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# Achieving Access Parity for Inpatient Psychiatric Care Requires Repealing the Medicaid Institutions for Mental Disease Exclusion Rule

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**Achieving Access Parity for Inpatient Psychiatric Care Requires Repealing the Medicaid**

**IMD Exclusion Rule**

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**Abstract**

Approximately 3.4% of Americans have a mental health condition and suicide is the 10th leading cause of death. While the rate of mental health conditions has slightly increased for adult populations, America's youth has experienced a significant rise in depression. From 2008 to 2017, occurrence of depression in the adolescent population increased from 8.3% to 13.3%. As adolescents mature into adults; it is likely the rate of mental health conditions for the adult population will rise as well as it is the common thread that binds the "diseases of despair": drug abuse, alcoholism and suicide.

Arising out of the deinstitutionalization movement of the 1960's, the Medicaid IMD Exclusion Rule (§1905(a)(B) of the Social Security Act) prohibits reimbursement for Medicaid recipients ages 21 to 64 years receiving inpatient care at a psychiatric hospital with 16 or more beds. Consequently, the rule limits payment for psychiatric treatment to general hospitals and smaller, non-specialized centers, which blocks patients from receiving inpatient care, and transfers the financial burden of care onto psychiatric hospitals.

The IMD Rule is approaching its 55th anniversary. It requires re-evaluation. Although a state waiver process is available, use of this option has the potential to increase the incidence of racial and ethnic disparities across states. Full repeal of the IMD Exclusion Rule could help provide immediate access to inpatient care that is consistent nationwide and be a vital step toward creating financial, treatment and ethical parity for mental health services.

*Keywords:* IMD Exclusion Rule, psychiatric care, parity

## **Achieving Access Parity for Inpatient Psychiatric Care Requires Repealing the Medicaid IMD Exclusion Rule**

Health care in America has reached a critical impasse. An inverse relationship between available resources and the demand for those resources has exacerbated existing gaps present in the quality and accessibility of health care. While this is a far-reaching problem that affects a wide breadth of patients, its impact is especially felt by patients with mental health conditions. Advances in treatment for physical diseases have steadily improved over the years. However, those with mental health conditions have not experienced the same pace in improvements in quality and availability of care. Rising rates of mental health conditions, coupled with disparate spending and persistent regulatory barriers, including the Medicaid Institutions for Mental Disease (IMD) Exclusion Rule (Rule), continue to limit access to care, especially inpatient treatment options, for this population. This paper presents the background and analysis of this Rule, reviews its impact, argues for its repeal, and addresses the role of nurses in advocating for policy change to improve access to mental health services.

### **Background**

It is estimated that 3.4% of Americans, over eight million people, have a mental health condition (Raphelson, 2017). While the rate of mental health conditions has increased slightly for adult populations, America's youth has experienced a significant increase in depression. From 2008 to 2017, occurrence of depression in the adolescent population increased from 8.3% to 13.3% (Office of Disease Prevention and Health Promotion [ODPHP], 2020). As these adolescents mature into adults, it is reasonable to assume the rate of mental health conditions for the adult population will rise. In addition, mental health is the common thread that binds the "diseases of despair": drug abuse, alcoholism and suicide. While deaths related to physical

ailments have decreased, diseases of despair have contributed to the United States' decreasing life expectancy (Cohen, 2018). Moreover, suicide is the 10th leading cause of death in America for adults and has been since 1980 (Heron, 2018). Again, the younger population is more vulnerable with suicide as the 2nd leading cause of death for individuals between the ages of 10 and 34 (Centers for Disease Control and Prevention [CDC], 2020). Mental health conditions cross all socioeconomic statuses, genders and cultures yet it is not given the same level of prioritization or attention as physical disorders despite the impact it has on physical health. People with mental health conditions are more likely to suffer from chronic medical issue (De hert et al., 2011) and live 10-20 years less than those without (Liu et al., 2017; Walker et al., 2015). Mental and physical illnesses do not exist within a vacuum as mind and body are deeply intertwined and suffering from one can increase the prevalence of the other. For example, having a chronic condition, such as heart disease and diabetes, increases the risk of depression (National Institute of Mental Health, n.d.) adding to the difficulty of managing one's chronic illness and mental health. Given the prevalence and mortality associated with mental health conditions, one could assume that there would be rich availability of resources for prevention, detection and treatment. Sadly, this is not the case as there are serious parity issues between mental health and physical health. In 2017, the United States spent 63% of the \$3.5 trillion health expenditure on hospital care, physician services and prescriptions but only 5% on "other care" which includes care provided in schools, community centers, ambulances, psychiatric and substance use facilities (Centers for Medicare and Medicaid Services [CMS], 2018). This disparity in national spending illustrates the disproportionate services available for mental health including access to inpatient treatment options for psychiatric patients and regulatory barriers such as the IMD Rule further limit access to care.

