CMS Allows State Payment For Inpatient Psychiatric, Substance Use Services

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CMS is loosening up restrictions on Medicaid reimbursement for institutional-based mental health and substance abuse services by allowing states to make a capitation payment for enrollees with a short-term stay in an institution for mental disease (IMD) in its massive Medicaid managed care final regulation released on Monday (April 25). Key House lawmakers, state Medicaid directors and some mental health advocates praised the move, but other stakeholders raised concerns it could open the door to institutionalized mental health care.

The final rule says states may make a capitation payment for enrollees with a short-term stay, no more than 15 days, in an Institution for Mental Disease (IMD) to address access problems for inpatient psychiatric and substance use disorder services. The provision will be implemented 60 days after the rule is published.

“[I]n response to comments herein on this provision, we maintain that the recognition of a managed care plan’s ability to cover short term inpatient stays of no more than 15 days in an IMD as an alternative setting in lieu of settings for inpatient services covered under the state plan serves an integral role in ensuring access to mental health and substance use disorder services in those states with
otherwise limited inpatient bed capacity,” CMS said.

Currently, a Medicaid provision called the “IMD exclusion” prohibits Medicaid from reimbursing institutions for mental disease (IMDs) with more than 16 beds for services provided to beneficiaries who are 21 to 64 years old. The policy applies to psychiatric and substance-abuse facilities. It has been part of Medicaid since the program's inception in 1965 and was designed to de-institutionalize mental health care, but many believe it is outdated and that more beds are needed for emergency psychiatric services.

Paul Gionfriddo, president of Mental Health America, said the provision in the final rule is a positive step forward. He said it is a low-cost way to appease both advocates who want to repeal the exclusion, or at least increase the number of beds allowed for inpatient care, and those who are fervently opposed to repealing the requirement.

Some stakeholders had urged CMS to fully repeal the IMD exclusion, but the agency responded that only Congress has the authority to do so.

Congress has been looking into fully repealing the exclusion but such a move would result in a sharp increase in Medicaid spending. Gionfriddo previously said it is possible to clear the financial hurdle by dealing with the exclusion in pieces, such as by increasing beds for substance-use treatment separately from mental health treatment. House Energy & Commerce Chairman Fred Upton (R-MI) said, “While we’re still evaluating the totality of CMS’ 1400 page Medicaid ‘mega-reg,’ it is welcome news to see restrictions eased on federal reimbursements for care in certain settings. This commonsense change will have an
important impact on families focused on getting their loved ones the care they need, and that’s good news. We still have work to do to bring this Great Society program into the 21st century, but this modernization of policy represents a real win when it comes to providing care for the mentally ill.”

E&C oversight & investigations Chairman Tim Murphy (R-PA) called for similar action in his legislation, H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015. Upton said he is encouraged about the legislative work ahead based on CMS' targeted improvement. “Kudos to Chairman Murphy for bringing attention to this vital issue, and for being such a passionate voice for those in need of care. Our work continues, and make no mistake, as evidenced by these latest change by CMS, we are headed in the right direction and gaining momentum to deliver real reform.”

The Senate Finance Committee will discuss mental health issues on Thursday (April 28). Sen. Susan Collins (R-ME) said she plans to offer an amendment to the committee's comprehensive mental health reform bill that would repeal the IMD exclusion. Since her amendment falls under the jurisdiction of the Finance Committee, she said she would like to work with the Finance chairman and others on changes to the IMD exclusion as the bill moves to the Senate floor.

Ipsita Smolinski, managing director of Capitol Street, noted Senate health committee ranking Democrat Patty Murray (WA) said at a recent hearing that there is bipartisan support for revisiting the IMD exclusion and that legislative work on mental health issues will continue as the bill moves to the floor.
A Senate aide said the provision in CMS' rule is a big step forward towards the IMD exclusion. “The administration took a big step on the IMD exclusion yesterday. However, there is still a lot of congressional interest in addressing the broader implications of the IMD exclusion,” the Senate aide said.

But the National Disability Rights Network spoke out against CMS' proposal to allow states to pay capitation payments to plans for months in which enrollees have a short stay in an IMD, laying out their concerns in comments on the proposed rule. NDRN said the wording of the proposed regulation would allow a stay for longer than 15 days. As an example, the organization said if an enrollee received crisis services at an IMD on Sept. 16th, the plan would have a financial incentive to have that person stay in the state hospital until mid-October, because the facility would be eligible to get the monthly capitation payment for September and October as long as the stay ended on Oct. 14.

Andrew Sperling, director of federal affairs at the National Alliance on Mental Illness, said this concern is unfounded because the health plan is taking on risk under a capitated contract so they are constantly watching the bottom line. NDRN also opposes the provision because the group believes it could lead to re-institutionalization of care.

The organization points out CMS and the courts have been pushing states to move away from institutional care. CMS responded to this concern in the final rule by saying it agrees beneficiaries are best served in the community, but some people may need more intensive services such as acute inpatient psychiatric care offered in general hospitals.
and inpatient psychiatric hospitals

“We take seriously our commitment to community integration approaches and adherence to Olmstead provisions requiring treatment in the least restrictive setting available. However, we balance those points with the recognition that short-term inpatient stays may be necessary for individuals with the most acute behavioral health needs and are concerned that access to them may not currently be sufficient,” CMS said.

The National Health Law Program noted that CMS also included a requirement that IMD services must meet requirements for “in lieu of” services. This policy allows states to cover alternative services or settings “in lieu of services” covered under the state plan, according to NHeLP. NHeLP pointed out that CMS said this will allow the enrollee to have a choice between IMD and community-based services and that the agency said a managed care plan cannot force an enrollee to get services at an IMD.

**But NHeLP does not think these requirements are sufficient.**

“Most individuals in crisis are either not in the position to demand ‘in lieu of services’ or not given the option to choose. Families of these people may feel that they have no choice but to agree to placement in an IMD. Meanwhile, plans and state agencies have less incentive to develop and provide community-based options,” NHeLP said in comments about the final rule.

**NDRN also questioned the 15-day period.**

“The preamble suggests that this change regarding IMD services would help those with substance use disorders, but there is no information to suggest that the 15-day period would be helpful for this population,” NDRN said.
CMS said it set this parameter based on data from the Medicaid Emergency Psychiatric Demonstration, which provides federal Medicaid matching funds over three years to allow IMDs to get Medicaid reimbursement for the treatment of psychiatric emergencies.

Rebecca Farley, director of policy and advocacy at the National Council for Behavioral Health, said there is a balance between some patients needing more than 15 days for clinical purposes and others that do not, but it is important that more than 15 days does not allow for a financial incentive for hospitals to keep people for an unlimited amount of time.

Gionfriddo said it is a good balance in that it is long enough to get a correct diagnoses and medications and to set up community services afterward.

The National Association of Medicaid Directors supports the IMD provision.
““This will give many states important tools with which to address some of the increasingly untenable provisions of the underlying statute and allow states to improve the delivery of mental health services to the Medicaid population. More needs to be done to fully address the inequities that still remain in the system, but further action will require an act or acts of Congress, and CMCS should be applauded for moving the ball forward in a helpful manner,” NAMD said. -- Erin Raftery (eraftery@iwptnews.com)