



OACCA IMD Report – December, 2010

I. BACKGROUND

The federal definition of IMD is in 42 CFR 435.1010: “*Institution for mental diseases* means 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. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.”

If an individual lives in an IMD, states are not permitted to claim Medicaid reimbursement for otherwise allowable services provided to them. Reimbursement is prohibited for services for 21 to 64 year-old IMD residents; and federal funding is permitted only for “inpatient psychiatric services”, a service that would have to be part of the state’s Medicaid plan, for residents under the age of 21. Furthermore, in order for “inpatient psychiatric services” to be reimbursed by Medicaid, the services must be provided in a Psychiatric Residential Treatment Facility (PRTF), another federally defined setting that would have to be added to Ohio’s Medicaid plan.

Ohio’s Medicaid plan has not been approved to include “inpatient psychiatric services” through Medicaid or to license programs as PRTFs. Therefore, Ohio is exposed to risks of strict enforcement of the IMD law, audits by the federal government, and possibly recoupment of federal matching payments for Medicaid services billed by children’s residential treatment centers.

The U.S. Department of Health and Human Services’ (HHS) Centers for Medicare and Medicaid Services (CMS) indicated to the State of Ohio that many residential treatment centers that serve children in our state appear to be IMDs and therefore are ineligible to bill Medicaid.¹ However, neither CMS nor the HHS Office of Inspector General (OIG) has issued a formal report or finding affirming this viewpoint. CMS’s unofficial determination was made following multiple on-site inspections of children’s residential centers in Ohio by OIG representatives.

If HHS officially determines that some or all of Ohio children’s residential centers are IMDs, the agencies that operate the centers may take certain steps to meet the law’s exclusion criteria, such as reducing the total number of beds in a program to 16 or fewer or pursuing licensure as PRTFs so that some, but not all, Medicaid services may be billed. At least 20 states have approved PRTF licensure categories.

¹ Ohio Responses to All Questions Asked by CMS Regarding State Plan Amendment 08-011: OH 08-011 Follow-up Questions to Ohio’s 3/25/09 Answers. April 15, 2009. Excerpt from page 2: “the 13 type 1 residential facilities with more than 16 beds are problematic because they are IMDs”.

II. OACCA ACTIVITIES

OACCA supports ODMH’s and ODJFS’ efforts to contest the claim that residential treatment centers in Ohio are IMDs. We are working with the National Association for Children’s Behavioral Health, the Child Welfare League of America, and the Alliance for Children and Families to urge Senator Sherrod Brown and other Members of Congress to draft legislation to “update” the IMD law to broaden the type of facilities that are exempt and thus may provide services through Medicaid. We are researching the PRTF classification and educating our members about its benefits and drawbacks. The OACCA Advocacy Committee and the Residential Treatment Advisory Committee are venues for discussion and planning our advocacy work on this important issue.

III. IMPLICATIONS FOR PROVIDERS OF RESIDENTIAL TREATMENT SERVICES TO CHILDREN

Strict enforcement of the federal IMD law by HHS would be detrimental for Ohio agencies and the children that they serve. HHS could potentially classify as an IMD any ODMH licensed or certified institution, such as a residential center, that has over 16 beds if it determines that the institution’s overall character is to treat individuals with mental and/or behavioral health disorders. However, based on correspondence between HHS and ODJFS-ODMH, the discussions focused on enforcement of the IMD law on programs that hold a Type I ODMH license to operate a children’s residential center with over 16 beds in a program. According to ODMH, programs that meet this licensure and bed criteria as of September 2009 are:

Agency	Program	Beds	OACCA Member
Beech Brook	Wade Cottage	17	✓
Belmont Pines	Belmont Pines Hospital	56	
Buckeye Ranch	Intensive Care Center	38	✓
Buckeye Ranch	Open Campus	56	✓
Catholic Charities Services	Parmadale Institute	80	✓
Cincinnati Children’s – College Hill	Cincinnati Children’s – College Hill	36	
Eastway Corp	Northcutt Residential Treatment Facility	22	✓
Fox Run	The Center for Children and Adolescents	100	✓
Oesterlen Services for Youth	Oesterlen Services for Youth	50	✓
Ohio Hospital for Psychiatry	Residential Treatments Centers of Ohio	28	
Pomegranate Health Systems	Pomegranate Health Systems of SE Ohio	54	
Pomegranate Health Systems	Pomegranate Health Systems of Central Ohio	70	
St. Vincent Family Centers	St. Vincent Family Centers	26	

An IMD classification would make the children who reside in the centers ineligible for Medicaid services, regardless of where those services are provided (such as at a doctor’s office, hospital emergency room, or at another agency). Without Medicaid, the state-county system would be responsible for payment of services provided in an IMD.

