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# Institution for Mental Disease (IMD) as an "in lieu of" service

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## Summary

*This paper has been updated from the original version to clarify a discrepancy in the effective date of compliance with the IMD provisions. It has also been updated to reflect additional sub-regulatory guidance issued by CMS through an addendum to the 2016 Medicaid Managed Care Rate Development Guide.*

Federal financial participation (FFP) is not available for Medicaid services for individuals between the ages of 21 and 64 who are patients in an Institution for Mental Disease (IMD). This IMD exclusion is a long-standing component of Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act (Title XIX), which has recently come under scrutiny because of the combination of inpatient psychiatric capacity constraints and rapid enrollment growth of the Medicaid population. The final Medicaid managed care regulations (final rule) clarify the use of IMDs as an "in lieu of" service. In the near term, states will need to carefully weigh their options based on their specific needs for inpatient psychiatric and subacute psychiatric capacity. The risk is that adding too much inpatient capacity could induce utilization and drive members away from community-based alternatives. The managed care rule also contains some rate-setting differences for IMDs as an "in lieu of" service. Beyond the impact of the final rule, IMDs will continue to be a topic of interest to state policy makers as they bolster the continuum of behavioral health and substance use disorder services.

## Introduction

The Centers for Medicare and Medicaid Services (CMS) has had a policy in place since Medicaid began that does not provide FFP for any services for a member between the ages of 21 and 64 either inside or outside an IMD while that member is a patient in an IMD. This law, generally termed the "IMD exclusion," has evolved over time but has largely remained unchanged. Outside of this age band, full FFP is provided as long as the service is included in the state plan for the over-65 population. The under-21 population is covered as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service at the state's regular match rate. The IMD exclusion applies to fee-for-service and managed care delivery systems.

This setting exclusion is defined in the Medicaid statute under 1905(a)(29). When Title XIX was passed by Congress in 1965, the treatment of mental illness was primarily performed in an institutional setting. States built and operated large mental institutions to house and feed people with mental illness. The IMD exclusion was included to ensure states would continue to be responsible for the costs of those large hospitals.[1] Over time, a few limited mechanisms have been developed to pull down FFP for IMD utilization within the exclusion age corridor of 21 to 64 years of age. In some cases, states may have already utilized IMDs as an "in lieu of" service.[2]

### Timeline: Major changes to the IMD exclusion[3]

- The original definition included a state option to cover enrollees 65 and older in an IMD (1965)
- State option to receive FFP at an IMD for enrollees under age 21 (1972)
- Facilities with fewer than 16 beds were excluded from the IMD exclusion (1988)
- FFP was made available for facilities other than hospitals for enrollees under 21 (1990)
- The definition of psychiatric residential treatment facilities (PRTF) was completed, allowing FFP for enrollees under age 21 based on the 1990 change (2001)

## What is an IMD?

An IMD is defined in federal statute as 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] CMS has published sub-regulatory

1 MACPAC (March 31, 2016). Proceedings of Public Meeting, p. 98. Retrieved May 18, 2016, from https://www.macpac.gov/wp-content/uploads/2015/05/March-April-2016-Public-Meeting.pdf.

2 MACPAC (March 31, 2016). The Medicaid Institution for Mental Diseases (IMD) Exclusion, slides 6 and 7. Retrieved May 18, 2016, from https://www.macpac.gov/wp-content/uploads/2016/03/The-Medicaid-Institution-for-Mental-Diseases-IMD-Exclusion.pdf.

3 Ibid.

4 Legal Information Institute (July 12, 2006). 42 CFR 435.1009 - Institutionalized individuals. Cornell University Law School. Retrieved May 18, 2016, from https://www.law.cornell.edu/cfr/text/42/435.1009.

guidance on the definition of an IMD, in the state Medicaid manual in section 4390.[5] These additional guidelines speak to distinct components of larger organizations and whether a psychiatric "wing" is an IMD or simply a component of the larger organization. The Medicaid manual adds specificity on whether the "overall character of a facility is that of an IMD." stating that "a facility's IMD status depends on whether the evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases." To the extent any of the following guidelines are met, the manual states, "a thorough IMD assessment must be made:"

- The facility is licensed as a psychiatric facility.
- The facility is accredited as a psychiatric facility.
- The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.)
- The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients is receiving psychopharmacological drugs.
- The current need for institutionalization for more than 50% of all the patients in the facility results from mental diseases.

Most states publish lists of IMDs, as the IMD designation is made by the state.

