STATE OF ILLINOIS
DEPARTMENT OF
ALCOHOLISM AND
SUBSTANCE ABUSE

STATE OF ILLINOIS CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: 312/814-3640
FAX NUMBER: 312/814-2419
TDD NUMBER: 312/419-6432

Jim Edgar
Governor

James E. Long
Director

November 24, 1993

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
Washington, D.C. 20201

Dear Secretary Shalala:

For your information, I have enclosed an editorial and an article from the Chicago Tribune citing how the "Institute for Mental Disease" (IMD) exclusion illogically restricts drug treatment capacity. I know this issue has been brought to your attention previously, but to date there has been no movement.

I personally concur with President Clinton's efforts for health care reform and his drug strategy goals. Eliminating the IMD exclusion now would be totally consistent with both efforts and an extremely bold policy move toward positive change. It would also offer hope and help to thousands of drug addicted women and their children, especially in our inner cities where the need for more drug treatment is staggeringly obvious. Please, consider this common sense policy change.

Thank you for you consideration and continued leadership.

Sincerely,

Jim Long

James E. Long
Director

JEL/mmb

Attachments (2)

cc: Mr. Peter Edelman

Chicago Tribune

FOUNDED JUNE 10, 1847

JOHN W. MADIGAN, *Publisher* JACK FULLER, *President* HOWARD A. TYNER, *Editor*

N. DON WYCLIFF, *Editorial Page Editor* F. RICHARD CICCONE, *Managing Editor* OWEN YOUNGMAN, *Features Editor*
ELLEN SOETEBEK, *Deputy Editorial Page Editor* ANN MARIE LIPINSKI, *Deputy Managing Editor*

A deft beginning on a crime plan. . .

There probably isn't a politician in America these days who doesn't claim to have a plan to fight crime.

Unfortunately, what most of them put forth is merely sloganeering, posturing and a "hang-'em-high" agenda—more of the same simplistic approach that has brought huge increases in prison costs but no end to the rise in violent crime.

Mayor Richard Daley, clearly positioning himself for next winter's re-election campaign, unveiled his latest package of crime-fighting ideas last week. But the mayor, a former state's attorney who is familiar with the complexities of crime and punishment, and his staff have taken a carefully wielded carving knife rather than a sledgehammer to the issue.

His plan is a detailed set of mostly well-reasoned proposals that address specific crime sources such as gangs, guns, drugs, domestic violence and child abuse. It warrants serious legislative consideration.

There are several dozen particulars on the mayor's list, ranging from community service for young offenders to the surrender of firearms by persons charged with stalking or domestic violence. Wiretaps, now largely restricted in Illinois to narcotics investigations, could be used against major gang criminals. Landlords seeking to oust gang activity could get help from the state's attorney. Gun-law enforcement would be tightened, and assault weapons would be banned statewide. Maximum sentences would be lengthened for several categories of drunk-driving, weapons-related and gang crimes.

Not every idea put forth is wise or valuable. The mayor advocates, for example, civil suits against manufacturers of weapons that can be readily converted to illegal automatic firepower. Such conversions are indeed a real and growing problem, but the answer lies in straightforward bans and sanctions, not another vehicle for tort-lawyer manipulation.

Also, none of these proposed measures—like the many criminal laws already on the books—can work in isolation. Social strategies such as community policing, recreational programs and stable schools can do more to reduce violence by young people than any number of laws dealing with crime after the fact. These are areas in which Daley has already launched initiatives, which he must pursue with vigor.

Related to this, the mayor suggests the state finally move on a concept outlined in 1990 by the Illinois Juvenile Justice Commission. Their idea was to set up community-based alternatives to Juvenile Court, emphasizing intervention with young delinquents who are at risk of growing into full-fledged criminals.

This is an idea that should indeed be dusted off and translated into action. But it shouldn't, and doesn't need to, entail a new layer of bureaucracy.

Cities, counties and the state already have many public, private and community programs designed to help troubled kids and families. But these various operations are most often fragmented and uncoordinated, reducing the effectiveness of the total money and effort expended.

Daley should turn loose the team that developed his crime-fighting package to develop an equally detailed, pinpointed plan for pooling and focusing crime-prevention programs. And he wouldn't need legislation to accomplish this—just an overriding, persistent commitment to rescuing endangered children.

. . . and an addlebrained drug policy

Elsewhere on the crime front:

President Clinton and Congress are gaining headlines as they move toward enactment of a $23 billion crime package that includes more prisons, more police and a raft of federal death-penalty offenses.

But an obscure classification that's already in the government rules book is actually impeding efforts by states and community organizations to employ one of the most desperately needed, under-used tools in the anti-crime arsenal: drug treatment.

A drug-treatment center that provides residential care for up to 16 addicts can get half the cost covered by federal Medicaid. But, in a process that only a thoroughly brainwashed bureaucrat could fathom, a center that takes in 17 patients, or more, gets cut off. Meanwhile, more than 10,000 people in Illinois alone are on waiting lists for drug treatment or evaluation.

This is not only a ridiculous policy in human terms but, as state officials point out, an absurd spending policy as well. It costs an average $7,000 in Illinois to treat a pregnant addict so she can deliver a drug-free baby. But the average price—typically borne by Medicaid—of caring for a baby addicted at birth runs to $31,000. Or a year in prison—where the pending federal crime bill does provide new funds for drug treatment—costs the state more than $16,000.

States are free to run larger drug-treatment centers as long as they pick up the entire tab. But doing so creates another dumb dilemma: Low-income clients then lose Medicaid benefits for *all* of their health care. This means a pregnant patient loses coverage for prenatal care and delivering her baby. If she stays hooked and delivers a coke-addicted infant, however, the feds will pay.

Clinton pledged in his campaign to re-direct more resources to drug treatment and prevention. It's a promise he has done little to effect, so far maintaining about the same level as the Bush administration, with far larger sums going to drug-law enforcement efforts. Clinton should start to move in the promised direction by straightening out the rules to help drug-treatment centers.

Tribune photos by José M. Osorio

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs because of the U.S. rules. She hopes a grant to open another 16-bed program for pregnant and parenting women won't jeopardize the center.

Drug centers' big nightmare

Having more than 16 beds can mean loss of U.S. funds

By Bob Karwath
Tribune Staff Writer

In 1990, Illinois officials announced plans to open one of the country's premier drug-treatment centers, with 70 beds for addicted women who were pregnant or raising young children.

Three years later, the Women's Treatment Center is operating in the former Mary Thompson Hospital, 140 N. Ashland Ave. But the West Side center has only 16 inpatient beds for pregnant women and mothers, the vulnerable population that the state was so interested in targeting.

State officials say they wish they could open more beds, but they say a federal law is standing in the way.

The federal law is known by three letters: IMD. They stand for "institute for mental diseases," which is what the federal government considers drug-treatment centers if they have more than 16 beds and aren't part of a full-service hospital.

Normally, Medicaid pays states for half the cost of medical care for the poor. But under a decades-old federal policy, Medicaid will not reimburse states for any of the costs of treating patients in institutes for mental diseases.

As a result, at a time when more than 10,000 Illinoisans are on waiting lists to receive drug treatment or to be evaluated for it, the states must limit inpatient

See Treatment, Page 5

Treatment

Continued From Page 1

programs to 16 beds if they want the federal government to split the costs.

States can operate larger centers if they want to pay all the costs. But the low-income clients would lose Medicaid coverage for all other health care. Pregnant drug addicts would lose coverage for prenatal care and delivering their babies.

Even so, many drug-treatment programs in Illinois and elsewhere are exceeding the 16-bed limit because of the great demand for their services. The larger centers can only hope that Medicaid never catches their clients when they go to the doctor for other medical treatment.

Officials from Illinois and other states have asked the federal government to lift the IMD restriction, calling it one of the largest impediments to expanding drug treatment.

"It's absolutely goofy. It doesn't make sense," said Jim Long, director of the Illinois Department of Alcoholism and Substance Abuse. This month during a tour of the Women's Treatment Center, Long urged President Clinton's drug czar, Lee Brown, to lift the restriction.

Henry Bartlett, an administrator in the New York Office of Alcoholism and Substance Abuse Services, said IMD "is just stifling to drug treatment."

But so far, the federal government isn't budging. Allowing treatment centers to expand and still qualify for Medicaid would cost the federal government tens of millions of dollars annually, federal officials say.

The states argue that lifting the IMD restriction would save Medicaid money in the long run.

In Illinois, caring for a baby born addicted to drugs costs an average of $31,000, a state task force found last year. Providing treatment to the baby's mother before she delivers costs an average $7,000.

The task force urged the federal government to lift the IMD restriction for drug treatment.

IMD restricts all inpatient-treatment programs, regardless of their clients.

But pregnant and parenting women are most significantly affected because they, more than other groups, need a place to live while breaking their addictions.

Haymarket House, which operates drug-treatment centers for a range of clients in the Chicago area, has had to scale back a program for pregnant women to 16 beds from 22. But Haymarket decided to forgo Medicaid coverage for another program for addicted men because of the great need for services, said Ray Soucek, Haymarket's executive director.

IMD "definitely hampers getting people into treatment," Soucek said.

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs, some of them without residential services, in the empty spaces that were left at the five-story former hospital when it was learned that the pregnant and parenting women's program would have only 16 beds, not 70.

Recently, Oates learned that the center had won a grant to open another 16-bed program for pregnant and parenting women. But Oates' happiness has been tempered with worry that under IMD, the new program may jeopardize Medicaid funding for the 16 beds she has.

"We're getting caught up in a bureaucratic nightmare," Oates said. "It's very frustrating."

As frustrating as IMD is, providers say it used to be worse. Until this year, the federal government counted children toward the 16-bed limit in programs where addicted mothers live with their kids.

As a result, women had to be separated from their children, many of whom had nowhere else to go, or else the treatment centers served fewer than 16 women.

Federal officials are sympathetic to the states' IMD complaints, said Chester Stroyny, director of the federal Health Care Financing Administration for the six-state Midwest region. But he acknowledged that there is no guarantee that the restriction will be lifted soon.

The federal government recently awarded six states money to study the impact of expanding drug treatment under Medicaid. Illinois failed to win one of those grants.

"The results from these demonstration projects may be the basis for some legislative proposal" to lift IMD, Stroyny said, "but that is several years away."

Jennifer Loney kisses her son Aaron in their room at the Women's Treatment Center. Loney lives with her three children at the center,which is restricted to only 16 inpatient beds because of a federal law that can cut off funding.

Tribune photo by José M. Osorio

Drug-treatment centers, such as the Women's Treatment Center, can only have 16 inpatient beds. If they have more, they risk losing Medicaid funding for low-income clients.

STATE OF ILLINOIS
DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

JAMES R. THOMPSON CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: (312) 814-3840
TDD NUMBER: (312) 419-8432
FAX NUMBER: (312) 814-2419

Jim Edgar
Governor

James E. Long
Director

January 4, 1994

Mr. José Cerda
Senior Policy Analyst
The White House
Old Executive Office Building
Room 222
Washington, D.C. 20500

Dear Mr. Cerda:

Thanks for your encouraging letter. I have enclosed a letter which I received from Sally Richardson in reply to my letter to Secretary Shalala, as well as, my response. Richardson's letter is bureaucratic evasiveness and as previous administrations did, avoids directly addressing the issue.

