

RATIONALE FOR ELIMINATING THE MEDICAID IMD EXCLUSION FOR BENEFICIARIES UNDER AGE 21

- ❖ The IMD exclusion violates the EPSDT mandate.
 - ❖ Covered services in Medicaid law have not evolved to include the currently recognized full array of services or best practice.
 - ❖ Outdated Medicaid law contradicts longstanding, approved Medicaid practice.
 - ❖ Unclear and subjective guidance for identifying IMDs leave states perpetually exposed to CMS reinterpretation, audits and recoupment of federal matching payments.
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BACKGROUND

When the Medicaid program was established in 1965, it included an **IMD exclusion** stating that federal financial participation (FFP) is not available for any services provided to an individual who is under age 65 and is a patient in an IMD. IMDs (Institutions for Mental Diseases) were defined as institutions primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. In 1988, the definition of IMDs was narrowed to only those facilities with more than 16 beds.

In 1972, an **exception** to the IMD exclusion was established for individuals under age 21. For them, FFP is available only for inpatient psychiatric hospital services, not any other services the child/youth may need until unconditionally discharged from the IMD. Temporary discharge to treat medical or dental needs is not considered unconditional discharge, for example.

Under the Early and Periodic Screening, Diagnosis and Treatment mandate (**EPSDT**), states must still provide all necessary Medicaid services to beneficiaries under age 21 in IMDs, but under the IMD exclusion, may not claim FFP for any that are not inpatient psychiatric services. The state is responsible for 100% of costs for other services.

Medicaid **inpatient psychiatric hospital services** may only be delivered in the following types of facilities: psychiatric hospitals, psychiatric units in general hospitals, and Psychiatric Residential Treatment Facilities (PRTFs), all defined in federal regulations.

A **PRTF** is a non-hospital facility with a provider agreement with a state Medicaid agency to deliver inpatient psychiatric services to Medicaid-enrolled individuals under age 21. The facility must be accredited by either the Joint Commission, the Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities, or another accrediting organization with comparable standards recognized by the state, and must comply with conditions of participation on the use of seclusion and restraint.

Fewer than half of the states have a licensing category for PRTFs. Absent a definitive list from CMS, the best available information indicates that the following states license PRTFs: Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maryland, Mississippi, Montana, Nebraska, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, South Dakota.

Psychiatric hospitals, psychiatric units and PRTFs are not the only IMDs. The definition of IMD is not mutually exclusive with any other provider type. Nursing homes, Intermediate Care Facilities for the Mentally Retarded, residential substance abuse treatment facilities, and others are also IMDs if they have more than 16 beds and their overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. **Mental diseases** include all diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM), including those for substance use and addiction.

The Centers for Medicare and Medicaid Services (CMS) relies on states to self-identify which of their licensed facilities are IMDs and to follow federal rules in their regard. The State Medicaid Manual provides guidelines for determining what constitutes an institution and whether an institution is an IMD, some of which are unambiguous and others which are more subjective. This has resulted in inconsistent decision making and guidance from regional CMS offices when reviewing state Medicaid plans, which themselves vary widely according to states' interpretations of federal policy and their own health and human service programs.

❖ **The IMD exclusion violates EPSDT.**

Under EPSDT, states must provide any medically necessary services to their under-21 beneficiaries, whether the services are explicitly included in the state plan or not. Presumably, states which do not license PRTFs would either send a child or youth to an out-of-state PRTF if that level of care were needed, or would provide the services in-state in a non-PRTF setting. If that non-PRTF setting had more than 16 beds (and were not a psychiatric hospital or unit), it might be an IMD. FFP could not then be claimed for any psychiatric services (because "inpatient psychiatric services" can only be delivered in a psychiatric hospital/psychiatric unit/PRTF) or for any non-psychiatric services (because the child/youth is in an IMD).

The Medicaid law is in conflict with itself by, on the one hand, requiring any necessary services under EPSDT, and on the other, denying FFP for some services in some settings. The services themselves are eligible for FFP under some circumstances but not others, unrelated to medical necessity.

❖ **Covered services in Medicaid law have not evolved to include the currently recognized full array of services or best practice.**

When the under-21 exception to the IMD exclusion was established in 1972, Medicaid covered children's mental health services based on a traditional medical model of care: outpatient and inpatient. Many treatment models and settings have been developed since then to more appropriately serve individual needs. The array of services ranges from in-home, in-school and other outpatient services to therapeutic family and group homes, to other residential programs requiring varying degrees of 24-hour supports and services, to acute inpatient hospitalization.

A strict interpretation of Medicaid regulation limits the under-21 inpatient psychiatric benefit to specific settings. The lack of available alternative mental health services and settings for children and youth, however, was evident when Congress created a 10-state demonstration program with the passage of the Deficit Reduction Act of 2005 to enhance children's mental health services. The Community-Based Alternatives to Psychiatric Residential Treatment Facilities is designed to create alternatives to PRTFs, assuring that those who need this level of care continue to receive it while providing options for those who do not.