Recoupment and Recent Investigations

Another concern about the HHS investigation of children's residential centers is the potential for recoupment of federal funds. If HHS determines that Ohio facilities are IMDs, it may be legally authorized to recoup funds that the State of Ohio has billed to Medicaid for services provided to children in centers that are determined, after the fact, to be IMDs. It is unclear if the State of Ohio could order recoupment of funds directly from providers, or if the state would assume responsibility for payment.

In recent years, HHS has requested recoupment of \$21 million of federal Medicaid funds from Maryland, Virginia, New Jersey, New York, Texas, California, and Florida due to improper billing of services to residents of IMDs.²

During 2010 the federal government upheld an appeal by the State of New York of an audit finding from the OIG which claims that the state improperly claimed Medicaid funding for children in private residential treatment centers determined to be IMDs. The facilities in question were not PRTFs authorized to provide inpatient psychiatric services for individuals under age 21.³

Florida Case Summary⁴

In 2003, CMS concluded an investigation into federal reimbursement for services provided to residents of IMDs located in Florida. The review found that the state agency did not have adequate controls in place to preclude claiming FFP for services provided to IMD residents under the age of 21-22. CMS identified 30,757 claims out of 153,323 claims applicable to these residents that were not eligible for federal reimbursement, yet FFP was claimed totaling \$362,931. CMS recommended that the state agency refund the \$362,931 and identify and return improper FFP applicable to other IMDs not included in their review. The state agency acknowledged the CMS audit findings and agreed to make an adjustment of \$362,931. Florida also responded by implementing a statewide 1915(b) waiver, approved by CMS, through which Medicaid eligible children may receive services in enrolled IMDs. The institutions that were included are Florida's Statewide Inpatient Psychiatric Programs (SIPP). The waiver program is designed with tight controls to prevent providers from being reimbursed for any other Medicaid services for individuals who are *also* receiving the Medicaid benefit of Inpatient Psychiatric Services for individuals under 21 in IMDs. Specifically, the payment system will deny a claim for any other service when a claim for the per diem for IMD services has been paid.

Utah Case Summary

During 2010, the State of Utah agreed to stop seeking federal Medicaid reimbursement for services provided in facilities determined by CMS to be IMDs. The move affected 27 agencies that operated residential treatment facilities with more than 16 beds. State officials have been working with provider organizations to downsize programs from the more common 24 to 28-bed facility size, to smaller programs with 16 or fewer beds per facility.⁵

² U.S. Department of Health and Human Services Office of Inspector General. [Seven States' Medicaid Claims For 21- To 64-Year-Old Residents Of Institutions For Mental Diseases Who Were Temporarily Released To Acute Care Hospital](#). A-02-03-0100. June 2004.

³ The State of Utah offers a timeline of HHS investigations of residential facilities in New York and other states at <http://le.utah.gov/interim/2010/pdf/00000207.pdf>.

⁴ Audit of Medicaid Payments for Under 21 Year Old Residents of Private Psychiatric Hospitals that are Institutions for Mental Diseases in Florida. U.S. Department of Health and Human Services Office of Inspector General. February 2003.

⁵ OPEN MINDS Weekly News Wire, September 13, 2010.

IV. CMS EVALUATION AND INVESTIGATION METHODS

In addition to the definitions of IMD in federal law and regulation (see Section VII), the CMS State Medicaid Manual (SMM) includes important guidelines and criteria to assist states in determining whether or not a facility is an IMD.⁶ Note: analysis of the guidelines and criteria presented below originates from a useful report on IMD compliance from George Washington University.⁷

The SMM states, “Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide ... [Medicaid] services ... if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.”

Further, the SMM includes the following guidelines to be used by CMS:

Guidelines

- 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)

Once an entity is identified for IMD evaluation purposes, CMS applies certain criteria to determine if it is an IMD. These criteria focus on the overall character of the facility (i.e. whether or not it is maintained primarily for the care and treatment of individuals with mental diseases).

Criteria

- whether the facility is licensed or accredited as a psychiatric facility,
- whether the facility is under the jurisdiction of the state’s mental health authority, specializes in providing psychiatric or psychological care (as determined by patient records, prescription drug patterns, and staff training and credentialing); and
- whether “the current need for institutionalization for more than 50% of all the patients in the facility results from mental diseases”

The determination is heavily fact driven and turns on both the character of the institution itself – its status, governance, staffing, services and treatments – as well as the current needs of the individuals who are receiving treatment.

⁶ SMM Section 4390.

