Medicaid IMD Exclusion and Options for MHDS
February 29, 2012

This white paper is intended to provide policy guidance regarding the impact and options associated with the Medicaid Institution for Mental Disease (IMD) exclusion for institutional psychiatric services for adults. Further research is needed in order to determine appropriate financial incentives and costs associated with implementing the recommendations below.

Summary and Policy Recommendations

As long as the IMD exclusion remains in federal statute it will have a profound impact on the ability of Nevada Medicaid to pay for mental health services provided in an IMD for individuals 21-64 years of age. This is envisioned to continue past January 2014 with the expansion of the Medicaid program under the PPACA. However, there are several policy options that should be considered. These options will require additional research.

- Psych services in a general hospital. Create incentives for licensed general hospitals to establish a separate hospital component as a psychiatric ward. This will be discussed later.
- Psych long-term care services. Create incentives for licensed nursing facilities to establish specialized behavioral health wards. This will also be discussed later.
- Consider establishing free-standing facilities licensed to provide inpatient psychiatric services or long-term skilled nursing care with less than 17 beds. Linking services with transitional programs is also essential. This is an exception to the IMD exclusion for both psychiatric and substance abuse treatment services.

Background

The IMD exclusion was included in the original Medicaid statute in 1965. The exclusion is limited to individuals 21-64 years of age and includes two exceptions for specific populations. The first has existed since Medicaid was established in law and applies to adults age 65 and older who receive IMD services. The second passed in 1972, and applies to children under age 21. For children, medically necessary inpatient mental health services are mandatory when diagnosed through Early Periodic Screening Diagnosis and Treatment (EPSDT).

By definition, an IMD is not limited to an inpatient psychiatric hospital. An IMD is any institution, including a nursing facility, where the overall character of the facility is that of an IMD.

There is another important exemption passed in 1988 involving institutions with fewer than 17 beds that specialize in treating persons with mental disorders. These are not technically considered IMDs.

Criteria for Defining an IMD

Federal guidelines are detailed and fact-based. It is not the intent of this white paper to delve extensively into the details of the criteria used by CMS to determine whether a facility is an IMD, but instead to highlight key points which can affect policy options.

CMS considers a number of facts in evaluating whether an IMD is an independent entity or a separate component, such as a wing of a general hospital. These include, but may not be limited to governance, medical oversight, licensure and organizational operations.

Once an entity is identified for an IMD review, other criteria apply. Most importantly, the determination is focused on whether the "overall character" of the facility is primarily for the treatment of individuals with mental disease. The review considers a number of facts including the overall needs of the patients receiving care in the facility. The types of admissions can change a facility to an IMD. The so-called "50% test" may apply here. This test evaluates whether the majority of the admissions during the year were primarily for mental disorders. The needs of the patients admitted to the facility weighs heavily at this point.

If determined an IMD, the facility is subsequently prohibited from receiving Medicaid payments for patients that meet the criteria of the exclusion.

Scope of the IMD Exclusion

It is important to note that the IMD exclusion follows the patient from the point of admission into the IMD through discharge. Federal financial participation is not available for any service throughout that period. The exclusion applies not only to services provided in an IMD, but to IMD patients inside or outside the facility. Services provided to an IMD patient while on trial leave or conditional release are allowable Medicaid covered services.

Unbundling Services in an IMD

Given the scope of the IMD exclusion affecting all services from admission through discharge, the possibility of having Medicaid pay for ancillary and physicians services separately is not feasible. These services are also captured in the scope of the exclusion.

Psych Services in a General Hospital

Establishing inpatient psychiatric in a general hospital is an important policy option to consider. However, care must be taken by hospitals and licensing agencies using this strategy. The "50% test" is not the only criteria used to establish whether the overall character of a facility is that of an IMD.

There are also several decisions by the U.S. Department of Health and Human Services Department Appeals Board (DAB) which are relevant in this area. In *In re NY State Department of Social Services* inpatient psychiatric facilities associated with two general hospitals were determined sufficiently distinct to be IMDs. This was despite common ownership and medical direction. Most significant was the fact that the facilities were separately licensed and accredited, certified as psychiatric hospitals by Medicare, filed separate cost reports, and were paid different reimburse rates.

In *California Dept. of Health Services* and *New York State Department of Social Services (II)*, the DAB rejected administrative relationships because of evidence that the entities were sufficiently separate and because the primary use of the "branch facilities" was for the care and treatment of persons of mental disease.

A less risky approach may be to encourage development of smaller psych wings (less than 17 beds) in licensed general hospitals. This takes advantage of the existing exception to the IMD exclusion.

Appropriate payments would be required to incentivize general hospitals to establish smaller psych wings under their general license.

Psych Services in Nursing Facilities

There was discussion of re-directing MHDS resources to establish specialized long-term behavioral health units. These services could be established in existing licensed nursing facilities. However, the IMD exclusion would apply if they were established as a distinct part of a state owned psychiatric hospital. As with psych services in general hospitals, the potential exists for an IMD evaluation to be triggered. Care must also be taken so that the establishment of new services does not change the overall character of the facility to that of an IMD.

As with psych services in general hospitals, it may be better to encourage licensed nursing facilities to establish smaller psych units (less than 17 beds) under their general license.

Free-standing Psychiatric Services Less Than 17 Beds

The less than 17 bed exception to the IMD exclusion is a very important option to consider in terms of increasing bed capacity in the community.

The Minnesota Department of Human Services recently opened ten 16-bed community behavioral health hospitals (CBHH) across the state. These facilities provide short-term, acute inpatient psychiatric services at community-based sites. They provide an array of services including: assessments; individuals treatment planning; medication management; 24-hour nursing care; and discharge and aftercare planning. Aftercare plans are coordinated with community based providers.

In St. Paul, a 16-bed transitional facility has been established with 12 beds that can accommodate patients for a maximum of five days and four beds for 30-day stays, and transitional programs for patients.

David Hartford, MN Adult Mental Health Administrator said the transition to CBHHs was a part of a planning process to move their mental health system from institutional services to community based **services.** He said the 16-bed model was a determined effort to use the exception to the IMD exclusion in order to bill Medicaid for services. Since their opening 5 years ago, one facility has closed due to low census. Two others have been converted to 16-bed psychiatric residential facilities, they call Intensive Residential Treatment. Mr. Hartford also said that all ten major medical centers in the Minneapolis/ St. Paul area have psychiatric wings and contract with the state to provide inpatient psychiatric services. The state retains one IMD in Anoko. It has 200 licensed beds, but they have downsized it to just over 100 staffed beds. This facility serves as the highest acuity behavioral health patients in Minnesota. Anoko also serves as a "safety net" facility for legal admissions in the greater Minnesota area. However, Mr. Hartford also said that the general hospitals have contracts to serve legal hold patients.

Conclusion

The policy recommendations provided in this white provide a starting point for further discussion, research and analysis. The possibility of establishing smaller hospital-based or free-standing inpatient psychiatric services present an important option to the State while avoiding issues associated with the Medicaid IMD exclusion rule.[1]

[1] This white paper summarizes research findings published in two separate reports dealing with the Institute for Mental Disease (IMD) exclusion in Medicaid:

- Ohio Association of Child Caring Agencies, Inc., "OACCA IMD Report – December, 2010"
- Rosenbaum, Teitelbaum, Maucry, "An Analysis of the Medicaid IMD Exclusion," Dec. 19, 2002, GWU School of Public Health and Health Services.