



Changes for Institutions for Mental Disease (IMDs) Effective July 1, 2013

March 21, 2013



Institutions for Mental Disease (IMDs)

- Federal Medicaid term
- Freestanding facility with more than 16 beds that provides inpatient psychiatric services
- Used to be primarily state hospitals; now IMDs are primarily private psychiatric residential treatment facilities (PRTFs)



Federal Reimbursement for IMDs

- Social Security Act excludes from the definition of “medical assistance” any payment for services to an individual who is under age 65 and in an IMD
 - The federal government did not want to assume the costs for residents already being served in state mental health facilities
- Except for “inpatient psychiatric services for individuals under age 21”



Federal Reimbursement, cont'd.

- Centers for Medicare and Medicaid Services (CMS) Interpretation (supported by the court)
 - Only allowable services for children under age 21 in an IMD are inpatient psychiatric services
- No coverage for adults 21-64 residing in an IMD



IMDs in Virginia

- State Freestanding Psychiatric Hospitals
 - Serving geriatric population-Catawba and Piedmont (eligible for normal reimbursement)
 - Serving adults (not eligible for Medicaid reimbursement)
 - Serving children-Commonwealth Center for Youth and Adolescents, Southwestern Virginia Mental Health Institute



IMDs in Virginia

- Private Freestanding Psychiatric Hospitals (for example, Poplar Springs, Dominion Hospital, Virginia Beach Psychiatric Center, Riverside Behavioral Health Center)
- Psychiatric Residential Treatment Facilities (PRTFs) or Level C Residential Treatment Centers (RTCs) serving children



Why Are Changes Necessary?

- US Department of Health and Human Services Office of Inspector General (OIG) audit report on March 17, 2004 concluded that DMAS owed CMS \$3.9 million for disallowed claims (mostly physician and pharmacy claims) for services furnished to children who resided in IMDs between July 1, 1997 through June 30, 2001
- These services were not included in the rates for the IMD but were billed and paid separately to other providers
- The OIG also made a number of recommendations
- Based on the OIG report, CMS issued a disallowance on February 29, 2008



OIG Audit Recommendations

- Implement controls to prevent federal funds from being claimed for non-inpatient psychiatric services furnished to IMD residents under the age of 21
- Issue guidance to providers to not submit separate medical claims for providers under the age of 21
- Establish procedures to identify all Medicaid recipients under the age of 21 who are admitted to an IMD
- Identify and refund any improperly claimed federal funds after the OIG audit period



Available Options in 2008

- Not pay for non-facility services furnished Medicaid members under age 21 residing in an freestanding psychiatric hospital or Level C Residential Treatment Center
- Increase per diem rates for freestanding psychiatric hospitals or Level C Residential Treatment Centers and require them to assume the financial risk to furnish some or all services needed by the resident
- Appeal



DMAS Appeals

DMAS appealed the CMS disallowance but each appeal was denied:

- Unfavorable decision by USHHS Departmental Appeals Board (DAB), December 31, 2008 (similar decision for New York and Kansas)
- Unfavorable decision by US District Court, April 28, 2011 (similar decision for Kansas)
- Unfavorable decision by US Court of Appeals for both Virginia and Kansas May 8, 2012



Potential Financial Liability

- Original \$3.9 million audit finding (already taken from DMAS)
- DMAS estimates a post-audit liability of \$31.4 million through FY12 (extrapolating audit results)
- DMAS estimates additional annual liability of \$3-\$4 million if no changes are made
- DMAS decided not to recover funds (federal and state) from physicians, pharmacies and other providers who furnished services to individuals in an IMD



Recent CMS Guidance

CMS Informational Bulletin published
November 28, 2012

- The inpatient psychiatric facility benefit is defined to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs



CMS Guidance, cont'd.

