June 2018 | Issue Brief

Key Questions about Medicaid Payment for Services in "Institutions for Mental Disease"

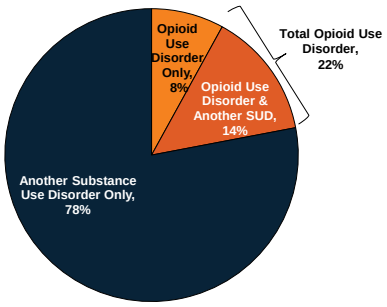
MaryBeth Musumeci

With the opioid epidemic continuing, state interest in expanding access to substance use disorder (SUD) services remains high. Medicaid financed 21% of SUD services and 25% of mental health services in 2014. Section 1115 waivers related to behavioral health remain the most frequent type of waiver sought and obtained by states, with most requesting authority to use federal Medicaid funds for services provided in "institutions for mental disease" (IMDs).[1] Since Medicaid's inception, Congress has prohibited states from using Medicaid funds for IMD services for non-elderly adults.[2] This brief provides new data and answers key questions about the Medicaid IMD payment exclusion as waiver activity continues, and Congress considers legislative changes, including a House bill that would restrict IMD SUD services to those with opioid use disorder, excluding those with other SUDs. Key issues include the following:

- **CMS continues to approve Section 1115 IMD SUD waivers, although recent waivers generally do not address coverage of community-based SUD services, while earlier waivers were contingent on coverage of services across the care continuum.** Twelve states have approved IMD SUD waivers, and 13 IMD SUD requests (including 12 new states, and one seeking to expand existing authority) are pending with CMS as of June, 2018.
- **Congress is considering amending the IMD payment exclusion, including a House bill that restricts IMD SUD services to those with opioid use disorder, a minority (22%) of nonelderly Medicaid adults with SUD.** The vast majority of those with SUD (78%) would be excluded from IMD treatment services under the House bill (Figure 1). The Senate Finance Committee also considered, but did not vote on, a proposal to alter the IMD SUD payment exclusion.

Figure 1

Share of nonelderly adult Medicaid enrollees with a substance use disorder who have opioid use disorder, 2016



Total: 3.4 million nonelderly adult Medicaid enrollees with a substance use disorder

NOTES: Includes adults ages 21-64. Opioid use disorder includes heroin and prescription opioids. Another substance use disorder includes alcohol, marijuana, cocaine, hallucinogens, inhalants, methamphetamine, prescription stimulants, prescription tranquilizers, and prescription sedatives.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Survey on Drug Use and Health.

As administrative and legislative activity related to Medicaid IMD payment continues, key issues to watch include diagnosis-based restrictions on service access, day limits, accompanying community-based service expansions, delivery system reforms, performance measures, and waiver evaluation results.

Key Questions

1. What Is the IMD Payment Exclusion?

Federal law bars states from receiving "any such [federal Medicaid] payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an [IMD]."[3] An IMD is 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."[4] Before Congress created Medicaid, inpatient behavioral health services were funded by states, and the IMD payment exclusion was aimed at preserving this financing[5] and preventing states from shifting mental health services provided by states onto the federal budget through Medicaid, a strategy known as "Medicaid maximization."

2. How Do States Use Medicaid Funds for IMD Services, Despite the Payment Exclusion?

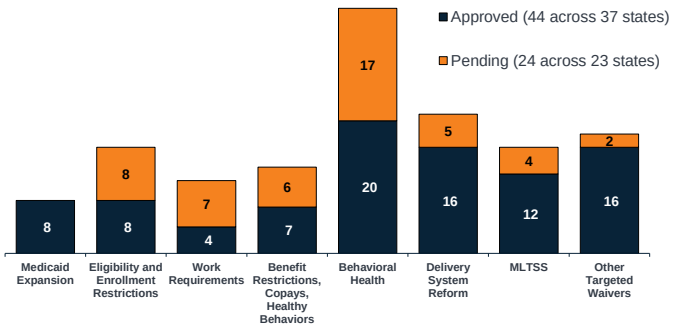
Despite the general prohibition in federal law, there are three main ways that states can receive federal Medicaid funds for IMD services for nonelderly adults: Section 1115 demonstration waivers, Medicaid managed care "in lieu of" authority, and disproportionate share hospital (DSH) payments.

