

Medicaid Reimbursement for Institutions for Mental Diseases

Change will be effective July 1, 2017

- Since 1965, the Medicaid Institutions for Mental Diseases (IMD) exclusion has prohibited the use of federal Medicaid funds for care provided to most patients in mental health and substance use disorder (SUD) residential treatment facilities larger than 16 beds. An IMD is a hospital, nursing facility, freestanding psychiatric hospital, or other institution with more than 16 beds that primarily provides diagnosis, inpatient psychiatric treatment or care for persons with mental diseases, including medical attention and related services.
- In April 2016, the Centers for Medicare and Medicaid Services issued final regulations that revise and strengthen existing Medicaid managed care rules. Under the final rule, states can, for the first time, receive federal matching funds for capitation payments for adults who receive psychiatric or substance use disorder (SUD) inpatient or crisis residential services in an IMD for no more than 15 days in a month. The change is intended to improve access to short-term inpatient psychiatric and SUD treatment for Medicaid managed care enrollees.
- ***Ohio Medicaid will implement the CMS allowance to pay for a stay of up to 15 days in a month in an IMD through managed care contracts beginning July 1, 2017.*** These services are not reimbursable through Medicaid fee-for-service (the IMD exclusion still applies to FFS) but Ohio Medicaid plans to extend managed care to all enrollees with behavioral health needs in January 2018. The Ohio General Assembly proposed to delay managed care for behavioral health until July 2018, but Governor Kasich vetoed the delay. He also vetoed a separate provision that would have required Medicaid to seek federal permission to provide the same IMD services that are already federally-approved to begin on July 1, 2017. As a result, Ohio Medicaid can move forward without delay to expand access to SUD inpatient benefits through Medicaid behavioral health redesign or psychiatric residential services in an IMD.
- ***The new IMD policy will expand the Medicaid-reimbursable inpatient psychiatric provider network, expand private inpatient provider capacity, and reduce stress on emergency services.*** It will provide Medicaid managed care plan members access to more timely, medically appropriate, and cost-effective services by allowing IMDs to be used in addition to other covered settings, such as inpatient psychiatric units in general medical hospitals and state-funded regional psychiatric hospitals. Ohio Medicaid will require managed care plans to contract with private IMD facilities and maintain provider network adequacy standards, which means the plans will have to build an IMD provider network that provides access to intensive mental health treatment and timely access to inpatient psychiatric services closer to home. The managed care plans also will be required to coordinate with the IMD to transition members back to the community with appropriate services and supports.

Frequently Asked Questions

Institutions for Mental Diseases (IMDs)

THE OHIO DEPARTMENT OF MEDICAID

APRIL 2017

Managed Care & Institutions for Mental Diseases

What is the policy change?

Starting July 1, 2017, Ohio will implement 42 C.F.R. 438.6 in the federal managed care regulations to allow for Medicaid recipients age 21 through 64, who receive their Medicaid benefits through a managed care plan (MCP), to receive inpatient treatment in an Institution for Mental Disease (IMD). In addition, it allows MCPs to receive a full monthly capitation payment on behalf of MCP members if stays do not exceed fifteen (15) days in any calendar month.

What is an Institution for Mental Diseases (IMD)?

An IMD is a hospital, nursing facility, freestanding psychiatric hospital, or other institution of more than sixteen beds which primarily provides diagnosis, inpatient psychiatric treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

What is changing as a result of this policy?

Medicaid recipients, age 21 through 64, enrolled and receiving their Medicaid services through an MCP, will have access to medically necessary and reimbursable treatment in an IMD setting. In addition, MCPs will receive funding to cover the costs for inpatient stays at an IMD regardless of a recipients age.

What is the intended outcome of this policy?

The policy expands the Medicaid-reimbursable inpatient psychiatric provider network to give Medicaid MCP members access to more timely, medically appropriate, and cost-effective services by allowing IMDs to be used in addition to other covered settings, such as inpatient psychiatric units' in general medical hospitals.

What is NOT changing as a result of this policy?

IMD services are not available through Medicaid for recipients age 21 through 64 who receive their Medicaid services through fee for service (FFS).

How will this impact individuals covered by both Medicare and Medicaid?

Medicaid is always the payer of last resort. When a member with Medicare coverage exhausts their lifetime Medicare allowance for inpatient psychiatric hospital stays, Medicaid MCP will provide coverage under this policy regardless of the member's age.

What does this policy require of MCPs?

MCPs will contract with private IMDs and cover medically necessary services provided by the IMD. MCPs will work with clinicians and/or facilities to determine both the level of care and the appropriate care setting. MCPs may cover the costs of a member's IMD stay for up to 15 days per calendar month.

What criteria must be met in order for the State to make a payment to an MCP for an IMD stay under this policy?

- The State certifies that the IMD is a medically appropriate and cost effective substitute for the covered service or setting.
- The member is not required by the MCP to use the alternative service or setting.
- The services are authorized and identified in the Managed Care Provider Agreement, and offered as an option for MCPs and their enrollees.

What happens if a member needs an inpatient stay longer than 15 days?

Length of stay is determined by medical necessity. Therefore, MCPs must be involved in the admission decision process in the event an inpatient stay is longer than 15 days. MCPs will address longer lengths of stay in their contracts with individual IMD facilities.

If an enrollee has an IMD stay exceeding 15 days per calendar month, ODM will recover a percentage of the MCPs monthly payment based on the total number of days in which the enrollee was in an IMD.

What will be the role of MCPs in the IMD admission process?

MCPs will work with their member, clinicians and/or facilities assessing the need for care to determine both the level of care and the appropriate care setting.

What will be the role of MCPs in the IMD discharge process?

MCPs will coordinate with the admitting facility to ensure proper care and transition of members back into the community, which may include coordinating with community mental health services and providers.

Does this mean that Medicaid will now cover forensic hospital stays?

Forensic admits do not apply to the new regulations.

How does this impact the role of state psychiatric hospitals?

State hospitals will continue to serve as a safety net and will operate as a reimbursable, out-of-network provider for managed care plans.

How does this impact the role of County Boards as the gatekeepers of state psychiatric admissions?

As they do today, and as required by statute, County Boards and/or their designees, will continue to approve admission to a state psychiatric hospital and provide notification of admission to the MCP.

How does this impact general hospitals?

General hospitals are not IMDs and, therefore, are not impacted by this policy.

Will this impact the role of local crisis providers who handle the coordination of psychiatric hospital admissions?

Crisis providers will continue to function as they do today, but will need to work with the MCP for coordinating admission to IMD facilities when necessary.

How will crisis providers or a county board pre-screener know if an IMD is in an MCP's network?

MCPs will work closely with providers for coordinating care and services for members. This will include providing information about how to reach MCPs for coordination of IMD stays, which IMD facilities are on their provider panel, and how to coordinate a stay if an IMD is not in the MCP's network. The information is also available on MCP websites.

Where do providers submit claims under this policy?

IMD facilities will need to bill MCPs appropriately for medically necessary services provided to members, regardless of age.

Questions? Contact the Ohio Medicaid Provider Hotline: 1-800-686-1516

For more information, go online: Medicaid.Ohio.gov

For More Information on Ohio's Participating Managed Care Plans and their Networks, go to:
<http://oahp.org/>