STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

July 27, 2015

Ms. Victoria Wachino
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Wachino,

I write to request an amendment to Maryland's §1115 HealthChoice demonstration to provide Medicaid payments for stays in Institutions for Mental Diseases (IMDs).

A waiver of the IMD exclusion will allow Maryland to reimburse IMDs for the treatment of Medicaid enrollees aged 21-64 with acute psychiatric and substance-use related needs and receive federal matching dollars. This policy would expand the scope of quality care available to Medicaid enrollees and allow the State to utilize cost-effective treatment options.

Due to the current IMD exclusion, many Medicaid enrollees with acute psychiatric and addiction treatment needs are referred to hospital emergency departments and general acute care inpatient units. These general acute care hospitals do not often maintain the resources and expertise to provide needed specialized care to these individuals, nor are they cost-effective for the services these individuals need. A waiver will allow adult Medicaid enrollees to receive services in private facilities that are dedicated to treating their specific needs and will promote access to high-quality, specialized care. Cost savings will be generated at both the state and federal levels by enabling appropriate care in appropriate settings. This alignment of clinical and financial goals makes an IMD waiver advantageous for both payers and beneficiaries.

Maryland is aware of the recent guidance on new service delivery opportunities for individuals with substance use disorder and looks forward to working with CMS to develop a program that will provide high-quality, cost-effective care for Medicaid enrollees. If you have any questions, please contact Tricia Roddy, Director of the Planning Administration, at 410-767-5809 or tricia.roddy@maryland.gov.

Sincerely,

Shannon M. McMahon
Deputy Secretary of Health Care Financing
Maryland Department of Health and Mental Hygiene

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Maryland HealthChoice Program

§1115 Waiver Amendment

Submitted by

The Maryland Department of Health and Mental Hygiene

July 27, 2015

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Overview & Objectives

The Maryland Department of Health and Mental Hygiene (the "Department") is seeking an amendment to Maryland's §1115 HealthChoice demonstration program waiver that will allow for Medicaid payments for individuals aged 21 to 64 receiving psychiatric care or substance use disorder (SUD) services in an institution for mental diseases (IMD) that is not publically-owned or -operated ("non-public IMD"). Services would require prior authorization but would not be limited in amount, duration or scope.

This waiver amendment would allow the State to continue and expand current policy. Maryland was one of the states selected for the Medicaid Emergency Psychiatric Demonstration, a pilot program established under Section 2707 of the Affordable Care Act that made Medicaid funds available to non-public psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid enrollees aged 21 to 64 for a three-year period.

The demonstration project was slated to run until December 31, 2015, but it ended earlier this year due to federal funding issues. Since the end of the demonstration, the IMD beds, an important cornerstone in expanding the availability for specialized inpatient care of individuals with mental diseases, have become unavailable to Medicaid enrollees. Without a waiver to the IMD exclusion, providers will be forced to make a difficult choice—either reduce the number of beds in their facilities to remain eligible for Medicaid reimbursement, or maintain their current beds and limit their ability to receive reimbursement for the treatment of Medicaid enrollees.

The practical impact is that an IMD provider such as Sheppard Pratt—one of the premier psychiatric hospitals in the country with over 400 licensed inpatient psychiatric beds—would be forced to reduce its capacity to a mere 16 beds to accept Medicaid patients. This is not tenable. This decision has serious ramifications on other parts of Maryland's delivery system, with many beneficiaries being forced into emergency departments (ED) and acute general inpatient units, creating capacity and resource pressures in those settings.

The Department's objective in seeking this waiver is to maintain and enhance beneficiary access to behavioral health services in appropriate settings, relieve capacity pressures on acute general hospitals and assure that individuals receive care in the facility most appropriate to their needs. This can be achieved by continuing the policies under the Medicaid Emergency Psychiatric Demonstration and expanding access to SUD services provided in a residential setting.

Waiver and Expenditure Authority

Maryland is seeking expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures by the State for mental health and substance abuse disorders in non-public IMDs—which are not otherwise included as expenditures under Section 1903—and to have those expenditures regarded as expenditures under the State's Title XIX plan.

Specifically, Maryland is seeking expenditure authority for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid managed care organization and who are residing in a non-public IMD.

