Increase access to and services for mental health

Key Points

• IMD exclusion – Mental and behavioral health treatment provided in stand-alone settings with 17 or more beds is not eligible for federal Medicaid reimbursement. In Minnesota, this means the costs of inpatient mental and behavioral health services offered through state hospital settings, such as Anoka-Metro Regional Treatment Center, are ineligible for matching federal Medicaid funding. As a result, the entire burden of costs for Medicaid enrollees served in these settings falls on county and state governments. Allowing federal Medicaid payments will free up county and state money to be invested in more community-based services, thereby lessening the need for more mental and behavioral health inpatient hospital treatment for many people.

• Room and board costs – Many individuals living with mental illnesses and substance abuse disorders receive intensive community treatment in residential settings. These short-term crisis or longer-term rehabilitation services are only able to bill Medicaid for medical services provided, not the room and board costs that are directly associated with treatment. Residential services can prevent costly hospitalizations and also offer step-down care when someone is discharged from inpatient treatment.

• Medicare credentialing of LMFTs, LPCCs, and LADCs – Nine of Minnesota’s 11 regions are designated mental health professional shortage areas as defined by federal Health Professional Shortage Areas. Although Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Clinical Counselors (LPCCs), and Licensed Alcohol and Drug Counselors (LADCs) are reimbursed for the services they provide to Medicaid enrollees,

Federal action requested

• Waive the Medicaid Institute for Mental Disease (IMD) payment exclusion for Minnesota’s large stand-alone mental and behavioral health settings.

• Authorize Medicaid payment for room and board costs associated with mental health intensive residential services.

• Allow Medicare credentialing and coverage of Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Clinical Counselors (LPCCs), and Licensed Alcohol and Drug Counselors (LADCs).

• Address the psychiatrist shortage in part by protecting Graduate Medical Education (GME) and Indirect Medical Education (IME).

• Update restrictions on exchanging patient record information between providers.
they are not allowed to bill Medicare for services they provide to Medicare beneficiaries. Medicare beneficiaries throughout Minnesota who need mental and behavioral health services within LMFTs’, LPCCs’ and LADCs’ scopes of practice could be served more quickly and at lower cost to Medicare by having access to these professionals as covered services.

• **Shortage of psychiatrists** – The psychiatrist shortage is the starkest example of Minnesota’s mental health workforce shortage, particularly in rural Minnesota. Shortages are particularly acute for psychiatrists serving children, older adults, and Minnesotans of color. Maintaining GME and IME funding and encouraging more medical students to enter psychiatry will help alleviate part of this workforce shortage.

• **Updating Rule 42** – Minnesota hospitals and health systems support the integration of mental, behavioral, and physical health care. Minnesota has led the nation in providing community-based care to people living with mental illnesses, including substance use disorders. Updating 42 CFR Part 2 to enable substance abuse providers to exchange medical record information with a patient’s other health care providers for treatment purposes will enhance behavioral health providers’ abilities to coordinate with acute care providers when necessary to ensure patients receive appropriate treatment and support.

**Background Information**

Minnesota has been nation-leading in building community-based services for people with mental illnesses and substance use disorders. Our state is fortunate to have partnered with the federal government for Medicare and Medicaid coverage of a number of these community services, which provide treatment and promote recovery for people living with mental illnesses.

One in four adults experience mental illness in their lifetime. Mental illnesses are treatable health conditions and like any other medical condition should be treated with the same urgency as diabetes or heart disease.

Unfortunately, this system is fragile. The workforce shortage and unstable funding have kept our community infrastructure from becoming the truly supportive and recovery-focused system it should be. Hospitals see the results of this lack of support every day, in our full emergency departments, extended waits for inpatient mental and behavioral health beds, overflowing inpatient mental and behavioral health units, and the inability to secure appropriate post-discharge treatment options for many patients.

Minnesota’s fragile mental and behavioral health system needs support from the federal government in order to meet the demand for treatment and service from Minnesotans with mental illnesses and substance use disorders. Minnesota’s hospitals and other mental and behavioral health providers cannot do it alone.