



Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House of Representatives

Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives

April 19, 2018

Dear Chairman Walden and Ranking Member Pallone:

The Bazelon Center for Mental Health Law writes to oppose the discussion draft proposal “Provide IMD Services Up to 90 Days for Medicaid Beneficiaries with SUD.” The Bazelon Center is a national non-profit legal advocacy organization that promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, community living, housing, education, employment, voting, and other areas.

First, and most importantly, we have serious concerns about the Maintenance of Effort requirements. Those provisions would lock states into maintaining or expanding inpatient substance use disorder (SUD) as well as inpatient psychiatric bed capacity at a particular date. The rest of the bill would make federal funds available not just for existing inpatient capacity, but also for any additional inpatient SUD capacity that states choose to develop while providing no such incentive to expand community-based outpatient services that are in short supply across the United States. We are concerned this will incentivize overreliance on institutionalizing people with behavioral health disabilities, instead of ensuring that they have access to the full continuum of services they need.

The discussion draft ignores the root of the problem leading to increased inpatient admissions—a lack of sufficient community-based services. The need for acute hospital behavioral health services is directly related to how available and easily accessible outpatient services are in the community, both before and after hospitalization. Increasing access to outpatient community-based services decreases the crises that lead to hospitalization and reduces inpatient admissions as well as allowing hospitals to discharge individuals more quickly to the aftercare services they need. This proposal, in contrast, would incentivize states to keep or expand their inpatient bed capacity in order to meet the MOE criteria, and doing so will almost certainly be to the detriment of community-based behavioral health services, which will not receive additional funding.

While some might argue that such a change will indirectly “free up” dollars that can then be redirected to community-based mental health and SUD services, there is no mandate or

guarantee that the money saved will be spent on community-based behavioral health services. If Congress would like to increase access to community behavioral health services, they should direct federal dollars to those services instead of modifying the IMD exclusion. Creating more inpatient beds at the expense of the community-based services that prevent inpatient admissions will only generate additional pressure on inpatient capacity.

The MOE requirement also has no connection to the actual service needs in a state—states that expand community-based behavioral health service capacity would need fewer inpatient beds and should be allowed to close those beds and shift dollars to community care. As the State Mental Health Program Directors pointed out recently, studies have shown that “demand for acute inpatient care was “elastic,” in that [bed] capacity was fully used when it was available, but when it was no longer available other options were found to meet patients’ basic needs.”¹ This MOE provision is bad policy and we strongly urge members to oppose this provision.

Second, as the Center for Budget and Policy Priorities² and the National Health Law Program³ have both recently noted, there are a multitude of ways to respond to the opioid crisis that do not expand inpatient bed capacity or harm outpatient service systems; Congress should focus instead on those strategies.

Third, it is unlikely that providing federal Medicaid funds for 90 days of inpatient care will effectively address the opioid crisis. What other services will individuals have access to in order to prevent the types of crises that lead to inpatient admissions, or once they leave the inpatient facility? Inpatient hospitalization is only one component of a system and should be addressed as part of that holistic picture. It is community-based services that are critical to ensure that individuals struggling with opioid use can achieve stability and recovery as they live their everyday lives. Funding likewise should be directed primarily at the gaps in a system, which as National Health Law Program points out, are primarily in the community services that individuals with behavioral health disabilities need--such as housing and intensive behavioral health treatment teams.⁴ Simply throwing federal money at hospital services without a comprehensive strategy to respond to the opioid epidemic is an extremely irresponsible use of federal funds.

¹ National Association of State Mental Health Program Directors, *The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity* (August 2017) (citing Martha Shumway, et al. *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services, Psychiatric Services*, Vol. 63 No. 2 (February 2012) and Human Services Research Institute, Technical Assistance Collaborative and the Public Policy Forum, *Analysis of Adult Bed Capacity for Milwaukee County Behavioral Health System* (2014)).

² Center for Budget and Policy Priorities, *Repealing Medicaid Exclusion for Institutional Care Risks Worsening Services for People With Substance Use Disorders* (April 17, 2018) <https://www.cbpp.org/research/health/repealing-medicaid-exclusion-for-institutional-care-risks-worsening-services-for>.

³ National Health Law Program, *Policy Implications of Repealing the IMD Exclusion* (April 18, 2018) <http://www.healthlaw.org/publications/browse-all-publications/policy-implications-repealing-imd-exclusion>.

⁴ *Id.*

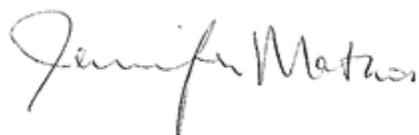
Fourth, the discussion draft seems to be in search of a problem to solve since it completely ignores the rule that CMS issued in 2016 authorizing states to expand inpatient services as part of a comprehensive 1115 waiver strategy, which also allows them to expand community-based services. These 1115 waivers do require review from the Department of Health and Human Services, but that reviews ensures states take a comprehensive and strategic approach to their behavioral health systems. Many states are already working through the 1115 waiver process and to add an addition option at this point in time will simply confuse the issue. If Congress wishes to help this process along, we would urge Congress to provide more direction or a template for these waivers instead of adding additional confusion.

We would also note that Medicaid already covers inpatient behavioral health care in general hospitals, which are much-better suited than freestanding behavioral health hospitals to treat the "whole person" including medical complications from psychiatric medications and co-occurring medical problems, which behavioral health-only hospitals are often ill-equipped to diagnose and treat.⁵

Finally, we are extremely concerned about how Congress intends to pay for this change. The Congressional Budget Office previously scored repeal of the IMD exclusion at \$40 billion to \$60 billion.⁶ We have not seen any discussion of pay-fors and strenuously object to any cuts to Medicaid to pay for these changes.

We are available and would be happy to discuss any of these concerns or alternative solutions such as the ones we have proposed above. Please contact Bethany Lilly (bethanyl@bazelon.org) with any questions.

Sincerely,



Jennifer Mathis
Director of Policy and Legal Advocacy

Bethany Lilly
Deputy Director of Policy and Legal Advocacy

⁵ For example, see Syracuse.com, *NY faults Hutchings Psychiatric for misdiagnosis, neglect in death of girl, 14* (April 11, 2018) http://www.syracuse.com/health/index.ssf/2018/04/post_58.html.

⁶ Congressional Budget Office, Direct spending effects of title V of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015 (November 3, 2015) <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr2646directspendingeffectsofitlev.pdf>.