

# Medicaid Handbook: Interface with Behavioral Health Services

## Module 4

### *Providers of Behavioral Health Services*

*This page intentionally left blank*

## ***Acknowledgments***

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Truven Health Analytics Inc, formerly the Healthcare business of Thomson Reuters, under SAMHSA IDIQ Prime Contract #HHSS283200700029I, Task Order #HHSS283200700029I/HHSS28342002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Rita Vandivort-Warren, Juli Harkins, and Kevin Malone served as the Contracting Officer Representatives.

## ***Disclaimer***

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

## ***Public Domain Notice***

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

## ***Electronic Access and Copies of Publication***

This publication may be downloaded at <http://store.samhsa.gov>. Or, call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

## ***Recommended Citation***

Substance Abuse and Mental Health Services Administration. Medicaid Handbook: Interface with Behavioral Health Services. HHS Publication No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

## ***Originating Offices***

Office of Policy, Planning, and Innovation, SAMHSA, 1 Choke Cherry Road, Rockville, MD 20857.

HHS Publication No. SMA-13-4773  
Printed in 2013

*This page intentionally left blank*

## Module 4: Providers of Behavioral Health Services

### ***Medicaid Providers***

Before addressing issues unique to providers of behavioral health services, it is useful to understand some principles relative to Medicaid providers, in general.

States have latitude within the bounds of federal statute and legislation in defining the types and qualifications of providers that may participate in their Medicaid programs. However, as described in Module 2, having an understanding of several important foundational Medicaid principles will help inform how and why states approach the design of their provider networks and establish their provider requirements.

**Reasonable Promptness and Statewideness.** The ability to ensure that Medicaid consumers can access needed services in a reasonably timely manner depends on having a sufficient number and type of providers in a given area. Although there may be sufficient numbers and types of providers available in the community, network requirements imposed by the state and the level of reimbursement for services (among other considerations) will impact providers' willingness to participate in the Medicaid program.

**Freedom of Choice Among Qualified Providers.** As described in Module 2, an individual who is eligible for Medicaid may obtain Medicaid services from any provider that is qualified and willing to furnish the services. The ability to waive this requirement is one of the principal reasons that states employ waivers. Module 5 includes a discussion of the checks and balances that states and the Centers for Medicare & Medicaid Services (CMS) use when states limit freedom of choice in a managed care system.

Many Americans want to be able to choose their provider. Affording a Medicaid consumer the ability to choose among all providers determined by the state to be qualified is considered an important component of quality and safety—the ability to, proverbially, “vote with one’s feet.” Thus, although the state is given flexibility within the confines of federal statute and regulation to determine provider qualifications and reimbursement rates, and although the state can be restrictive in setting these parameters, once the state establishes the qualifications the consumer is empowered with the ability to choose from among all providers that meet the state’s qualifications.

**Single State Agency.** The role of the single state agency in directing the state’s Medicaid policy includes the responsibility to establish and apply consistent requirements for becoming an eligible Medicaid provider. These requirements typically are codified in state law or rule.

Although many states have dedicated departments of behavioral health that are separate from the Medicaid agency, the Medicaid agency is ultimately responsible for the policy structures of the Medicaid program and interactions with CMS. The behavioral health and Medicaid departments may jointly file rules—or the behavioral health department may maintain administrative rules with greater policy detail—while the Medicaid department maintains a rule that “authorizes” the other department’s requirements. When

the Medicaid and behavioral health authorities are in the same department, any concerns about the ultimate authority for Medicaid purposes is lessened significantly.

**Efficiency, Economy, and Quality of Care While Assuring Access.** Although access to needed services is a primary consideration, it is not the only factor related to provider networks. States must maintain a balance between assuring access and providing quality services in an economical and efficient manner. For example, Medicaid agencies are not required to pay significantly more than the market rate for services simply to assure access. In fact, they are prohibited from doing so. The provider requirements and reimbursement rates the states set must consider efficiency and economy *as well as* quality. Often, states will utilize managed care authorities and waive freedom of choice of providers in order to have a smaller, more manageable, and more cost-effective network.