Clearly, the reason for avoidence is fear of increasing costs. However, I believe that HCFA does not understand the issues and does not have enough facts to analyze the issues objectively. Wherever Medicaid pays hospital rates for drug treatment, Medicaid is paying too much. And, study after study verifies that drug treatment results in decreased health expenditures. The untreated Medicaid addict generally costs Medicaid more than the average Medicaid client. This same reasoning is one of the key reasons the Presidents' Health Care Reform Proposal includes drug treatment in non-hospital programs as the preferred setting.

I will also share my letter to Richardson with Secretary Shalalas' Office, Martha Gagne, and Dr. Brown. As I said in my letter to Richardson, I will continue to try to get the key folks to look at the facts.

I hope you have A Happy and Healthy New Year.

Sincerely,

James E. Long
DIRECTOR

JEL:bjk

STATE OF ILLINOIS
DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

JAMES R. THOMPSON CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: (312) 814-3840
TDD NUMBER: (312) 419-8432
FAX NUMBER: (312) 814-2419

Jim Edgar
Governor

James E. Long
Director

January 4, 1994

Ms. Sally K. Richardson
Director
Department of Health & Human Services
Medicaid Bureau
6325 Security Boulevard
Baltimore, MD 21207

Dear Ms. Richardson:

Thank you for your timely response on behalf of Secretary Shalala regarding my letter on the "IMD exclusion". However, your letter neither addresses nor refutes my specific points about the inappropriate application of the "IMD exclusion" to non-hospital, residential substance abuse treatment centers.

Your references to Medicaid law are accurate. But, the references do not explain or require application of the "IMD exclusion" to substance abuse treatment centers.

1. The "IMD exclusion" is intended to restrict federal payment for state mental hospitals, probably those serving the chronically mentally ill.

2. Addiction to alcohol and/or other drugs is not a mental illness. The American Medical Association and the World Health Organization are two of numerous professional organizations which recognize addiction as a primary illness, not a subset of mental illness. HCFA stands alone in defining addiction as a mental illness.

3. HCFA's inclusion of addiction as a mental illness is an administrative decision not a statutory mandate.

4. In Illinois, as in most states, state government operates state mental hospitals. Substance abuse treatment centers are generally operated by not for profit organizations or local public health departments. The "IMD exclusion" was intended to apply to state mental hospitals.

5. Current policy allows substance abuse treatment to be conducted in a hospital without any restrictions. Hospital-based treatment is more costly and, no more effective than community-based non-hospital treatment. The "IMD exclusion" is inconsistent with the Medicaid principal in Section 1396a(a)(30)(A) of the Social Security Act that payments be "consistent with efficiency, economy, and quality of care and... sufficient to enlist enough providers".

In our Illinois experience, most hospitals are disinterested in serving the poor addict and they are unwilling to accept our rates for this population. However, current medicaid policy would allow us to raise our average daily rates from $150 to $500 or $600 to attract hospitals to serve poor addicts, especially pregnant women and women with children. We have not done this in Illinois because it would be wrong and illogical to pay more and get lower quality care. At the same time we have unused non-hospital capacity which could be utilized quickly, efficiently, and economically if the "IMD exclusion" were eliminated.

I have also enclosed a brief paper on this issue which explains our reasoning further.

Obviously, I feel very strongly about this issue. Regardless of the outcome, I would truly appreciate a direct and meaningful discussion of the issues, pertinent law, and policy.

Thank you for your consideration.

Sincerely,

James E. Long
Director

JEL/jy

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

FQA-421

6325 Security Boulevard
Baltimore, MD 21207

DEC -8 1993

DIRECTOR'S OFFICE

DEC 15 1993

STATE OF ILLINOIS
DEPARTMENT OF ALCOHOLISM
AND SUBSTANCE ABUSE

Mr. James E. Long
Director
State of Illinois Department of
Alcoholism and Substance Abuse
State of Illinois Center
100 West Randolph Street
Suite 5-600
Chicago, Illinois 60601

Dear Mr. Long:

This is in response to your letter to Secretary Shalala, which was referred to this agency for review since we administer the Federal aspects of the Medicaid statute. Specifically, you wrote to the Secretary regarding the "IMD exclusion."

Section 1905 of the Medicaid law excludes from consideration as medical assistance any payment on behalf of individuals between the ages of 22 and 65 who are inpatients of institutions for mental diseases (IMDs). This exclusion has a long history in the context of the Medicaid program and other public medical assistance programs that preceded it. It reflected a Congressional decision that funds made available under the Medicaid program should be used by States to augment rather than replace State expenditures for medical care. Since States had traditionally maintained institutions for the care of the mentally ill, Medicaid funds were generally prohibited for that purpose. Although there have been proposals in the Congress to eliminate this exclusion from the law, none of them has been enacted to date.

Outside the IMD exclusion, however, there is no Federal limit on Medicaid funding of services for the mentally ill. Specifically, there is no limit on the extent to which the costs of outpatient hospital or physician services may be covered by the States.

The reason for which drug treatment centers with 16 or fewer beds are not considered to be IMDs, and therefore not subject to the statutory exclusion, is also contained in the Medicaid law. Specifically, section 1905(i) specifies that "The term 'institution for mental diseases' means a hospital, nursing facility, or other institution <u>of more than 16 beds</u>, that is

primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." [Emphasis supplied.] Thus, the 16-bed limit is not, as the Chicago Tribune would have it, "a process that only a thoroughly brainwashed bureaucrat could fathom." Rather, it is a matter of law as enacted by Congress, and we are bound by that law.

Thank you for giving us the opportunity to address your concerns. If I may be of assistance in the future, please do not hesitate to write to me.

Sincerely yours,

Sally K. Richardson
Director
Medicaid Bureau

Chicago Tribune

FOUNDED JUNE 10, 1847

JOHN W. MADIGAN, *Publisher* JACK FULLER, *President* HOWARD A. TYNER, *Editor*

N. DON WYCLIFF, *Editorial Page Editor* F. RICHARD CICCONE, *Managing Editor* OWEN YOUNGMAN, *Features Editor*
ELLEN SOETEBEER, *Deputy Editorial Page Editor* ANN MARIE LIPINSKI, *Deputy Managing Editor*

A deft beginning on a crime plan. . .

There probably isn't a politician in America these days who doesn't claim to have a plan to fight crime.

Unfortunately, what most of them put forth is merely sloganeering, posturing and a "hang-'em-high" agenda—more of the same simplistic approach that has brought huge increases in prison costs but no end to the rise in violent crime.

Mayor Richard Daley, clearly positioning himself for next winter's re-election campaign, unveiled his latest package of crime-fighting ideas last week. But the mayor, a former state's attorney who is familiar with the complexities of crime and punishment, and his staff have taken a carefully wielded carving knife rather than a sledgehammer to the issue.

His plan is a detailed set of mostly well-reasoned proposals that address specific crime sources such as gangs, guns, drugs, domestic violence and child abuse. It warrants serious legislative consideration.

There are several dozen particulars on the mayor's list, ranging from community service for young offenders to the surrender of firearms by persons charged with stalking or domestic violence. Wiretaps, now largely restricted in Illinois to narcotics investigations, could be used against major gang criminals. Landlords seeking to oust gang activity could get help from the state's attorney. Gun-law enforcement would be tightened, and assault weapons would be banned statewide. Maximum sentences would be lengthened for several categories of drunk-driving, weapons-related and gang crimes.

Not every idea put forth is wise or valuable. The mayor advocates, for example, civil suits against manufacturers of weapons that can be readily converted to illegal automatic firepower. Such conversions are indeed a real and growing problem, but the answer lies in straightforward bans and sanctions, not another vehicle for tort-lawyer manipulation.

Also, none of these proposed measures—like the many criminal laws already on the books—can work in isolation. Social strategies such as community policing, recreational programs and stable schools can do more to reduce violence by young people than any number of laws dealing with crime after the fact. These are areas in which Daley has already launched initiatives, which he must pursue with vigor.

Related to this, the mayor suggests the state finally move on a concept outlined in 1990 by the Illinois Juvenile Justice Commission. Their idea was to set up community-based alternatives to Juvenile Court, emphasizing intervention with young delinquents who are at risk of growing into full-fledged criminals.

This is an idea that should indeed be dusted off and translated into action. But it shouldn't, and doesn't need to, entail a new layer of bureaucracy.

Cities, counties and the state already have many public, private and community programs designed to help troubled kids and families. But these various operations are most often fragmented and uncoordinated, reducing the effectiveness of the total money and effort expended.

Daley should turn loose the team that developed his crime-fighting package to develop an equally detailed, pinpointed plan for pooling and focusing crime-prevention programs. And he wouldn't need legislation to accomplish this—just an overriding, persistent commitment to rescuing endangered children.

. . . and an addlebrained drug policy

Elsewhere on the crime front:

President Clinton and Congress are gaining headlines as they move toward enactment of a $23 billion crime package that includes more prisons, more police and a raft of federal death-penalty offenses.

But an obscure classification that's already in the government rules book is actually impeding efforts by states and community organizations to employ one of the most desperately needed, under-used tools in the anti-crime arsenal: drug treatment.

A drug-treatment center that provides residential care for up to 16 addicts can get half the cost covered by federal Medicaid. But, in a process that only a thoroughly brainwashed bureaucrat could fathom, a center that takes in *17* patients, or more, gets cut off. Meanwhile, more than 10,000 people in Illinois alone are on waiting lists for drug treatment or evaluation.

This is not only a ridiculous policy in human terms but, as state officials point out, an absurd spending policy as well. It costs an average $7,000 in Illinois to treat a pregnant addict so she can deliver a drug-free baby. But the average price—typically borne by Medicaid—of caring for a baby addicted at birth runs to $31,000. Or a year in prison—where the pending federal crime bill does provide new funds for drug treatment—costs the state more than $16,000.

States are free to run larger drug-treatment centers as long as they pick up the entire tab. But doing so creates another dumb dilemma: Low-income clients then lose Medicaid benefits for *all* of their health care. This means a pregnant patient loses coverage for prenatal care and delivering her baby. If she stays hooked and delivers a coke-addicted infant, however, the feds will pay.

Clinton pledged in his campaign to re-direct more resources to drug treatment and prevention. It's a promise he has done little to effect, so far maintaining about the same level as the Bush administration, with far larger sums going to drug-law enforcement efforts. Clinton should start to move in the promised direction by straightening out the rules to help drug-treatment centers.

Tribune photos by José M. Osorio

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs because of the U.S. rules. She hopes a grant to open another 16-bed program for pregnant and parenting women won't jeopardize the center.

Drug centers' big nightmare

Having more than 16 beds can mean loss of U.S. funds

By Rob Karwath
TRIBUNE STAFF WRITER

In 1990, Illinois officials announced plans to open one of the country's premier drug-treatment centers, with 70 beds for addicted women who were pregnant or raising young children.

Three years later, the Women's Treatment Center is operating in the former Mary Thompson Hospital, 140 N. Ashland Ave. But the West Side center has only 16 inpatient beds for pregnant women and mothers, the vulnerable population that the state was so interested in targeting.

State officials say they wish they could open more beds, but they say a federal law is standing in the way.

The federal law is known by three letters: IMD. They stand for "institute for mental diseases," which is what the federal government considers drug-treatment centers if they have more than 16 beds and aren't part of a full-service hospital.

Normally, Medicaid pays states for half the cost of medical care for the poor. But under a decades-old federal policy, Medicaid will not reimburse states for any of the costs of treating patients in institutes for mental diseases.

