabilities Act, and in 2018, landmark legislation—the Family First Prevention Services Act—was enacted to help make this a reality.¹³ Now is not the time to undermine this progress and make it easier for states to obtain federal funding for foster children in institutions.

Modifications to the IMD Exclusion Will Not Solve the Problems Identified

The pressing issues this committee has identified, including the overdose epidemic, emergency department boarding, and a lack of providers, will not be solved by funding more beds in IMDs. The evidence related to IMDs actually paints a much more complex picture.

For example, the claim that more federal funding for IMDs would reduce emergency department (ED) boarding was recently explicitly tested by a federal demonstration and found to be unsupported by the federally-authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by the Section 2707 of the Affordable Care Act.¹⁴ The MEPD evaluation found that in those states that had sufficient data to draw conclusions, “[t]he results do not support our hypothesis that [emergency room] visits would decrease as a result of MEPD.”¹⁵ The MEPD evaluation also found that the MEPD did not reduce psychiatric admissions to non-psychiatric beds, often called “scatter-bed” admissions.¹⁶ Qualitative interviews with stakeholders in states participating in the MEPD instead suggested that long wait times in EDs were attributable to factors unrelated to the availability of beds, including time waiting for

¹² American Academy of Pediatrics, Children’s Defense Fund, Foster Club, Think of Us, and Youth Law Center (Jan. 2022), *The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care*, <https://familyfirstact.org/resources/path-well-being-children-and-youth-foster-care-relies-quality-family-based-care-what%E2%80%99s>

¹³ See *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006); *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1158 (9th Cir. 2007); Settlement Agreement, *T.R. v. Dreyfus*, C09-1677-TSZ (W.D. Wash. Dec. 19, 2013), https://www.disabilityrightswa.org/wp-content/uploads/2017/12/Settlement-Agreement-and-Ordersigned-8.30.2013_0.pdf; Dep’t of Justice, Findings Letter, Investigation of West Virginia Children’s Dep’t of Justice, Findings Letter, Investigation of West Virginia Children’s Mental Health System Pursuant to the Americans with Disabilities Act 22 (June 1, 2015), https://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf.

¹⁴ Crystal Blyer et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report*, MATHEMATICA POLY RESEARCH (Aug. 18, 2016), <https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf> (hereinafter “MEPD Evaluation”).

¹⁵ *Id.* at 49.

¹⁶ *Id.* at 41.



specialists to do evaluations, the need for detox prior to transfer, waits for appropriate transportation, and time spent completing the involuntary commitment process.¹⁷

Another reason some claim that the IMD exclusion needs to be modified is to improve access to SUD treatment, and specifically treatment for opioids. However, the single most important intervention for individual with opioid use disorder is medication for opioid use disorder (MOUD), when compared to other treatment pathways, including inpatient detoxification and residential services.¹⁸ And while all states must cover MOUD in Medicaid, far too many states place unreasonable restrictions on accessing MOUD for Medicaid enrollees, such as preferred drug lists and prior authorization, step therapy, quantity limits, and scope of practice limits.¹⁹ Additional federal funding for IMDs for SUD treatment is unlikely to solve the problem identified, but reducing state-level barriers to MOUD could.

Conclusion

In summary, changes to the IMD exclusion are unnecessary—they are not a barrier to services, but rather a prohibition on federal funding for certain settings. In fact, changes to the IMD exclusion are not likely to solve the problems articulated, and instead risks undermining community integration and recent efforts to ensure that children with disabilities are able to live in family-like settings.

We appreciate this opportunity to provide comments on this committee's work to improve behavioral health. If you have questions about these comments, please contact Jennifer Lav (lav@healthlaw.org).

¹⁷ *Id.* at 77.

¹⁸ Sarah E. Wakeman, et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, JAMA Network Open (Feb. 5, 2020) (In a comparison of treatment pathways for OUD, only treatment with buprenorphine and methadone was associated with reduced risk of overdosing during a 3 month and 12-month follow-up. Inpatient detoxification and residential services were not associated with a reduced risk.).

¹⁹ Cathren Cohen, National Health Law Prog., *Eliminating Barriers to Medication-Assisted Treatment in Medicaid* (Feb. 2022), https://healthlaw.org/resource/eliminating-barriers-to-medication-assisted-treatment-in-medicaid/?fbclid=IwAR3Rf0_Ct2oKA16iw4XR2PxiEj3A60vBuOstwl43HUkqaJ8PcFGBXQO8GE8.

