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Medicaid's Institutions of Mental Diseases (IMD) Exclusion Rule

A POLICY DEBATE

Argument to Retain the IMD Rule
Jennifer Mathis, J.D.

Argument to Repeal the IMD Rule
Dominic A. Sisti, Ph.D. and
Aaron Glickman, B.A.

Spring 2018

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PEG'S FOUNDATION

Dear Reader,

Now is a time of change in health and human services policy. Many of the changes could have profound implications for behavioral health. This paper is one in a series of papers proposing solution-oriented behavioral health policies.

The past decade has been a time of steady advances in behavioral health policy. For example, we have met many of the objectives related to expanding health insurance coverage for people with behavioral health conditions. Coverage is now expected to be on a par with that available to individuals with any other health conditions, although parity implementation has encountered roadblocks. Coverage of evidence-based treatments has expanded with insurance, but not all of these services are covered by traditional insurance, necessitating other sources of funding, such as from block grants.

Much has improved; much remains to be accomplished.

As funders, The Thomas Scattergood Behavioral Health Foundation and Peg's Foundation believe that now more than ever philanthropic support in the area of policy is critical to improving health outcomes for all. We ask that you share this paper and the others in the series with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters.

We believe that these papers analyze important issues in behavioral health policy, can inform policy-making, and improve health outcomes. In the back of the paper, there are suggested ways of how one can use the paper to further share these solution-oriented ideas and advocate for change. We hope these papers help to extend progress and avoid losing ground at a time of change in policy.

Sincerely,

Joseph Pyle, M.A.
President
Thomas Scattergood Behavioral Health Foundation

Rick Kellar, M.B.A.
President
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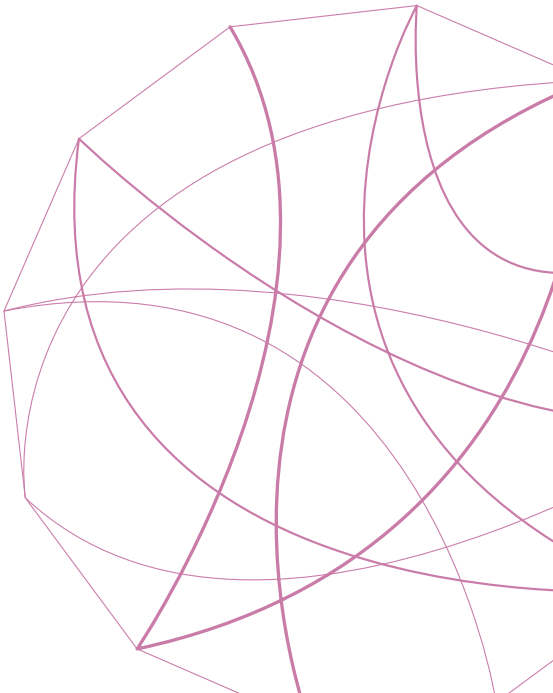