As a result, at a time when more than 10,000 Illinoisans are on waiting lists to receive drug treatment or to be evaluated for it, the states must limit inpatient

SEE TREATMENT, PAGE 5

Treatment

CONTINUED FROM PAGE 1

programs to 16 beds if they want the federal government to split the costs.

States can operate larger centers if they want to pay all the costs. But the low-income clients would lose Medicaid coverage for all other health care. Pregnant drug addicts would lose coverage for prenatal care and delivering their babies.

Even so, many drug-treatment programs in Illinois and elsewhere are exceeding the 16-bed limit because of the great demand for their services. The larger centers can only hope that Medicaid never catches their clients when they go to the doctor for other medical treatment.

Officials from Illinois and other states have asked the federal government to lift the IMD restriction, calling it one of the largest impediments to expanding drug treatment.

"It's absolutely goofy. It doesn't make sense," said Jim Long, director of the Illinois Department of Alcoholism and Substance Abuse. This month during a tour of the Women's Treatment Center, Long urged President Clinton's drug czar, Lee Brown, to lift the restriction.

Henry Bartlett, an administrator in the New York Office of Alcoholism and Substance Abuse Services, said IMD "is just stifling to drug treatment."

But so far, the federal government isn't budging. Allowing treatment centers to expand and still qualify for Medicaid would cost the federal government tens of millions of dollars annually, federal officials say.

The states argue that lifting the IMD restriction would save Medicaid money in the long run.

In Illinois, caring for a baby born addicted to drugs costs an average of $31,000, a state task force found last year. Providing treatment to the baby's mother before she delivers costs an average $7,000.

The task force urged the federal government to lift the IMD restriction for drug treatment.

IMD restricts all inpatient-treatment programs, regardless of their clients.

But pregnant and parenting women are most signficantly affected because they, more than other groups, need a place to live while breaking their addictions.

Haymarket House, which operates drug-treatment centers for a range of clients in the Chicago area, has had to scale back a program for pregnant women to 16 beds from 22. But Haymarket decided to forgo Medicaid coverage for another program for addicted men because of the great need for services, said Ray Soucek, Haymarket's executive director.

IMD "definitely hampers getting people into treatment," Soucek said.

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs, some of them without residential services, in the empty spaces that were left at the five-story former hospital when it was learned that the pregnant and parenting women's program would have only 16 beds, not 70.

Recently, Oates learned that the center had won a grant to open another 16-bed program for pregnant and parenting women. But Oates' happiness has been tempered with worry that under IMD, the new program may jeopardize Medicaid funding for the 16 beds she has.

"We're getting caught up in a bureaucratic nightmare," Oates said. "It's very frustrating."

As frustrating as IMD is, providers say it used to be worse. Until this year, the federal government counted children toward the 16-bed limit in programs where addicted mothers live with their kids.

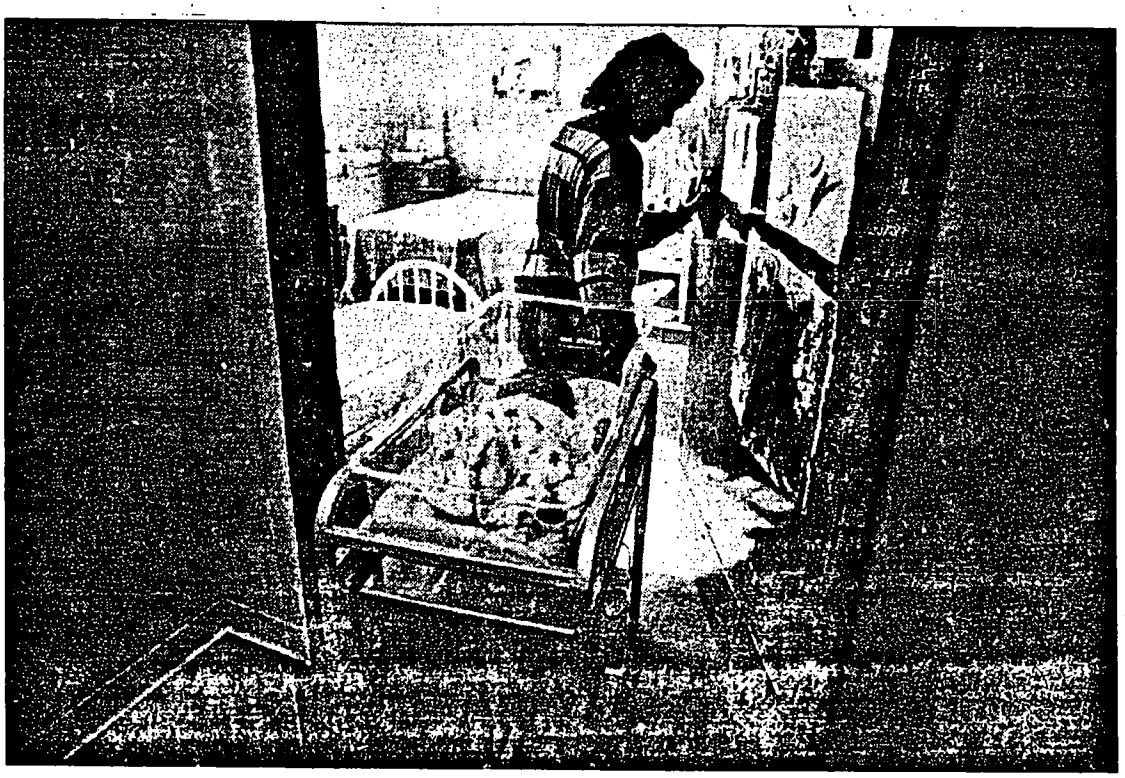
As a result, women had to be separated from their children, many of whom had nowhere else to go, or else the treatment centers served fewer than 16 women.

Federal officials are sympathetic to the states' IMD complaints, said Chester Stroyny, director of the federal Health Care Financing Administration for the six-state Midwest region. But he acknowledged that there is no guarantee that the restriction will be lifted soon.

The federal government recently awarded six states money to study the impact of expanding drug treatment under Medicaid. Illinois failed to win one of those grants.

"The results from these demonstration projects may be the basis for some legislative proposal" to lift IMD, Stroyny said, "but that is several years away."

Jennifer Loney kisses her son Aaron in their room at the Women's Treatment Center. Loney lives with her three children at the center,which is restricted to only 16 inpatient beds because of a federal law that can cut off funding.



Tribune photo by José M. Osorio

Drug-treatment centers, such as the Women's Treatment Center, can only have 16 inpatient beds. If they have more, they risk losing Medicaid funding for low-income clients.

IL Dept. of Alcoholism & Substance Abuse
James Long 312 814 2291

COVERAGE OF SUBSTANCE ABUSE TREATMENT UNDER MEDICAID/THE IMD EXCLUSION

THE PROBLEM

Since Medicaid began in 1965, medical assistance has been denied by law for certain patients in Institutions for Mental Disease (IMD). Currently, an IMD is defined as a facility of more than 16 beds that specializes in psychiatric care. Residential treatment facilities for substance abuse are covered under this provision - presenting a significant barrier to alcohol and other drug treatment for pregnant women and women with children and other individuals who are Medicaid eligible. Not only do low income individuals lose their ability to obtain alcohol and other drug treatment services in an IMD but they lose all other Medicaid services as well.

Currently individuals with alcohol and substance abuse problems may be admitted to a hospital for alcohol and other drug treatment without loss of Medicaid benefits. Not only are hospitals more costly but they often lack essential ancillary services available through a community based treatment programs.

Many critics believe that the Health Care Financing Administration's (HCFA) interpretation of alcohol and other drug problems as being subject to the IMD exclusion is flawed. The impact of this interpretation is that it perversely restricts the provision of needed alcohol and substance abuse treatment - especially to pregnant and parenting women who can not afford to lose Medicaid services and whose untreated substance abuse often increases the cost of other health care services.

WOMEN AND CHILDREN: A VULNERABLE POPULATION

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates there will be six million women who abuse alcohol alone by 1995, four million of whom will be of child-bearing age. Other statistics indicate that 10% of the female population abuse alcohol and/or other drugs.

COST TO SOCIETY

The cost of such alcohol and other drug use to society is astronomical. In addition to general health care costs for the women, children who are born to pregnant abusers could conservatively cost the health care system as much as 3 billion dollars annually (this figure does not include estimates regarding social service and education costs required as these children get older). Substance abuse treatment services for these women are woefully inadequate with at most, only 11% of the pregnant substance abusers in the country currently receiving treatment. Without intervention before or during these women's pregnancies, drug-affected babies will continue to push up the costs of health care. (A report this year by the Columbia University Center on

Addiction and Substance Abuse notes that "the Medicaid program covers a large number of pregnant women and children. Substance abuse has a significant impact not only on pregnancy and birth outcomes but also on life-long health care costs for infants born to substance abusing mothers". See "The Cost of America's Health Care System, Report 1: Medicaid Hospital Costs, A CASA Report".

RECOMMENDATIONS FOR ACTION

The National Association of State Alcohol and Drug Abuse Directors recommends the following:

1. The Federal Government and Congress should recognize alcoholism and substance abuse as separate, diagnosable and treatable illnesses, rather than as subcategories of mental illnesses. This would, in theory, eliminate the application of the IMD exclusion to substance abuse treatment services.

2. Per the 1990 Moynihan amendment, alcoholism and substance abuse treatment services should be immediately recognized by HCFA as eligible for reimbursement in any appropriate setting.

3. At a minimum HFCA should provide immediate alternative relief to pregnant and post partum women and other individuals by removing the IMD exclusion from alcohol and other drug residential treatment programs, or by increasing the 16 bed limit to 40 to expand capacity (although such alternatives are short sighted and contrary to the tenants of simplicity of administration and cost efficiency, and do not cover all reasonable costs).

4. The Federal Government and Congress should provide reimbursement for the most cost effective treatment setting possible. Generally, hospital treatment programs are significantly more costly than non-hospital programs, yet both settings use similar treatment practices and protocols; and non-hospital treatment programs are more philosophically suited and experienced in serving poor and indigent substance abusers.

These recommendations are consistent with the intent of Medicaid because it will assure the provision of care and services which are in the best interests of these recipients, which are consistent with simplicity of administration, and which will enlist sufficient providers. By such a policy the Federal Government and the State share a financial commitment to serving this priority population in need.

MEDICAID REIMBURSEMENT FOR ALCOHOL AND DRUG PROBLEMS: A DILEMMA

A large portion of those in need of substance abuse treatment are Medicaid eligible and yet the Medicaid system does not currently cover non-hospital residential treatment programs for such women fully, adequately or appropriately. Treatment is essential to preventing the adverse pregnancy outcomes.

Residential Program Restriction

The IMD is the most serious barrier to providing substance abuse treatment services to those in need. Many experts have questioned HCFA's interpretation of this provision. Section 1905(i) of the SSA describes an "Institution for Mental Disease" as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases". HCFA has determined alcoholism and substance abuse to be "mental diseases" and, therefore, classifies residential substance abuse treatment facilities as IMD's. However, the initial purpose of this exclusion was to ensure that Medicaid did not pay for state mental hospital care which was considered a state responsibility, and that long term institutional residents should not be permanently housed in large facilities.

Substance Abuse Treatment as "Medical Assistance"

"Medical assistance" reimbursable under Title XIX, is geared toward a medical model. Substance abuse services, which are based on counselor interaction, are not considered to be "mandated" Medicaid services. Therefore, medical detoxification, methadone maintenance under physician supervision, treatment in a hospital or a psychiatric hospital, and other "medical" components of substance abuse treatment are reimbursable, while non-hospital counselor-based subacute treatment is not. However, hospital in-patient treatment services, are generally similar to the community-based treatment services, except they are much costlier because of the setting.