⁷ An Analysis of the Medicaid IMD Exclusion. Rosenbaum, S. et al. George Washington University. December 19, 2002.

Admissions

Based on admissions alone, a facility can be transformed from a covered Medicaid entity to an excluded IMD. CMS notes that in applying the 50% test, it is *not necessary* to determine whether mental disease treatment currently is being furnished; the only relevant matter is whether the current need for institutional care results from a mental disease either currently or at the time of admission within the past year. In interpreting whether admission ties to a mental disease, CMS instructs staff to consult the International Classification of Diseases (ICD-9-CM) of which the DSM is a subclass. If patient record review is not possible, surveyors are authorized to rely on their professional observations, discussion with staff, and the specialty of the attending physician.

When a beneficiary or Medicaid eligible person is a patient in an IMD, all FFP is denied for covered benefits whether furnished inside or outside the IMD. However, federal regulations on conditional release or convalescent leave from an IMD are not considered to be patients of the institution. Trial home visits are convalescent leave and as a result, health services received in the community during a trial leave would qualify for federal payments. Similarly, continuing to receive outpatient treatment in ambulatory settings is considered conditional leave and thus the outpatient treatment would be recognized as qualifying for federal assistance, even if the individual continues to be classified as a resident of the IMD.

Emergencies that arise during a conditional or convalescent leave are covered; but if a patient experiences a medical emergency while an IMD patient and not on conditional or convalescent leave, then the exclusion travels with the patient and medical emergency and follow-up treatment would be denied because of the individual's IMD patient status.

Administrative Organization

The determination of when a portion of an institution is in fact sufficiently distinct in character and operation to be classified as an IMD is a factual one and therefore, disputes over classification would be common. In *In re NY State Department of Social Services*⁸ two Westchester psychiatric facilities were determined to be sufficiently distinct from St. Vincent's, a New York City general acute care hospital of which they were a part, to be considered IMDs. The state attempted to prove that because the facilities were under a common ownership and common medical direction and shared a common CEO and board of trustees did not satisfy the HHS Departmental Appeals Board. *Of great importance was the fact that the facilities were separately licensed and accredited, were certified as psychiatric hospitals for Medicare purposes, filed separate Medicare and Medicaid cost reports, and were paid at different rates from the parent corporation.* The Board held that even putting aside the operation of state licensure law, the overall character of the Westchester branches of St. Vincent's was such that for Medicaid purposes they would be considered distinct IMDs rather than branches of a parent entity.

Similar results were reached in *California Dept. of Health Services*⁹ and *New York State Department of Social Services (II)*¹⁰, in which the Appeals Board rejected arguments by the state regarding ownership and management because of evidence of separate locations, licensure and accreditation, scope of services, specialized management, and payment rates. In *New York State II* the Board made clear that *an entity could be an IMD even if it is merely a portion of a larger institution that is not primarily for the care and treatment of persons with mental diseases.* If the primary use of branch facilities is for the care and

⁸ DAB No. 91-48 (1992); reprinted at CCH Medicare/Medicaid Guide para. 40343.

⁹ DAB No. 1495 (1994).

¹⁰ DAB No. A-95-34 (1995); reprinted at CCH Medicare/Medicaid Guide para. 45886.

treatment of persons with mental diseases, then the overall character is that of an IMD. Administrative relationship alone is basically irrelevant.

V. PRTF INFORMATION

One method that states may follow to avoid Medicaid ineligibility for residents of IMDs is to establish a psychiatric residential treatment facility (PRTF) license category into its State Medicaid Plan. Such a facility is authorized to provide inpatient psychiatric hospital services, a Medicaid service, even if it is determined to be an IMD. PRTFs may obtain a provider agreement with their state Medicaid agency to deliver inpatient psychiatric services to Medicaid-enrolled individuals under age 21. The facility must be accredited by the Joint Commission, COA, or CARF, or another accrediting organization with comparable standards recognized by the state, must comply with federal conditions of treatment planning and use of seclusion and restraint.

Funding of services in PRTFs through Medicaid is only available for inpatient psychiatric services which involve active treatment that a team has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary. Since child residents of PRTFs who are screened for EPSDT are entitled to receive all needed covered services, the remaining medical services which not eligible for FFP would, according to federal regulations, have to be funded by the state, not the federal government (unless the child is discharged from the program and no longer a PRTF resident). Therefore, while the expectation is that the PRTF provides care and services to meet the child's medical needs in accordance with EPSDT, the federal government is able shift the payment for the services to states. This policy would prevent PRTFs for billing Medicaid for somatic health care, dental care, pharmacy services/medication, or any other outpatient Medicaid eligible services. (Pending federal legislation, S. 1217, addresses this issue by clarifying that Medicaid will reimburse for the services provided in PRTFs.) Although the restrictive federal policy exists, CMS has not enforced it, with the exception of a limited compromise in New York, and, in fact, we are not aware of any state that is *not* claiming Medicaid for such highly individualized services for children in PRTFs.