### **Is It a Service or a Provider?**

When states consider the design of their provider networks, it is helpful to understand at the outset whether the network is comprised of services or providers. The list of mandatory and optional *services* described in Module 2 is actually a combination of services and *types of providers*. Prescription drugs, dentures, family planning, and respiratory care, for example, are services. A federally qualified health center (FQHC), inpatient hospital, nurse midwife, rural health clinic, and nursing facility are specific types of providers of certain services. The difference between the two categories is illustrated by an example: although several types of providers may be qualified to provide family planning services, only a nursing facility can provide nursing facility services.

For those services that are not provided by a unique type of provider, the state has additional latitude to define the types of providers and requirements needed to provide the service. For example, a state may specify that physical therapy may only be provided through a clinic and not allow independently practicing physical therapists to become eligible providers of physical therapy services.

### **State-Specific Professional Practice Acts**

Professional practice acts are state laws and regulations that define the scope of practice for a particular provider type. They identify what constitutes the independent practice of a certain professional and what activities the professional can or cannot undertake. These requirements apply to providers regardless of the payer source. In other words, state professional practice acts establish practice requirements for providers regardless of whether they receive reimbursement from Medicaid or private insurance.

In addition, the specific licensing requirements, professional standards, and prohibited acts, etc. of professional practice acts often specify the type of oversight or supervision required in order to practice in that state. State laws vary considerably; for example, although all states define who may practice as a nurse or physician, not all will define or allow lay or non-nurse midwives to practice.

Supervision and delegation are important components of professional practice acts. For example, some states define how many physician assistants may be supervised by a single physician. The

requirements for supervision often address various levels within a professional group; a Master's or Ph.D. degree may be required to supervise an entry-level professional holding a bachelor's degree. Also, certain types of tasks may be delegated to another type of professional, with the primary responsibility for the patient's care remaining with the licensed professional. For example, in many state mental health or developmental disability systems, a registered nurse may delegate certain tasks to a trained aide while retaining patient responsibility and liability.

Medicaid regulations give considerable deference to state professional practice acts. In many areas of health care, it is clear what type of provider can perform certain services (e.g., surgery, prescribing medications). However, where a licensing category does not exist or does not fit for the purposes of providing a particular service *within the Medicaid program*, the state can define the requirements for background, training, level of education, etc. Through this process, the state can create its own type of paraprofessional provider solely for delivery of services within the Medicaid program. In reviewing state Medicaid State Plans, CMS pays particular attention to these unique types of providers and their associated requirements. This is particularly important in the behavioral health arena, as we consider rehabilitative services, peer support services, and other essential components of the behavioral health benefit package.

There is an additional distinction that is helpful in understanding how Medicaid approaches provider issues, especially related to non-institutional services. There are at least two layers of provider policy issues that should be considered, and there may be separate requirements addressing each.

**The Medicaid provider** is the provider agency or independent practitioner who has a direct relationship with the state. It has a signed Medicaid agreement with and is reimbursed directly by the state. The state specifies the requirements to be a Medicaid-eligible provider. The principles discussed above relate to defining who is an eligible provider for Medicaid purposes, and the associated principles of freedom of choice of providers apply to these Medicaid providers. The Medicaid provider may, in turn, employ or subcontract with clinicians or staff members who provide *hands on care* to the Medicaid consumer. These may be known as *rendering providers*.

**The rendering provider** is a clinician, therapist, program staff, or paraprofessional who provides hands-on care to the Medicaid consumer. The rendering provider may also be the Medicaid provider, as in the case of an independent therapist who is self-employed. Depending on the type of Medicaid service and whether a professional practice act applies, a state may have very specific Medicaid requirements associated with who is eligible to provide hands-on care. If this is the case, such requirements must be followed in order for the service to be properly provided and reimbursed.

## ***Providers of Behavioral Health Services***

Many types of providers serve individuals with behavioral health needs. As discussed, behavioral health services are often delivered by a counselor, social worker, physician, psychologist, or community support paraprofessional in an office, outpatient clinic, or community setting. State Medicaid programs frequently cover other provider types that give behavioral health care, such as primary care physicians, clinics, FQHCs, psychiatric residential treatment facilities (PRTFs), and special institutions of mental diseases, as described below. States' administrative rules

and/or statutes typically specify the provider types—including required licensure or certification—that are permitted to provide behavioral health services. A provider can determine if he or she can participate in its state Medicaid program as a provider of behavioral health services by assessing the services for which the state’s Medicaid program provides reimbursement, to which populations, and by what types of providers.