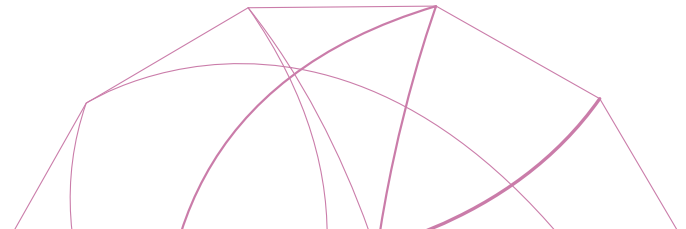

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A POLICY DEBATE

Argument to Retain the IMD Rule
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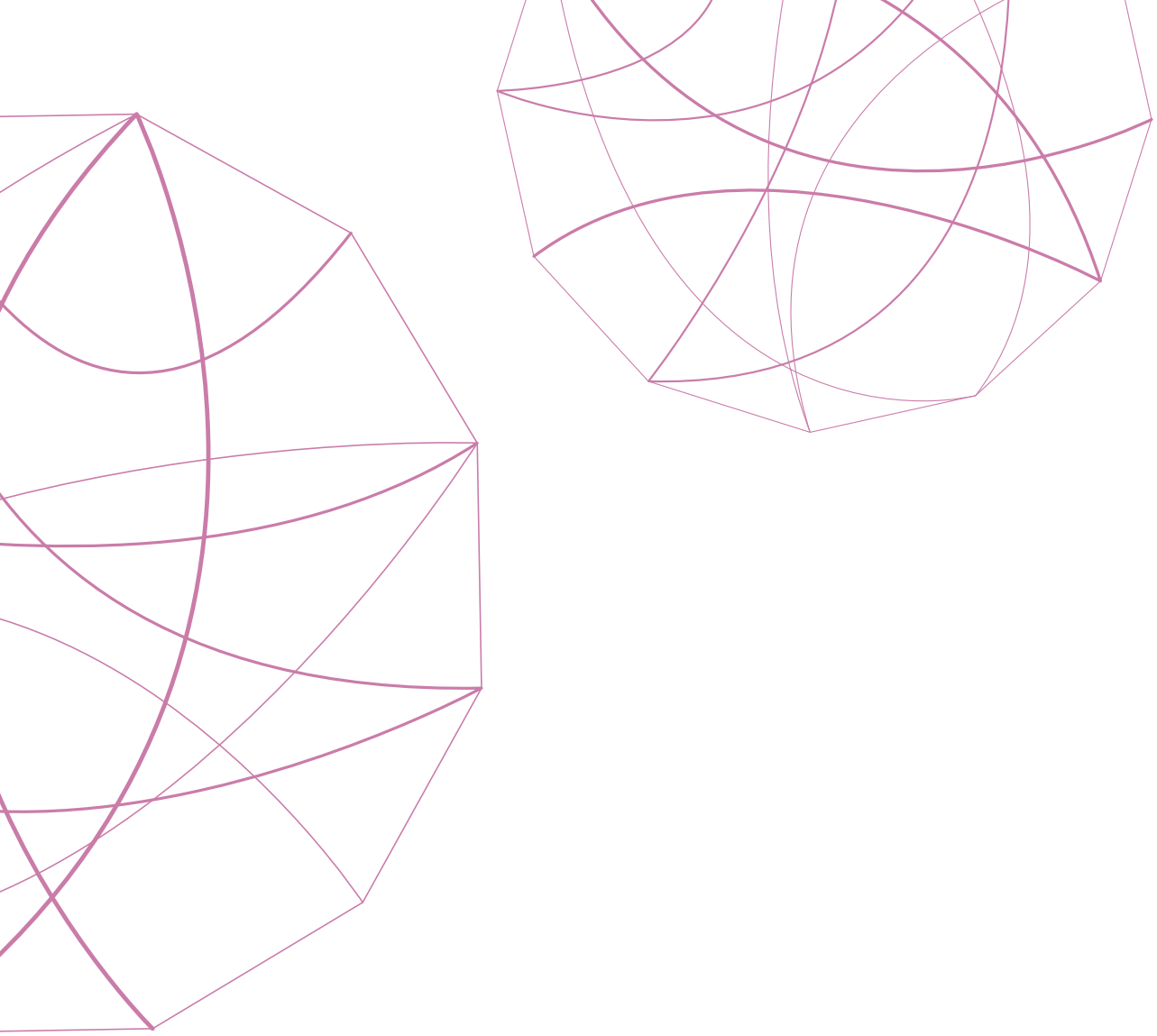


The IMD exclusion rule, which has been in place since the beginning of the Medicaid program in 1965, bars the use of federal Medicaid funds to finance services for individuals ages 22 to 64 residing in "institutions for mental diseases" or IMDs—hospitals, nursing homes, or other institutions with more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with "mental diseases" other than dementia or intellectual disabilities.

Argument to Retain the IMD Rule

Introduction

Recent years have brought increasing calls for the repeal of Medicaid's long-standing IMD exclusion rule, accompanied by the refrain that deinstitutionalization has "gone too far" and by the contention that dramatic downsizing of psychiatric hospital capacity over the past half century reflects a crisis. Although our mental health systems are in crisis, neither the IMD rule nor insufficient hospital beds are the primary problem. The primary problem is the failure to implement an effective system of intensive community-based services, which have been shown to prevent or shorten hospitalizations. Repealing the IMD rule would do little to alleviate the true crises in our public mental health systems and would likely deepen those crises.

1 The IMD Rule Has Been an Important Driver of the Shift Toward Community Services

The IMD exclusion rule, which has been in place since the beginning of the Medicaid program in 1965, bars the use of federal Medicaid funds to finance services for individuals ages 22 to 64 residing in "institutions for mental diseases" or IMDs—hospitals, nursing homes, or other institutions with more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with "mental diseases" other than dementia or intellectual disabilities (1). Congress's adoption of the rule reflected its view that serving individuals in mental institutions was a state responsibility. Lawmakers did not want federal payments to replace state financial commitments[i].

The rule's enactment, coming two years after Congress passed the Community Mental Health Centers Act, also reflected congressional intent to promote a shift toward community-based services. In adopting the IMD rule, Congress explained that community mental health centers were "being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963," that "often the care in [psychiatric hospitals] is purely custodial," and that Medicaid would provide for "the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals" (1).

i. "The committee believes that responsibility for the treatment of persons in mental hospitals—whether or not they be assistance recipients—is that of the mental health agency of the State" (1). When Congress adopted the IMD rule, state psychiatric hospitals predominated and states generally did not pay for care in private psychiatric hospitals. Nevertheless, Congress also made the rule applicable to freestanding private psychiatric hospitals, likely reflecting the concerns about long-term institutional care described below and to encourage the use of community services and acute-care general hospitals instead.

Because states can draw down federal Medicaid reimbursement for community services but generally not for care in psychiatric hospitals, the IMD rule has been an important driver of state systems shifting toward community services. That has been good policy.