Current methods for drawing down FFP on IMDs within the exclusion:

- Section 1115 waivers
- Medicaid Emergency Psychiatric Demonstration
- The new Medicaid managed care rule
- Disproportionate share (DSH) hospital payments

## Existing usage of IMDs

The final rule should be considered a clarification of CMS's policy on Medicaid funds covering IMD, rather than a significant shift in policy. As CMS notes in its fiscal estimate in the final rule, 17 states have claims experience in the IMD exclusion age corridor. Many states have already considered IMDs as an "in lieu of" service or they have other pilot programs or 1115 waivers to utilize this setting. As states continue to review their entire continuums of behavioral health services, additional 1115 waivers may be proposed to CMS to include the use of IMDs to alleviate capacity issues. In July 2015, CMS issued a State Medicaid Director letter regarding "New Service Delivery Opportunities for Individuals with a Substance Use Disorder."[6] In this letter, CMS includes the use of IMDs if certain criteria are met.

## Summary of the regulatory requirements

Section 438.6(e) of the final rule clarifies that states can receive FFP and make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD if the following conditions are met:

- The provision of this service must meet the four following conditions for "in lieu of" services, as stated in Section 438.3(e)(2).
  1. The state determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.
  2. The enrollee is not required by the managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) to use the alternative service or setting.
  3. The services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP.
  4. The utilization and actual cost of "in lieu of" services is taken into account in developing the component of the capitation rates that represents the covered state plan services.
- The facility must be a hospital providing psychiatric or substance use disorder inpatient care or a subacute facility providing psychiatric or substance use disorder crisis residential services.
- The length of stay cannot exceed 15 days during a given month (capitation payment period).
- IMD utilization may be included in the development of a managed care capitation rate, *but utilization must be priced at the cost of same services included under the state plan* (note: further discussion is provided in the next section of this paper).

While FFP is being introduced for short-term IMD stays for adults of ages 21 to 64, changes in the usage of IMD is highly discretionary for both states and managed care entities (MCEs), given that the services must meet the conditions of an "in lieu of" service.

5 CMS.gov. The State Medicaid Manual, Section 4390. Retrieved May 18, 2016, from https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

6 CMS (July 27, 2015). New Service Delivery Opportunities for Individuals With a Substance Use Disorder. Letter to State Medicaid Director. Retrieved May 18, 2016, from https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf.

In the comments section of the final rule, CMS provides an explanation for granting FFP for adult IMD stays and limiting it to 15 days in a month:

- **Ensuring access to and availability of short-term stay inpatient psychiatric services.** With additional demand for mental health services brought about by Medicaid expansion and insurance marketplace coverage, and a corresponding need by MCEs to ensure access to services under their contracts, CMS believes it appropriate for MCEs to use alternative settings "to provide appropriate medical services in lieu of Medicaid-covered settings."
- **Limitation of 15 days.** CMS indicates that the 15-day parameter is supported by IMD length of stay evidence from the Medicaid Emergency Psychiatric Demonstration, which indicated an average length of stay of 8.2 days, with the 15-day definition accounting for variability in length of stay for acute inpatient psychiatric services. CMS also notes the 15-day limitation is consistent with existing federal statute that prohibits FFP for non-elderly adult IMD services.

The utilization of IMDs as an "in lieu of" service is optional at many levels:

- States have the option to authorize it through their managed care contracts.
- MCEs have the option to offer it to their enrollees.
- Enrollees have the option of accepting it in lieu of state plan services.

The administration of the adult IMD provision in the final rule is also addressed in the comments section of the final rule:

- The MCE must determine if the enrollee has an inpatient level of care need that necessitates treatment for no more than 15 days.
- While the final rule limits coverage of adult IMD stays to no more than 15 days, CMS indicates it is possible that an MCE could receive two capitation payments for consecutive months if the length of stay exceeded 15 days, with no more than 15 days occurring in each month.
- CMS reiterates that it is the state's responsibility to design contract terms with MCEs to prevent managed care capitation payments from being made for beneficiaries enrolled in an IMD more than 15 days in a given month.

This rule stipulates that this regulation is effective 60 days from publication, however CMS issued sub-regulatory guidance on compliance on July 1, 2016.[7] The guidance was issued through an addendum to the 2016 Medicaid Managed Care Rate Development Guide.

The bulletin describes how CMS will handle compliance for provisions of the mega reg that are effective July 5, 2016. In short, there are three time spans described in the letter that will dictate how CMS will review rates relative to the new provisions. The IMD provisions fall under this guidance.

- CMS does not intend to review rates already approved for the requirements effective July 5, 2016.
- For states that have already developed their Medicaid managed care rates for rating periods starting before October 1, 2016, CMS does not intend to require states to redevelop their rates solely to comply with the new requirements. If a state does not comply with the July 5 provisions, they will be placed on a corrective action plan until the next rate-setting period.
- States with rate periods beginning on or after October 1, 2016, that have not yet had contracts and rates for that period reviewed and approved by CMS, will be expected to fully comply with the new July 5 requirements.