ALCOHOL AND OTHER DRUG PROBLEMS ARE DIFFERENT THAN MENTAL ILLNESS

The World Health Organization, the American Medical Association and the American Psychiatric Association view alcohol and other drug problems (AOD) as separate, identifiable and treatable illnesses rather than as forms of mental illnesses. The adopt the DSM-III-R (Diagnostic Statistical Manual of Disorders, 3rd Edition, Revised) classification of the illnesses, rather than ICD-9-CM (International Classification of Diseases, 9th Edition). Thus, it is both inaccurate and detrimental to classify alcoholism and substance abuse as mental diseases. It is unlikely that Congress ever intended the IMD exclusion to apply to substance abuse treatment facilities because it was concerned about state mental hospitals.

Congress spoke clearly about substance abuse treatment services in 1990 when it passed the Moynihan amendment to the Medicaid statute which mandates that:

> No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency (42 U.S.C. §1396d(a)).

Unfortunately, the spirit and intent of this amendment has been ignored by HCFA's current interpretation of the IMD exclusion, which severely restricts reimbursement for non-hospital subacute treatment services.

History of Legal Challenges

There have been and continue to be court challenges to HCFA's interpretation of the IMD exclusion. In IDPA v. Brown (7th Cir. 1986), a series of Granville House cases (8th Cir. 1983 and 1986), and Minnesota v. Hekler (8th Cir. 1983), the courts tended to agree that the problem of substance abuse is not a mental disease. Plaintiffs in the cases have either run out of money to pursue the issues or have changed their status in order to get reimbursement rather than spending more in legal fees.

One important impact of the cases so far has been that HCFA was ordered to issue guidelines regarding when a facility should be considered to be an IMD. These guidelines issued in 1986, skirted the underlying issue of whether alcoholism and substance abuse are "mental diseases".

Current Court Challenges

Currently cases are pending in two jurisdictions regarding the IMD exclusion as applied to substance abuse facilities. In the U. S. District Court for the Eastern District of Pennsylvania an injunction is being sought to required Title XIX coverage for these services (currently a motion to dismiss is under advisement by the court). In Texas there is an administrative challenge to the IMD interpretation. The hearing has been concluded and a decision is pending. If it is unfavorable Texas anticipates an appeal to the U.S. 5th Circuit.

STATE'S REACTION TO IMD

HCFA interpretations have led to anything but simplicity in this area. Since non-hospital residential treatment services are not considered Medicaid-reimbursable, states have attempted numerous creative strategies to get coverage for portions of residential substance abuse treatment services. In many States eligible recipients are simply precluded from receiving services.

Illinois - A State Study

For example, Illinois has extended its State Medicaid Plan to cover as broad a range of optional substance abuse services as can be found to be federally matchable under current interpretations. HCFA has allowed Illinois to receive federal match for treatment units of 16 beds-or-under and within larger treatment facilities when the units are separately licensed, Medicaid certified and have separately identified cost centers. But the reimbursement does not cover room and board costs, which constitute about 30% of the expense of such treatment. Downsizing to 16 beds not only reduces capacity but is less efficient and less cost effective.

Illinois has over a thousand residential treatment beds in non-hospital facilities which are not Medicaid reimbursable. Many of these beds spaces are in women's programs. That is more than the number of bed spaces in Medicaid certified substance abuse facilities (there ar about nine hundred bed spaces in certified non-hospital facilities, the majority of which are not eligible for the room and board costs). It is impossible to measure the number of residential bed spaces which may have been created if they had been Medicaid-reimbursable. In Illinois hospitals there are about 1,500 bed spaces devoted to substance abuse. These are clearly eligible for Medicaid-reimbursement and yet hospitals have chosen to certify only about three hundred of the beds for Medicaid reimbursement (Illinois pays for actual treatment costs and overhead related to treatment only. This approach excludes general hospital overhead costs and makes Medicaid unattractive to most hospitals).

Therefore, many Medicaid eligible recipients in Illinois go untreated. Known Illinois waiting lists consist of about 5,000 persons, with many of those being pregnant women. At this time it is unknown how many on the waiting lists are Medicaid eligible, but pregnant women with little income would most likely qualify.

NEW DIRECTIONS

Small steps have been made toward re-thinking how the IMD exclusion affects the provision of alcohol and substance abuse. After pressure from States, HCFA reversed its policy stating that children's beds are to be counted when children are in residence with their mother at residential substance abuse facilities. Formerly these were required to be counted in determining whether or not the facility had 16 beds and was subject to the exclusion.

HCFA has also granted a waiver for a demonstration project for pregnant substance abusers in a few residential treatment facilities. They will evaluate the 3 year demonstration project (located in New York, Washington, Massachusetts, and South Carolina) where substance abuse treatment in residential facilities for pregnant women are being reimbursed under Title XIX (HCFA has historically refused requests for direct waiver of the IMD exclusion, but has created a situation in this demonstration whereby services are reimbursable). The demonstration will begin its second year in October '93. HCFA indicates that the demonstration will be evaluated at the end of the three years, with the possibility of changing current IMD policy.

We believe these to be positive steps in the absence of a decisive and direct removal of the IMD exclusion barrier. We support and encourage further movement in this direction.

CONCLUSION

The IMD and other Medicaid barriers established at the Federal level mean residential care has been severely limited even though it is far less expensive than inpatient hospital services. Furthermore, this often means that outpatient service may be chosen for a client who really requires inpatient services. However, recent evidence suggests that appropriate inpatient treatment initially may be the most effective way of preventing the costly recidivism common

among substance abusers. (See "A Randomized Trial of Treatment Options for Alcohol-Abusing Workers", New England Journal of Medicine, Sept. 12, 1991). Additional treatment was required significantly more often for substance abusers who were initially given only outpatient treatment, or who were allowed to choose their own form of treatment, as opposed to those initially assigned to inpatient treatment.

While the effect of the IMD exclusion may be most disastrous for pregnant substance abusing women and their children (costs to society caused by lack of treatment during pregnancy are more long range than failure to treat a man - pregnancy complications, bad birth outcomes, possible life long ailments and problems of the baby, etc.), HCFA must be forced to rethink its policy for all patients. The IMD barrier is contrary to the intent of Congress, is counterproductive and drives up rather than reducing health care costs.

Because of the IMD exclusion, temporary and short-sighted cost determinations end up governing treatment choice, which in the long run only drives up general health care costs. The intent of Medicaid is that care and services be provided in a manner consistent with simplicity of administration and the best interests of the recipient, and that payments are sufficient to enlist enough providers so that care and services are available to recipients at least to the extent that such care and services are available to the general population (See 42 U.S.C. §1396a(a)(19) and (c) and §1396a(a)(30)(A)).

State Alcohol and Drug Agency Directors believe it is time to approach residential substance abuse treatment coverage in a more reasonable fashion. We are encouraged by signs from the Administration and HCFA that show greater flexibility and a desire to review previously accepted administration interpretations. It is time to give those on waiting lists the services they need. The issue will be driven, of course, by the costs of expansion of coverage. NASADAD and its members believe that we can't afford not to provide services. The cost of denying service is far greater in the long run.

ILLINOIS DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

COVERAGE OF SUBSTANCE ABUSE TREATMENT UNDER MEDICAID/THE IMD EXCLUSION

Prepared by:

James E. Long, Director
Nancy J. Bennett, Chief General Counsel

COVERAGE OF SUBSTANCE ABUSE TREATMENT UNDER MEDICAID/THE IMD EXCLUSION

THE PROBLEM

Since Medicaid began in 1965, medical assistance has been denied by law for certain patients in Institutions for Mental Disease (IMD). Currently, an IMD is defined as a facility of more than 16 beds that specializes in psychiatric care. Residential treatment facilities for substance abuse are covered under this provision - presenting a significant barrier to alcohol and other drug treatment for pregnant women and women with children and other individuals who are Medicaid eligible. Not only do low income individuals lose their ability to obtain alcohol and other drug treatment services in an IMD but they lose all other Medicaid services as well.

Currently individuals with alcohol and substance abuse problems may be admitted to a hospital for alcohol and other drug treatment without loss of Medicaid benefits. Not only are hospitals more costly but they often lack essential ancillary services available through a community based treatment programs.

Many critics believe that the Health Care Financing Administration's (HCFA) interpretation of alcohol and other drug problems as being subject to the IMD exclusion is flawed. The impact of this interpretation is that it perversely restricts the provision of needed alcohol and substance abuse treatment - especially to pregnant and parenting women who can not afford to lose Medicaid services and whose untreated substance abuse often increases the cost of other health care services.

WOMEN AND CHILDREN: A VULNERABLE POPULATION

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates there will be six million women who abuse alcohol alone by 1995, four million of whom will be of child-bearing age. Other statistics indicate that 10% of the female population abuse alcohol and/or other drugs.

COST TO SOCIETY

The cost of such alcohol and other drug use to society is astronomical. In addition to general health care costs for the women, children who are born to pregnant abusers could conservatively cost the health care system as much as 3 billion dollars annually (this figure does not include estimates regarding social service and education costs required as these children get older). Substance abuse treatment services for these women are woefully inadequate with at most, only 11% of the pregnant substance abusers in the country currently receiving treatment. Without intervention before or during these women's pregnancies, drug-affected babies will continue to push up the costs of health care. (A report this year by the Columbia University Center on

Addiction and Substance Abuse notes that "the Medicaid program covers a large number of pregnant women and children. Substance abuse has a significant impact not only on pregnancy and birth outcomes but also on life-long health care costs for infants born to substance abusing mothers". See "The Cost of America's Health Care System, Report 1: Medicaid Hospital Costs, A CASA Report".

RECOMMENDATIONS FOR ACTION

The National Association of State Alcohol and Drug Abuse Directors recommends the following:

1. The Federal Government and Congress should recognize alcoholism and substance abuse as separate, diagnosable and treatable illnesses, rather than as subcategories of mental illnesses. This would, in theory, eliminate the application of the IMD exclusion to substance abuse treatment services.

2. Per the 1990 Moynihan amendment, alcoholism and substance abuse treatment services should be immediately recognized by HCFA as eligible for reimbursement in any appropriate setting.

3. At a minimum HFCA should provide immediate alternative relief to pregnant and post partum women and other individuals by removing the IMD exclusion from alcohol and other drug residential treatment programs, or by increasing the 16 bed limit to 40 to expand capacity (although such alternatives are short sighted and contrary to the tenants of simplicity of administration and cost efficiency, and do not cover all reasonable costs).

4. The Federal Government and Congress should provide reimbursement for the most cost effective treatment setting possible. Generally, hospital treatment programs are significantly more costly than non-hospital programs, yet both settings use similar treatment practices and protocols; and non-hospital treatment programs are more philosophically suited and experienced in serving poor and indigent substance abusers.

These recommendations are consistent with the intent of Medicaid because it will assure the provision of care and services which are in the best interests of these recipients, which are consistent with simplicity of administration, and which will enlist sufficient providers. By such a policy the Federal Government and the State share a financial commitment to serving this priority population in need.

MEDICAID REIMBURSEMENT FOR ALCOHOL AND DRUG PROBLEMS: A DILEMMA

A large portion of those in need of substance abuse treatment are Medicaid eligible and yet the Medicaid system does not currently cover non-hospital residential treatment programs for such women fully, adequately or appropriately. Treatment is essential to preventing the adverse pregnancy outcomes.