SECTION 1115 WAIVERS

Section 1115 waivers related to behavioral health remain the most frequent type of waiver sought and obtained by states (Figure 2). Within the broader category of behavioral health waivers, most states are seeking authority to alter the IMD payment exclusion. As of June, 2018, there are 12 approved and 13 pending Section 1115 waivers related to IMD payment in 24 states (Figure 3).[6] The IMD waivers distinguish between payments for SUD services and mental health services. All 12 states with approved IMD waivers to date (California, Indiana, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah, Vermont, Virginia, and West Virginia) have authority to use federal Medicaid funds to pay for IMD SUD services. One state (Vermont) also has waiver authority for IMD mental health services,[7] although those payments must be phased out between 2021 and 2025 (Figure 3).[8] Vermont had sought expanded waiver authority for IMD mental health services along with new SUD authority, but CMS approved only the SUD authority in June, 2018.[9] Similarly, Illinois requested authority for both IMD mental health and SUD services, but CMS approved Illinois' waiver for SUD services only in May,

Figure 2

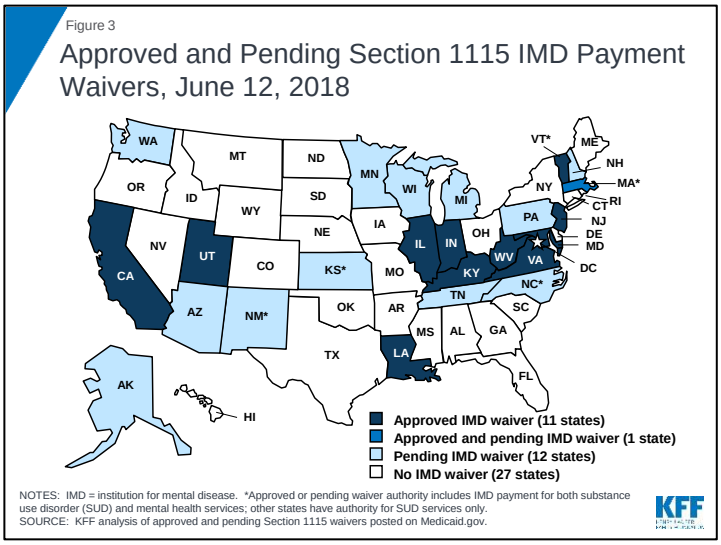
Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, as of June 12, 2018



NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. "MLTSS" = Managed long-term services and supports.

2018.[10] In both cases, CMS cited its policy to not allow Medicaid payments for individuals who receive only mental health treatment in IMDs.

Thirteen states (Alaska, Arizona, Kansas, Massachusetts, Michigan, Minnesota, New Hampshire, North Carolina, New Mexico, Pennsylvania, Tennessee, Washington, and Wisconsin) presently have IMD payment waivers pending with CMS. All are seeking authority to pay for IMD SUD services, and four (Kansas, Massachusetts, North Carolina, and New Mexico) also are seeking IMD mental health authority. Twelve of the pending requests are for new IMD waivers, and one state (Massachusetts) is seeking to expand its existing waiver authority (Figure 3).



MANAGED CARE "IN LIEU OF" AUTHORITY

Of the 39 states using comprehensive risk-based managed care organizations, 26 use Medicaid managed care "in lieu of" authority to cover IMD SUD and/or mental health services in FY 2017 and/or FY 2018.[11] This authority is included in the federal Medicaid managed care regulations, which permit states to use federal Medicaid funds for capitation payments to managed care plans that cover IMD inpatient or crisis residential services for non-elderly adults "in lieu of" other services covered under the state plan.[12] Under this regulation, federal payments for IMD services are limited to 15 days per month.[13] In addition, IMD services must be medically appropriate and cost-effective, and enrollees cannot be required to accept IMD services instead of those that are covered under the Medicaid state plan. This regulation took effect in July, 2016, and codified pre-existing long-standing federal sub-regulatory guidance that allowed federal Medicaid payments for IMD services without a day limit.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