Summary of the Proposal

Policy Rationale

Historical Concerns Surrounding IMD Payments Do Not Apply

The original purpose of the IMD exclusion was to ensure that states did not pay for custodial care of individuals with serious mental illnesses; custodial care was viewed to be the role of the State, not a medical service. However, in Maryland's circumstances, this reasoning does not apply to the present amendment request, rendering the IMD exclusion unnecessary.

Traditionally, state and local psychiatric hospitals treated persons with severe mental illness at the public's expense. The IMD exclusion was put in place to ensure that Medicaid dollars were not used as a replacement of local and state resources. Maryland's current request of an IMD waiver only includes non-public IMDs; that is, with the approval of Maryland's IMD exclusion waiver application, non-public IMDs will be eligible for Medicaid reimbursement, while publically-owned or -operated IMDs will remain exempt.

Additionally, in Maryland, residential treatment for substance use disorders in an IMD is not custodial and by policy and practice is treated the same as other rehabilitative services designed to provide medical treatment. Maryland benefits from strict licensing standards for its SUD treatment facilities, which are based on criteria developed by the American Society of Addiction Medicine (ASAM). SUD treatment facilities in Maryland must adhere to the ASAM criteria, and individuals may only receive residential treatment if they meet the appropriate ASAM Level III criteria through a clinical assessment.

Furthermore, Maryland SUD residential treatment facilities are not 'fixed length of stay' programs but rather offer services with lengths of stay that are individualized according to patient needs. These facilities and the State are committed to implementing treatment plans that include outpatient services designed to provide ongoing treatment and to treat SUD as a chronic condition. (See Appendix C for letters of support from residential treatment facilities.)

Growing Recognition on the Need for Behavioral Health Access

IMD exclusion waivers have been granted in the past; the Centers for Medicare and Medicaid (CMS) has approved IMD exclusion waivers that targeted facilities treating individuals with psychiatric needs in Maryland, Arizona, Delaware, Hawaii, Iowa, Massachusetts, Oregon, Rhode Island, Tennessee and Vermont.

In particular, waivers of the IMD exclusion have long contributed to Maryland's safety-net approach. The State's previous IMD exclusion waiver, which began in 1997, increased access for adults between 21 and 64 who needed acute psychiatric care. CMS phased out the use of IMDs beginning in fiscal year (FY) 2006. Maryland received 100 percent of its expected federal match (FFP) for FY 2006, 50 percent for FY 2007 and zero percent for FY 2008.

According to the State Medicaid Manual (CMS Pub. 45, § 4390), chemical dependency disorders are included in the definition of "mental disease." CMS has recently shown a strong interest in providing parity for mental health on par with that of somatic disorders. On April 6, 2014, CMS announced a proposed rule to align mental health and SUD benefits for low-income Americans with benefits required of private health plans and insurance. The proposed rule seeks to ensure that all Americans, regardless of their health care payer, have access to quality mental health services and substance use services. An IMD waiver exclusion in Maryland will help CMS achieve the parity goal by allowing Medicaid recipients to receive high quality mental health services and substance use treatment in clinically-appropriate settings.

Furthering the efforts toward parity, CMS' currently-proposed managed care rule seeks to add a new provision to the Medicaid managed care regulations to allow capitation payments to managed care organizations (MCOs) for enrollees who are patients in an IMD for 15 days or less.[1] The rationale in the proposed managed care rule is that IMD services will be paid in lieu of more costly hospital based services. That rationale pertains to federal and state expenditures for IMD services since cost in an IMD is less costly than costs in an acute hospital, thereby saving state and federal tax dollars. While this proposed rule, if enacted, would not affect Maryland Medicaid due to the State's behavioral health carve-out, it demonstrates a trend by the federal government toward extending these services in the IMD setting.

Expected Impact

Continuing access to IMD services for individuals with mental health needs and expanding coverage to individuals with SUD needs will result in greater and more appropriate clinical treatment options for Medicaid beneficiaries and reductions in hospital and ED admissions.

Data Show a Need for IMD Treatment Options

Preliminary data from the demonstration at the national level are very promising. Of the total number of Medicaid beneficiaries admitted to these community-based psychiatric hospitals, 84 percent had just one admission during the entire first year of the demonstration. The average length of stay was only 8.2 days and, in 88 percent of the admissions, the beneficiaries were discharged to their homes or self-care.[2]

In Maryland, the demonstration has shown the importance of private psychiatric hospitals. In 2014, Medicaid recipients who received services in an IMD had an average length of stay of 9.4 days. Table 1 provides additional information on IMD cost for both mental health and substance use services.