## **Community Mental Health Centers**

The Mental Retardation Facilities and Community Mental Health Centers Construction Act was signed into law in October of 1963 only nine months after President John F. Kennedy proposed in a major public address a national mental health program. The Act provided an alternative to institutionalization for those with serious mental illness (SMI). It “drastically altered the delivery of mental health services and inspired a new era of optimism in mental health care. This law led to the establishment of more than 750 comprehensive community mental health centers (CMHCs) throughout the country.”<sup>1</sup>

Along with pharmacologic advances, growing evidence about the efficacy of community-based treatments, and changes in underlying beliefs and attitudes about mental illness, the CMHCs became an important vehicle for change. Rather than a singularly-focused medical approach to caring for those with mental illness, the CMHCs developed an array of medical, social, educational and rehabilitative supports and services designed to address the practical needs of individuals who were being discharged from state psychiatric hospitals.

Although there is no standard definition of what constitutes a CMHC, what made them unique was the comprehensive scope of their services, their provision of services for individuals who were indigent and to individuals with SMIs or children with SEDs, and their distinctive involvement in their community and neighborhood. These agencies have remained the backbone of community mental health services in the United States, providing a comprehensive array of community support services as well as embracing the need for coordinated care and addiction treatment services.

Over time, the CMHCs have adapted to the changing service and reimbursement environment by providing services to those with commercial insurance, Medicare, and, particularly, Medicaid. Unlike FQHCs—discussed more fully below—community mental health centers are subject to the varied requirements of state Medicaid programs and have no consistent federal requirements. Some state regulatory frameworks acknowledge comprehensive providers as a unique subset of providers, and some receive special funding. For example, Minnesota indicates that covered Medicaid services include “community mental health center services” and identifies a minimum set of services that must be available.<sup>2</sup> Other states require service-specific regulations without regard to the type of provider entity.

There have been efforts in Congress to create a statutory definition of *federally qualified behavioral health centers*. Doing so would establish a federal status for community mental health and addiction providers—similar to the status for FQHCs—and would make them subject to federal requirements while also opening up the potential for federal grant funding and alternative payment methodologies under Medicare and Medicaid.

## **Federally Qualified Health Centers**

FQHCs are community-based and consumer-governed organizations that serve populations with limited access to health care. There are three types of FQHCs:

1. Health Center grantees are grant-supported FQHCs that are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Program (respectively, Sections 1861(aa)(4) and 1905(1)(2)(B) of the Social Security Act) and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). Some health center grantees receive specific funding to focus on certain special populations:
  - Migrant and seasonal farmworkers
  - Individuals and families experiencing homelessness
  - Residents of public housing.
2. FQHC Look-Alikes are non-grant supported health centers that have been identified by the Health Resources and Services Administration (HRSA) as meeting the definition of a health center under §330 of the Public Health Service (PHS) Act, but they do not receive grant funding under §330 of the Act.
3. Outpatient health programs or facilities operated by tribal organizations (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

Most FQHCs are specifically described in §330 of the Federal PHS Act. Many health centers receive Section 330 grant funds and have a unique, direct relationship with the HRSA of HHS. But FQHC Look-Alikes, tribal groups, or Urban Indian Health Organizations are FQHCs that do not receive 330 grant funding. These Section 330 FQHCs:

- Are located in or serve a high-need community
- Are governed by a community board, a majority (51 percent or more) of whose members are health center patients who represent the population served
- Provide comprehensive primary, preventive, and enabling health care services as well as supportive services (e.g., education, language translation, transportation) that promote access to health care
- Provide services to all individuals, whether insured or not, with fees adjusted based on the person's ability to pay
- Meet other performance and accountability requirements.<sup>3</sup>

States are *required* by §1905(a) of the Social Security Act to provide FQHC services in the Medicaid program, and FQHCs are eligible for a distinct payment system under both Medicare and Medicaid. In 2009, FQHCs served almost 7.8 million Medicaid patients.<sup>4</sup> The Affordable Care Act included a significant increase in funding for new and expanded health centers in anticipation of an expanded need for services.