States must make Medicaid DSH payments to offset uncompensated care costs incurred by hospitals that serve a disproportionate number of low-income patients, and federal law allows states to spend some of their DSH funds on IMD services.[14]

3. How Have Section 1115 IMD Payment Waivers Changed Under Recent CMS Guidance?

Most of the recent IMD payment waiver activity has been in response to CMS guidance issued by the Obama Administration in July, 2015,[15] and revised by the Trump Administration in November, 2017.[16]

Both state Medicaid director letters set out parameters for states to obtain Section 1115 waivers to test using federal Medicaid funds to provide short-term inpatient and residential SUD treatment services in IMDs. Neither letter addresses the use of federal Medicaid funds for IMD mental health services.

IMD SUD payment waivers approved under the Trump Administration differ from those approved under the Obama Administration in some ways. For example, waivers approved under the Obama guidance specified numeric day limits on IMD stays eligible for federal Medicaid funds: Maryland's waiver allows two 30-day stays, while California has approval for two 90-day stays for adults and two 30-day stays for adolescents.[17] By contrast, most waivers approved under the Trump Administration, such as Indiana, Kentucky, Louisiana, New Jersey, Utah, Virginia, and West Virginia, do not have an explicit day limit.[18] The most recent waivers approved by the Trump Administration, in Illinois and Vermont, note that those state "will aim for a statewide average length of stay of 30 days. . . to ensure short-term residential treatment stays."[19] In addition, waivers approved under the 2015 guidance were contingent on states covering community-based services[20] along with short-term institutional services that "supplement and coordinate with, but do not supplant, community-based services."[21] While the 2017 guidance notes that "states should indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state" and directs states to "demonstrate how they are implementing evidence-based treatment guidelines,"[22] most of those waivers generally do not detail the state's coverage of SUD services across the care continuum as the earlier waivers do.

4. What Modifications to the IMD Payment Exclusion is Congress Considering?

In May, 2018, the House Energy and Commerce Committee approved a bill for consideration by the full House that would alter the IMD payment exclusion. Specifically, the IMD CARE Act would create a five-year state plan option, from January, 2019 through December, 2023, to allow states to receive federal Medicaid payments for IMD services only for adults ages 21 to 64 with opioid use disorder.[23] The bill limits IMD payments to any 30 days in a 12-month period. States electing this option would have to include a plan for how the state will improve access to outpatient care[24] and ensure appropriate clinical screening to determine the appropriate level of care and length of stay.[25] How to address the bill's projected cost, estimated at $991 million,[26] is yet to be determined. The House Energy and Commerce Committee also approved a bill that would direct the Medicaid Payment and Access Commission to study IMDs that receive Medicaid payments.[27]

The Senate Finance Committee held a markup on the Helping to End Addiction and Lessen Substance Use Disorders Act on June 12, 2018.[28] Provisions related to Medicaid IMD services in this bill include authorizing payment for other Medicaid services provided to pregnant women receiving SUD treatment in IMDs[29] and codifying the 2016 Medicaid managed care regulation that allows capitation payments to include up to 15 days of IMD services in a month.[30] The Committee discussed an amendment to the bill that would remove the IMD payment exclusion for SUD services for adults ages 21 through 64 for five

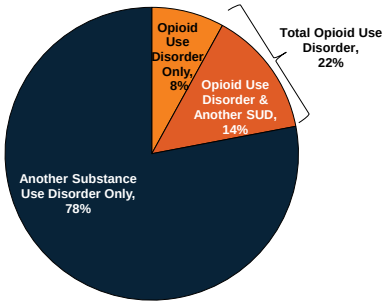
years, from January, 2019 through December, 2023, provided that states maintain their current level of spending on inpatient services.[31] The bill's projected cost and how the cost would be offset are yet to be determined, and the Committee did not vote on the amendment.