- To comply with the requirements that services be “provided by” a qualified psychiatric facility, the facility
 - Must arrange for and oversee the provision of all services, including services furnished through contracted providers;
 - Must maintain all medical records of care furnished to the individual; and
 - Must ensure that all services are furnished under the direction of a physician
- If the above requirements are met, states may directly reimburse individual practitioners or suppliers of services as “inpatient psychiatric services”



DMAS Goals

- Minimize changes to the way services are furnished to Medicaid members in freestanding psychiatric hospitals and Level C Residential Treatment Centers
- Minimize financial risk for freestanding psychiatric hospitals and Level C Residential Treatment Centers for non-psychiatric services



DMAS Goals, cont'd.

- Minimize reimbursement changes for freestanding psychiatric hospitals and Level C Residential Treatment Centers and providers of services to children in these facilities
- Ensure that the federal government continues to share in the funding for services furnished Medicaid members in freestanding psychiatric hospitals and Level C Residential Treatment Centers



No Rate Changes

- There will be no change to the per diem rates paid freestanding psychiatric hospitals (either private or state) or Level C Residential Treatment Centers
- There will be no change to the rates paid to non-facility providers of services (physicians, pharmacies, etc.)



Proposed Facility Changes

- Track Medicaid members under age 21 who are in an freestanding psychiatric hospital (either private or state) or Level C Residential Treatment Center (whether DMAS is billed for facility services or not)
 - For RTCs and private freestanding psychiatric hospitals, this information will be tracked by KePRO as part of the authorization process for Medicaid covered facility services
 - New process will be developed for CSA covered facility services
 - New process will be developed for state mental hospitals



Proposed Facility Changes, cont'd.

- Enforce the requirement that plans of care for members in an IMD to be comprehensive covering medical, psychological, social, behavioral and developmental needs (including emergency services)
 - Comprehensive individual plan of care already required for Level C Residential Treatment Centers (12 VAC 30-130-890)



Proposed Facility Changes, cont'd.

- Require the freestanding psychiatric hospital (either private or state) or Level C Residential Treatment Center to be responsible for “arranging” and “overseeing” all services in the comprehensive individual plan of care, including services that are not included in the facility per diem



Proposed Facility Changes, cont'd.

- Require the freestanding psychiatric hospital (either private or state) or Level C Residential Treatment Center to contract with non-facility providers to furnish services in the plan of care that are not-included in the facility per diem



Proposed Non-Facility Provider Changes

- Requirements for separate billing by non-facility providers
 - The facility must make a documented referral to contracted non-facility providers for services in the plan of care that are not included in the facility per diem
 - The non-facility provider must include the facility NPI in the referring provider field on the claim



Proposed Non-Facility Provider Changes

- Claims for non-facility providers for Medicaid members under age 21 in a freestanding psychiatric hospital (private or state) or Level C Residential Treatment Center will be denied (or recovered) if they don't have the NPI of the referring facility on the claim



Proposed Non-Facility Provider Changes

- Claims for non-facility providers who are employees of the freestanding psychiatric hospital, Level C Residential Treatment Center, or State Mental Hospital with the same tax ID number as the facility will be denied (or recovered)
- Group practices may reorganize so that they have their own tax ID number (providers may have to contact the Provider Enrollment Unit to reenroll)

Services Eligible for Separate Billing

Preliminary List

- Physician and other practitioners
- Pharmacy (except in private or state freestanding psychiatric hospitals)
- Physical Therapy, Occupational Therapy and Speech Language Pathology
- Laboratory and X-ray
- DME (except in private or state freestanding psychiatric hospitals)
- Vision
- Dental
- Transportation
- Emergency Services



Steps Taken to Date

- The General Assembly adopted budget item 307.CCC authorizing DMAS to make changes as soon as feasible
- Target implementation date July 1, 2013
- Regulations are being drafted as well as manual changes
- There will be additional communication to providers through a Medicaid Memo along with further provider training later this Spring



Contact Information

Please provide feedback by sending an email to the address below :

CMHRS@dmas.virginia.gov

Comments will be compiled and posted in an FAQ document