Residential Program Restriction

The IMD is the most serious barrier to providing substance abuse treatment services to those in need. Many experts have questioned HCFA's interpretation of this provision. Section 1905(i) of the SSA describes an "Institution for Mental Disease" as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases". HCFA has determined alcoholism and substance abuse to be "mental diseases" and, therefore, classifies residential substance abuse treatment facilities as IMD's. However, the initial purpose of this exclusion was to ensure that Medicaid did not pay for state mental hospital care which was considered a state responsibility, and that long term institutional residents should not be permanently housed in large facilities.

Substance Abuse Treatment as "Medical Assistance"

"Medical assistance" reimbursable under Title XIX, is geared toward a medical model. Substance abuse services, which are based on counselor interaction, are not considered to be "mandated" Medicaid services. Therefore, medical detoxification, methadone maintenance under physician supervision, treatment in a hospital or a psychiatric hospital, and other "medical" components of substance abuse treatment are reimbursable, while non-hospital counselor-based subacute treatment is not. However, hospital in-patient treatment services, are generally similar to the community-based treatment services, except they are much costlier because of the setting.

ALCOHOL AND OTHER DRUG PROBLEMS ARE DIFFERENT THAN MENTAL ILLNESS

The World Health Organization, the American Medical Association and the American Psychiatric Association view alcohol and other drug problems (AOD) as separate, identifiable and treatable illnesses rather than as forms of mental illnesses. They adopted the DSM-III-R (Diagnostic Statistical Manual of Disorders, 3rd Edition, Revised) classification of the illnesses, rather than ICD-9-CM (International Classification of Diseases, 9th Edition). Thus, it is both inaccurate and detrimental to classify alcoholism and substance abuse as mental diseases. It is unlikely that Congress ever intended the IMD exclusion to apply to substance abuse treatment facilities because it was concerned about state mental hospitals.

Congress spoke clearly about substance abuse treatment services in 1990 when it passed the Moynihan amendment to the Medicaid statute which mandates that:

> No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency (42 U.S.C. §1396d(a)).

Unfortunately, the spirit and intent of this amendment has been ignored by HCFA's current interpretation of the IMD exclusion, which severely restricts reimbursement for non-hospital subacute treatment services.

History of Legal Challenges

There have been and continue to be court challenges to HCFA's interpretation of the IMD exclusion. In IDPA v. Brown (7th Cir. 1986), a series of Granville House cases (8th Cir. 1983 and 1986), and Minnesota v. Hekler (8th Cir. 1983), the courts tended to agree that the problem of substance abuse is not a mental disease. Plaintiffs in the cases have either run out of money to pursue the issues or have changed their status in order to get reimbursement rather than spending more in legal fees.

One important impact of the cases so far has been that HCFA was ordered to issue guidelines regarding when a facility should be considered to be an IMD. These guidelines issued in 1986, skirted the underlying issue of whether alcoholism and substance abuse are "mental diseases".

Current Court Challenges

Currently cases are pending in two jurisdictions regarding the IMD exclusion as applied to substance abuse facilities. In the U. S. District Court for the Eastern District of Pennsylvania an injunction is being sought to required Title XIX coverage for these services (currently a motion to dismiss is under advisement by the court). In Texas there is an administrative challenge to the IMD interpretation. The hearing has been concluded and a decision is pending. If it is unfavorable Texas anticipates an appeal to the U.S. 5th Circuit.

STATE'S REACTION TO IMD

HCFA interpretations have led to anything but simplicity in this area. Since non-hospital residential treatment services are not considered Medicaid-reimbursable, states have attempted numerous creative strategies to get coverage for portions of residential substance abuse treatment services. In many States eligible recipients are simply precluded from receiving services.

Illinois - A State Study

For example, Illinois has extended its State Medicaid Plan to cover as broad a range of optional substance abuse services as can be found to be federally matchable under current interpretations. HCFA has allowed Illinois to receive federal match for treatment units of 16 beds-or-under and within larger treatment facilities when the units are separately licensed, Medicaid certified and have separately identified cost centers. But the reimbursement does not cover room and board costs, which constitute about 30% of the expense of such treatment. Downsizing to 16 beds not only reduces capacity but is less efficient and less cost effective.

Illinois has over a thousand residential treatment beds in non-hospital facilities which are not Medicaid reimbursable. Many of these beds spaces are in women's programs. That is more than the number of bed spaces in Medicaid certified substance abuse facilities (there are about nine hundred bed spaces in certified non-hospital facilities, the majority of which are not eligible for the room and board costs). It is impossible to measure the number of residential bed spaces which may have been created if they had been Medicaid-reimbursable. In Illinois hospitals there are about 1,500 bed spaces devoted to substance abuse. These are clearly eligible for Medicaid-reimbursement and yet hospitals have chosen to certify only about three hundred of the beds for Medicaid reimbursement (Illinois pays for actual treatment costs and overhead related to treatment only. This approach excludes general hospital overhead costs and makes Medicaid unattractive to most hospitals).

Therefore, many Medicaid eligible recipients in Illinois go untreated. Known Illinois waiting lists consist of about 5,000 persons, with many of those being pregnant women. At this time it is unknown how many on the waiting lists are Medicaid eligible, but pregnant women with little income would most likely qualify.

NEW DIRECTIONS

Small steps have been made toward re-thinking how the IMD exclusion affects the provision of alcohol and substance abuse. After pressure from States, HCFA reversed its policy stating that children's beds are to be counted when children are in residence with their mother at residential substance abuse facilities. Formerly these were required to be counted in determining whether or not the facility had 16 beds and was subject to the exclusion.

HCFA has also granted a waiver for a demonstration project for pregnant substance abusers in a few residential treatment facilities. They will evaluate the 3 year demonstration project (located in New York, Washington, Massachusetts, and South Carolina) where substance abuse treatment in residential facilities for pregnant women are being reimbursed under Title XIX (HCFA has historically refused requests for direct waiver of the IMD exclusion, but has created a situation in this demonstration whereby services are reimbursable). The demonstration will begin its second year in October '93. HCFA indicates that the demonstration will be evaluated at the end of the three years, with the possibility of changing current IMD policy.

We believe these to be positive steps in the absence of a decisive and direct removal of the IMD exclusion barrier. We support and encourage further movement in this direction.

CONCLUSION

The IMD and other Medicaid barriers established at the Federal level mean residential care has been severely limited even though it is far less expensive than inpatient hospital services. Furthermore, this often means that outpatient service may be chosen for a client who really requires inpatient services. However, recent evidence suggests that appropriate inpatient treatment initially may be the most effective way of preventing the costly recidivism common

among substance abusers. (See "A Randomized Trial of Treatment Options for Alcohol-Abusing Workers", New England Journal of Medicine, Sept. 12, 1991). Additional treatment was required significantly more often for substance abusers who were initially given only outpatient treatment, or who were allowed to choose their own form of treatment, as opposed to those initially assigned to inpatient treatment.

While the effect of the IMD exclusion may be most disastrous for pregnant substance abusing women and their children (costs to society caused by lack of treatment during pregnancy are more long range than failure to treat a man - pregnancy complications, bad birth outcomes, possible life long ailments and problems of the baby, etc.), HCFA must be forced to rethink its policy for all patients. The IMD barrier is contrary to the intent of Congress, is counterproductive and drives up rather than reducing health care costs.

Because of the IMD exclusion, temporary and short-sighted cost determinations end up governing treatment choice, which in the long run only drives up general health care costs. The intent of Medicaid is that care and services be provided in a manner consistent with simplicity of administration and the best interests of the recipient, and that payments are sufficient to enlist enough providers so that care and services are available to recipients at least to the extent that such care and services are available to the general population (See 42 U.S.C. §1396a(a)(19) and (c) and §1396a(a)(30)(A)).

State Alcohol and Drug Agency Directors believe it is time to approach residential substance abuse treatment coverage in a more reasonable fashion. We are encouraged by signs from the Administration and HCFA that show greater flexibility and a desire to review previously accepted administration interpretations. It is time to give those on waiting lists the services they need. The issue will be driven, of course, by the costs of expansion of coverage. NASADAD and its members believe that we can't afford not to provide services. The cost of denying service is far greater in the long run.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

DRUG TEAM

725 17th St. N.W.
Room 9202 N.E.O.B.
Washington, D.C. 20503

FAX # - 202-395-7238
Alternate Fax # - 202-395-4797

Number of Pages: ☐ (including this page)

To: Jose Cerda 67739

From: Jim Duke
202-395-3451

Martha M. Gagné
202-395-3452

Time Sensitive

Comments: Jose, FYI regarding the IMD exclusion. Could we get some wordage on this issue in the Strategy? I have contacted the OMB Health Financing branch about this.

Martha

STATE OF ILLINOIS
DEPARTMENT OF
ALCOHOLISM AND
SUBSTANCE ABUSE

JAMES R. THOMPSON CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: (312) 814-3840
TDD NUMBER: (312) 419-8432
FAX NUMBER: (312) 814-2419

Jim Edgar
Governor

James E. Long
Director

January 4, 1994

Ms. Martha M. Gagné
Budget Examiner
Executive Office of the President
Drug Control Programs
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Dear Ms. Gagné:

I have enclosed a letter which I received from Sally Richardson in reply to my letter to Secretary Shalala, as well as, my response. Richardson's letter is bureaucratic evasiveness and as previous administrations did, avoids directly addressing the issue.

Clearly, the reason for avoidence is fear of increasing costs. However, I believe that HCFA does not understand the issues and does not have enough facts to analyze the issues objectively. Wherever Medicaid pays hospital rates for drug treatment, Medicaid is paying too much. And, study after study verifies that drug treatment results in decreased health expenditures. The untreated Medicaid addict generally costs Medicaid more than the average Medicaid client. This same reasoning is one of the key reasons the Presidents' Health Care Reform Proposal includes drug treatment in non-hospital programs as the preferred setting.

I do hope that you will visit Chicago to see first hand the negative impact of the IMD exclusion. We only need a short notice to arrange a worthwhile and informative visit.

Thank you for your consideration and help.

Sincerely,

James E. Long
DIRECTOR

JEL:bjk

STATE OF ILLINOIS
DEPARTMENT OF
ALCOHOLISM AND
SUBSTANCE ABUSE

STATE OF ILLINOIS CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: 312/814-6040
FAX NUMBER: 312/814-6419
TDD NUMBER: 312/419-6468

Jim Edgar
Governor

James E. Long
Director

November 24, 1993

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
Washington, D.C. 20201

Dear Secretary Shalala:

For your information, I have enclosed an editorial and an article from the Chicago Tribune citing how the "Institute for Mental Disease" (IMD) exclusion illogically restricts drug treatment capacity. I know this issue has been brought to your attention previously, but to date there has been no movement.

I personally concur with President Clinton's efforts for health care reform and his drug strategy goals. Eliminating the IMD exclusion now would be totally consistent with both efforts and an extremely bold policy move toward positive change. It would also offer hope and help to thousands of drug addicted women and their children, especially in our inner cities where the need for more drug treatment is staggeringly obvious. Please, consider this common sense policy change.

Thank you for you consideration and continued leadership.