5. Which Populations Would the House IMD Bill Affect?

The vast majority of nonelderly Medicaid adults with SUD (78%) do not have opioid use disorder and would be excluded from the IMD SUD treatment services available under the House bill (Figure 4). Unlike the Section 1115 waivers discussed above and previous legislative proposals,[32] the bill, passed by the House Energy and Commerce Committee and expected to come to a floor vote, limits IMD services to those with the specific diagnosis of opioid use disorder and excludes those who need treatment services for other SUDs. About one in five (22%) nonelderly Medicaid adults with SUD has opioid use disorder (Figure 4). Older (FY2013) state-level data reveals similar patterns, with most enrollees receiving services for SUD not also receiving services for opioid use disorder services (Appendix Table 1). However, there is state variation in the share of SUD patients who receive opioid use disorder services, likely reflecting a combination of state factors including enrollee needs, availability of treatment services, and state policy decisions on Medicaid eligibility and benefits. Additionally, these state-level data pre-date the 2014 ACA Medicaid expansion, which increased nonelderly adult Medicaid eligibility and enrollment in states that adopted the expansion.

Figure 4

Share of nonelderly adult Medicaid enrollees with a substance use disorder who have opioid use disorder, 2016

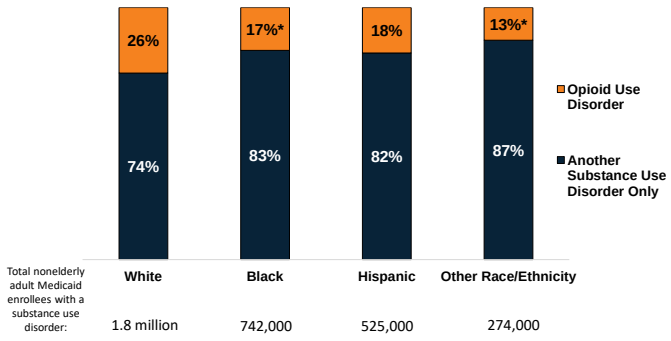


Total: 3.4 million nonelderly adult Medicaid enrollees with a substance use disorder

NOTES: Includes adults ages 21-64. Opioid use disorder includes heroin and prescription opioids. Another substance use disorder includes alcohol, marijuana, cocaine, hallucinogens, inhalants, methamphetamine, prescription stimulants, prescription tranquilizers, and prescription sedatives.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Survey on Drug Use and Health.

Figure 5

Share of nonelderly adult Medicaid enrollees with a substance use disorder who have opioid use disorder by race/ethnicity, 2016



NOTES: * indicates statistically significant difference from White at the p<.10 level. Includes ages 21-64. Opioid use disorder includes heroin and prescription opioids. Another substance use disorder includes alcohol, marijuana, cocaine, hallucinogens, inhalants, methamphetamine, prescription stimulants, prescription tranquilizers, and prescription sedatives.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Survey on Drug Use and Health.

Two-thirds of nonelderly Medicaid adults with opioid use disorder (14%) have a co-occurring SUD of another type, compared to those with opioid use disorder only (8%) (Figure 4). Among nonelderly Medicaid adults with SUD, blacks (17%) and those in the other race/ethnicity group (13%) are marginally significantly less likely than whites (26%) to have opioid use disorder, as opposed to another SUD (Figure 5).

6. How Does Increasing IMD Services Interact with States' Community Integration Obligation Under the Americans with Disabilities Act?

Waiving the IMD payment exclusion and expanding institutional services without also ensuring adequate access to community-based services could have implications for states' community integration obligations under the Americans with Disabilities Act (ADA) if people with disabilities are inappropriately institutionalized.[33] The Supreme Court's *Olmstead* decision found that the unjustified institutionalization of people with disabilities violates the ADA. The ADA's community integration mandate is separate from federal Medicaid law, although states rely on Medicaid funding to help meet their ADA obligations, because Medicaid is the primary payer for long-term services and supports, including home and community-based services.[34] Medicaid also is an important source of financing for behavioral health services, paying for 21% of SUD services and 25% of mental health services as of 2014.[35] Waiver or legislative provisions regarding restrictions on access to IMD services based on diagnosis, IMD day limits, community-based service expansions, delivery system reforms, performance measures, and evaluation results will be key issues to watch in this area.

