

Frequently Asked Questions

Institutions for Mental Diseases (IMDs)

THE OHIO DEPARTMENT OF MEDICAID

April 2017 and UPDATED October 2017

Medicaid Managed Care & Institutions for Mental Diseases

GENERAL QUESTIONS

What is an IMD?

As defined in [42 CFR 435.1010](#), an IMD is a nursing facility, hospital, or other institution of more than sixteen beds which primarily provides diagnosis, inpatient psychiatric treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

What is the policy change?

Starting July 1, 2017, Ohio implemented [42 CFR 438.6\(e\)](#) that allows States to make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD. As a result, Medicaid recipients, age 21 through 64, enrolled and receiving their Medicaid services through MCPs and MCOPs, will have access to medically necessary and reimbursable psychiatric treatment in IMD settings. In addition, it allows MCPs and MCOPs to receive a full monthly capitation payment on behalf of MCP members if stays do not exceed fifteen (15) days in any calendar month.

What is the intended outcome of this policy?

The policy expands the Medicaid-reimbursable inpatient psychiatric provider network to give Medicaid MCP members access to more timely, medically appropriate, and cost-effective services by allowing IMDs to be used “in lieu of services” in other covered settings, such as inpatient psychiatric units in general medical hospitals. State policy goals include:

- ✓ [Increased access to intensive mental health treatment](#)
- ✓ [Services closer to home](#)
- ✓ [Community alternatives](#)
- ✓ [Fewer re-admissions](#)
- ✓ [Expands provider network](#)

- ✓ [Continuity of care](#)
- ✓ [Coordination of care](#)

What is NOT changing as a result of this policy?

Medicaid reimbursement is not available for services provided to recipients age 21 through 64 who receive their Medicaid services through fee for service (FFS) when they are in an IMD.

How does this impact general hospitals?

General hospitals are not IMDs and, therefore, are not impacted by this policy from an IMD payment perspective.

What does “in lieu of services” mean?

For a person needing medically appropriate inpatient psychiatric care, in order to meet the federal “in lieu of services” requirements, inpatient psychiatric services must be offered in a general hospital psychiatric unit or psychiatric hospital less than 17 beds in order to offer inpatient psychiatric services in an IMD. This ensures inpatient psychiatric services are provided “in lieu of services” covered under the state plan (e.g., general hospital psychiatric unit, psychiatric hospital less than 17 beds).

What are the conditions for “in lieu of services” that must be met in order for the State to make a capitation payment to an MCP/MCOP for an enrollee who has a short term stay (15 or less days in a calendar month) in an IMD?

- The state determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.
- The enrollee is not required to use the alternative service or setting.
- The approved in lieu of services are authorized and identified in the Managed Care Provider Agreement, and offered as an option for the MCP/MCOP and its enrollees.
- The utilization and actual cost of in lieu of services is taken into account in development of the component of the capitation rates that represents the covered State plan services.

How will this benefit individuals covered by both Medicare and Medicaid (dually eligible)?

For dually eligible members who are enrolled in an MCP or MCOP, Medicaid is always the payer of last resort. When a dually eligible member age 21 through 64 exhausts his or her lifetime Medicare allowance for inpatient psychiatric services, Medicaid may provide coverage under this policy.

LENGTH OF STAY

What happens if a member needs an inpatient stay longer than 15 days?

Length of stay is determined by medical necessity. MCPs/MCOPs must be involved in the level of care determination, service setting, and admission decision process and will address lengths of stay exceeding 15 calendar days in their contracts with individual IMDs.

If an enrollee has an IMD stay exceeding 15 days per calendar month, ODM will recover a percentage of the MCP/MCOP's monthly capitation payment based on the total number of days of the member's IMD stay.

If a patient does stay more than 15 days, will they be covered in the IMD as long as medical necessity is met or will the days be denied?

Yes, length of stay may exceed 15 days per calendar month and will be determined based on medical necessity. Please note that the limitation is 15 days *per calendar month, cumulative not continuous*. If a stay exceeds 15 days in a calendar month, the MCP/MCOP must report to ODM. A process has been established to ensure ODM adheres to the prohibition of federal funding reimbursement for stays exceeding 15 days in a calendar month. The patient will not be responsible for paying for their Medicaid covered services since they are Medicaid eligible unless the requirements of [Ohio Administrative Code 5160-1-13.1](#) are met.

ROLE OF THE MCPs/MCOPs

What are the requirements of MCPs/MCOPs?

MCPs and MCOPs will contract with IMDs and cover medically necessary inpatient psychiatric services. MCPs and MCOPs will work together with clinicians and/or facilities along with their member to determine both the level of care and length of stay based on medical necessity and the appropriate care setting.

What will be the role of MCPs/MCOPs in the IMD admission process?

MCPs/MCOPs will work with their members, clinicians and/or facilities assessing the need for care to determine level of care, appropriate care setting options and length of stay and authorize services as medically necessary.