Complaints about the loss of psychiatric hospital beds often give short shrift to the important reasons why public systems deliberately reduced investment in hospital capacity and shifted resources to community capacity: to promote better and less costly treatment in the community and in particular new approaches and improved services that enable even people with challenging conditions to regain their independence, dignity, and autonomy. This shift reflects a dramatic, albeit insufficient, reinvestment in more modern, effective community services, which has resulted in thousands of people once warehoused in state hospitals thriving in community settings. Furthermore, Medicaid does cover inpatient services in general hospitals, including those provided in specialized psychiatric units. In contrast to 1963, when state systems provided state hospital services and little else,[ii] the vast majority of public service system dollars now support individuals in community settings (2).[iii] That is a benefit, not a loss. And although much of the savings from hospital closures was never reinvested in community services, that failure suggests the remedy of making good on the promise to expand community services, not rebuilding hospitals.

ii. "Until the passage of the Community Mental Health Act in 1963, community mental health programs had been initiated in a few states, but in most states, 'SMHA' meant 'state hospital.' The vast majority of state expenditures and services for individuals with mental illness was devoted to state psychiatric hospitals" (2).
iii. Between FY 1981 and FY 2015, state hospital expenditures increased 159% while community expenditures increased 1,528% (2).

2 Inpatient Bed Shortages Reflect Gaps in Community Services

As the state mental health program directors themselves have emphasized, pressure to increase psychiatric inpatient capacity "often actually stems from an underfunded community mental health system, exemplified by emergency department over-crowding and boarding, visible chronic homelessness, increased police encounters and jail census, stigma, or a high profile-incident" (3).

Accordingly, "When determining psychiatric inpatient capacity, system leaders should first assess the capacity of evidence-based community programs and services to reduce the need for inpatient care" (3). Community services such as assertive community treatment, crisis services, supportive housing, and other services have proven successful in reducing inpatient admissions and bed-days, as well as incarceration in jails and prisons (3). Yet calls for more psychiatric hospital beds almost never take into account what additional community capacity is needed and how much reduction in inpatient beds—or arrests and incarceration—could be expected if that capacity were developed. Dr. Jess Jamieson, former Director of State Hospitals in Washington State, observed (4): "When I was running the State hospitals in Washington, we were right in the middle of this controversy…boarding patients in the ERs waiting for a bed. My hospitals were full, so the prevailing attitude was we needed more beds. This is not the solution! What I needed was a stronger community-based system to divert patients from inpatient hospitalizations and the community resources to discharge my patients who were ready for community placement, thus opening up a bed for those patients who needed hospitalization. The problem was the community system was under funded and lacked resources."

Community services such as assertive community treatment, crisis services, supportive housing, and other services have proven successful in reducing inpatient admissions and bed-days, as well as incarceration in jails and prisons.

Not only is the expansion of community services frequently overlooked as a solution, so too is the fact that the number of private psychiatric hospital beds has actually increased in recent decades (2),[iv] and it is these beds, not state hospital beds, that are especially suited for crisis care. Moreover, the significant decreases in state hospital beds occurred years ago. As the state mental health program directors observed: "The shortage of bed capacity is often attributed to the closure of state psychiatric hospitals. But…most of the state psychiatric hospital bed capacity that has been closed was actually closed decades ago, with the rate of downsizing drastically slowed in recent years" (2).

iv. Between 1982 and 2010, while state and county psychiatric hospital beds decreased by 69%, all other mental health inpatient and residential beds increased by 14%. Between 1983 and 2014, state and county psychiatric hospital beds decreased 66%, from 117,084 to 39,907, while private psychiatric hospital beds increased 77%, from 16,079 to 28,461. Notably, much of the decrease in state hospital capacity was occasioned not only by the increased reliance on community services but also by a significant decrease in their use to serve individuals with "organic brain syndrome" or intellectual and developmental disabilities, who occupied nearly 40% of state hospital beds in 1970 but now are largely served in other settings (2).