Sincerely,

Jim Long

James E. Long
Director

JEL/mmb

Attachments (2)

cc: Mr. Peter Edelman

Chicago Tribune

Founded June 10, 1847

John W. Madigan, Publisher Jack Fuller, President Howard A. Tyner, Editor

N. Don Wycliff, Editorial Page Editor R. Richard Crooke, Managing Editor Owen Youngman, Features Editor
Ellen Soffredin, Deputy Editorial Page Editor Ann Marie Lipinski, Deputy Managing Editor

A deft beginning on a crime plan. . .

There probably isn't a politician in America these days who doesn't claim to have a plan to fight crime.

Unfortunately, what most of them put forth is merely sloganeering, posturing and a "hang-'em-high" agenda—more of the same simplistic approach that has brought huge increases in prison costs but no end to the rise in violent crime.

Mayor Richard Daley, clearly positioning himself for next winter's re-election campaign, unveiled his latest package of crime-fighting ideas last week. But the mayor, a former state's attorney who is familiar with the complexities of crime and punishment, and his staff have taken a carefully wielded carving knife rather than a sledgehammer to the issue.

His plan is a detailed set of mostly well-reasoned proposals that address specific crime sources such as gangs, guns, drugs, domestic violence and child abuse. It warrants serious legislative consideration.

There are several dozen particulars on the mayor's list, ranging from community service for young offenders to the surrender of firearms by persons charged with stalking or domestic violence. Wiretaps, now largely restricted in Illinois to narcotics investigations, could be used against major gang criminals. Landlords seeking to oust gang activity could get help from the state's attorney. Gun-law enforcement would be tightened, and assault weapons would be banned statewide. Maximum sentences would be lengthened for several categories of drunk-driving, weapons-related and gang crimes.

Not every idea put forth is wise or valuable. The mayor advocates, for example, civil suits against manufacturers of weapons that can be readily converted to illegal automatic firepower. Such conversions are indeed a real and growing problem, but the answer lies in straightforward bans and sanctions, not another vehicle for tort-lawyer manipulation.

Also, none of these proposed measures—like the many criminal laws already on the books—can work in isolation. Social strategies such as community policing, recreational programs and stable schools can do more to reduce violence by young people than any number of laws dealing with crime after the fact. These are areas in which Daley has already launched initiatives, which he must pursue with vigor.

Related to this, the mayor suggests the state finally move on a concept outlined in 1980 by the Illinois Juvenile Justice Commission. Their idea was to set up community-based alternatives to Juvenile Court, emphasizing intervention with young delinquents who are at risk of growing into full-fledged criminals.

This is an idea that should indeed be dusted off and translated into action. But it shouldn't, and doesn't need to, entail a new layer of bureaucracy.

Cities, counties and the state already have many public, private and community programs designed to help troubled kids and families. But these various operations are most often fragmented and uncoordinated, reducing the effectiveness of the total money and effort expended.

Daley should turn loose the team that developed his crime-fighting package to develop an equally detailed, pinpointed plan for pooling and focusing crime-prevention programs. And he wouldn't need legislation to accomplish this—just an overriding, persistent commitment to rescuing endangered children.

. . . and an addlebrained drug policy

Elsewhere on the crime front:

President Clinton and Congress are gaining headlines as they move toward enactment of a $23 billion crime package that includes more prisons, more police and a raft of federal death-penalty offenses.

But an obscure classification that's already in the government rules book is actually impeding efforts by states and community organizations to employ one of the most desperately needed, under-used tools in the anti-crime arsenal: drug treatment.

A drug-treatment center that provides residential care for up to 16 addicts can get half the cost covered by federal Medicaid. But, in a process that only a thoroughly brainwashed bureaucrat could fathom, a center that takes in 17 patients, or more, gets cut off. Meanwhile, more than 10,000 people in Illinois alone are on waiting lists for drug treatment or evaluation.

This is not only a ridiculous policy in human terms but, as state officials point out, an absurd spending policy as well. It costs an average $7,000 in Illinois to treat a pregnant addict so she can deliver a drug-free baby. But the average price—typically borne by Medicaid—of caring for a baby addicted at birth runs to $31,000. Or a year in prison—where the pending federal crime bill does provide new funds for drug treatment—costs the state more than $16,000.

States are free to run larger drug-treatment centers as long as they pick up the entire tab. But doing so creates another dumb dilemma: Low-income clients then lose Medicaid benefits for all of their health care. This means a pregnant patient loses coverage for prenatal care and delivering her baby. If she stays hooked and delivers a coke-addicted infant, however, the feds will pay.

Clinton pledged in his campaign to re-direct more resources to drug treatment and prevention. It's a promise he has done little to effect, so far maintaining about the same level as the Bush administration, with far larger sums going to drug-law enforcement efforts. Clinton should start to move in the promised direction by straightening out the rules to help drug-treatment centers.

Tribune photos by Joel M. Gross

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs because of the U.S. rules. She hopes a grant to open another 16-bed program for pregnant and parenting women won't jeopardize the center.

Drug centers' big nightmare

Having more than 16 beds can mean loss of U.S. funds

By Bob Kerwath
Tribune Staff Writer

In 1990, Illinois officials announced plans to open one of the country's premier drug-treatment centers, with 70 beds for addicted women who were pregnant or raising young children.

Three years later, the Women's Treatment Center is operating in the former Mary Thompson Hospital, 140 N. Ashland Ave. But the West Side center has only 16 inpatient beds for pregnant women and mothers, the vulnerable population that the state was so interested in targeting.

State officials say they wish they could open more beds, but they say a federal law is standing in the way.

The federal law is known by three letters: IMD. They stand for "institute for mental diseases," which is what the federal government considers drug-treatment centers if they have more than 16 beds and aren't part of a full-service hospital.

Normally, Medicaid pays states for half the cost of medical care for the poor. But under a decades-old federal policy, Medicaid will not reimburse states for any of the costs of treating patients in institutes for mental diseases.

As a result, at a time when more than 10,000 Illinoisans are on waiting lists to receive drug treatment or to be evaluated for it, the states must limit inpatient

See Treatment, Page 6

Treatment

Continued From Page 1

programs to 16 beds if they want the federal government to split the costs.

States can operate larger centers if they want to pay all the costs. But the low-income clients would lose Medicaid coverage for all other health care. Pregnant drug addicts would lose coverage for prenatal care and delivering their babies.

Even so, many drug-treatment programs in Illinois and elsewhere are exceeding the 16-bed limit because of the great demand for their services. The larger centers can only hope that Medicaid never catches their clients when they go to the doctor for other medical treatment.

Officials from Illinois and other states have asked the federal government to lift the IMD restriction, calling it one of the largest impediments to expanding drug treatment.

"It's absolutely crazy. It doesn't make sense," said Jim Long, director of the Illinois Department of Alcoholism and Substance Abuse. This month during a tour of the Women's Treatment Center, Long urged President Clinton's drug czar, Lee Brown, to lift the restriction.

Henry Bartsen, an administrator in the New York Office of Alcoholism and Substance Abuse Services, said IMD "is just sitting to drug treatment."

But so far, the federal government isn't budging. Allowing treatment centers to expand and still qualify for Medicaid would cost the federal government tens of millions of dollars annually, federal officials say.

The states argue that lifting the IMD restriction would save Medicaid money in the long run.

In Illinois, caring for a baby born addicted to drugs costs an average of $31,000, a state task force found last year. Providing treatment to the baby's mother before she delivers costs an average $7,000.

The task force urged the federal government to lift the IMD restriction for drug treatment.

IMD restricts all inpatient-treatment programs, regardless of their clients.

But pregnant and parenting women are most significantly affected because they, more than other groups, need a place to live while breaking their addictions.

Haymarket House, which operates drug-treatment centers for a range of clients in the Chicago area, has had to scale back a program for pregnant women in 16 beds from 32. But Haymarket decided to forgo Medicaid coverage for another program for addicted men because of the great need for services, said Ray Soucek, Haymarket's executive director.

IMD "definitely hampers getting people into treatment," Soucek said.

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs, some of them without residential services, in the empty spaces that were left at the five-story former hospital when it was learned that the pregnant and parenting women's program would have only 16 beds, not 70.

Recently, Oates learned that the center had won a grant to open another 16-bed program for pregnant and parenting women. But Oates' happiness has been tempered with worry that under IMD, the new program may jeopardize Medicaid funding for the 16 beds she has.

"We're getting caught up in a bureaucratic nightmare," Oates said. "It's very frustrating."

As frustrating as IMD is, providers say it used to be worse. Until this year, the federal government counted children toward the 16-bed limit in programs where addicted mothers live with their kids.

As a result, women had to be separated from their children, many of whom had nowhere else to go, or else the treatment centers served fewer than 16 women.

Federal officials are sympathetic to the states' IMD complaints, said Chester Stroyny, director of the federal Health Care Financing Administration for the six-state Midwest region. But he acknowledged that there is no guarantee that the restriction will be lifted soon.

The federal government recently awarded six states money to study the impact of expanding drug treatment under Medicaid. Illinois failed to win one of those grants.

"The results from these demonstration projects may be the basis for some legislative proposal" to lift IMD, Stroyny said, "but that is several years away."

Jennifer Loney kisses her son Aaron in their room at the Women's Treatment Center. Loney lives with her three children at the center,which is restricted to only 16 inpatient beds because of a federal law that can cut off funding.

Tribune photo by José M. Osorio

Drug-treatment centers, such as the Women's Treatment Center, can only have 16 inpatient beds. If they have more, they risk losing Medicaid funding for low-income clients.

STATE OF ILLINOIS
DEPARTMENT OF
ALCOHOLISM AND
SUBSTANCE ABUSE

JAMES R. THOMPSON CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: (312) 814-3640
TDD NUMBER: (312) 419-8432
FAX NUMBER: (312) 814-2419

Jim Edgar
Governor

James E. Long
Director

January 4, 1994

Ms. Sally K. Richardson
Director
Department of Health & Human Services
Medicaid Bureau
6325 Security Boulevard
Baltimore, MD 21207

Dear Ms. Richardson:

Thank you for your timely response on behalf of Secretary Shalala regarding my letter on the "IMD exclusion". However, your letter neither addresses nor refutes my specific points about the inappropriate application of the "IMD exclusion" to non-hospital, residential substance abuse treatment centers.

Your references to Medicaid law are accurate. But, the references do not explain or require application of the "IMD exclusion" to substance abuse treatment centers.

1. The "IMD exclusion" is intended to restrict federal payment for state mental hospitals, probably those serving the chronically mentally ill.

2. Addiction to alcohol and/or other drugs is not a mental illness. The American Medical Association and the World Health Organization are two of numerous professional organizations which recognize addiction as a primary illness, not a subset of mental illness. HCFA stands alone in defining addiction as a mental illness.

3. HCFA's inclusion of addiction as a mental illness is an administrative decision not a statutory mandate.

4. In Illinois, as in most states, state government operates state mental hospitals. Substance abuse treatment centers are generally operated by not for profit organizations or local public health departments. The "IMD exclusion" was intended to apply to state mental hospitals.

5. Current policy allows substance abuse treatment to be conducted in a hospital without any restrictions. Hospital-based treatment is more costly and, no more effective than community-based non-hospital treatment. The "IMD exclusion" is inconsistent with the Medicaid principal in Section 1396a(a)(30)(A) of the Social Security Act that payments be "consistent with efficiency, economy, and quality of care and... sufficient to enlist enough providers".

In our Illinois experience, most hospitals are disinterested in serving the poor addict and they are unwilling to accept our rates for this population. However, current medicaid policy would allow us to raise our average daily rates from $150 to $500 or $600 to attract hospitals to serve poor addicts, especially pregnant women and women with children. We have not done this in Illinois because it would be wrong and illogical to pay more and get lower quality care. At the same time we have unused non-hospital capacity which could be utilized quickly, efficiently, and economically if the "IMD exclusion" were eliminated.