What will be the role of MCPs/MCOPs in the IMD discharge process?

MCPs/MCOPs will participate in discharge planning activities, including making arrangements for a safe discharge in the community and arranging for appropriate services specified in the discharge plan. This may include coordinating with community behavioral health service providers.

ROLE OF PROVIDERS (e.g., emergency departments, community providers, physicians)

Will this impact the role of local providers who handle the coordination of psychiatric hospital admissions?

Yes. When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan must be contacted for triage, level of care determination, and setting options. This includes MyCare Ohio plans when an enrollee has exhausted their lifetime Medicare inpatient psychiatric benefit.

Providers and the MCP/MCOP will work together on coordinating admission for inpatient psychiatric treatment when necessary.

How will providers know if an IMD is in an MCP's/MCOP's network?

MCPs/MCOPs will work closely with providers for coordinating care and services for members. This will include providing information about how to reach MCPs/MCOPs for level of care coordination for inpatient psychiatric services, which IMD and non-IMD facilities are on their provider panel for inpatient psychiatric services, and how to coordinate an admission for inpatient psychiatric services. The information will also be available on MCP/MCOP websites.

If the emergency department or practitioner recommending an inpatient level of care is not able to contact the MCP/MCOP, will that practitioner be able to choose an IMD even if there may be beds available in the hospital or in a private facility with less than 17 beds?

When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan must be contacted for triage, level of care determination, and setting options. This includes MyCare Ohio plans when an enrollee has exhausted their lifetime Medicare inpatient psychiatric benefit.

If a plan is not able to be reached prior to admission, the MCP/MCOP has deferred its triage, level of care determination, and placement authority to the clinical judgment of the practitioner recommending inpatient psychiatric care. Admissions must meet medical necessity criteria.

STATE PSYCHIATRIC HOSPITALS

Does this mean Medicaid will now cover forensic hospital stays?

No. Medicaid will not cover an individual's forensic hospital stay in an IMD if the individual is under one of the following four legal statuses: not guilty by reason of insanity (NGRI), incompetent to stand trial – restorable (ISTR), incompetent to stand trial – unrestorable, criminal court jurisdiction (ISTU-CJ), or competency/sanity

evaluation (EVAL). Individuals under one of these four legal statuses are not able to select their service provider, therefore, the “in lieu of services” in other covered settings requirement cannot be met.

How does this impact the role of state psychiatric hospitals?

State psychiatric hospitals will continue to serve as the safety net, covered by Medicaid as non-contracting, out-of-network providers for managed care plans.

How does this impact the role of County Boards of Alcohol, Drug Addiction and Mental Health Services (ADAMHS) as the “front door” for state psychiatric hospital admissions?

County Boards of ADAMHS and/or their designees will continue to approve admissions to state psychiatric hospitals in accordance with [Ohio Revised Code Chapter 5122](#).

DOCUMENTATION, CLAIMS SUBMISSION & CONTRACTING

Where do IMDs submit claims under this policy?

IMDs will need to bill MCPs/MCOPs per their contract, for medically necessary services provided to members.

How is the “in lieu of services” provision documented?

When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan must be contacted for triage, level of care determination, and setting options. The MCP/MCOP ensures and documents inpatient psychiatric services are provided “in lieu of services” covered under the state plan. In instances in which the MCP/MCOP could not be contacted and has deferred the triage to the provider, the provider ensures and documents inpatient psychiatric services are provided “in lieu of services” covered under the state plan. See reference Chart A below.

Is the admitting IMD responsible for assuring and documenting that “in lieu of services” settings have been considered prior to admission?

No, the IMD is not responsible for assuring or documenting that this requirement has been met.

Do providers of inpatient psychiatric services need a MyCare Ohio Plan contract and a separate traditional Medicaid managed care plan contract?

Providers will want to check with the managed care plan they are contracted with to ensure their contract covers both the traditional Medicaid and MyCare lines of business.

SUBSTANCE USE DISORDER

How are community Substance Use Disorder (SUD) residential treatment programs that are certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) affected by this policy?

OhioMHAS certified community SUD residential treatment programs will not be impacted by this policy for the following reasons:

- Services provided to members in an IMD setting must be provided in lieu of comparable services already covered by the Ohio Medicaid program. Since Ohio's Medicaid program doesn't currently have identifiable coverage of SUD residential treatment services, the "in lieu of services" in other covered settings requirement cannot be met.
- Services provided to members in an IMD setting must be delivered by a hospital providing psychiatric or SUD inpatient care OR a sub-acute facility providing psychiatric or SUD crisis residential services. OhioMHAS certified community SUD residential treatment programs are not SUD hospitals providing a hospital level of care appropriate for treating SUDs nor are they identified as providing SUD crisis residential services.