## State policy implications

The final rule provides a state Medicaid program with a potential additional avenue to provide inpatient psychiatric and substance use disorder services. In order to determine if policy changes are warranted, states and other payers, including Medicaid MCEs, will need to understand the current supply and demand for inpatient psychiatric and substance use disorder services. Based on this capacity analysis, decisions can be made whether to offer IMDs as an "in lieu of" service. Any material increase in provider capacity should be done carefully to avoid utilization that is not medically appropriate.

### EXISTING SERVICE CAPACITY SUFFICIENT

If a state does not face capacity issues for inpatient services, it may not be inclined to include IMD as an "in lieu of" service in its managed care contracts. States may already provide inpatient psychiatric and substance use disorder services through the mechanisms previously discussed. If the state has been effective at alleviating capacity constraints, it may decide not to offer this service for fear of shifting the balance of enrollees served in the home and community-based setting to the institutional setting.

### EXISTING SERVICE CAPACITY CONSTRAINED

If capacity in a region is constrained, calculations for pent-up demand may be needed for the geographic region to accurately estimate the utilization of newly available IMD services. Pent-up demand may be estimated by evaluating existing utilization of short-term acute behavioral health services in other states, or geographies within a state that do not have capacity constraints. A reliance on local jails or emergency rooms for "boarding" individuals with mental health or substance use disorder conditions may also be an indication of

7 CMS (July 1, 2016) Addendum to 2016 Medicaid Managed Care Rate Setting Guide.

the need for additional service capacity.[8] An analysis done by the Bureau of Justice Statistics indicated that more than 60% of local jail inmates had a mental health problem. Substance use disorders were reported to occur in 76% of local inmates with a mental health problem (relative to 53% of inmates without a mental health problem).[9]

## Rate-setting guidance in final rule for "in lieu of" services

Previous rate-setting guidance for "in lieu of" services published by CMS[10] allowed actuaries to use the expected utilization and unit cost of "in lieu of" services as a proxy for the state plan services being replaced. While the final rule maintains this provision of other "in lieu of" services, it makes an exception for IMD services. For purposes of rate setting, the state's actuary may use service utilization from an IMD stay, but the unit cost may not reflect that of the IMD. Rather, IMD utilization "must be priced consistent with the cost of the same services through providers included in the state plan." This exception was made to preserve the intent of the law, which, in part, was not to shift costs from the state to the federal government. There is the possibility that an IMD's unit could be lower than a benchmark that the state's actuary might use. This is an area of the final rule that may require additional sub-regulatory guidance.

Actuaries are not required to use only IMD utilization and may also review other inpatient psychiatric stays on which to base their IMD utilization estimates. The utilization reflected in the rate development process may not include IMD stays that exceed 15 days per month (including the portion of the stay prior to the 15-day limitation). Possible unit cost data points to reflect "state plan unit cost" include per diem rates for members outside the IMD exclusion age band, rates for facilities with fewer than 16 beds, and commercial rates.

As required under Section 438.7(b), the incorporation of IMD utilization in the rate development process should be documented in a transparent fashion. A requirement of "in lieu of" services is that they be cost-effective relative to the substituted service. Because the service being substituted is simply the same service in a different setting, if the unit cost is at or lower than inpatient psychiatric in a non-IMD, this would be cost-effective. If possible, cost-effectiveness could also make assumptions about emergency room and acute inpatient bed avoidance. The state's actuary may be called upon to demonstrate this cost-effectiveness as part of the rate review process.

## Where does the IMD exclusion go from here?

Over the last few years there has been a groundswell of activity around the IMD exclusion. Most of the large state-run institutions that permeated the mental health treatment landscape have closed and the network of providers is very different from 1965. This rule was written in direct response to access concerns over inpatient and subacute psychiatric and substance use disorder services. These access concerns have increased significantly with Medicaid expansion and insurance coverage expansion through the marketplace. This rule is likely only the beginning of other changes to the IMD exclusion. It is important to remember that the rule is only applicable to managed care. The disabled population is most likely to use IMDs as an "in lieu of" service, and this group typically has the lowest managed care penetration. It is also important to note that behavioral health services are frequently carved out of managed care or are sometimes offered in a separate delivery system, such as a PIHP or PAHP.

In summary, allowing Medicaid MCEs to utilize IMDs as an "in lieu of" service is one component of a state's overall efforts to bolster its continuum of behavioral health and substance use disorder treatment in the face of rapid enrollment increases and demand. There are likely some near-term analytical challenges in estimating demand and finding suitable unit cost proxies. The level of effort required to set rates is likely to vary by region, based on a state's service delivery design.

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9 U.S. Department of Justice (December 14, 2006). Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics Special Report. Retrieved May 18, 2016, from http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

10 CMS (December 2009). Providing Long-Term Services and Supports in a Managed Care Delivery System: Enrollment Authorities and Rate Setting Techniques. Retrieved May 18, 2016, from http://www.pasrrassist.org/sites/default/files/attachments/10-07-23/ManagedLTSS.pdf.

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