The deinstitutionalization movement began with the passage of the federal Community Mental Health Centers Act of 1963. Signed into law by President John F. Kennedy, the intent was to improve the quality of care of individuals with mental health conditions by shifting their care into the communities. With this act, there were plans to create 1500 centers for treatment to optimize and provide appropriate care (Sheffield, 2013). This change in treatment approach was intended to decrease inappropriate hospitalization of children and adults and was spurred from a growing concern over civil rights and mistreatment of patients in psychiatric hospitals (Sheffield, 2013). If patients could be successfully treated and supported in their communities, they would therefore be less likely to need inpatient psychiatric care. Post-passage, there was a rapid decline in the availability of inpatient psychiatric hospitals; however, it was not coupled with an increase in community resources (Alakeson et al., 2010). Despite best intentions, the act did not improve access to individual help in their communities nor decrease the demand for inpatient psychiatric care. Ten years after its passing, 32 states failed to provide equal access to community-based services (Canady, 2018). According to Sharfstein (2000), “service follows dollars” and the continued lack of insurance coverage and subsequent insufficient financial support has resulted in a continued deficit of outpatient treatment options. Considering that Los Angeles County jail, Rikers Island in New York, and Cook County correctional facilities are the three largest mental health facilities in the United States (Canady, 2018), the crippling lack of community treatment options and support for those with mental health condition is evident. Further limiting the availability of treatment options is the Medicaid IMD Rule.

### **Rationale for the IMD Rule**

After the passage of the Community Mental Health Centers Act, the IMD Rule has had the largest impact on those with mental health conditions. Implemented in 1965, it blocks federal

payment for Medicaid beneficiaries age 21-64 for inpatient care at an institution of mental disease, which is defined as a mental health treatment facility that has more than 16 beds (Rosenbaum et al., 2002). Similar to the Community Mental Health Centers Act, the intent was to improve the treatment of patients with mental health conditions by minimizing inappropriate and excessive inpatient hospitalization by preventing states from using federal funds to pay for mental health care (LaCouture, 2015) and ensuring that states would bear primary responsibility for funding inpatient psychiatric services. The Rule impacts access, coverage and service providers (Rosenbaum et al., 2002) and these limit Medicaid coverages of mental health care to be more similar to commercial insurance than typical Medicaid coverage. Psychiatric and substance use disorder treatment are the only conditions in which Medicaid prohibits treatment at certain institutions (Legal Action Center, 2014). This Rule has a large impact on service providers because nearly all inpatient psychiatric facilities have more than 16 beds and treat patients with Medicaid coverage; thus, many continue to treat this patient population without receiving reimbursement (Knopf, 2014). This further exacerbates the closing of psychiatric hospitals due to their fiscal instability. Moreover, Medicaid will not authorize or reimburse for services regardless of the medically necessity of the psychiatric care, making the Rule a financial penalty for many organizations that choose to admit and treat patients who are Medicaid beneficiaries (Rosenbaum et al., 2002). Since its passage, there have been efforts to evaluate the Rule's impact as well as minimize other financial blocks to care, such as the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010, but the IMD Rule remains in effect today despite growing focus on mental health conditions. Recent increases in awareness of and advocacy for mental health, while notable, remain superficial. Healthcare services continue to emphasize physical health, and the stigma

towards mental health remains with disproportionately fewer champions advocating for change. There are many possible hypotheses for why this gap remains, but the core reason is that there is little financial or political incentive for policy makers to change the status quo for those with mental health conditions.