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability. Proposed Rule. Section 438.3

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services. (2013). Report to Congress on the Evaluation of the Medicaid Emergency Psychiatric Demonstration. Available: http://innovation.cms.gov/files/reports/mepd_rtc.pdf.

Table 1. Cost Information for IMD Services, 2014[3]

	Number of Days	Average Length of Stay	Average Cost per Day	Average Cost per Episode	Total Cost
Substance Use Disorder Services	11,400	25.1	$218.90	$5,494.49	$2,495,505.42
Emergency Psychiatric Services	20,392	9.4	$863.69	$8,118.69	$17,612,382.00

The figures in Table 1 correspond with services funded by the emergency psychiatric demonstration and a calculation for SUD service utilization for Medicaid beneficiaries based on the experience of other state programs funding SUD services in a residential setting. With the authorization for Medicaid coverage of emergency psychiatric and SUD services in IMDs, Maryland expects utilization to increase.

Maintaining and Expanding Access to Services Removes Treatment Barriers

Maryland IMD providers have expressed frustration that, despite the availability of beds in their facilities, they cannot fill them. Many people on their waitlists are Medicaid beneficiaries awaiting the availability of grant funds to support their treatment.

Johns Hopkins Medicine has stated, "Many community-based substance use providers have beds available for treatment, but because of the IMD exclusion, these beds cannot be utilized, which forces providers to put patients on waiting lists." This is supported by residential treatment provider Gaudenzia, Inc., who stated, "As of today [June 12, 2015] we have 47 people scheduled for admission in the next two weeks but [we] have 30 open beds. If we could bill Medicaid for this service these people seeking help would have gotten it; instead they are either using a higher-cost service or are a public health liability."

Conversely, several additional Maryland providers (e.g. Hope House, Mountain Manor, et al.) have stated that they have lengthy waiting lists for treatment due to the 16-bed limit. Other stakeholders noted that the decision to seek treatment is often overwhelmed by the disease; that is to say, if initially turned away, many individuals will not return when beds or grant funds become available. Maryland providers have unilaterally expressed that allowing Medicaid to reimburse IMDs will enable them to reach and treat more people.

The data show that limiting services to SUD-only or mental health-only would create a barrier for recovery and the quality of care to an increasing number of people. From CY 2008 through CY 2014, the number of Maryland HealthChoice participants with a dual diagnosis of mental health and substance use disorders grew from 15,254 to 37,055. To mitigate this barrier, Maryland is requesting that its IMD exclusion waiver cover both SUD and emergency psychiatric services.

[3] SUD services are from FY 2014; emergency psychiatric are from CY 2014.

Anticipated Outcomes

Increase access to clinically-appropriate care

One outcome Maryland hopes to achieve with an IMD exclusion waiver is to provide clinically-appropriate care to Medicaid enrollees needing treatment for psychiatric and substance use disorders. The IMD exclusion promotes hospitalization over specialized care. While hospitalization treats the medical effects of individuals' illnesses, it does not treat the illnesses themselves or address the far-ranging consequences of mental health disorders. Hospital emergency departments and general acute inpatient units are not the best setting to provide psychiatric and substance use treatment. The leading treatment standards widely acknowledge that effective treatment of mental disorders takes place along a continuum of care. This continuum ranges from outpatient care to residential care to intensive inpatient services.

Hospital EDs are not equipped or designed to provide the multitude of care options that treating mental diseases require. Maryland providers have overwhelmingly expressed that acute hospital EDs and inpatient units are not the best setting to treat such disorders. Johns Hopkins Medicine specifically addressed this issue, saying, "…some acute care hospitals lack the resources or expertise to provide the intensive behavioral health care that some patients need, where as hospitals such as Johns Hopkins with expertise in treating these patients are often faced with overcrowded emergency departments and inpatient units. This creates a less than optimal patient care experience." The National Council on Alcoholism & Drug Dependence provided similar comments, stating "The IMD exclusion results in people seeking treatment in lower levels of care than what is clinically recommended." Likewise, the Community Behavioral Health Association of Maryland also states, "general acute hospitals are often ill equipped to meet the needs of this specialized population."