Appendix Table 1: Number of Medicaid Enrollees Age 21-64 Receiving Treatment for Substance Use Disorder and Opioid Use Disorder by State, FY2013			
State	Received Any Substance Use Disorder (SUD) Service (including Opioid Use Disorder)	Received Opioid Use Disorder Service	
		Number	As a Share of All SUD
AK	8,500	1,100	13%
AL	49,000	4,800	10%
AR	17,100	1,000	6%
AZ	80,700	13,500	17%
CA	140,700	8,100	6%
CO	36,000	N/A	N/A
CT	76,200	26,700	35%
DC	21,700	2,300	11%
DE	19,400	6,900	36%
FL	140,700	17,400	12%
GA	57,100	6,200	11%
HI	18,000	2,500	14%
IA	23,100	1,800	8%
ID	12,600	1,300	10%
IL	117,000	16,700	14%
IN	70,400	8,300	12%
KS	5,800	500	9%
KY	77,400	8,900	11%
LA	48,300	6,000	12%
MA	136,000	54,000	40%
MD	71,300	31,800	45%
ME	46,400	12,200	26%
MI	137,600	19,000	14%
MN	107,200	14,800	14%
MO	60,400	7,000	12%
MS	27,000	3,500	13%
MT	7,300	1,000	14%
NC	76,900	12,300	16%
ND	3,700	400	12%
NE	9,700	600	6%
NH	9,700	3,100	32%
NJ	50,900	17,800	35%
NM	25,200	5,800	23%
NV	10,100	2,400	23%
NY	312,200	74,100	24%
OH	215,800	32,000	15%
OK	44,700	5,900	13%

OR	54,300	9,100	17%
PA	109,400	21,800	20%
RI	10,700	3,200	30%
SC	37,200	3,100	8%
SD	3,600	200	6%
TN	89,500	12,400	14%
TX	89,500	9,000	10%
UT	11,600	2,900	25%
VA	50,300	5,500	11%
VT	14,700	6,200	42%
WA	68,900	9,700	14%
WI	69,300	11,600	17%
WV	23,500	7,100	30%
WY	3,000	300	10%
National Total	**3,007,300**	**533,800**	**17%**

NOTES: Rhode Island data are FY2012. Counts include any individual aged 21-64 with a service claim for which a substance use disorder was coded as a reason for the visit.
SOURCE: Kaiser Family Foundation analysis of FY2013 Medicaid Statistical Information System.

Endnotes

[1] An antiquated term in the statute.

[2] Ages 21 to 64.

[3] 42 U.S.C. § 1396d (a)(29)(B). States can use federal Medicaid funds for inpatient hospital and nursing facility services in IMDs for individuals age 65 and older and inpatient psychiatric hospital services for individuals under age 21. 42 U.S.C. § 1396d (a)(14) and (16)(A).

[4] 42 U.S.C. § 1396d (i).

[5] David G. Smith and Judith D. Moore, MEDICAID POLITICS AND POLICY, at 188-89 (2008).

[6] Section 1115 of the Social Security Act allows the Health and Human Services Secretary to waive certain provisions of federal Medicaid law for an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of" the program. 42 U.S.C. § 1315 (a). The Secretary's Section 1115 waiver authority is limited to provisions contained in 42 U.S.C. § 1396a, while the IMD payment exclusion is contained in 42 U.S.C. § 1396d. However, the Secretary has approved IMD payment exclusion waivers under Section 1115 expenditure authority, which has been interpreted to independently permit the "costs of such [demonstration] project[s] which would not otherwise be included as [federal Medicaid] expenditures. . . [to] be regarded as expenditures under the State [Medicaid] plan. . . ." 42 U.S.C. § 1315 (a)(2).