Health centers are required to provide primary health services with an identified team of health professionals.<sup>5</sup> *Required primary health services* include those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians and, where appropriate, physician assistants, nurse practitioners, and nurse midwives.<sup>6</sup> In addition to health

services provided by physicians and physician extenders, health centers must provide in their package of required primary health services referrals to providers of “other health-related services, including substance use disorder and mental health services.”<sup>7</sup> The referral requirement is a minimum and does not preclude a health center from directly providing behavioral health services. Therefore, although FQHCs may not *target* individuals with serious and persistent mental illness (SPMI) or serious addictions, anyone receiving services at the FQHC is eligible to have his or her behavioral health needs addressed—even if it is not onsite but provided on referral. Those with SPMI or serious addictions are disproportionately represented in the health centers targeting homeless individuals or targeting those in public housing.

Health centers, at their discretion, also may provide *additional health services* “appropriate to meet the health needs of the population served by the health center.”<sup>8</sup> These may include behavioral, mental health, and substance use disorder (SUD) services.<sup>9</sup>

A health center that receives grant funding to serve homeless populations is required by statute to provide—either with staff or under contract with outside specialty providers—SUD services (including detoxification, risk reduction, outpatient treatment, and rehabilitation for substance use provided in settings other than hospitals).<sup>10</sup>

FQHCs are important providers of behavioral health services because: (1) they serve as safety net providers to individuals who might not otherwise have access to care, and (2) they are largely committed to integrating behavioral and physical health care. According to a survey conducted by the National Association of Community Health Centers (NACHC)—

Mental health services are provided by over 70 percent of FQHCs, and SUD services are provided by 55 percent of the health centers that responded to the NACHC survey. Almost 65 percent of FQHCs that responded meet all of the components of integrated care. That is, services are co-located on site; they have good communication and coordination among behavioral health and primary care providers; they share behavioral health treatment plans, problem lists, medication and laboratory results; and behavioral health and medical providers make joint decisions on patient treatment. Only 10 percent of the FQHCs that responded do *not* routinely screen for depression. FQHCs are utilizing evidence-based tools for screening for M/SUD.<sup>11</sup>

The Substance Abuse and Mental Health Services Administration (SAMHSA) has historically worked and continues to work with HRSA to increase and improve delivery of behavioral health services in FQHCs and to more fully integrate behavioral and physical health services.

### **Psychiatric Residential Treatment Facilities**

The Social Security Act was amended in 1972 to allow states the option of covering inpatient psychiatric hospital services for individuals younger than age 21 (the *psych under 21 benefit*). Originally, the statute required that inpatient psychiatric hospital services for individuals younger than age 21 be provided exclusively by psychiatric hospitals that were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). However, the Omnibus Budget Reconciliation Act of 1990 (OBRA ‘90) specified that states can provide inpatient psychiatric services for this population in psychiatric hospitals *or* in another inpatient setting that

the Secretary of HHS has specified in regulations. OBRA '90 authorized CMS to specify inpatient settings *in addition to* the traditional psychiatric hospital setting for the *psych under 21 benefit* without continuing to require that providers obtain JCAHO accreditation. Thus, CMS established the PRTF as a new type of setting where inpatient psychiatric hospital services for individuals younger than age 21 can be provided.<sup>12</sup>

The major benefit of a PRTF is that an individual can receive inpatient psychiatric care in a nonhospital setting and reimbursement rates can include room, board, and expenses. PRTFs are secured facilities that provide a structured, therapeutic environment for children and youth younger than 21 years who need intensive services to effectively treat severe behavioral and/or developmental disturbances. Most individuals are referred following the receipt of outpatient treatment or stabilization in an acute care setting. The goal is to provide a specialized, therapeutic treatment setting so that individuals can improve their functioning and transition to a less-restrictive community placement or, when possible, to a family setting.

PRTFs must comply with many federal regulations, but states are also given significant flexibility in designing policies in areas including daily rate, services provided, licensing, and admissions certification.

**Daily Rate and Services:** Medicaid funding for the PRTF benefit is called the *daily rate*. The services that states provide as part of the PRTF benefit vary, as do the daily rates at which the services are reimbursed, as shown in Table 4-1. For example, as of 2008:

**Table 4-1 PRTF Benefit Services Provided, By State and Daily Rate**

State	Daily Rate	Services Provided
Iowa	\$165.53	Rate covers all room, board, and services with the exception of medical expenses such as prescriptions, physician fees, and hospitalization.
Indiana	\$322.00	Medicaid reimbursement excludes pharmaceutical supplies and physician services.
Kentucky	\$230.00	Rate covers total facility costs for PRTF services, excluding the cost of drugs.
Mississippi	from \$425 to \$564	Mississippi's Division of Medicaid is responsible for determining what services are included.
Nebraska	from \$235.98 to \$295.28	These rates are all inclusive, although medication is excluded.
Oklahoma	vary between \$190.97 and \$413.49	Rates vary depending on the type of treatment.
Oregon	vary between \$270 and \$640	Rates vary depending on the type of treatment.