I have also enclosed a brief paper on this issue which explains our reasoning further.

Obviously, I feel very strongly about this issue. Regardless of the outcome, I would truly appreciate a direct and meaningful discussion of the issues, pertinent law, and policy.

Thank you for your consideration.

Sincerely,

James E. Long
Director

JEL/jy

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

FQA-421

6325 Security Boulevard
Baltimore, MD 21207

DEC -8 1993

DIRECTOR'S OFFICE

DEC 15 1993

STATE OF ILLINOIS
DEPARTMENT OF ALCOHOLISM
AND SUBSTANCE ABUSE

Mr. James E. Long
Director
State of Illinois Department of
Alcoholism and Substance Abuse
State of Illinois Center
100 West Randolph Street
Suite 5-600
Chicago, Illinois 60601

Dear Mr. Long:

This is in response to your letter to Secretary Shalala, which was referred to this agency for review since we administer the Federal aspects of the Medicaid statute. Specifically, you wrote to the Secretary regarding the "IMD exclusion."

Section 1905 of the Medicaid law excludes from consideration as medical assistance any payment on behalf of individuals between the ages of 22 and 65 who are inpatients of institutions for mental diseases (IMDs). This exclusion has a long history in the context of the Medicaid program and other public medical assistance programs that preceded it. It reflected a Congressional decision that funds made available under the Medicaid program should be used by States to augment rather than replace State expenditures for medical care. Since States had traditionally maintained institutions for the care of the mentally ill, Medicaid funds were generally prohibited for that purpose. Although there have been proposals in the Congress to eliminate this exclusion from the law, none of them has been enacted to date.

Outside the IMD exclusion, however, there is no Federal limit on Medicaid funding of services for the mentally ill. Specifically, there is no limit on the extent to which the costs of outpatient hospital or physician services may be covered by the States.

The reason for which drug treatment centers with 16 or fewer beds are not considered to be IMDs, and therefore not subject to the statutory exclusion, is also contained in the Medicaid law. Specifically, section 1905(i) specifies that "The term 'institution for mental diseases' means a hospital, nursing facility, or other institution of more than 16 beds, that is

primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." [Emphasis supplied.] Thus, the 16-bed limit is not, as the Chicago Tribune would have it, "a process that only a thoroughly brainwashed bureaucrat could fathom." Rather, it is a matter of law as enacted by Congress, and we are bound by that law.

Thank you for giving us the opportunity to address your concerns. If I may be of assistance in the future, please do not hesitate to write to me.

Sincerely yours,

Sally K. Richardson
Director
Medicaid Bureau

ILLINOIS DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

COVERAGE OF SUBSTANCE ABUSE TREATMENT UNDER MEDICAID/THE IMD EXCLUSION

Prepared by:

James E. Long, Director
Nancy J. Bennett, Chief General Counsel

COVERAGE OF SUBSTANCE ABUSE TREATMENT UNDER MEDICAID/THE IMD EXCLUSION

THE PROBLEM

Since Medicaid began in 1965, medical assistance has been denied by law for certain patients in Institutions for Mental Disease (IMD). Currently, an IMD is defined as a facility of more than 16 beds that specializes in psychiatric care. Residential treatment facilities for substance abuse are covered under this provision - presenting a significant barrier to alcohol and other drug treatment for pregnant women and women with children and other individuals who are Medicaid eligible. Not only do low income individuals lose their ability to obtain alcohol and other drug treatment services in an IMD but they lose all other Medicaid services as well.

Currently individuals with alcohol and substance abuse problems may be admitted to a hospital for alcohol and other drug treatment without loss of Medicaid benefits. Not only are hospitals more costly but they often lack essential ancillary services available through a community based treatment programs.

Many critics believe that the Health Care Financing Administration's (HCFA) interpretation of alcohol and other drug problems as being subject to the IMD exclusion is flawed. The impact of this interpretation is that it perversely restricts the provision of needed alcohol and substance abuse treatment - especially to pregnant and parenting women who can not afford to buy Medicaid services and whose untreated substance abuse often increases the cost of other health care services.

WOMEN AND CHILDREN: A VULNERABLE POPULATION

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates there will be 5 million women who abuse alcohol alone by 1995, four million of whom will be of child bearing age. Other statistics indicate that 10% of the female population abuse alcohol and/or drugs.

COST TO SOCIETY

The cost of such alcohol and other drug use to society is astronomical. In addition to health care costs for the women, children who are born to pregnant abusers could conservatively cost the health care system as much as 3 billion dollars annually (this figure does not include estimates regarding social service and education costs required as these children grow). Substance abuse treatment services for these women are woefully inadequate with only 11% of the pregnant substance abusers in the country currently receiving treatment intervention before or during these women's pregnancies, drug-affected babies can easily push up the costs of health care. (A report this year by the Columbia Univ

Addiction and Substance Abuse notes that "the Medicaid program covers a large number of pregnant women and children. Substance abuse has a significant impact not only on pregnancy and birth outcomes but also on life-long health care costs for infants born to substance abusing mothers". See "The Cost of America's Health Care System, Report 1: Medicaid Hospital Costs, A CASA Report".

RECOMMENDATIONS FOR ACTION

The National Association of State Alcohol and Drug Abuse Directors recommends the following:

1. The Federal Government and Congress should recognize alcoholism and substance abuse as separate, diagnosable and treatable illnesses, rather than as subcategories of mental illnesses. This would, in theory, eliminate the application of the IMD exclusion to substance abuse treatment services.

2. Per the 1990 Moynihan amendment, alcoholism and substance abuse treatment services should be immediately recognized by HCFA as eligible for reimbursement in any appropriate setting.

3. At a minimum HFCA should provide immediate alternative relief to pregnant and post partum women and other individuals by removing the IMD exclusion from alcohol and other drug residential treatment programs, or by increasing the 16 bed limit to 40 to expand capacity (although such alternatives are short sighted and contrary to the tenants of simplicity of administration and cost efficiency, and do not cover all reasonable costs).

4. The Federal Government and Congress should provide reimbursement for the most cost effective treatment setting possible. Generally, hospital treatment programs are significantly more costly than non-hospital programs, yet both settings use similar treatment practices and protocols; and non-hospital treatment programs are more philosophically suited and experienced in serving poor and indigent substance abusers.

These recommendations are consistent with the intent of Medicaid because it will assure the provision of care and services which are in the best interests of these recipients, which are consistent with simplicity of administration, and which will enlist sufficient providers. By such a policy the Federal Government and the State share a financial commitment to serving this priority population in need.

MEDICAID REIMBURSEMENT FOR ALCOHOL AND DRUG PROBLEMS: A DILEMMA

A large portion of those in need of substance abuse treatment are Medicaid eligible and yet the Medicaid system does not currently cover non-hospital residential treatment programs for such women fully, adequately or appropriately. Treatment is essential to preventing the adverse pregnancy outcomes.

Residential Program Restriction

The IMD is the most serious barrier to providing substance abuse treatment services to those in need. Many experts have questioned HCFA's interpretation of this provision. Section 1905(i) of the SSA describes an "Institution for Mental Disease" as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases". HCFA has determined alcoholism and substance abuse to be "mental diseases" and, therefore, classifies residential substance abuse treatment facilities as IMD's. However, the initial purpose of this exclusion was to ensure that Medicaid did not pay for state mental hospital care which was considered a state responsibility, and that long term institutional residents should not be permanently housed in large facilities.

Substance Abuse Treatment as "Medical Assistance"

"Medical assistance" reimbursable under Title XIX, is geared toward a medical model. Substance abuse services, which are based on counselor interaction, are not considered to be "mandated" Medicaid services. Therefore, medical detoxification, methadone maintenance under physician supervision, treatment in a hospital or a psychiatric hospital, and other "medical" components of substance abuse treatment are reimbursable, while non-hospital counselor-based subacute treatment is not. However, hospital in-patient treatment services, are generally similar to the community-based treatment services, except they are much costlier because of the setting.

ALCOHOL AND OTHER DRUG PROBLEMS ARE DIFFERENT THAN MENTAL ILLNESS

The World Health Organization, the American Medical Association and the American Psychiatric Association view alcohol and other drug problems (AOD) as separate, identifiable and treatable illnesses rather than as forms of mental illnesses. They adopted the DSM-III-R (Diagnostic Statistical Manual of Disorders, 3rd Edition, Revised) classification of the illnesses, rather than ICD-9-CM (International Classification of Diseases, 9th Edition). Thus, it is both inaccurate and detrimental to classify alcoholism and substance abuse as mental diseases. It is unlikely that Congress ever intended the IMD exclusion to apply to substance abuse treatment facilities because it was concerned about state mental hospitals.

Congress spoke clearly about substance abuse treatment services in 1990 when it passed the Moynihan amendment to the Medicaid statute which mandates that:

> No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency (42 U.S.C. §1396d(a)).

Unfortunately, the spirit and intent of this amendment has been ignored by HCFA's current interpretation of the IMD exclusion, which severely restricts reimbursement for non-hospital subacute treatment services.

History of Legal Challenges

There have been and continue to be court challenges to HCFA's interpretation of the IMD exclusion. In IDPA v. Brown (7th Cir. 1986), a series of Granville House cases (8th Cir. 1983 and 1986), and Minnesota v. Hekler (8th Cir. 1983), the courts tended to agree that the problem of substance abuse is not a mental disease. Plaintiffs in the cases have either run out of money to pursue the issues or have changed their status in order to get reimbursement rather than spending more in legal fees.

One important impact of the cases so far has been that HCFA was ordered to issue guidelines regarding when a facility should be considered to be an IMD. These guidelines issued in 1986, skirted the underlying issue of whether alcoholism and substance abuse are "mental diseases".

Current Court Challenges

Currently cases are pending in two jurisdictions regarding the IMD exclusion as applied to substance abuse facilities. In the U. S. District Court for the Eastern District of Pennsylvania an injunction is being sought to required Title XIX coverage for these services (currently a motion to dismiss is under advisement by the court). In Texas there is an administrative challenge to the IMD interpretation. The hearing has been concluded and a decision is pending. If it is unfavorable Texas anticipates an appeal to the U.S. 5th Circuit.

STATE'S REACTION TO IMD

HCFA interpretations have led to anything but simplicity in this area. Since non-hospital residential treatment services are not considered Medicaid-reimbursable, states have attempted numerous creative strategies to get coverage for portions of residential substance abuse treatment services. In many States eligible recipients are simply precluded from receiving services.

Illinois - A State Study

For example, Illinois has extended its State Medicaid Plan to cover as broad a range of optional substance abuse services as can be found to be federally matchable under current interpretations. HCFA has allowed Illinois to receive federal match for treatment units of 16 beds-or-under and within larger treatment facilities when the units are separately licensed, Medicaid certified and have separately identified cost centers. But the reimbursement does not cover room and board costs, which constitute about 30% of the expense of such treatment. Downsizing to 16 beds not only reduces capacity but is less efficient and less cost effective.