Reduce total cost of care

On January 10, 2014, Maryland received approval from CMS to implement an all-payer rate setting system for hospital services ("All-Payer Model").[4] One of the primary goals of the All-Payer Model is to reduce hospital costs and eventually total cost of care per capita, which aligns with the potential of Maryland's IMD exclusion waiver to reduce the Medicaid program's hospital expenditures. The average charge per day in an acute care hospital in Maryland in CY 2014 was $2,965, and substantially more in major metropolitan hospitals such as University of Maryland Medical Center and Johns Hopkins Hospital ($4,260 per day and $3,740 per day, respectively). In comparison, as shown above in Table 1 above, the average treatment cost per individual for emergency psychiatric services provided in IMDs in CY 2014 was $864 per day and $8,119 per episode; for SUD stays, these figures were $219 and $5,494 for FY 2014, respectively.

With the closing of the Emergency Psychiatric Demonstration, patients who previously could have sought treatment in IMDs are forced to seek treatment in acute care hospitals.

[4] Maryland has operated a hospital all-payer waiver since 1977. This system is made possible, in part, by Medicare waiver (codified in Section 1814(b) of the Social Security Act) that exempts Maryland from the Inpatient Prospective Payment System (IPPS). CMS approved a new waiver terms on January 10, 2014.

Conservatively assuming that the average inpatient stay in an acute care hospital is 40 percent less than the average inpatient stay in a community facility, by using the 20,392 days from CY 2014 as a baseline (see Table 1), treating Medicaid patients in acute care hospitals at the average statewide charge for psychiatric episodes rather than IMDs will cost approximately $25 million. This far exceeds the approximately $17 million spent under the Emergency Psychiatric Demonstration in CY 2014 (see Table 1). This additional sum of approximately $8 million would also be subject to a federal match and increase federal spending. The increase in spending is directly at odds with the aims of the All-Payer Model. An IMD exclusion waiver will reduce the total cost of care and save both Maryland and the federal government millions of dollars.

Reduce substance-use related deaths

Another primary outcome Maryland hopes to achieve through the IMD exclusion is to reduce the number of SUD-related deaths, particularly heroin-related overdose deaths. According to the CDC, heroin use has more than doubled among young adults ages 18-25 in the past decade.[5] The CDC states, "States pay a central role in prevention, treatment, and recovery efforts for this growing epidemic"[6] and recommends that states increase access to substance use services.

Maryland is committed to address the growing substance use crisis. Governor Larry Hogan has declared Maryland's heroin problem a public health epidemic. The number of heroin-related in Maryland deaths has risen at an alarming rate over the past several years. In fact, the number of heroin-related deaths in Maryland more than doubled from 2010 to 2014, from 238 deaths in 2010 to 578 deaths in 2014.[7] Unfortunately, the overdose problem is not limited to heroin-related deaths; in 2014, 1,039 Marylanders died from an overdose-related cause—a 60 percent increase since 2010.[8]

The IMD exclusion waiver creates a barrier to treatment by limiting the number of beds a treatment facility may operate in order to receive reimbursement from Medicaid to less than 16. Multiple providers have stated that this bed limit forces them to place patients on waiting lists or in some cases turn patients away. As told by a recovering addict during one of Maryland's public hearings on the IMD exclusion waiver, people experiencing addiction who are turned away from treatment are at a high risk of continuing substance use and not returning to seek treatment. Thus, timely treatment is critical toward curbing substance use. The bed limit under the IMD exclusion is a life-threatening barrier. Receiving a waiver of the IMD exclusion would allow Maryland providers to admit more patients into residential treatment and save lives.

Reduce emergency department visits

Maryland also hopes to reduce ED visits with the IMD exclusion waiver. Maryland has seen a large increase in the number of addiction-related ED visits, which is tied in part to the heroin

[5] The Centers for Disease Control and Prevention, CDC Vital Signs. (July 2015). *Today's Heroin Epidemic*. http://www.cdc.gov/vitalsigns/pdf/2015-07-vitalsigns.pdf
[6] Ibid.
[7] The Maryland Department of Health and Mental Hygiene. (May 2015). *Drug- and Alcohol-Related Intoxication Deaths in Maryland.* http://dhmh.maryland.gov/data/Documents/Annual%20OD%20Report%202014_merged%20file%20final.pdf
[8] Ibid.

epidemic in Maryland. Between 2010 and 2013, the number of heroin-related ED visits more than tripled, from 392 to 1,200.[9] This contributed to a correlated rise in the number of addiction-related ED visits over the same time period. An IMD exclusion waiver encompassing SUD services will reduce the number of addiction-related ED visits. The provider Gaudenzia, Inc. states, "These are people in crisis and when they are scheduled based on the limited availability of beds they go to emergency rooms or they continue to use their substances of abuse."