### **Impact of the IMD Rule across the Health Care Continuum**

#### **Emergency Departments**

The treatment of patients with mental health conditions in emergency departments (ED) is both a symptom of the lack of treatment options as well as a short-term solution. In most communities, EDs are the primary treatment source due to lack of outpatient options for evaluation and treatment (Singh et al., 2019). Between 2006 and 2013, the rate of emergency room visits for a mental health complaint increased 15% (Weiss et al., 2016). It is estimated that 12.5% of emergency department visits are for a psychiatric complaint (Weiss et al., 2016) and 3.4% of visits are for a suicide attempt (Canner et al., 2016). Increasing the urgency of this crisis, the rate of emergency room visits for suicide attempt or ideation in children ages 5-18 nearly doubled from 2007-2015 to 1.12 million visits (Burstein et al., 2019). While EDs are an accessible option for many, historical research has shown they cannot offer the best treatment (National Alliance on Mental Illness [NAMI], 2020) and there are concerns about the quality of care provided in EDs (Alakeson et al., 2010). For example, in the seminal work by Crandall et al. (2006), the suicide rate of ED patients with suicidal ideation or attempt was found to be higher than population suicide rates; 18.3 per 100,000 person years vs 10.4 per 100,00 person years. Despite evaluation and treatment by physicians and nurses, patients' mental health crises are not adequately managed nor are they provided with enough resources for safe outpatient discharge. Many providers in EDs do not get training and education on therapeutic treatment of this patient



population beyond sedative medications. Moreover, many EDs focus only on the safe keeping of these patients to prevent self-harm while in the ED. Furthermore, they may have limited interactions with their patients and rely on psychiatric practitioners for evaluation and treatment during the ED visit. However, access to these trained mental health professionals in the ED is a standard of care yet, discouragingly, in a survey of 223 EDs, no mental health practitioner was available for these patient evaluations 50% of the time and 23% reported discharging patients with suicide ideation without an evaluation (Baraff et al., 2006). Of the patients that do receive evaluation, 11% need to transfer for additional services but have limited options (Raphelson, 2017). Even in incidents of a higher level of care being recommended, patients are not always successfully transferred due to the lack of inpatient treatment facilities. For those who don't require inpatient admission, their outlook is not much better as outpatient services are lacking (Baraff et al., 2006). Without inpatient or outpatient treatment options, the complexity of appropriately treating this patient population continues to rise.

The challenges in treating this patient population are especially felt by ED providers. In addition to providing critical care services, these providers often function as a primary care clinic in many communities that lack sufficient access to services medical and psychiatric patients. It is mandatory for them to quickly pivot between treating vastly different chief complaints from the critically ill to the minor illness. Moreover, many providers feel overwhelmed in meeting patients with psychiatric complaints needs including assessment, stabilization and safe discharging. In one survey, 76% of ED doctors reported reduced outpatient psychiatric services and 60% said pressure to treat psychiatric patients had increased due to psychiatric patient boarding, resource consumption and subsequent impact on productivity (Baraff et al., 2006). Boarding is undesirable for both the providers and the patients as many of these patients wait for services,

sometimes in isolation rooms or in the corridors, for extensive periods of time (Glickman & Sisti, 2019) contributing to extended lengths of stay. In one study, patients with mental health complaints discharged home had average length of stay of 8.6 hours compared to 15 hours for those transferred to a care unit outside of the healthcare system (Weiss et al., 2012). In another survey of ED stays, 88% of all extremely long lengths of stay (over 24 hours) were patients with mental health complaints (Stephens et al., 2014). Moreover, Nicks and Manthey's (2012) study reported 3.2 times longer length of ED stay for patients with mental health conditions than other medical patients. This boarding can exacerbate symptoms due to the chaotic environment of an ED as well the lack of psychiatric care during the boarding period. Glickman and Sisti report that 62% of boarded patients receive zero mental health services during their boarding (2019). It is difficult to imagine withholding medically necessary care from a patient experiencing any other health crisis event. While it may be easy to postulate what impact withholding medical treatment would have, it is more difficult with psychiatric care. Literature regarding mental health care in the ED focuses on cost, provider impact and financial consequences with little attention given to patient experience and outcomes. This poor understanding of the impact of poor delivery of care demands further research as systems, structures and policies are in place without knowledge of their impact on these vulnerable patients.

