

# Medicaid Institutes for Mental Diseases (IMD) Exclusion

## Overview, Impact, and Cause for Repeal



### Paul's Legacy Project

Equal Access to Long-Term In-Patient Treatments

Because Mental Illness is a Medical Illness

# Medicaid Institutes for Mental Diseases (IMD) Exclusion

- Definition of Institutes for Mental Diseases (IMD)
- History of the IMD Exclusion
- Isn't Recovery Possible?/The Need for Institutionalized Care
- Discriminatory Aspects of the IMD Exclusion
- What went wrong/Impact of IMD Exclusion
- NAMI's Position on Repeal
- Partial Repeal
- Appropriate Treatment Works; Call for full Repeal
- Other Necessary Action

# What is an "Institute for Mental Disease" and What is Excluded?

- Hospital, nursing facility, or other institution
- Greater than sixteen beds
- Primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including nursing and related services
- All patients in a facility classified as an "IMD" lose all Medicaid coverage regardless of diagnosis
- Federal Medicaid matching payments are prohibited for IMDs
- Payments for non-mental illness related treatments are also prohibited
- Long-term treatment facilities are monitored and the classification can be change to an IMD if the mix of patients changes

# HISTORY of IMD Exclusion

- Enacted in 1965 at Medicaid's inception
- Coincided with Community Mental Health Act of 1964
- Congress insisted that new Medicaid dollars were **not** to supplant the public effort that was already going on with resources from state and local governments.
- Updated at later dates to carve out populations under 21 and over 65, and to include the 16 bed requirement
- Further defined by Olmstead Decision in 1999

# Olmstead Decision

- Supreme Court Decision
- Introduced "least restrictive" terminology
- Person is "qualified" for non-institutional care
- Wants to live in the community
- Adequate housing and other resources are available
- **Decision does not "condone termination of institutional settings for persons unable to handle or benefit from community settings"**

# Isn't "Recovery" Possible?

- Yes, but... "Even with the best treatments available, most patients with schizophrenia do not recover fully" National Institute for Mental Health website on schizophrenia.
- Cognitive loss is not recoverable at all, although new research in cognitive therapy is promising; RAISE program
- 50% of people with schizophrenia and severe bipolar also have Anosognosia, which is the lack of insight to one's illness
- The Olmstead decision set criteria for appropriate release, and acknowledged the need for some people to remain in an institutional care setting
- Experts estimate that 50 public psychiatric beds per 100,000 population, or **117,000** beds, are needed

# What went wrong?

- The Medicaid IMD Exclusion has created a financial incentive for the states **not** to provide appropriate treatment.
- The supportive community housing and smaller long-term care facilities never materialized due to "not in my back yard" push back and financial drain from the Vietnam war
- Patients continued, and continue, to be released, regardless of whether or not they could handle living in the community
- Patients released un-stabilized, with only a prescription, a little money, and directions to the nearest homeless shelter
- Tighter restrictions on civil commitments were made, creating barriers for access to any in-patient treatment
- HIPPA laws prevent family members from staying informed

# Discriminatory Aspects

"Adults with severe mental illnesses, is the sole category for whose inpatient care Medicaid will not reimburse except under circumstances which narrowly limit choice, and likely compromise quality. Nearly forty[-seven] years after enactment, this has become discriminatory treatment." NAMI

"No one who is chronically mentally ill should be summarily discharged to the community unless the community can provide an appropriate and safe place for him or her to live. Our present policy of discharging helpless human beings to a hostile community is immoral and inhumane. It is a return to the Middle Ages, when the mentally ill roamed the streets and little boys threw rocks at them." Dr. Robert Reich

# Replacing State Hospitals for Homelessness and Incarceration

## In NY Alone...

	<u>1973</u>	<u>2000</u>
State Hospitals	93,000	5,000
Prisons	12,500	72,000

## Nationwide...

	<u>1960</u>	<u>Now</u>
State Hospitals	500,000	35,000
Homeless	???	200,000
Prisons	25,000*	500,000

\*Using 7% on 333,000; Justice Policy Institute and NAMI statistics

# Lack of Psychiatric Beds, Length of Hospital Stays

- The Medicaid IMD Exclusion provides a financial disincentive to provide long-term care, even when appropriate
- Long-term treatments in state hospitals are rare now; of 117,000 beds needed, only 35,000 were available in 2002, and more state hospitals have closed since then
- Nursing homes will not admit for fear of IMD classification; new ruling on nursing homes in New York
- Average stay in acute care admission 6-8 days
- Patients released "sicker and quicker"

# "Frequent Flyer" Syndrome

- 70% of Medicaid costs are from 30% of people with chronic illnesses of any kind, not just mental illness
- In one study regarding people with severe mental illness:
  - 75% had been admitted to state hospital 1 - 50 times
  - 65% had been admitted to an acute care hospital
  - The average number of acute care hospitalizations was seven
- Each psychotic event damages cognitive reasoning capabilities making it less and less likely the person can live independently (RAISE project, NIMH)

# Homelessness

- 20 - 25% of all people who are homeless have a severe mental illness; some claims are as high as 50% when Anxiety and other disorders are taken into account, and over 60% when substance abuse/addiction is added in
- Approximately 200,000 people who are homeless have schizophrenia or bipolar disorder
- People with severe mental illness who are homeless are more likely to be a victim of violence, rather than a perpetrator
- People with severe mental illness who are homeless lack adequate medical care and often have other medical problems