3 Federal Reimbursement for IMDs Is Not a Guarantee of Increased Access to Care

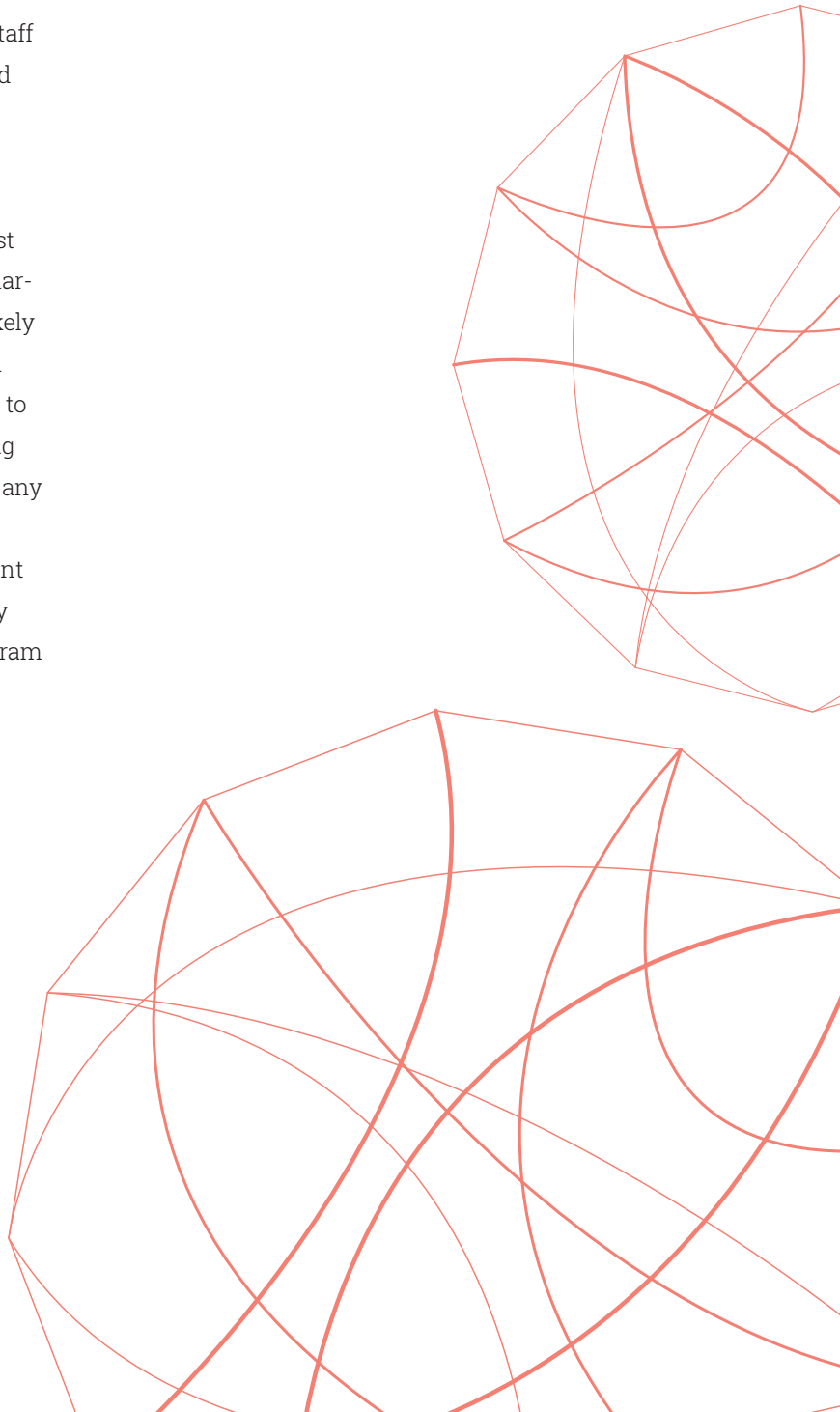
IN FACT, IT WOULD LIKELY DECREASE ACCESS

Allowing federal reimbursement to states for providing inpatient psychiatric care does not guarantee expansion of such care. Repeal of the IMD rule would make each hospital bed less expensive for the state to operate or rely on but would not require an expansion of this form of care. Indeed, the long history of states' underinvestment in mental health services strongly suggests that states would not use the savings they realize from repeal of the IMD rule to expand mental health services.

In fact, a large federal demonstration project recently examined whether allowing federal reimbursement for private IMD beds for adults ages 21 to 64 would improve access to inpatient care. The demonstration project, authorized by the Affordable Care Act, required the Centers for Medicare and Medicaid Services to assess the effects of providing Medicaid reimbursements to private psychiatric hospitals for individuals ages 21–64. The Medicaid Emergency Psychiatric Services Demonstration Evaluation ran from 2012 through 2015. Through this project, 11 states and the District of Columbia received federal Medicaid matching funds for inpatient treatment in participating private IMDs for beneficiaries with psychiatric emergency medical conditions, which were defined as being suicidal, homicidal, or dangerous to oneself or others. As mandated by the ACA, the evaluation addressed the following areas: Medicaid inpatient access, length of stay, and emergency room visits; discharge planning by participating hospitals; impact on costs of the full range of mental health services, including inpatient, emergency, and ambulatory care; and the percentage of individuals admitted to participating IMDs as a result of the demonstration, compared with those admitted to the same facilities through other means.

The final evaluation report indicated that federal reimbursement for private IMD beds did not increase access to inpatient care for adults ages 21–64 (5). The evaluation found no increase in the number of inpatient admissions or the length of stays in IMDs, no decrease in the number of emergency room visits or the length of emergency department boarding, and no decrease in the number of admissions to or lengths of stay in non-psychiatric units in general hospitals (5). The report did note, however, that "one of the most consistent findings from our interviews was the existence of significant shortages of community-based outpatient services. Both beneficiaries and facility staff almost universally reported difficulties in obtaining needed aftercare services from community providers."

Whether repeal of the IMD rule would expand psychiatric hospital services or not, the enormous sum that it would cost the federal government would almost certainly bring similar-sized federal cuts to other parts of the Medicaid program, likely resulting in reduced funding for community services and generating new pressures on inpatient capacity. It is naïve to assume that the $40 billion to $60 billion federal price tag estimated for repeal of the IMD rule (6) would be adopted by any Congress without offsetting cuts, particularly in light of pay-go rules—but especially now, with federal commitment to the Medicaid program at a historic low, as evidenced by the near passage of legislation that would have cut the program to the bone.