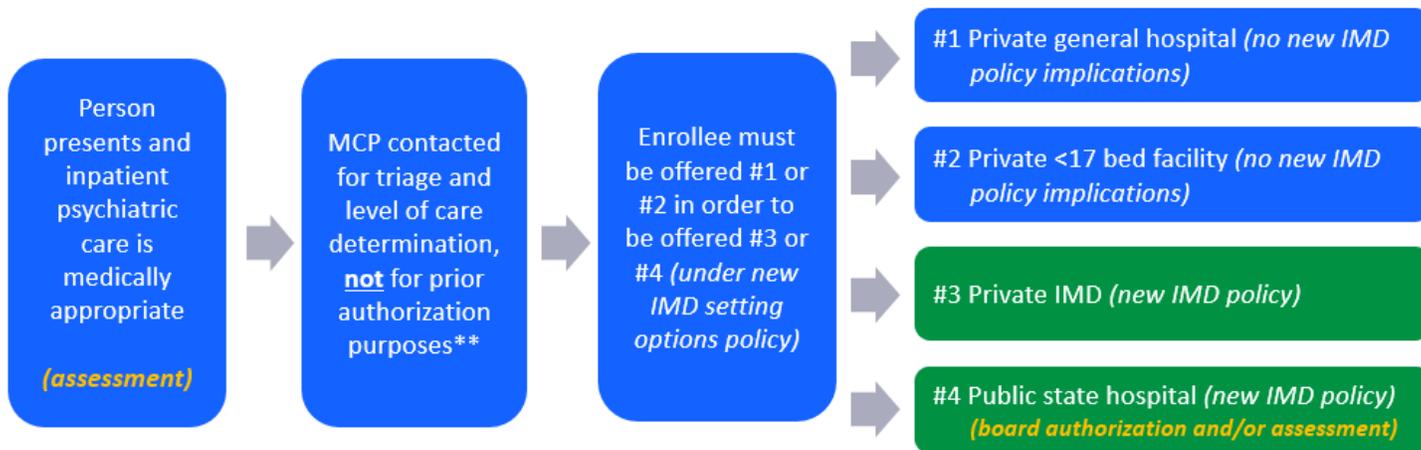
ODM and OhioMHAS will continue to monitor the behavioral health service needs of Ohio's Medicaid enrollees and may pursue available Medicaid options that offer additional or expanded coverage for community SUD residential treatment post implementation of the redesigned Medicaid community behavioral health benefit.

Plan Process for Inpatient Psychiatric Care



When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan **MUST*** be contacted for triage, level of care determination, and setting options. This includes MyCare Ohio plans when an enrollee has exhausted their lifetime Medicare inpatient psychiatric benefit.

*If a plan is not able to be reached prior to admission, the MCP has deferred its triage, level of care determination, and placement authority to the clinical judgment of the practitioner recommending inpatient psychiatric care. Admissions must meet medical necessity criteria. If medical necessity for admission is not met, the MCPs would be responsible for the medically necessary professional services only.



** MCPs may review LOC, assessments and other pertinent information to authorize the length of stay, setting, etc. based on medical necessity

For a person needing medically appropriate inpatient psychiatric care, they must be offered #1 or #2 to then be offered #3 or #4.

- This ensures inpatient psychiatric services are provided “in lieu of services” covered under the state plan (#1 and #2)

Reference Chart B: Inpatient Psychiatric Admissions – Managed Care

		IMDs: Pre-July 1	IMDs: July 1 – Dec. 31, 2017	IMDs: Jan. 1, 2018, & Forward	General Hospital Psych Units
Ages 21- 64	Benefit Coverage	N/A	Managed Care Plans	Managed Care Plans	Managed Care Plans
	Payment	N/A	Professional Services: MCPs Facility Charges*: MCPs *If admission meets medical necessity criteria	Professional Services: MCPs Facility Charges*: MCPs *If admission meets medical necessity criteria	Managed Care Plans
Under Age 21 OR Over Age 64	Benefit Coverage	Permedion	Permedion	Managed Care Plans	Managed Care Plans
	Payment	Professional Services: MCPs Facility Charges: Medicaid	Professional Services: MCPs Facility Charges: Medicaid	Managed Care Plans	Managed Care Plans

Questions? Contact the Ohio Medicaid Provider Hotline: 1-800-686-1516

For more information, go online: Medicaid.Ohio.gov

See below for managed care plans' websites and provider services numbers:

Plan	Website	Provider Services Number
Aetna	www.aetnabetterhealth.com/ohio	1-855-364-0974
Buckeye	www.buckeyehealthplan.com	1-866-296-8731
CareSource	www.caresource.com	1-800-488-0134
Molina	www.molinahealthcare.com	1-855-322-4079
Paramount	www.paramounthealthcare.com	1-888-891-2564
United Healthcare	www.uhcommunityplan.com	1-800-600-9007

For more information on Ohio's participating managed care plans and their networks, go to: <http://oahp.org/>.