



Institutions for Mental Diseases (IMDs) – Concept and Process Overview

Senate Appropriations

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Background

An institution for mental diseases (IMD) is defined in section 1905(i) of the Social Security Act to mean 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.”

Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an IMD. There are two exceptions to the IMD exclusion: 1) inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 and older in IMDs (42 CFR § 440.140), and 2) inpatient psychiatric hospital services for individuals under age 21, furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a “Psychiatric Residential Treatment Facility” (PRTF) (42 CFR § 440.160).

IMDs in North Dakota

In North Dakota, the following facilities are classified as IMDs: The State Hospital in Jamestown (140 beds); Prairie St. John’s in Fargo (110 beds); ShareHouse in Fargo (87 beds); and Summit Prairie Recovery Center in Raleigh (36 beds).

‘Waiving’ the Prohibition of Medicaid Payment for IMD Services

Section 1115 of the Social Security Act gives the Secretary of the U.S. Department of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and Children’s Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of Medicaid law to give states additional flexibility to design and improve their programs.

Some states have received approval from CMS for 1115 waivers related to substance abuse disorder (SUD) treatment services provided in IMDs. In November 2018, CMS clarified that they will also approve 1115 waivers for services provided in IMDs that focus primarily on treatment for individuals with serious mental illness (SMI) or serious emotional disturbance (SED)¹. States may choose to focus their 1115 waivers on SUD treatment, SMI/SED treatment, or both at the same time.

States have the flexibility to design 1115 demonstrations aimed at making significant improvements over the course of a five-year period. Compliance with the following goals and milestones is required.

Required Goals for SUD 1115 waiver:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;

¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

- Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improved access to care for physical health conditions among beneficiaries.

Required Milestones for SUD 1115 waiver:

- Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
- Widespread use of evidence-based, SUD-specific patient placement criteria;
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
- Sufficient provider capacity at each level of care;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Improved care coordination and transitions between levels of care.

Required Goals for SMI/SED 1115 waiver:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Required Milestones for SMI/SED 1115 waiver:

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FFP for services provided to beneficiaries;
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers);

Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services - as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to;
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and

psychiatric consultants in EDs to help with discharge and referral to treatment providers);

- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED;

Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model as well as consideration of a self-direction option for beneficiaries;
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, to help determine appropriate level of care and length of stay;

Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

Other 1115 Waiver Requirements:

- Demonstrations must be "budget neutral" to the Federal government, which means that, during the project, federal Medicaid expenditures will not be more

than federal spending without the demonstration². Calculations are based on per member, per month expenditures pre- and post-implementation for the targeted population [PMPM*Member Months]. Other methodologies may be accepted by CMS.

- Demonstrations must have implementation and evaluation plans approved by CMS.
- 1115 waivers do not allow for room and board payments unless the facility qualifies as an inpatient facility under section 1905(a) of the Social Security Act.
- States are required to have staff and/or contractual resources necessary to conduct independent and robust interim and final evaluations.

Other Considerations:

- Even if ND was approved for an 1115 waiver that would allow Medicaid to reimburse for treatment within an IMD, there would still be limits on the number of days that can be reimbursed (15 days per year for inpatient IMD; 30 days per year for residential IMD³). An 1115 waiver would apply only to traditional fee-for-service Medicaid.
- IMD reimbursement for the Medicaid Expansion group, which is currently operated as managed care, would not be included in an 1115 waiver. Federal managed care rules allow capitation payments to be made to a managed care organization (MCO) for a member aged 21 through 64 receiving inpatient treatment in an IMD if it is for psychiatric or SUD crisis residential services and the length of stay is no more than 15 days during the month of the capitation payment⁴. These services must also meet the requirements for 'in lieu of services, meaning that the state has determined the IMD is medically appropriate and a cost effective substitute, the member is not required by the MCO to choose the IMD setting and the approved in lieu of services are considered in developing the component of the capitation rates that represents the covered services⁵.
- There are a targeted number of IMD beds in the state that a waiver would open to Medicaid reimbursement. Also, since Medicaid is the only health care payer with a restriction on paying for IMD services and is the payer of last resort, other payers would pay before Medicaid.
- A waiver for IMDs would not expand eligibility or services. SUD and SMI/SED treatment can already be accessed by Medicaid members in settings not classified as IMDs. The only SUD treatment service that would be offered by an IMD is medically managed detoxification, which is a higher level of SUD treatment than most people need.
- Budget neutrality may be difficult to achieve, given the complex needs of the population who would be eligible for the waiver services, the infrastructure development requirements associated with the required goals and milestones, and the assumptions that are used to generate cost estimates. CMS monitors

² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf>

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>

⁴ <https://www.law.cornell.edu/cfr/text/42/438.6>

⁵ <https://www.law.cornell.edu/cfr/text/42/438.3>

budget neutrality throughout the demonstration period and performs a formal adjudication at the end of the demonstration period to determine whether a state's actual spending has remained within the specified limit. During demonstration approval, the state must agree to limit their receipt of federal financial participation to the amounts indicated in the budget neutrality test and to return any funds they receive above those limits to CMS⁶.

- In two Human Services Research Institute studies pursuit of an IMD waiver was not a recommendation.
- The milestones required to be addressed by states that implement 1115 waivers are broad and would require significant development of the behavioral health continuum.
- The US Government Accountability Office (GAO) found⁷ that selected states' evaluations of these demonstrations had widespread, significant limitations that affected their usefulness in informing policy decisions. The limitations included gaps in reported evaluation results for important parts of the demonstrations. CMS is attempting to strengthen evaluation requirements and hold states accountable for meaningful and timely 1115 evaluation requirements.

Examples

Colorado's SUD 1115 waiver

- 2018 started the process, 2021 completed the process
- 2 FTEs allocated; unclear others that contribute to supporting roles.
- ~\$500,000 year 1 and year 2; year 1 of implementation \$174 million (inpatient and residential treatment)
- Post-implementation \$1.58 million for consultants and IT systems (annually)

Virginia's 1115 waiver on Community Engagement, Premiums and Wellness Accounts, Housing and Employment Supports for High Need Enrollees

- 3 FTEs working 100%; 9 total from Compass Division chart (housing analyst, employment analyst, data analyst, wellness accounts analyst, finance analyst, Senior Advisor, Senior Program Analyst, Senior Policy Analyst)
- Manatt as a consultant to write the waiver; cost \$3.495 million for Manatt
- Timeline- 2018 to December 2019 but an added 6 months after that to implement. Negotiate with CMS on budget neutrality, implementation plan, and evaluation plan.

⁶ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf>

⁷ <https://www.gao.gov/products/GAO-18-220>