Introduction to "Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate"

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The following two Viewpoints present a debate on the future of Medicaid's so-called institutions for mental diseases (IMD) exclusion rule. The debate has particular salience for the larger policy debate on whether the United States has enough psychiatric inpatient beds and the types of facilities and services needed in a comprehensive system of psychiatric services.

Editor's Note: After the final editing of this Commentary, on November 13, 2018, the Centers for Medicare and Medicaid Services (CMS) issued a letter to state Medicaid directors announcing new policies modifying the IMD exclusion (https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicaid-demonstration-opportunity-expand-mental-health-treatment-services). CMS will authorize states to seek Medicaid waivers to pay for "short-term stays" for Medicaid enrollees under specific circumstances. There are many unanswered questions regarding this new policy. We understand that these papers informed the discussion and will provide important context as the new policies are clarified and evolve.

The IMD exclusion rule was part of the original Medicaid policy from 1965. Understanding the IMD rule requires understanding what is meant by "institutions for mental diseases." For purposes of current Medicaid policy, IMDs are 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. The IMD exclusion rule prohibits federal Medicaid payments for services delivered to individuals ages 22 to 64 who reside in IMDs. Originally, the IMD designation was reserved for facilities where half the resident population had a mental disease. In the 1980s, the federal government clarified that individuals with a diagnosis of dementia or intellectual disabilities were not counted toward the 50% limit. Over time, the rule was also driven by whether the facility was considered to be "primarily engaged" in providing psychiatric services. Later still, the policy was amended to apply only to facilities with more than 16 beds. All of these criteria are now in place (1).

Congress adopted the exclusion rule for various reasons. The main reason for excluding free-standing public hospitals from receiving federal Medicaid funding was a concern that such payments should not supplant state funding for public hospitals, a historic responsibility in every state. Lawmakers also wanted to encourage care in general hospitals and community mental health centers, where such care would be eligible for Medicaid reimbursement, because these facilities were not considered to be IMDs. The IMD exclusion rule favored short-term hospital care in community-based settings and not in free-standing public and private psychiatric hospitals and nursing homes, which historically involved longer lengths of stay. The rule, however, did not specify anything about length of stay. The 16-bed criterion was introduced to permit small, community-based facilities to receive Medicaid payments. The rule also does not exclude payments to specialized inpatient and residential services for children (under age 22) and specialized geriatric inpatient and residential services (for Medicaid beneficiaries over age 64). States may include such services in their state Medicaid plans.

Over the past 50 years of limiting federal Medicaid payments to certain psychiatric facilities, the IMD exclusion rule has periodically come under scrutiny. A few modest changes have been made, but for the most part the rule has remained in place. In recent years, some stakeholders and policy makers have argued for a complete repeal of the rule, and others have argued that the rule serves its original purposes well enough and that no further change is needed. In the following debate, Jennifer Mathis, J.D., of the Judge David L. Bazelon Center for Mental Health Law, takes the affirmative position to retain the IMD exclusion rule. Her Viewpoint is followed by an argument for total repeal of the rule, written by Dominic A. Sisti, Ph.D., and Aaron Glickman, B.A., of the University of Pennsylvania.

Publication of this debate is part of a collaboration between *Psychiatric Services* and two foundations, the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. The foundations engaged one of us

(HHG) to edit a series of policy papers for publication as free-standing essays to support advocacy in behavioral health services. These papers can be found on the Web site of the Scattergood Foundation (www.scattergoodfoundation.org/policy-paper-series#.W42NROhKhPZ). At the invitation of the other of us (LBD), several of the policy papers have been submitted for publication in the journal. The following debate was published recently in the Scattergood series (1), and we present it here for our readership. We feel that the issue of the IMD exclusion rule is timely and significant. We hope you will agree that the issues are complex and interesting. We find that each of the arguments has merit. Where do you stand on this important issue? Let us know what you think about the IMD exclusion rule.

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1. Mathis J, Sisti DA, Glickman A: Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate. Philadelphia, Thomas Scattergood Behavioral Health Foundation, 2018. http://www.scattergoodfoundation.org/sites/default/files/IMD_Exclusion_Rule_Debate_053118.pdf

Submissions Invited for Culture & Mental Health Services Column

A new column in *Psychiatric Services,* Culture & Mental Health Services, edited by Roberto Lewis-Fernández, M.D., aims to clarify the ways that culture shapes the utilization, delivery, and organization of mental health services. Submissions may examine the influence of culture at the level of the individual seeking care (e.g., the impact of a person's cultural views of illness on treatment choice and level of engagement), the provider (e.g., the role of implicit racial-ethnic biases on service recommendations), the program (e.g., how local socioeconomic and organizational factors influence the package of services offered at a clinic), or the mental health system (e.g., how political forces affect reimbursement structures that determine availability of services). Dr. Lewis-Fernández welcomes papers that focus on aspects of culture related to interpretation (meaning making), social group identity (e.g., race-ethnicity, language, and sexual orientation), and social structures and systems. The goal of the column is to make visible the social-contextual frameworks that shape care. Papers, limited to 2,400 words, may be submitted online as columns via ScholarOne Manuscripts at mc.manuscriptcentral.com/appi-ps. The cover letter should specify that the submission is for the Culture & Mental Health Services column.