Illinois has over a thousand residential treatment beds in non-hospital facilities which are not Medicaid reimbursable. Many of these beds spaces are in women's programs. That is more than the number of bed spaces in Medicaid certified substance abuse facilities (there are about nine hundred bed spaces in certified non-hospital facilities, the majority of which are not eligible for the room and board costs). It is impossible to measure the number of residential bed spaces which may have been created if they had been Medicaid-reimbursable. In Illinois hospitals there are about 1,500 bed spaces devoted to substance abuse. These are clearly eligible for Medicaid-reimbursement and yet hospitals have chosen to certify only about three hundred of the beds for Medicaid reimbursement (Illinois pays for actual treatment costs and overhead related to treatment only. This approach excludes general hospital overhead costs and makes Medicaid unattractive to most hospitals).

Therefore, many Medicaid eligible recipients in Illinois go untreated. Known Illinois waiting lists consist of about 5,000 persons, with many of those being pregnant women. At this time it is unknown how many on the waiting lists are Medicaid eligible, but pregnant women with little income would most likely qualify.

NEW DIRECTIONS

Small steps have been made toward re-thinking how the IMD exclusion affects the provision of alcohol and substance abuse. After pressure from States, HCFA reversed its policy stating that children's beds are to be counted when children are in residence with their mother at residential substance abuse facilities. Formerly these were required to be counted in determining whether or not the facility had 16 beds and was subject to the exclusion.

HCFA has also granted a waiver for a demonstration project for pregnant substance abusers in a few residential treatment facilities. They will evaluate the 3 year demonstration project (located in New York, Washington, Massachusetts, and South Carolina) where substance abuse treatment in residential facilities for pregnant women are being reimbursed under Title XIX (HCFA has historically refused requests for direct waiver of the IMD exclusion, but has created a situation in this demonstration whereby services are reimbursable). The demonstration will begin its second year in October '93. HCFA indicates that the demonstration will be evaluated at the end of the three years, with the possibility of changing current IMD policy.

We believe these to be positive steps in the absence of a decisive and direct removal of the IMD exclusion barrier. We support and encourage further movement in this direction.

CONCLUSION

The IMD and other Medicaid barriers established at the Federal level mean residential care has been severely limited even though it is far less expensive than inpatient hospital services. Furthermore, this often means that outpatient service may be chosen for a client who really requires inpatient services. However, recent evidence suggests that appropriate inpatient treatment initially may be the most effective way of preventing the costly recidivism common

among substance abusers. (See "A Randomized Trial of Treatment Options for Alcohol-Abusing Workers", New England Journal of Medicine, Sept. 12, 1991). Additional treatment was required significantly more often for substance abusers who were initially given only outpatient treatment, or who were allowed to choose their own form of treatment, as opposed to those initially assigned to inpatient treatment.

While the effect of the IMD exclusion may be most disastrous for pregnant substance abusing women and their children (costs to society caused by lack of treatment during pregnancy are more long range than failure to treat a man - pregnancy complications, bad birth outcomes, possible life long ailments and problems of the baby, etc.), HCFA must be forced to rethink its policy for all patients. The IMD barrier is contrary to the intent of Congress, is counterproductive and drives up rather than reducing health care costs.

Because of the IMD exclusion, temporary and short-sighted cost determinations end up governing treatment choice, which in the long run only drives up general health care costs. The intent of Medicaid is that care and services be provided in a manner consistent with simplicity of administration and the best interests of the recipient, and that payments are sufficient to enlist enough providers so that care and services are available to recipients at least to the extent that such care and services are available to the general population (See 42 U.S.C. §1396a(a)(19) and (c) and §1396a(a)(30)(A)).

State Alcohol and Drug Agency Directors believe it is time to approach residential substance abuse treatment coverage in a more reasonable fashion. We are encouraged by signs from the Administration and HCFA that show greater flexibility and a desire to review previously accepted administration interpretations. It is time to give those on waiting lists the services they need. The issue will be driven, of course, by the costs of expansion of coverage. NASADAD and its members believe that we can't afford not to provide services. The cost of denying service is far greater in the long run.

COVERAGE OF SUBSTANCE ABUSE TREATMENT
UNDER MEDICAID/THE IMD EXCLUSION

THE PROBLEM

Since Medicaid began in 1965, medical assistance has been denied by law for certain patients in Institutions for Mental Disease (IMD). Currently, an IMD is defined as a facility of more than 16 beds that specializes in psychiatric care. Residential treatment facilities for substance abuse are covered under this provision - presenting a significant barrier to alcohol and other drug treatment for pregnant women and women with children and other individuals who are Medicaid eligible. Not only do low income individuals lose their ability to obtain alcohol and other drug treatment services in an IMD but they lose all other Medicaid services as well.

Currently individuals with alcohol and substance abuse problems may be admitted to a hospital for alcohol and other drug treatment without loss of Medicaid benefits. Not only are hospitals more costly but they often lack essential ancillary services available through a community based treatment programs.

Many critics believe that the Health Care Financing Administration's (HCFA) interpretation of alcohol and other drug problems as being subject to the IMD exclusion is flawed. The impact of this interpretation is that it perversely restricts the provision of needed alcohol and substance abuse treatment - especially to pregnant and parenting women who can not afford to lose Medicaid services and whose untreated substance abuse often increases the cost of other health care services.

WOMEN AND CHILDREN: A VULNERABLE POPULATION

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates there will be six million women who abuse alcohol alone by 1995, four million of whom will be of child-bearing age. Other statistics indicate that 10% of the female population abuse alcohol and/or other drugs.

COST TO SOCIETY

The cost of such alcohol and other drug use to society is astronomical. In addition to general health care costs for the women, children who are born to pregnant abusers could conservatively cost the health care system as much as 3 billion dollars annually (this figure does not include estimates regarding social service and education costs required as these children get older). Substance abuse treatment services for these women are woefully inadequate with at most, only 11% of the pregnant substance abusers in the country currently receiving treatment. Without intervention before or during these women's pregnancies, drug-affected babies will continue to push up the costs of health care. (A report this year by the Columbia University Center on

THE WHITE HOUSE

WASHINGTON

December 2, 1993

James E. Long
Director
Illinois Department of Alcoholism
and Substance Abuse
222 South College Street
Second Floor
Springfield, IL 62704

Dear Jim:

It was great to see you at ONDCP's state and local affairs conference this week. It's hard to believe how quickly the time passes, and that we haven't spoken since my visit to the Cook County Day Reporting Center last July. In any event, I trust that will be in better contact in the coming months as the Administration puts together its full-blown strategy and the FY 1995 Budget.

I've just spoken to Martha at OMB, with whom you met before leaving. She's been on a 48-hour crusade to discover as much as possible about the IMD exclusion -- and to educate as many folks as she can on the issue. It looks like will have to tunnel our way into the inner bowels of HCFA to get some answers. We'll let you know if we make any progress.

Sincerely,

Jose Cerda III
Senior Policy Analyst

Jennifer Loney kisses her son Aaron in their room at the Women's Treatment Center. Loney lives with her three children at the center,which is restricted to only 16 inpatient beds because of a federal law that can cut off funding.

Tribune photos by José M. Osorio

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs because of the U.S. rules. She hopes a grant to open another 16-bed program for pregnant and parenting women won't jeopardize the center.

Drug centers' big nightmare

Having more than 16 beds can mean loss of U.S. funds

By Rob Karwath
TRIBUNE STAFF WRITER

In 1990, Illinois officials announced plans to open one of the country's premier drug-treatment centers, with 70 beds for addicted women who were pregnant or raising young children.

Three years later, the Women's Treatment Center is operating in the former Mary Thompson Hospital, 140 N. Ashland Ave. But the West Side center has only 16 inpatient beds for pregnant women and mothers, the vulnerable population that the state was so interested in targeting.

State officials say they wish they could open more beds, but they say a federal law is standing in the way.

The federal law is known by three letters: IMD. They stand for "institute for mental diseases," which is what the federal government considers drug-treatment centers if they have more than 16 beds and aren't part of a full-service hospital.

Normally, Medicaid pays states for half the cost of medical care for the poor. But under a decades-old federal policy, Medicaid will not reimburse states for any of the costs of treating patients in institutes for mental diseases.

As a result, at a time when more than 10,000 Illinoisans are on waiting lists to receive drug treatment or to be evaluated for it, the states must limit inpatient

SEE TREATMENT, PAGE 5

Tribune photo by José M. Osorio

Drug-treatment centers, such as the Women's Treatment Center, can only have 16 inpatient beds. If they have more, they risk losing Medicaid funding for low-income clients.

Treatment

CONTINUED FROM PAGE 1

programs to 16 beds if they want the federal government to split the costs.

States can operate larger centers if they want to pay all the costs. But the low-income clients would lose Medicaid coverage for all other health care. Pregnant drug addicts would lose coverage for prenatal care and delivering their babies.

Even so, many drug-treatment programs in Illinois and elsewhere are exceeding the 16-bed limit because of the great demand for their services. The larger centers can only hope that Medicaid never catches their clients when they go to the doctor for other medical treatment.

Officials from Illinois and other states have asked the federal government to lift the IMD restriction, calling it one of the largest impediments to expanding drug treatment.

"It's absolutely goofy. It doesn't make sense," said Jim Long, director of the Illinois Department of Alcoholism and Substance Abuse. This month during a tour of the Women's Treatment Center, Long urged President Clinton's drug czar, Lee Brown, to lift the restriction.

Henry Bartlett, an administrator in the New York Office of Alcoholism and Substance Abuse Services, said IMD "is just stifling to drug treatment."

But so far, the federal government isn't budging. Allowing treatment centers to expand and still qualify for Medicaid would cost the federal government tens of millions of dollars annually, federal officials say.

The states argue that lifting the IMD restriction would save Medicaid money in the long run.

In Illinois, caring for a baby born addicted to drugs costs an average of $31,000, a state task force found last year. Providing treatment to the baby's mother before she delivers costs an average $7,000.

The task force urged the federal government to lift the IMD restriction for drug treatment.

IMD restricts all inpatient-treatment programs, regardless of their clients.

But pregnant and parenting women are most signficantly affected because they, more than other groups, need a place to live while breaking their addictions.

Haymarket House, which operates drug-treatment centers for a range of clients in the Chicago area, has had to scale back a program for pregnant women to 16 beds from 22. But Haymarket decided to forgo Medicaid coverage for another program for addicted men because of the great need for services, said Ray Soucek, Haymarket's executive director.

IMD "definitely hampers getting people into treatment," Soucek said.

Jewell Oates, executive director of the Women's Treatment Center, has had to open other treatment programs, some of them without residential services, in the empty spaces that were left at the five-story former hospital when it was learned that the pregnant and parenting women's program would have only 16 beds, not 70.

Recently, Oates learned that the center had won a grant to open another 16-bed program for pregnant and parenting women. But Oates' happiness has been tempered with worry that under IMD, the new program may jeopardize Medicaid funding for the 16 beds she has.

"We're getting caught up in a bureaucratic nightmare," Oates said. "It's very frustrating."

As frustrating as IMD is, providers say it used to be worse. Until this year, the federal government counted children toward the 16-bed limit in programs where addicted mothers live with their kids.

As a result, women had to be separated from their children, many of whom had nowhere else to go, or else the treatment centers served fewer than 16 women.

Federal officials are sympathetic to the states' IMD complaints, said Chester Stroyny, director of the federal Health Care Financing Administration for the six-state Midwest region. But he acknowledged that there is no guarantee that the restriction will be lifted soon.

The federal government recently awarded six states money to study the impact of expanding drug treatment under Medicaid. Illinois failed to win one of those grants.

"The results from these demonstration projects may be the basis for some legislative proposal" to lift IMD, Stroyny said, "but that is several years away."