[7] Another state (Maryland) indicated that CMS denied its request for IMD mental health payment waiver authority, while approving its request for IMD SUD payment authority. GAO, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652 at 34 (Aug. 2017), https://www.gao.gov/assets/690/686456.pdf.

[8] Vermont must submit a schedule to CMS by the end of 2018 to begin reducing federal Medicaid IMD spending in January, 2021, and completely end this spending by the end of 2025.

[9] Letter from CMS, CMCS Acting Director Timothy B. Hill to Vermont Agency of Human Services Secretary Al Gobeille, at 1 (June 6, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf.

[10] Letter from CMS Administrator Seema Verma to Illinois Healthcare and Family Services Director Felicia Norwood at 1 (May 7, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf.

[11] Five states report that they do not use this authority, and eight answered "undetermined." Kaiser Family Foundation, *Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018*, at 19 (Oct. 2017), https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/.

[12] Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

[13] States can effectively receive federal matching funds for capitation payments made for enrollees with IMD stays up to 30 days if the stay does not exceed 15 days in a single month. *Id.*

[14] DSH payments to IMDs are limited to the lesser of the state's FY 1995 DSH payment to IMDs and other mental health facilities or one-third of the state's FY 1995 DSH allotment. 42 U.S.C. § 1396r-4 (h); GAO, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652 at 34 (Aug. 2017), https://www.gao.gov/assets/690/686456.pdf.

[15] CMS, *New Service Delivery Opportunities for Individuals with a Substance Use Disorder*, SMD #15-003, (July 27, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf.

[16] CMS, *Strategies to Address the Opioid Epidemic*, SMD #17-003 (Nov. 1, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[17] California allows a one-time 30-day extension if medically necessary, and peri-natal patients may stay for the duration of pregnancy and 60 days post-partum. California's waiver notes that the average length of stay is 30 days. Massachusetts has waiver authority for specified diversionary behavioral health services in IMDs provided by managed care plans, expanded SUD treatment services in IMDs provided to all full benefit enrollees regardless of delivery system, and payments to IMDs through the waiver's safety net care pool.

[18] Virginia and West Virginia's waivers note that the average length of stay is 30 days.

[19] CMS Special Terms and Conditions, *Illinois Behavioral Health Transformation Demonstration,* at p.8, section V., ¶ 20 (July 1, 2018-June 30, 2023), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf; CMS Special Terms and Conditions, *Vermont Global Commitment to Health Demonstration* at p. 53-54, section XV., ¶ 92 (Jan. 1, 2017-Dec. 31, 2021, amended June 6, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf.

[20] Medicaid community-based behavioral health services can be covered under state plan or waiver authority.

[21] CMS, *New Service Delivery Opportunities for Individuals with a Substance Use Disorder*, SMD #15-003, (July 27, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf.

[22] *Id*. The revised guidance requires states to address certain components, such as residential treatment provider qualifications and capacity, opioid prescribing guidelines, access to naloxone, prescription drug monitoring programs, and care coordination between residential and community settings. States must report on core and state-specific quality measures and perform waiver evaluations.

[23] *House Energy and Commerce Committee Vote on Opioids Legislation* (May 17, 2018), https://energycommerce.house.gov/markups/energy-and-commerce-committee-vote-on-opioids-legislation/; House Energy and Commerce Committee, *Combatting the Opioid Crisis: Legislation*, https://energycommerce.house.gov/opioids-legislation/; *Individuals in Medicaid Deserve Care that is Appropriate and Responsible in its Exclusion Act,* H.R. 5797, http://docs.house.gov/meetings/IF/IF14/20180517/108343/BILLS-1155797ih-U1.pdf, as amended by https://docs.house.gov/meetings/IF/IF14/20180517/108343/BILLS-115-5797-W000820-Amdt-CMT-AMD_01-U1.pdf.

[24] The state's plan should include the process by which individuals will transition from IMD services to outpatient care and the process the state will use to ensure that care is provided in the most integrated setting appropriate to the individual's needs. H.R. 5797.