### **Healthcare Systems and Hospitals**

Boarding not only has negative consequences for the patients but also the healthcare system. While being boarded, patients with mental health conditions consume a great deal of ED resources (Stephens et al., 2014), affect nurse and physician safety (Stephens et al., 2014) and hospital financials. Under current fee for service and DRG bundle payment structures, hospitals do not receive payment for care rendered the boarding period (Alakeson et al., 2010). Each

boarded patient can cost the hospital \$2,400 for lengths of stays 7-24 hours from lack of insurance provider reimbursement and loss revenue potential (Nicks & Manthey, 2012).

Diverting patients with mental health conditions to EDs negatively impacts patients, providers and healthcare organizations.

### **Modifications to the Medicaid IMD Rule**

#### **Mental Health Parity and Addiction Equity Act**

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) improved mental health benefit parity at the federal level by requiring private insurance plans to provide mental health and substance use coverage on par with medical coverage (Cummings et al., 2013). Initially this law applied to group health plans through employers but was expanded to individual plans with the passage of the Patient Protection and Affordable Care Act in 2010 (Centers for Medicare and Medicaid Services [CMS], n.d.). The intent of the MHPAEA was to close coverage barriers for individuals and support provider reimbursement. For individuals with commercial plans, the MHPAEA did decrease some out of pocket costs by shifting them to the health plans but did not impact treatment access or utilization of benefits (Ettner et al., 2016). Moreover, the MHPAEA regulated private and commercial insurance and did not impact those with other coverage such as Medicare or Medicaid. State Medicaid enrollees range from 11% in North Dakota to 47% in Puerto Rico's of the total population (Kaiser Family Foundation [KFF], 2020). Therefore, the MHPAEA did not improve access or coverage for the over 55 million Medicaid recipients nationwide (KFF, 2020). Improving parity to the Medicaid population began with Patient Protection and Affordable Care Act of 2010.

### **The Patient Protection and Affordable Care Act and CMS Demonstration Projects**

Under the Patient Protection and Affordable Care Act, mental health and SUD coverage was included as an essential health benefit in state benefit packages sold in the state marketplaces (Cummings et al., 2013), and since 2013 an additional 14.7 million individuals have enrolled in Medicaid (Medicaid and CHIP Payment and Access Commission [MACPAC], 2020). This has been a leap in the direction of improving coverage for mental health services. However, coverage does not equate with actualization of treatment when exclusions and limitations still exist such as the IMD Rule. In a step towards closing this gap, the Medicaid Emergency Psychiatric Demonstration (MEPD) provided \$75 million in Medicaid funding for in-patient psychiatric care in 11 states and the District of Columbia, effectively suspending the IMD Rule in these states. This temporary suspension of the Rule not only allowed temporary Medicaid reimbursement but also permitted a long overdue evaluation of the Rule. Overall, during suspension from 2012 to 2015, evaluation of the MEPD revealed little to no support for the hypothesis that suspension of the Rule results in an increase in admissions or length of stay (Glickman & Sisti, 2019), the precipitating justification for the Rule's enactment. However, the MEPD also did not demonstrate an increase in ED visits or length of stay (Blyler et al., 2016). This may be due to the MEPD did not include patients with substance-related disorders or mental health complaints beyond those who presented as a danger to self or others (Blyler et al., 2016). Patients with suicidal ideation, self-harm or homicidal thoughts only represent a portion of patients who seek care in the ED and whose care is limited by the IMD Rule. The MEPD provides objective data and a platform to begin discussing abolishment or refinement of the IMD Rule. While neither has occurred to date, states now have options to access federal funds for inpatient services for mental health conditions.