4 The IMD Rule Does Not Promote Discrimination—It Prevents It

Arguments that the IMD rule discriminates against people with mental illness miss the mark and ignore the discrimination that comes from needless institutionalization. The IMD rule does not bar Medicaid from covering inpatient psychiatric hospital services. Medicaid covers these services and always has, if they are provided in a general hospital setting rather than in a freestanding psychiatric hospital. Congress's decision to provide Medicaid coverage for inpatient psychiatric care in a general hospital setting, where people without mental illnesses also receive care, rather than in a segregated setting does not amount to discrimination. If anything, the opposite is true.

Moreover, Congress's choice promotes the integration of mental health care and medical care, the importance of which has been widely recognized. People with serious mental illnesses have high rates of diabetes, heart disease, cancer, stroke, and pulmonary disease and tend to die at a much earlier age than the general population. These physical health problems may be exacerbated by obesity, smoking, substance use, and side effects of psychiatric medications. General hospitals with psychiatric units are well positioned not only to address a mental health crisis but also to treat the "whole person," including co-occurring and interrelated physical health issues.

Not only does the IMD rule not discriminate, it helps prevent discrimination by promoting compliance with the Americans with Disabilities Act (ADA). The ADA's "integration mandate" and the 1999 Olmstead decision prohibit institutionalization of people with disabilities who could be served in community settings if providing community services can be reasonably accommodated. Although the worst abuses of psychiatric institutions may be in the past,[v] institutionalization of individuals

v. Although the types of abuses that occurred in the Willowbrook State School on Staten Island or Byberry (Philadelphia State Hospital) are not common today, abuse, neglect, and poor conditions in psychiatric hospitals are hardly a relic of the past, as evidenced by numerous Justice Department findings and enforcement actions and other examples (https://bit.ly/1WiyQ5b).

who could be served in community settings is itself harmful, regardless of whether abuse occurs. As the Supreme Court observed in its Olmstead decision, needless institutionalization is a form of discrimination because "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life…and institutional confinement severely diminishes the everyday life activities of individuals" (7).

Enforcement by the U.S. Department of Justice and private plaintiffs has resulted in Olmstead settlement agreements across the country that require states to offer sufficient assertive community treatment, supported housing, mobile crisis services, supported employment, and peer support services to avoid needless institutionalization in state psychiatric hospitals, psychiatric nursing facilities, adult homes, and other institutional settings.[vi] These settlements show that even today, there is significant overreliance on hospitals and other institutions that could be avoided with the development of community services. As the Senate Health, Education, Labor, and Pensions Committee observed several years ago, needless institutionalization remains widespread, including for people with mental illnesses (8).