**Licensing:** States may establish licensing requirements in addition to those established by federal law. In addition to accreditation by the JCAHO, some states include accreditation from the Commission on Accreditation of Rehabilitation Facilities or the Council on Accreditation.

**Admissions Certification:** For Medicaid purposes, patients entering a PRTF must be certified by the state as meeting specific criteria for admission and additional criteria for continued stay.<sup>13</sup>

Fewer than half of states have PRTFs; states that have PRTFs may call them something else (e.g., Psychiatric Medical Institutions for Children in Iowa). Absent a definitive list from CMS, the best available information indicates that the following states have PRTFs: Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Mississippi, Montana, Nebraska, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, South Dakota, and Wyoming.<sup>14</sup>

### **Institutions for Mental Diseases**

*Mental diseases* include all diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Edition 4, Text Revision (DSM-IV-TR), including those for substance use and addiction. Section 1905(a) of the Social Security Act prohibits the federal government from reimbursing states under the Medicaid program for services rendered to a Medicaid beneficiary who is a patient in an institution for mental disease (IMD).<sup>15</sup> This prohibition, known as the *IMD exclusion*, does not mean that an individual in an IMD cannot receive treatment; it means that federal Medicaid reimbursement is not available for those services or any other Medicaid-funded services rendered to a patient in an IMD.

It is generally understood that this exclusion was developed so that Medicaid would not pay for care in the large state psychiatric hospitals that existed in the 1960s when the Medicaid program was implemented; state hospital care should remain the responsibility of states. These state psychiatric hospitals are largely closed or significantly downsized; however, the IMD payment exclusion remains as a barrier to Medicaid reimbursement for acute behavioral health services.

An IMD is a *hospital, nursing facility, or other institution* that is primarily engaged in providing diagnosis, treatment, or care for persons with mental or substance use disorders, including medical attention, nursing care, and related services.<sup>16</sup> The *IMD exclusion* does not apply to inpatient treatment for mental illnesses in facilities that are part of larger medical entities not primarily engaged in the treatment of mental illnesses. Identification of IMDs is fact specific but includes tests to determine if 51 percent or more of the patient population was admitted for treatment of a mental illness, whether the primary mission of the facility is to treat mental illnesses, and whether the staff of the facility is primarily in professions that treat mental illnesses. Some facilities are excluded from the definition of an IMD because they are primarily engaged in treating those with physical illnesses with staff trained in treating physical illnesses. Assume that a general hospital has a psychiatric unit; if treatment of psychiatric conditions is not the primary business of the general hospital and 51 percent or more of the patient population was not admitted for treatment of a mental illness, this psychiatric unit can receive Medicaid payments for inpatient behavioral health treatment. The determination of when a portion of an institution is sufficiently distinct in character and operation to be classified as an IMD requires a fact-specific analysis; therefore, disputes over classification may not be uncommon.<sup>17</sup>

There are four limitations to the IMD exclusion:

1. It does not apply to adults aged 65 years and older residing in a Medicare-certified hospital or nursing facility.
2. It does not apply to individuals younger than age 21 or, in certain circumstances, younger than age 22 receiving services under the inpatient psychiatric services for individuals under age 21 benefit (subject to the limitation on Federal financial participation [FFP] for other, non-IMD services discussed below).
3. It does not apply to institutions with 16 or fewer beds.
4. It does not apply to partial hospitalization and day-treatment programs that do not *institutionalize* their patients.<sup>17</sup>

The *psych under 21 benefit* allows individuals younger than age 21 to receive inpatient psychiatric services in three settings: psychiatric hospitals, psychiatric units in general hospitals, and PRTFs. FFP is available only for the inpatient psychiatric services that are provided to children and youths in these facilities who are enrolled in Medicaid; FFP is not available for any other health services that the beneficiary may need until unconditionally discharged from the IMD. For example, temporary discharge to treat medical or dental needs is not considered unconditional discharge; therefore, Medicaid will not pay for this medical treatment.<sup>14</sup>