Additionally, the waiver will reduce the number of acute psychiatric ED visits. Johns Hopkins Medicine, in its letter of support of this application, has acknowledged that the IMD exclusion directly contributes to ED overcrowding. The National Alliance on Mental Illness reports that the Emergency Psychiatric Demonstration project has "reduced the 'boarding' or long wait times in emergency departments for individuals experiencing psychiatric crises." An IMD exclusion waiver will allow the positive outcomes experienced under the demonstration, such as reduced ED overcrowding, to continue.

Budget Neutrality

The Department estimates that the amendment will result in savings under the waiver. The impact of an IMD exclusion for mental health services is already modeled in the hospital expenditure estimates in the waiver. As discussed earlier, the Department estimates that the increased use of SUD services in an IMD setting would result in savings under the waiver by reducing hospital expenditures.

Detailed budget neutrality calculations can be found in the Budget Neutrality worksheet (Appendix A).

Evaluation Design

Maryland's annual HealthChoice evaluation design will be modified to incorporate the IMD exclusion waiver amendment and track the outcomes mentioned above. The Hilltop Institute (Hilltop) at the University of Maryland, Baltimore County, which maintains Maryland Medicaid's data, performs an annual evaluation of the HealthChoice program, as mandated by Maryland's §1115 waiver. This demonstration will test whether authorizing the provision of emergency psychiatric and SUD services in IMDs affects the existing quality and cost measures against which the broader HealthChoice demonstration is evaluated.

Hilltop will track data through the Healthcare Effectiveness and Data Information Set (HEDIS) measures. The Department anticipates that several of these current HEDIS measure will directly capture some of the impact of the IMD exclusion waiver, including Mental Health Utilization – Inpatient Utilization, Initiation and Engagement of Alcohol and Other Drug Dependency,and Plan All-Cause Readmission.

[9] The Maryland Department of Health and Mental Hygiene. (July 2014). *Heroin-Related Emergency Department Visits on the Rise in Maryland.* http://dhmh.maryland.gov/data/Documents/heroin%20ED%20brief_draft.pdf

Additionally, the Department would design an evaluation focused on evaluating the impact an IMD waiver would have on utilization. Under this study, the Department would look to see whether utilization of IMD services would increase, decrease or stay level, as well as track whether greater access to and utilization of IMDs affects utilization of acute inpatient and ED admissions.

Both the quality and utilization evaluation approaches may allow the Department to identify opportunities to improve the usage of IMD facilities and generate best practices for the state.

The Department will also collaborate with the Lieutenant Governor's Heroin and Opioid Emergency Task Force to monitor any impact on heroin- and other opioid-related deaths and ED visits. The evaluation of IMD exclusion waiver will be housed under the Special Topics section of the annual HealthChoice evaluation.

Compliance with Public Notice Requirements

Pursuant to the Special Terms and Conditions (STC) that govern Maryland's §1115 HealthChoice demonstration, Maryland must provide documentation of its compliance with the Demonstration of Public Notice process (42 CFR §431.408), as well as document that the tribal consultation requirements outline in the STC have been met. Maryland's public notice for this IMD amendment consisted of public postings in the *Baltimore Sun* newspaper and the Maryland Register (see Appendix B), prompting a 30-day public comment period (May 15, 2015 – June 15, 2015), as well as two in-person hearings, held in Baltimore and Annapolis.

The State received comments from interested citizens, advocates, and providers via email, fax and the in-person hearings. The feedback received was overwhelmingly positive and has been incorporated, as appropriate, into the waiver request. The stakeholder letters we received are attached to this document in their original format (see Appendix C). Tribal consultation was sought from Kerry Hawk Lessard, M.A.A. Ms. Lessard is the executive director of the Baltimore chapter of Native American LifeLines and a member of the Maryland Medicaid Advisory Committee. Ms. Lessard's letter of support is attached (see Appendix D).