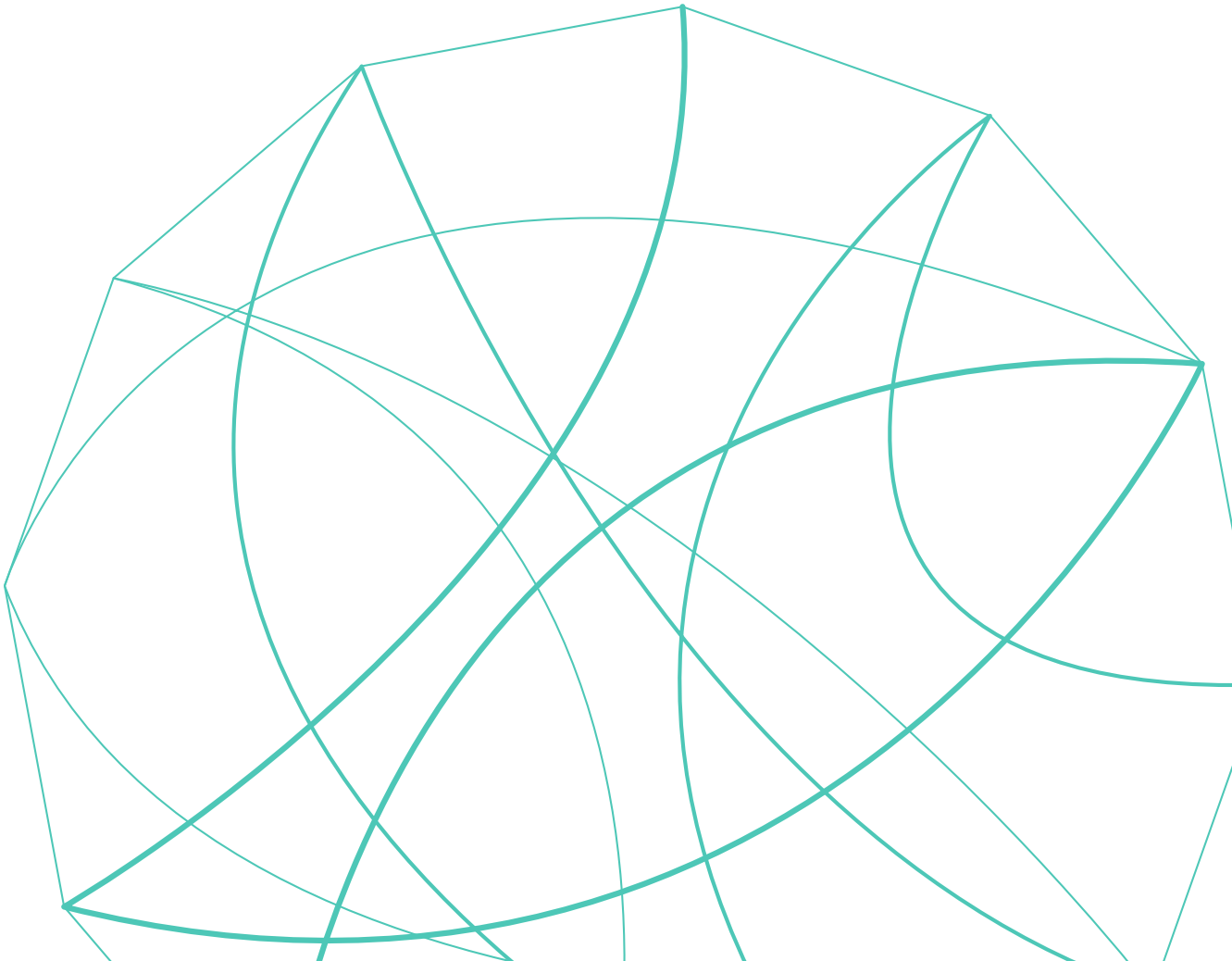
vi. See, for example, United States v. Georgia (state psychiatric hospitals; settlement approved 2010); United States v. Delaware (state psychiatric hospital and private IMDs; settlement approved 2011); United States v. North Carolina (privately operated adult care homes for individuals with mental illness; settlement approved 2012); United States v. New Hampshire (state psychiatric hospital and state nursing home for individuals with serious mental illness; settlement approved 2014); United States v. New York (adult homes for individuals with mental illness; settlement approved 2014); Disability Rights New Jersey v. Velez (state psychiatric hospitals; settlement approved 2009); Williams v. Quinn (privately operated IMD nursing homes in Illinois; settlement approved 2010); T.W. v. Carroll (state psychiatric hospitals; settlement approved 2015); Office of Protection and Advocacy v. Connecticut (privately operated nursing homes; settlement approved 2014); Napper v. County of Sacramento (individuals at risk of placement in psychiatric hospitals, emergency rooms, or psychiatric nursing homes due to community service cuts; settlement approved 2012); Katie A. v. Bonta (California foster care children with mental health needs in or at risk of placement in institutions; settlement approved 2011); and T.R. v. Quigley (Washington State children with mental health needs in or at risk of placement in institutions; settlement approved 2013).

5 The Federal Government Has Already Enacted a Partial Repeal of the IMD Rule

The federal government has already modified its interpretation of the IMD exclusion rule in 2016 to allow federal reimbursement of short stays (15 days or fewer) in IMDs in Medicaid managed care systems (9). Federal Medicaid reimbursement is now available for stays in an IMD of up to 15 days in a month for individuals ages 21–64 enrolled in Medicaid managed care plans, provided that the services are medically appropriate and cost-effective compared with covered inpatient psychiatric services in a general hospital (9).

6 / Conclusions

It makes little sense to forge ahead with a full repeal of the IMD rule, given the harmful consequences that may occur, without first examining the impact of the partial repeal of the rule that was recently enacted. And more significantly, it makes little sense to do so without first building the community service system that everyone agrees is lacking and that would significantly ease pressure on inpatient capacity as well as reduce incarceration of people with serious mental illness. That is where we should start.



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Argument to Repeal the IMD Rule

Introduction

It is widely acknowledged that the U.S. mental health care system is fragmented and uncoupled from the larger health care enterprise, owing, in part, to severe resource constraints, payment carve outs, and the long-standing systemic stigma that pushes individuals with mental illness and addiction into the shadows of society. Legislation that mandates insurance parity has helped to right decades of injustice. But beyond disparity in insurance coverage, more fundamental inequalities are at work. Conceptual disparity between physical and mental illness—the view that mental illness should be treated as separate from and unequal to physical illness—remains embedded in many health care policies.

Medicaid's institutions for mental diseases (IMD) exclusion rule is one such policy. Although originally well intentioned, the current IMD rule perpetuates systemic injustices. It amplifies many of the obstacles that block the development of a comprehensive mental health care system, including a lack of service capacity that limits access to care for some individuals with serious mental illness. Therefore, we argue, the IMD rule has become ethically indefensible and should be repealed.