Criteria

A PRTF facility must:

1. Complete and send Attestation Statements to the State Medicaid Agency yearly, which attests that the facility is in compliance with CMS's standards governing the use of seclusion and restraint.
2. Comply with the federal regulations on the use of restraint and seclusion.
3. Report serious occurrences to the State Medicaid Agency and the State-designated protection and advocacy organization no later than close of the next business day following a serious occurrence. Serious occurrences include a resident's death, serious injury to a resident, suicide attempt. The facility must also notify the child's parents or legal guardians as soon as possible, and no later than 24 hours after the serious occurrence. Serious occurrences must be documented by staff.
4. Provide staff with ongoing education and training, such as for CPR and seclusion and restraint.

PRTFs must certify in a child's treatment plan that 1) ambulatory care resources available in the community do not meet the treatment needs of the child; 2) proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and, 3) services can reasonably be expected to improve the child's condition or prevent further regression so that

the services will no longer be needed.

The State Medicaid Agency is responsible for surveying the PRTFs in accordance with the PRTF protocol and guidelines. It is required to conduct 20% yearly validation surveys, including complaint surveys, regarding the improper use of restraint and seclusion. After the State Medicaid Agency assigns a provider number to the facility, the State Mental Health Agency will enter the information from the provider's attestation statement, as well as validation and complaint survey information, into ASPEN. It is the State Mental Health Agency responsibility to update information as necessary.

Treatment Planning

The admission of a child into a PRTF must be certified by a treatment team before Medicaid is sought for the child's services. The treatment team must include a physician, preferably a child psychiatrist. For emergency placements, this process must be completed by 14 days after admission.

The treatment plans for children in PRTFs must be developed no later than 14 days after admission and be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

The treatment plan must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the child's situation and reflects the need for inpatient psychiatric care. The treatment plan must be reviewed every 30 days by the treatment team.

The treatment team members must be either employed by the agency, or provide services to the child in the facility. The treatment team must be capable of 1) assessing the child's immediate and long term therapeutic needs, developmental priorities, and personal strengths and liabilities; 2) assessing the potential resources of the recipients family; 3) setting treatment objectives; and, 4) prescribing therapeutic modalities to achieve the plan's objectives.

The team must include as a minimum **either**:

1. a psychiatrist;
2. a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
3. a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State.

The treatment team (either #1, #2, or #3) must ALSO include one of the following: a psychiatric social worker, a registered nurse with specialized training or experience in treating mentally ill individuals, an occupational therapist who has specialized training or experience in treating mentally ill individuals, or a psychologist who has a master's degree in clinical psychology or who has been certified by the State.

For more information on PRTF regulations, click on the following link for key sections of the Code of Federal Regulations: <http://www.oacca.org/documents/prtfregs.pdf>.

VI. HISTORY AND OVERVIEW OF THE IMD LAW

- IMD exclusion prohibited the use of federal funds for services provided in IMDs with more than 16 beds to people under age 65.
- In 1972, Congress passed an exception to that exclusion permitting those under age 21 to receive "inpatient psychiatric hospital services." The exception appears in the Social Security Amendments of 1972 (Public Law 92-603), which became effective on January 1, 1973.
- In 1988, the definition of IMDs was narrowed to only those facilities with more than 16 beds.
- Under EPSDT, states must provide all necessary Medicaid services to beneficiaries under age 21 in IMDs, **but under the IMD exclusion, may not claim federal financial participation for any that are not inpatient psychiatric services**. The state is responsible for 100% of the cost of 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.
 - Fewer than half of the states have a licensing category for PRTFs – Ohio does not.
 - Residents of an IMD that do not meet the exclusion are ineligible for FFP of Medicaid services, regardless of the setting in which services are provided. The only exception is if the IMD resident is on a conditional release or convalescent leave, in accordance federal regulations.
- Under EPSDT, states must provide medically necessary services to under-21 beneficiaries, regardless if the services are explicitly included in the state plan.
- 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.

VII. KEY DEFINITIONS

Federal Definition of IMD - 42 CFR 435.1010

Institution for mental diseases means 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. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Federal Definition of IMD - 42 U.S.C. §1396d(i)

The term "institution for mental diseases" means 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.

Federal Definition of PRTF - 42 CFR 483.352

Psychiatric Residential Treatment Facility means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.