### State Options

Beginning in 2015, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states that provided new mechanisms to finance some behavioral health services for nonelderly adults through Medicaid under specific circumstances (Centers for Medicare and Medicaid Services [CMS], 2015). The intended purpose of these options is to close the gap created by IMD Rule without updating the Rule itself. These options include Section 1115 waivers, Medicaid managed care “in lieu of” authority, disproportionate share payments and the SUPPORT act (Musumeci et al., 2019). Section 1115 waivers permit states to explore new methods to address issues and opportunities without changing federal law (Hinton et al., 2019). In response to the opioid crisis, these waivers have been utilized by states to expand treatment for SUD treatment as well as mental health conditions. Another option for states with capitated managed care is managed care “in lieu of” authority (Musumeci et al., 2019). This permits states to receive Medicaid funds for inpatient treatment for SUD and mental health conditions instead of other healthcare services (Musumeci et al., 2019). Disproportionate Share Hospital (DSH) payments also provide flexibility to states to use Medicaid DSH to cover the gap from the IMD Rule but again does not impact the IMD Rule directly. In contrast, the SUPPORT Act for Medicaid impacts services typically not covered due to the IMD Rule (Musumeci et al., 2019). However, it only pertains to SUD treatment. Notably, it was the opioid crisis which stimulated the initial CMS guidance and subsequent uptake of payment options by the states. In absence of that crisis, many of these state options would not exist. Moreover, they are an example of how policy change can be stifled until the financial and political impact surpasses the desire to maintain status quo. Will it take similar consequences from mental health conditions until parity is addressed?

### **Role of Nurses**

Nurses are the largest healthcare profession worldwide, yet their voices often remain silent in healthcare policy reform. At the forefront of patient care, nurses are aware of the challenges individuals and communities face in achieving optimal physical and mental health. However, they may be unaware of how health policy can create barriers or influences positive outcomes. It is imperative that nurses are well versed in healthcare policy to understand the connections between healthcare policy and delivery. Nurses must vocalize their perspectives of these connections in both local and national government forums. This can be done through partnership with other healthcare professions and membership with professional organizations. Through collective efforts, nurses are capable of influencing the financial and political drivers of policy change.

For nurses, there are many avenues for involvement and advocacy that can impact the repeal of the IMD Rule. Joining and supporting national organizations, such as the National Alliance on Mental Illness, provides additional collective membership strength and financial support for advocacy of policy change. If nurses are already involved in professional organizations, such as the Emergency Nurses Association, they should explore these organizations' stance on the IMD Rule and encourage their political involvement. As previously discussed, the IMD Rule negatively impacts patient experience and throughput flow in EDs. Nurses can make their healthcare organization's leadership cognizant of this connection to encourage the organization's political involvement. Finally, the power of voting should not be underappreciated. Nurses should arrive at the voting booth informed and aware of the candidates' positions on topics that impact healthcare delivery such as the IMD Rule.

In the case of the IMD Rule, nurses are at the forefront of care delivery and witness daily the devastating impact that lack of appropriate care has on individuals experiencing mental health crises. Furthermore, as providers in overextended and stressed health care systems, nurses understand the toll the status quo takes on fellow providers and systems alike. Nurses must share their experiential knowledge with policy makers and offer workable solutions.

### **Recommendations for Policy Makers**

Revisiting the IMD Rule may be the most impactful policy option for increasing the availability of inpatient psychiatric treatment. Not only antiquated in its name, the Rule does not protect those with mental health conditions and is detrimental to both patients and providers. For those with Medicaid, the Rule results in overuse of EDs and general care hospitals which are not capable of providing the specialized care to patients with mental health conditions need and deserve (LaCouture, 2015; NAMI, n.d.; Treatment Advocacy Center [TAC], 2018). This is neither in the patients' best interests nor is fiscally sound. For example, one study found higher readmission rates for patients with mental health conditions and Medicaid coverage than private insurance, 15.8% vs 24.9%, which was a more significant difference than any other readmission cause (Glickman & Sisti, 2019). Glickman and Sisti also cite the importance of parity of treatment and repealing the Rule would not only improve access and financial equality but would support "conceptual parity" (Glickman & Sisti, 2019, p. 7). Improving treatment parity between mental health conditions and physical illness is ethically, socially and culturally correct. Patients deserve access to a continuum of care that includes inpatient, outpatient, and community services regardless of the source of their ailment. Furthermore, this Rule impacts a large portion of patients who require intense or complex care that can only occur in an inpatient psychiatric setting. Many of those with a severe mental health conditions lack regular income or insurance