1 The IMD Rule Undermines Health Care Parity

Transforming mental health care will require dramatic policy changes—akin to civil rights legislation of the 1960s—to fully integrate mental and physical health care. These changes will require full and equal consideration of both mental and physical health and disease—a shift that requires far more than insurance coverage parity. What is required is a paradigmatic shift in how we conceive of mental health and illness to recognize the fact that mental illnesses exist within the same ontological realm as physical illness. Mental illness is illness and there is no health without mental health. This is what we call "conceptual parity" (1).

Repeal of the IMD rule would serve to advance conceptual parity by allowing for the development of appropriate clinical settings for individuals with serious mental illness. In the limited cases in which federal funding has flowed to IMDs, evidence suggests that the change in policy resulted in improved quality of care. Provisions in the Affordable Care Act (ACA) required the Centers for Medicare and Medicaid Services (CMS) to conduct a demonstration project to assess the effects of providing Medicaid reimbursements to private psychiatric hospitals, which are considered IMDs under the current rule. The Medicaid Emergency Psychiatric Services Demonstration Evaluation (MEPD) ran from 2012 through 2015. Eleven states and the District of Columbia participated. Cost data limitations prevented CMS from expanding the program, but the final report yielded some limited insights regarding the use of IMDs (2).

Concerns over warehousing of patients appear to be unfounded. Across more than 16,000 admissions to IMDs, the median length of stay was seven days, 89% of stays lasted fewer than 31.4 days, and the vast majority of patients were discharged to their homes rather than to other facilities (2). Furthermore, interviews with Medicaid beneficiaries and program staff found that MEPD may have improved the quality of care: enrollees overwhelmingly reported satisfaction with the quality of care they received at IMDs, and state and facility staff believed that the demonstration improved access to higher quality psychiatric care (2). The temporary waiving of the IMD exclusion of private psychiatric hospitals did not result in inappropriate institutionalization or

decreased funding for community-based interventions. It simply expanded the supply of inpatient beds available to Medicaid beneficiaries and removed barriers to care. Therefore, the tendency to frame investments in inpatient care and community care as a zero-sum scenario appears to be misguided.

In addition, some states have applied for and received Section 1115 innovation waivers to treat Medicaid beneficiaries in IMDs. Requests to waive the exclusion for substance use disorders and mental disorders are among the most common type of waiver applications. Seven states have received approval to receive Medicaid reimbursement for substance abuse services in IMDs, and one state has authority to receive Medicaid reimbursement for mental health services in IMDs. Five additional states are seeking authorization to provide substance abuse treatment for Medicaid beneficiaries in IMDs, and two have pending applications to provide mental health care in IMDs. Applications to waive the IMD exclusion rule come from politically and geographically diverse states, ranging from Arizona and West Virginia to California and Vermont (3).

These waivers carry the stipulation that IMDs cannot supplant community-based services, and applications to waive the IMD rule are frequently paired with waivers to provide additional community-based care. Given the current structure of Medicaid as state administered and jointly funded, waiving the IMD rule simply gives state health administrators another tool for treating a subset of acute patients.

Repealing the IMD rule is fiscally responsible, medically appropriate, and ethically defensible. When hospitalization is required, the current Medicaid reimbursement structure incentivizes the use of psychiatric facilities with fewer than 16 beds and inpatient care in non-specialized units throughout hospitals. Financially, limiting care to small facilities is less efficient. Because certain administrative costs remain fixed as facility size increases, the IMD rule prevents public payers from taking advantage of economies of scale. Furthermore, providing care for psychiatric emergencies in non-specialized hospitals fails the basic ethical obligation to provide individuals with care in the most appropriate setting. Persons with psychiatric emergencies ought to be treated in psychiatric settings staffed by well-trained behavioral health professionals.

Table 1 / Section 1115 Innovation Waivers for IMDs

	Pending	Approved
IMD for Substance Use Disorders	Arizona, Illinois, Indiana, Kentucky, Massachusetts, Michigan, Wisconsin	California, Maryland, Massachusetts, New Jersey, Utah, Virginia, West Virginia
	Pending	**Approved**
IMD for Mental Illness	Illinois and Massachusetts	Vermont

2 Community Treatment and "Bedless" Psychiatry

Proponents of the IMD rule argue that it is essential to prevent states from shirking their responsibilities to persons with mental illness through over-reliance on long-term, inappropriate institutionalization rather than investment in community-based services. Yet, warehousing of individuals with mental illness continues unabated through mass incarceration. The opioid crisis has increased the need for structured care settings, and the advent of more effective modalities of psychiatric treatment has reduced inappropriate institutionalization. Ultimately, the IMD rule is a policy mismatched in both time and place. It violates conceptual parity without encouraging adequate care across the mental health continuum, either in communities or in inpatient settings.

Many critics of the IMD rule cite the rule as a primary cause of inpatient psychiatric bed shortages, whereas those who continue to defend the rule argue that improved medication-assisted treatment, decreased lengths of stay, and treatment in outpatient and community settings can provide adequate mental health treatment and reduce the need for inpatient beds. The reality of treatment capacity in the United States is far more nuanced and likely a blend of the two views. However, on straightforward observation we may note that even with sufficient funds for a comprehensive community psychiatry system, there will remain a proportion of seriously ill people who require structured inpatient care settings.

