Substance Abuse and Mental Health Services Administration

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The IMD Exclusion—What Is It? Why Is It Important?

John O'Brien

Senior Advisor

SAMHSA

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

The IMD Exclusion

- An Institution for Mental Diseases (IMD) is any inpatient or residential facility of more than 16 beds that specializes in psychiatric care
- Written in to 1965 Title XIX Medicaid law to avoid costs for the State Psych Hospitals
- Specific to Medicaid beneficiaries aged 21 to 65 years; Not a barrier for children
- IMD affect SA facilities because HCFA/CMS rules that since SA in DSM, it is a psychiatric illness

What is the Definition of an IMD?

- A hospital nursing facility or other institution greater than 16 beds that:
  - Is engaged in providing diagnosis, treatment or care of persons with mental diseases
  - Treatment and care includes medical attention, nursing care and related services

Guidelines for Determining an IMD

- Licensed or accredited
- Under the jurisdiction of state MH or SA Agency
- More than 50% of patients have MH/SUD diagnoses—not 50% are receiving MH care
- Specializing in MH/SUD therapies, medications patterns, staff training or credentials

Guidelines for Determining an IMD

- In determining whether an entity is appropriate for consideration as an IMD (as opposed to simply a portion of a larger entity to which the exclusion would not apply), CMS examines:
  - governance (e.g., all components controlled by one owner or governing body);
  - medical direction (one chief medical officer in control of medical staff in all components of the entity)
  - administrative control (one CEO in control of all administrative activities in all components of the entity);
  - licensure (is there a separate entity license)
  - organizational operation as a single entity
  - an ability of several operating components within a larger unit to independently meet the conditions of participation under the applicable provider category (e.g., nursing facilities)

Chemical Dependency Treatment Facilities and IMD

- “Chemically dependent patients” admitted for treatment psychological in nature are counted as mentally ill.
- Facilities that are over 17 beds and provide peer counseling and meetings to promote group support are not considered IMD..however
- Federal matching funds may not be claimed for “institutional services” when peer counseling/lay treatment is the reason for inpatient stay

Subtleties of IMD

- Public MH hospitals nevertheless receive Medicaid support:
  - persons >64
  - DSH as safety net hospital
- Must be medical in character; non-medical are considered group living and Medicaid pays for treatment by no room & board
- Under 17 beds or Psych under 21, will pay per diem rates (treatment plus room/board)

Subtleties of IMD

- CMS interprets the exclusion to services that are furnished to IMD patients either inside or ***outside*** the facilities..however
- Individuals that are on conditional release or convalescent leave from an IMD and not considered patients of the institution..however
- Emergencies care are not considered a release or leave
- Beds that are used to accommodate the children of individuals who are being treated are excluded from the total bed count

IMD at the Provider Level

- Have dispersed multiple units of under 16 beds
- Pay for housing out of other funds, but still use Medicaid for treatment program
- Some SUD residential treatment is not “medical” enough (e.g. PRTF) to be eligible for per diem payments.

IMDs and 1115 Medicaid Waivers

- Several states were granted IMD exclusion waiver in 1997
- The IMD exclusion waiver allowed individuals with acute episodes of mental illness to receive Medicaid-covered treatment in IMDs rather than general acute hospitals.
- IMD rate was generally less than the bed in a private psychiatric unit.
- CMS discontinued IMD waivers because standing policy has been to hold states accountable for inpatient treatment of mental illness.
- CMS phased out & subsequently discontinued the use of IMDs by FY‘07.

Policy Options That Have Been/ May Be Considered

- Eliminate the IMD but hard to sell that want more institutions?
- Apply IMD just to MH, but not to SUD, as that was not the original intent
- Increase the number of beds because under 17 is not financially viable
- Current health care reform legislation includes an IMD pilot—focuses on MH

Arguments Against IMD Exclusion

- Conflicts Medicaid philosophy—Federal medical assistance payments are denied even when:
  - Services are medically necessary
  - Regardless that a qualified provider is rendering the service
- Patient's eligibility is not based on medical necessity/provider qualifications—but the setting where it is rendered
- Other payers cover residential treatment as a benefit regardless of number

Litigation and Appeals

- Early Litigation—HCFA/OIG conducted reviews of IMDs in 4 states (CT, MN, IL and CA)—found institutions were IMDs and disallowed payments.
- States appealed decisions.
- HCFA/OIG did additional reviews to collect evidence re:
  - Percentage of patients with mental illness
  - Number of transferees from state hospitals
  - Staff credentials
  - Facilities advertised as a referral for treatment of mental diseases
- Disallowances were upheld in most cases

Litigation and Appeals

- Where disallowances were reversed:
  - Court found that HCFA focused solely on the individuals MH diagnosis or needs versus medical or rehabilitative care.
  - Court found that diagnosis-based criteria were initially invalid
- Other interesting case:
  - Three providers challenged the classification of alcoholism and chemical dependency as a mental disease
    - DAB concluded that only institutions treating alcoholism were IMDs and
    - Required HCFA to develop clearer guidelines about CD providers

Questions??