# Incarceration

- Approximately 500,000 people with a severe mental illness are incarcerated. Another 800,000 are on parole.
- Prisons are now the largest psychiatric facilities in the country
- People with severe mental illness serve longer sentences, on average due to inability to follow orders, resulting in time added to sentence
- People with severe mental illness serve more time in solitary confinement than other inmates, and for longer time periods

# Costs in Lives

- On average, someone with a severe mental illness will die 25 years sooner than someone who does not have a mental illness
- Subtract another 5 years if you are homeless
- 1,000 homicides per year committed by people with severe mental illness (often untreated)
- 17% of people with severe mental illness commit suicide
- Kelly Thomas, recent example of killing by police

# Costs in Dollars

- \$317 billion spent annually on hospitals (frequent flyers), SSDI and loss of productivity/loss of work
- \$15 billion spent annually on incarcerating people with severe mental illness (does not include people with substance abuse)
- Costs for 911 calls, ambulance, police, courts, social service agencies - ???
- Costs for homeless outreach, mental health advocacy, prison advocacy - ???

# NAMI Position on Repeal

- Changes in IMD Exclusion should **not** result in:
  - withdrawal of public funds from the treatment system;
  - warehousing of persons with severe mental illnesses in state mental hospitals;
  - denial of lengths of stay appropriate to what is clinically indicated case-by-case;
  - diminished funding for the treatment of persons with severe mental illnesses;
  - diminished community-based systems of care for persons with severe mental illnesses.

# NAMI Position Continued

- Changes in IMD Exclusion **should**:
  - eliminate discrimination against people with severe mental illnesses;
  - eliminate bureaucratic barriers to treatment (at the very least it should not enhance bureaucratic barriers);
  - eliminate perverse incentives on treatment systems by ceasing to finance policy that impairs treatment of people with severe mental illnesses;
  - **let clinical need--for acute hospitalizations or long-term care--determine the intervention needed by the patient.**

# 3-Year Partial Repeal

- Part of the Health Care Reform Act
- Covers emergency hospitalization for stabilization only; long-term treatments are still not covered
- Covers only private intuitions; state hospitals are still not covered
- Goals are to demonstrate extended coverage will
  - Improve timely access to emergency psychiatric care,
  - Reduce the burden on overcrowded emergency rooms, and
  - Improve the efficiency and cost-effectiveness of inpatient psychiatric care

# What the Partial Repeal Won't Do

- Enable equal access to long-term treatments to everyone otherwise Medicaid eligible
- Cover stays in public psychiatric hospitals; is this the beginning of privatizing in-patient psychiatric care?
- Stop the premature release of patients from acute care admissions
- Correct the problems of inadequate transition planning and follow up when a patient is released
- Correct the problem of inadequate long-term supportive housing
- Correct Education, Jobs and other issues

# Treatment Works

- Analysis of Assisted Outpatient Treatment shows treatment works:
  - 74% fewer participants experienced homelessness
  - 77% fewer experienced psychiatric hospitalization
  - On average, AOT recipients' length of hospitalization was reduced 56% from pre-AOT levels.
  - 83% fewer experienced arrest
  - 87% fewer experienced incarceration.
  - 49% fewer abused alcohol
  - 48% fewer abused drugs

# Call for Full Repeal

- The Olmstead decision expressly stated that it did not condone the release of patients unable to handle or benefit from community settings. The Medicaid IMD Exclusion has created a financial reimbursement system that created an incentive to do just that.
- The term "least restrictive" has been too broadly interpreted to mean that everyone should live independently when it was qualified by a person being capable of living in the community.
- Lives would be saved by reducing homelessness, and incidents with police, stabilizing symptoms, reducing suicides and homicides, and improving health care over all.
- Money would be saved. If treatment works, then "appropriate" treatment would work even better. Areas where AOT laws have been enacted have seen \$1.80 saved for every \$1.00 spent.

# Other Necessary Action

- Support enactment of Assisted Outpatient Treatment laws nationwide; enforce and improve the laws already on the books
- Support changes to civil commitment laws to include "grave disability," which focuses on the person's inability to meet his or her basic survival need
- Support improvements of discharge/step-down process; assessment criteria, transition planning, and follow up
- Support funding of long-term supportive housing initiatives
- Support integration of mental health care with primary care and community public health clinics, health homes, etc.

# Resources

- National Institutes of Mental Health: [www.nimh.gov](http://www.nimh.gov)
- National Alliance on Mental Illness: [www.nami.org](http://www.nami.org)
- Treatment Advocacy Center: [www.treatmentadvocacycenter.org](http://www.treatmentadvocacycenter.org)
- National Health Care for the Homeless Council: [www.nhchc.org](http://www.nhchc.org)
- National Coalition for the Homeless: [www.nationalhomeless.org](http://www.nationalhomeless.org)
- Mental Illness Policy: [www.mentalillnesspolicy.org](http://www.mentalillnesspolicy.org)
- The National Association of State Mental Health Program Directors  
[www.nasmhpd.org](http://www.nasmhpd.org)
- Justice Policy Institute: [www.justicepolicy.org](http://www.justicepolicy.org)
- Prison Policy Initiative: [www.prisonpolicy.org](http://www.prisonpolicy.org)