coverage and therefore are and rely on Medicaid for coverage. While Medicaid covers hospitalization in a general hospital or other facilities with lower bed counts, these care areas often cannot provide specialized care and carry a risk of providing a lower quality of care (Rheinstein, 2000). To protect patients with mental health conditions, many individuals and organizations support addressing the IMD Rule. The American Hospital Association, National Association of State Mental Health Program Directors, the Interdepartmental Serious Mental Illness Coordinating Committee, National Alliance on Mental Illness and the Treatment Advocacy Center identify the Rule as “discriminatory”, “outdated” and “counter-productive” and recommend reform or full repeal (American Hospital Association [AHA], 2018; (NAMI, 2020.; National Association of State Mental Health Program Directors, 2000; Treatment Advocacy Center [TAC], 2018). The seemingly only public supporter for the Rule is the Department of Health and Human Services (HHS) which states that the IMD Rule improves states’ care improvement, patients’ care and aligns insurance plan regulations (Knopf, 2016). Given the public criticisms of the IMD Rule and growing concerns for the treatment of mental health conditions, it is essential that the IMD Rule be re-evaluated by policy makers.

The shortcomings of the IMD Rule can be addressed through several options. Congress could fully repeal the Rule permitting Medicaid reimbursement for inpatient psychiatric and substance use disorder care for participants ages 21-64 in all inpatient psychiatric centers. Full repeal could have serious financial implications for state and federal budgets (LaCouture, 2015) and there are concerns it might incentivize inpatient treatment when outpatient treatment would be appropriate (Treatment Advocacy Center [TAC], 2018). A less disruptive option would be to reform the Rule with either an adjustment to the bed size or separating treatment for SUD from mental health conditions (LaCouture. 2015; Treatment Advocacy Center [TAC], 2016).



However, the latter option may further complicate mental health treatment as many patients have both a SUD and mental health conditions and it would divide already limited resources.

Additionally, this option may be challenging as many individuals with SUD also have a dual diagnosis of a mental health condition. Another option is for the federal government to provide waivers under Section 1115 (a) of the Social Security Act (“§1115 waivers”) to the states and allow each state to manage mental health services. In November 2018, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states, as mandated by Section 12003 of the 21st Century Cures Act (P.L. 114- 255), that would allow them to apply for IMD Rule waivers for mental health treatment for short-term (less than 15 days) stays in IMDs for adults with serious mental health conditions and children with serious emotional disturbance (Centers for Medicare and Medicaid Services [CMS], 2018). This directive expands the availability of

Medicaid demonstration waivers which were initiated under the Obama and Trump Administrations for the treatment of SUD to address the opioid crisis (Meltzer, 2018). As of July 2019, CMS had already approved SUD waivers for twenty-four states and one state for mental health services, with pending waivers for SUD services in five states and a pending waiver for mental health services in one state (Mitchell, 2019). States appear to be benefitting from these actions. For example, since increasing bed capacity in residential treatment programs, Virginia has experienced a 39% decrease in opioid related ED visits and a 31% reduction in all SUD-related visits (Kang, 2018). The agency will now consider covering the full continuum of care for mental health conditions, including short-term stays for acute care provided in psychiatric hospitals or residential treatment centers. In return, the state must expand access to community-based mental health services. Notably, only demonstration projects that are “budget neutral” to the federal government may be approved under this new directive.