The extent and distribution of psychiatric bed shortages remains a subject of debate. The past half century has been marked by deinstitutionalization of persons with mental illness. In 1955, there were nearly 560,000 state hospital psychiatric beds; today there are just over 37,000 public inpatient beds and nearly 36,000 private beds. Much of the downsizing is attributable to appropriate shifts in care modalities, such as medication-assisted treatment and decreased reliance on prolonged institutionalization. Other exogenous factors, such as the adoption of managed care in the 1990s and lower profit

margins for hospital psychiatric units compared with medical-surgical wings, have also contributed to downsizing psychiatric wards. Fewer inpatient beds on a national per capita basis does not necessarily mean there is a national shortage of beds. Some communities may have adequately calibrated capacity, and others may have a surplus (4).

Ultimately, the IMD rule is a policy mismatched in both time and place. It violates conceptual parity without encouraging adequate care across the mental health continuum, either in communities or in inpatient settings.

However, the pendulum may have swung too far in some localities. In 2015, a survey by the National Association of State Mental Health Program Directors found that 35 of 46 states experienced shortages of psychiatric hospital beds (5). Of the 35 states reporting bed shortages, 25 reported increased waiting lists for state hospital beds, and 16 reported increased wait times for beds in private psychiatric institutions and general hospital psychiatric units. Given the federal policies that disincentivize institutional care, state governments typically respond to inpatient bed shortages with community-based alternatives, such as funding residential crisis beds and increasing assertive community treatment. Such workarounds may provide adequate care in some cases and reduce inpatient hospitalizations, but they fail to address the significant problem of lack of inpatient beds for those who need them.

3 Gaps in Care Still Exist for Some Medicaid Beneficiaries

The litany of complaints about gaps in care for persons with mental illnesses does not begin and end with the IMD rule, but several care shortcomings related to capacity constraints are linked to the rule—in particular, over-reliance on less appropriate care in emergency departments (EDs) and unspecialized beds in general hospitals. Recent evidence indicates that too much of America's mental health care occurs in EDs and non-specialized beds distributed across hospitals (known as "scatter beds"), rather than in psychiatric units of hospitals or in IMDs. Research conducted for the Substance Abuse and Mental Health Services Administration estimated that scatter beds account for 36% of general hospital mental health expenditures (6), and an American College of Emergency Physicians (ACEP) survey of ED medical directors found that 81% believed that dedicated emergency psychiatric facilities would improve care (7). For persons whose care requires a hospital admission, scatter beds cannot provide the specialized treatment required—and provided—by psychiatric hospitals.

Furthermore, reliance on EDs for mental health crises has increased. A 2016 study by the Agency for Healthcare Research and Quality found that from 2006 to 2013, ED visits per capita increased 52% for psychoses or bipolar disorder and 37% for substance use disorders (8). Many of these visits are preventable. In 2014, 30-day all-cause readmission rates after hospitalization for schizophrenia and other psychiatric disorders were 15.8% among the privately insured but 24.9% among those with Medicaid (9). Medicaid beneficiaries have higher readmissions rates than individuals with private insurance across all hospitalizations, but the gap is nearly twice as wide for mental health admissions (10).

High readmission rates reflect the lack of appropriate care in EDs. In EDs, psychiatric patients are more likely to wait for extended periods (ranging from a single day to weeks) in beds, hallways, and locked rooms until inpatient beds become available—a practice euphemistically referred to as "boarding" (11). For psychiatric patients in particular, stress-inducing and restrictive EDs can cause deterioration, and an ACEP survey found that 62% of EDs provided no psychiatric services to patients who were boarded (7).

Although there are no systemic data on the prevalence of boarding, recent studies suggest a widespread and growing problem that causes disruption in care. ACEP found that 80% of ED medical directors reported boarding psychiatric patients, and 90% of medical directors boarded psychiatric patients at least once per week, and over half boarded patients on a daily basis (7). The U.S. Department of Health and Human Services, ACEP, and the Joint Commission have all expressed concern over the prevalence and effect of psychiatric boarding and have identified insufficient inpatient bed supply as a common cause of the practice (12–14). Addressing boarding, scatter beds, and other disjunctions in the mental health care system will require significant shifts in care delivery, and the IMD rule's curtailment of financing options for inpatient care is one of several barriers to essential reform.

4 Conclusions

Providers, payers, policymakers, and the public would balk at arbitrary care restrictions for any other illness. There are no comparable limitations on institution size for inpatient oncologic or cardiac care. And although mental health parity typically refers to uniformity of insurance coverage, conceptual parity between mental illness and physical illness means that mental illness is recognized as illness. Conceptual parity should be the ultimate goal (1).

The road to conceptual parity requires eliminating the IMD rule. Meeting our nation's enormous mental health care needs requires a comprehensive continuum of services, unencumbered by ideological commitments and facile appeals to the worst aspects of psychiatry's history. There is now compelling evidence that allowing the federal government to pay for Medicaid beneficiaries to receive treatment in IMDs improves care—without resulting in the deplorable conditions of the past (15).

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