The IMD exclusion is instructive, as it illustrates the disconnect between policies related to individuals with severe mental illnesses compared to other persons who rely upon Medicaid:

- Adults with severe mental illness are severely limited in their ability to receive inpatient care that is reimbursed for their disease, whereas other individuals can receive inpatient care for their chronic health condition. For youths younger than age 21, states *must* provide inpatient psychiatric care under EPSDT, and states have the *option* of providing inpatient psychiatric care to adults older than age 64.
- Nursing home care is available to seniors and individuals with disabilities, as long as they are not primarily disabled by severe mental illness.
- Medicaid covers residential treatment for adults with developmental disabilities.

The President's New Freedom Commission on Mental Health, appointed by President George W. Bush, addressed the IMD issue along with many others. Specifically, the Commission recommended that CMS explore Medicaid reform efforts to address the IMD exclusion, including using HCBS as an alternative to IMDs; redefine IMDs and the services funded; and use self-directed services and supports for people with mental illnesses.<sup>18</sup>

Additionally, adherence to the law has proved cumbersome for states. The problems that states face are described in a policy brief published by the National Association for Children's Behavioral Health (quote):

As noted, CMS relies upon states to self-identify which of their licensed facilities are IMDs and to comply with the IMD exclusion and exception. The CMS State Medicaid Manual gives vague, subjective and even inaccurate guidance to identify IMDs, 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 for which states may then claim FFP.

The manual's 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 that 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 percent of the residents of the facility "require specialized treatment of serious mental illness." 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* [emphasis added]. The need for a person to be in a particular 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.<sup>14</sup>

### **The Medicaid Emergency Psychiatric Demonstration**

Section 2707 of the Affordable Care Act created the Medicaid Emergency Psychiatric Demonstration, a 3-year demonstration that allows participating states to provide payment to certain nongovernment psychiatric hospitals for inpatient emergency psychiatric care. The target population is Medicaid recipients aged 21 to 64 years who have expressed suicidal or homicidal thoughts or gestures and are determined to be dangerous to themselves or others. The federal government will contribute its regular FFP for these services. The purpose of the demonstration is to determine whether coverage of certain emergency services provided in nongovernment inpatient psychiatric hospitals improves access to—and quality of—medically necessary care, discharge planning by participating hospitals, and Medicaid costs and utilization.<sup>19</sup>

The demonstration provides \$75 million over 3 years to 11 states and the District of Columbia. Each state selects which private psychiatric hospitals with 17 or more beds will participate in the demonstration. States will contact the hospitals they wish to include in the demonstration and make arrangements to provide Medicaid payment for emergency psychiatric admissions under the demonstration. The Center for Medicare & Medicaid Innovation (CMMI) estimates that, based on state applications, 26 IMDs among the 11 states and the District of Columbia will participate. Participating states will submit a quarterly statement to CMS enumerating all inpatients receiving services under the demonstration. CMS will provide federal matching funds for Medicaid payments made by participating IMDs for the services they provided to beneficiaries aged 21 to 64 years.<sup>19</sup>

## **Institutions for Mental Diseases and Substance Use Disorder Services**

In evaluating IMDs with regard to SUD services, CMS guidance indicates that there is a continuum of care for chemical dependency. At one end of the spectrum, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. Services like this are considered medical treatment of a mental disease, and patients admitted for such treatment are considered as mentally ill. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.<sup>20</sup>

At the other end of the spectrum are facilities that provide services based on peer counseling models and meetings to promote group support and encouragement, such as Alcoholics Anonymous. These programs primarily use laypersons and recovering peers as counselors. Lay counseling does not constitute medical or remedial treatment. In these settings, consumers receiving lay counseling or peer recovery services are not considered mentally ill for purposes of determining whether a facility is an IMD. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD.<sup>20</sup>

## **Institutions for Mental Diseases and Managed Care**

In a 2003 Special Report, SAMHSA identified a number of ways in which Medicaid managed care may play a role in allowable Medicaid reimbursement for services provided to residents of IMDs. Specifically, SAMHSA identified three ways in which states can use managed care programs to pay for IMD services.