In theory, waivers support creative, cost efficient management of mental health at the state level and the flexibility for each state to address their unique challenges (LaCouture, 2015). However, such an option widens the chasm of social and racial disparities across the country as each state must apply for a waiver. As noted, only about half of all states have applied for a waiver to date. Access to psychiatric services is a complex issue that requires local, state and federal agencies to work collaboratively with providers and subject matter experts to devise a solution that will support increased psychiatric inpatient care options. Waivers are a temporary solution to this longstanding inequality resulting from the IMD Rule, as waivers are generally only valid for five years, and they are not impervious to administrations' changing priorities.

To create a healthcare system in America where there is true parity for the treatment of mental health conditions, several actions must take place. These include increasing the quantity of inpatient psychiatric beds, removing financial and insurance coverage barriers and improvement to outpatient psychiatric screening and treatment in EDs. Conservative recommendations for available inpatient psychiatric beds are 40-60 beds per 100,000 people (Ollove, 2016). However, the current state average is 11.7 beds per 100,000 people (Ollove, 2016). To close this gap and treat the growing population, the United States needs an additional 123,300 psychiatric beds (Ollove, 2016). Private and public sectors need to invest in inpatient care options so that those with mental health conditions have the same access to a complete care continuum as those with physical ailments. While this will have high initial costs, the return on investment due to better management of mental health conditions makes it a worthy endeavor. This could be done by allocating funds that are currently used for the criminal justice system for more appropriate treatment options. There is a higher prevalence of individuals with mental health conditions in the United States prison system (Prins, 2014) with as many of half of

inmates diagnosed with a mental health condition (Al-Rousan et al., 2017). As already noted, LA County Jail, NY Riker's Island and Illinois's Cook County are the largest psychiatric facilities in America (Arceneaux, 2013). The cost savings from the IMD Rule is merely an illusion as the financial cost of treatment in general hospitals, jails and the impact of homelessness is far greater (Treatment Advocacy Center, 2016). The US Bureau of Prisons estimated in 2017 the average cost per inmate in a federal prison was \$36,299.25 (Hyle, 2018). Perhaps those funds could be allocated to psychiatric treatment in the community rather than jail as there more humane and cost-effective methods for treatment of a mental health condition than prison. Another source of financial support for increasing the psychiatric bed count is removing the financial and insurance coverage barriers. Many facilities cannot meet operating costs without reimbursement for care from all insurance providers. Inpatient psychiatric treatment can cost \$840-\$1,100 per day (Stensland et al., 2012), an amount unaffordable for many without insurance coverage. Moreover, many of those with mental health conditions rely on Medicaid for coverage and the current IMD Rule blocks their access to inpatient care due to their coverage gap. Since many institutions rely on insurance reimbursement, including Medicaid, the lack of coverage makes it impossible to have bed availability match patient demands. The final opportunity is to improve the care received in the ED. The ED's treatment for patients with mental health conditions should function in a similar fashion as medical patients; a service for prompt and rapid evaluation, stabilization and discharge to further inpatient care or outpatient services. However, that is not the current state as many EDs board patients with mental health conditions for extended periods due to lack of outpatient and inpatient referral services. Until the inpatient psychiatric bed crisis is improved, EDs have an opportunity to improve screening of patients, compassionate treatment and appropriate discharges.

### **Conclusion**

While there has been an increase in awareness in the importance of mental health, including screening and treatment, many of those with mental health conditions face stigma and parity issues. One of the principal gaps in treatment is the availability of inpatient care for patients requiring enhanced diagnosis, medication evaluation and crisis stabilization. Without accessible inpatient treatment options, many patients are boarded in EDs, imprisoned or experience homelessness. While mental health is a complicated issue, there is opportunity to immediately impact access to inpatient psychiatric care through IMD Rule repeal. The IMD Rule prohibits reimbursement for Medicaid recipients ages 21-64 receiving inpatient care at a psychiatric hospital with 16 beds or more, limits treatment to general hospitals, smaller, non-specialized centers, blocks patients from receiving inpatient care and places the financial burden of care onto the psychiatric hospital. While there is also a need to improve community-based services, focus on inpatient care should be the priority of policy reform due to the acuity of the patients requiring such care. IMD Rule repeal would be a vital step into creating financial, treatment and ethical parity for mental health services.

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