[25] These factors are to be based on the American Society of Addiction Medicine criteria. *Id.*

[26] Congressional Budget Office Cost Estimate, *Opioid Legislation, as ordered reported by the House Committee on Energy and Commerce on May 9 and May 17, 2018* at 7 (June 6, 2018), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53949-opioid.pdf.

[27] House Energy and Commerce Committee, *Combatting the Opioid Crisis: Legislation*, https://energycommerce.house.gov/opioids-legislation/; *Medicaid IMD Additional Info Act*, H.R. 5800, https://docs.house.gov/meetings/IF/IF14/20180517/108343/BILLS-1155800ih-U1.pdf.

[28] United States Senate Committee on Finance, *Open Executive Session to Consider an Original Bill Entitled Helping to End Addiction and Lessen Substance Use Disorders Act of 2018* (June 12, 2018), https://www.finance.senate.gov/hearings/open-executive-session-to-consider-an-original-bill-ihelping-to-end-addition-and-lessen-heal-substance-use-disorders-act-of-2018.

[29] Senate Committee on Finance, *Description of the Chairman's Mark, The Helping to End Addiction and Lessen Substance Use Disorders Act of 2018* at § 206 (June 12, 2018), https://www.finance.senate.gov/imo/media/doc/HEAL%20Substance%20Use%20Disorders%20Act%20Mark%20Final%206.7.18.pdf.; *see also Help for Moms and Babies Act*, S. 2922 (introduced May 22, 2018), https://www.congress.gov/bill/115th-congress/senate-bill/2922/text. CBO estimates that this provision will cost $48 million from 2019-2028. Senate Finance Committee Opioid Legislation, Preliminary Estimate, ERN18252 with modifications based on discussions with staff (June 4, 2018), https://www.finance.senate.gov/imo/media/doc/SFC%20Opioid%20Legislation%20preliminary%20estimate,%20June%204,%202018_203pm.pdf.

[30] Senate Committee on Finance, *Description of the Chairman's Mark, The Helping to End Addiction and Lessen Substance Use Disorders Act of 2018* at § 207 (June 12, 2018), https://www.finance.senate.gov/imo/media/doc/HEAL%20Substance%20Use%20Disorders%20Act%20Mark%20Final%206.7.18.pdf.; *Securing Flexibility to Treat Substance Use Disorders Act*, S. 2921 (introduced May 22, 2018), https://www.congress.gov/bill/115th-congress/senate-bill/2921.

[31] Portman Amendment #2, *Medicaid Coverage for Addiction Recovery Expansion Act*, https://www.finance.senate.gov/imo/media/doc/Amendments%20HEAL%20Act1.pdf.

[32] For example, two of the larger Affordable Care Act repeal and replace bills that failed in Congress last year (the Better Care Reconciliation Act and the Graham-Cassidy-Heller-Johnson Amendment) included a state option to cover IMD services for nonelderly adults up to 30 consecutive days and up to 90 days in a calendar year. Both of those bills also would have fundamentally changed the federal financing structure of Medicaid from guaranteed matching funds to a limited per capita cap or block grant, which was estimated to result in overall substantially reduced federal funding to states. *See, e.g.,* Kaiser Family Foundation, *Medicaid: What We Learned from the Recent Debate and What to Watch for in September 2017* (Sept. 2017), https://www.kff.org/medicaid/issue-brief/medicaid-what-we-learned-from-the-recent-debate-and-what-to-watch-for-in-september-2017/.

[33] Kaiser Family Foundation, Olmstead's *Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's* Olmstead *Decision* (June, 2014), https://www.kff.org/medicaid/issue-brief/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-15-years-after-the-supreme-courts-olmstead-decision/. Although the ADA's anti-discrimination provisions do not apply to individuals who are currently using illegal drugs, the ADA does protect people who previously used illegal drugs and people with mental health disabilities. *ADA Title II Technical Assistance Manual*, § II-2.3000, https://www.ada.gov/taman2.html.

[34] Kaiser Family Foundation, *Medicaid Long-Term Services and Supports: A Primer* (Dec. 2015), https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[35] Kaiser Family Foundation, *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals* (June 2017), https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/.