1. **States can pay for IMD services with savings generated from Medicaid managed care programs.** As explained in Module 5, states can use §1915(b) authority to create a managed care program. Four subsections of §1915(b) allow states to structure their programs in a variety of ways. Section 1915(b)(3) offers states the opportunity to provide additional services to waiver enrollees that are paid through savings achieved under the waiver. If a state uses the §1915(b)(3) authority, the managed care program must be cost effective and must demonstrate that it will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services.

According to the SAMHSA Special Report, a §1915(b)(3) waiver does not grant “IMD expenditure authority,” meaning it does not give states the authority to reimburse IMDs directly for inpatient services provided to adults. However, because states are allowed to use any savings generated from the §1915(b)(3) managed care program to provide additional services to waiver enrollees, states technically can use the savings to pay for inpatient services provided to adults in IMDs.<sup>21</sup>

2. **IMD services may be provided by a managed care plan or behavioral health organization (BHO) that contracts with the state’s Medicaid program.** A BHO is an organization that manages the behavioral health of Medicaid consumers; it is a specialty managed care organization. In some states, psychiatric inpatient services may be included in the managed care arrangement, and managed by a BHO or other managed care plan. In some states with these arrangements, the state requires the

inclusion of the state psychiatric hospital in the provider network. Whether mandatory or voluntary, the Medicaid managed care plan may purchase services from an IMD.<sup>21</sup>

3. **The states can obtain IMD expenditure authority through a §1115 Medicaid waiver.** As discussed in Module 5, §1115 waivers offer states significant flexibility in designing their managed care programs. Some states have sought and received CMS approval to incorporate IMD services into their Medicaid managed care programs by obtaining IMD expenditure authority. According to SAMHSA's 2003 Special Report, CMS indicated at the time the report was published that as §1115 waivers with IMD expenditure authority expire, the authority would not be reapproved.<sup>21</sup> CMS continues to receive requests to grant §1115 expenditure authority for services provided to individuals residing in an IMD. These requests are heavily scrutinized to determine the potential for evaluating health reform initiatives.

## **Medication-Assisted Treatment Providers**

Specific to SUDs, providers of Medication-Assisted Treatment (MAT) provide treatment that includes a pharmacologic intervention as part of a comprehensive substance use treatment plan with an ultimate goal of patient recovery with full social function. In the United States, a variety of Food and Drug Administration approved drugs have been proven effective in the treatment of alcohol dependence, including disulfiram, naltrexone, and acamprosate; similarly, opioid dependence has been treated successfully with methadone, naltrexone, and buprenorphine<sup>22</sup>.

---

<sup>1</sup> National Council for Community Behavioral Healthcare. *About Us: History*. Retrieved July 9, 2013 from <http://www.thenationalcouncil.org/cs/history>.

<sup>2</sup> 2011 Minnesota Statutes. 256B.0625 *Covered Services*. Retrieved July 9, 2013 from <https://www.revisor.mn.gov/statutes/?id=256B.0625&year=2011>.

<sup>3</sup> U.S. Department of Health and Human Services. *Health Services and Resources Administration. Primary Care: The Health Center Program. What is a health center?* Retrieved July 9, 2013 from <http://www.bphc.hrsa.gov/about/>.

<sup>4</sup> National Association of Community Health Centers. (July 11, 2011.) *Letter to the Centers for Medicare & Medicaid Services RE: Request for Information Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare*. [PDF version.] Retrieved July 9, 2013 from <http://www.nachc.com/client/documents/7%202011%20NACHC%20Comment%20on%20MC%20MCD%20aligning%20duals.pdf>.

<sup>5</sup> 42 USC 254b(a)(1)(A). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

<sup>6</sup> 42 USC 254b(b)(1). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

<sup>7</sup> 42 USC 254b(b)(1)(A)(ii). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

<sup>8</sup> 42 USC 254b(b)(2). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

<sup>9</sup> 42 USC 254b(b)(2)(A). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

<sup>10</sup> 42 USC 254b(h)(2) and (h)(5)(C). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

<sup>11</sup> National Association of Community Health Centers. (January 2011.) *NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers. Clinical Division*. [PDF version.] Report retrieved July 9, 2013 from [http://www.nachc.com/client/NACHC%202010%20Assessment%20of%20Behavioral%20Health%20Services%20in%20FQHCs\\_1\\_14\\_11\\_FINAL.pdf](http://www.nachc.com/client/NACHC%202010%20Assessment%20of%20Behavioral%20Health%20Services%20in%20FQHCs_1_14_11_FINAL.pdf).