Some children and youth need treatment in a secure, supervised environment, but not at a high level of intensity or medical staffing. If the IMD exclusion were eliminated, treatment services in additional 24-hour settings would be eligible for FFP. FFP should also be available for room and board in those settings, which are inherent and necessary to the treatment plan, whether through IV-E foster care maintenance payments for those eligible, or Medicaid for others.

At various times, Congress has amended the Medicaid law with the intent of providing flexibility to the states to cover a broader range of services. Waiver programs have been difficult to design for children with substantial behavioral health care needs, because the demonstration of budget neutrality cannot include the costs of non-psychiatric services to children in PRTFs or any services to children in excluded IMDs. The addition of the clinic, rehabilitation and case management options to federal law was interpreted by many states to allow additional services to be covered, and state Medicaid plan amendments to do so were approved by CMS. The point is that both clinical and administrative practice have evolved, with implicit or explicit CMS approval. The law must be changed to allow all necessary services to be covered in appropriate settings.

❖ **Outdated Medicaid law contradicts longstanding, approved Medicaid practice.**

Many foster children and youth with behavioral health care needs are in non-PRTF residential settings licensed by a variety of state agencies. The facilities are licensed as child caring institutions, group homes, or other facility types, and provide a full array of 24-hour treatment services and supports. Services vary in range and intensity. In some cases, residents receive the same services they would in a PRTF, from identically credentialed staff, under the same accreditation programs that accredit PRTFs. If the state were to self-identify or CMS were to determine that these facilities are IMDs, the state could not claim FFP for any Medicaid services delivered to the residents. This would eviscerate decades of practice approved by CMS, which has long recognized the difficult balance states must strike between conflicting federal programs, as well as its own obligation to meet the health care needs of all young Medicaid beneficiaries.

In addition, the federal Medicaid and child welfare laws are misaligned, leaving states at risk for costs that should be shared under the federal-state partnership programs. Interpretation of the Medicaid law creates conflict for states in administering their responsibilities under another title of the Social Security Act, Title IV-E, Foster Care and Adoption Assistance. States must provide for the health and safety of children and youth in their custody. IV-E eligibility automatically confers Medicaid eligibility, intended to provide all necessary treatment services. Safety is achieved by placement in state-licensed and regulated homes and facilities. Both of these entitlement programs are federal-state partnerships, and the federal matching percentage is the same for both in a given state. Clearly, Congressional intent was for the cost of serving these youth to be shared equitably by the federal and state governments. The effective and appropriate design of states' child welfare systems should not be held hostage to an arbitrary limitation in the Medicaid law. States should have the ability to serve children in the living environments

and treatment programs most responsive to the children's needs, without foregoing federal support to which the children are entitled.

❖ **Unclear and subjective guidance for identifying IMDs leave states perpetually exposed to CMS reinterpretation, audits and recoupment of federal matching payments.**

CMS's State Medicaid Manual gives vague, subjective and even inaccurate guidance, beginning with the statement that inpatient psychiatric hospital services are "currently being provided in a wide variety of psychiatric facilities." This leaves the impression that more than three types of facilities may deliver the services (psychiatric hospitals, psychiatric units and PRTFs).

The guidelines for determining what constitutes an institution and whether an institution is an IMD list factors to be considered, such as ownership, governance and licensure, with the statement that "if any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered." No description of the assessment or other factors is included. The relative weight of known and unknown factors is determined by CMS regional staff, headquarters staff or auditors on a case-by-case basis.

Part of the regulatory definition of IMDs is whether the "overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." The State Medicaid Manual says that the guidance is met if more than 50% of the residents of the facility "require specialized treatment of serious mental illness." Not all mental diseases are serious mental illnesses, but the terms seem to be used interchangeably. One statement focuses on the purpose of the facility. The other focuses on the mental health needs of the residents, regardless of whether the facility is providing mental health treatment or was established to do so, or even whether that was the reason for admission. The need for a person to be in a given facility, e.g., a rehabilitation facility for traumatic injury, is not necessarily related to their mental health needs. The reliance on individuals' understanding of the intent of inconsistent language results in subjective and variable decision making.

CONCLUSION

An examination of recent changes in several states directed by the CMS regional offices and the monitoring of financial audits in other states reveals that children's mental health services are severely threatened and many are at risk of dissolution. States are constantly under the threat of exposure for audit and recoupment of federal matching payments. Providers are threatened with rate reductions, service and reimbursement restructuring, while continuing to provide needed care and services. Children are denied access to necessary services to which they are entitled.

Bringing the law into comportment with practice is the right thing to do.