- 
- <sup>12</sup> CMS.gov. *Psychiatric Residential Treatment Facility Providers*. Retrieved July 9, 2013 from <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/PRTFs.html>.
- <sup>13</sup> Psychiatric Residential Treatment Facilities. (2008.) *Iowa Policy Research Organization*. Retrieved July 9, 2013 from <http://www.docstoc.com/docs/2986536/Psychiatric-Residential-Treatment-Facilities-This-IPRO-report-compares-Psychiatric-Residential>.
- <sup>14</sup> National Association for Children's Behavioral Health. *Rationale for Eliminating the IMD Exclusion for Beneficiaries Under Age 21*. Retrieved July 9, 2013 from [http://www.nacbh.org/PubDocs/IMD\\_Exclusion\\_for\\_Under-21\\_080112.pdf](http://www.nacbh.org/PubDocs/IMD_Exclusion_for_Under-21_080112.pdf).
- <sup>15</sup> Social Security Act §1905. Retrieved July 9, 2013 from [http://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm).
- <sup>16</sup> Social Security Act §1905(i). Retrieved July 9, 2013 from [http://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm).
- <sup>17</sup> Rosenbaum S, Teitelbaum J, and D. Richard Mauery. (December 19, 2002.) *An Analysis of the Medicaid IMD Exclusion*. [PDF version.] Retrieved July 9, 2013 from [http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/behavioral\\_health/reports/IMD%20Report%201202.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/behavioral_health/reports/IMD%20Report%201202.pdf).
- <sup>18</sup> The President's New Freedom Commission on Mental Health. Delivered to the President on July 22, 2003. Retrieved July 9, 2013 from <http://www.nami.org/Template.cfm?Section=Policy&Template=/ContentManagement/ContentDisplay.cfm&ContentID=16699>.
- <sup>19</sup> Medicaid Emergency Psychiatric Demonstration. (Publication date not provided). *Demonstration Design and Solicitation*. [PDF version.] Retrieved July 9, 2013 from [http://www.innovations.cms.gov/Files/x/MedicaidEmerPsy\\_solicitation.pdf](http://www.innovations.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf).
- <sup>20</sup> Medicaid Manual. Attachment Three. *Requirements and Limits Applicable to Specific Services. 4390. Institutions for Mental Diseases*. [PDF version.] Retrieved July 9, 2013 from [http://www.dmh.ca.gov/DMHDocs/docs/letters10/10-02\\_Enclosure3.pdf](http://www.dmh.ca.gov/DMHDocs/docs/letters10/10-02_Enclosure3.pdf).
- <sup>21</sup> Medicaid Financing of State and County Psychiatric Hospitals. (2003.) *Special Report. U. S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Mental Health Services*. [PDF version.] Retrieved July 9, 2013 from <http://www.ime.state.ia.us/docs/MedicaidFinancingofGovernmentHospitals-SAMHSA.pdf>.
- <sup>22</sup> Substance Abuse and Mental Health Services Administration. *Medication-Assisted Treatment for Substance Use Disorders. Pharmacotherapy for Substance Use Disorders*. Retrieved July 9, 2013 from <http://www.dpt.samhsa.gov/medications/medsindex.aspx>.

*This page intentionally left blank*

## **Appendix A: Authors and Reviewers**

### ***Authors***

#### **Vorys Health Care Advisors**

Maureen M. Corcoran, M.S.N, M.B.A

Daphne Kackloudis Saneholtz, J.D.

#### **Truven Health Analytics**

John Easterday, Ph.D.

Rosanna Coffey, Ph.D.

Linda Lee, Ph.D.

Anika Hines, Ph.D.

Katharine Levit

Susan Raetzman, M.S.P.H.

### ***Reviewers***

#### **Substance Abuse and Mental Health Services Administration**

Kevin Malone

Juli Harkins

Rita Vandivort-Warren, M.S.W.

Allison Colker

#### **Centers for Medicare & Medicaid Services**

John O'Brien, M.A.

*This page intentionally left blank*



SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities

HHS Publication No. SMA-13-4773  
Printed 2013