Frequently Asked Questions: Medicaid Reimbursement Status for Certain Chemical Dependency Programs in Minnesota

*FAQ’s are not listed in order of importance. The FAQ’s will be updated as needed. Please note the date breaks to see where new questions begin.

Posted 12/31/2015

Our program was not reclassified in the initial review, but we have questions about whether we will be subject to reclassification in the future?

If a program was not reclassified as an IMD during the first review, it may still have a change in status following review in the future. CCĐTTF-funded programs that may yet be determined to be IMDs include, but are not limited to, residential programs of a campus nature and those licensed by an entity other than Minnesota DHS if their capacity exceeds 16 beds.

How do state contracted Managed Care Organizations authorize placements at an IMD?

The MCO, as a placing authority, authorizes the services determined by the assessment. Currently, MCOs are only responsible to pay for the treatment services of residential placements for a CD placement and do not cover and are not liable for the room and board service component. The provider bills the room and board portion to DHS.

Specific to IMD residential programs, IMDs are not covered under the current managed care contract. MCOs typically do not authorize placement in IMDs unless it is for an “in lieu of another service”, which is not routine.

What happens if a managed care enrollee is placed in an IMD by another placing authority (County or Tribe)?

If an IMD eligibility span (major program IM, the Medicaid Management Information System (MMIS) identifier for an IMD) has been created in MMIS, the individual will not be enrolled in managed care. Additionally, if the eligibility span is updated with that major program, the individual will be dis-enrolled from the MCO.

Recipients who are initially placed in an IMD through the CCĐTTF and are then enrolled in an MCO remain the responsibility of the CCĐTTF until discharge.
How is that ‘disenrollment’ accomplished?

Updating the living arrangement in MMIS to show “IMD” or “RTC” does not automatically trigger disenrollment. Someone, generally at the county, must enter the exclusion reason of “ZZ” to exclude the individual from enrollment in managed care. The reason the disenrollment is not automatic is to accommodate those situations where the MCO may place the individual in this setting “in lieu of another service.”

What kind of coverage does the client have under program IM?

Major program IM is a state-funded program for people who would be eligible for MA if they weren’t residing in an IMD. Refer to the Minnesota Health Care Programs (MHCP) Provider Manual, Programs and Services section for program IM coverage information.

Please contact Diane Hulzebos in the Alcohol and Drug Abuse Division at diane.hulzebos@state.mn.us for more information.

How do we calculate the cost increase to the counties for placing in newly reclassified IMD’s?

Counties can expect to pay 22.95% of placements in IMDs. Assigning that percent to the average treatment cost in an IMD would be the simplest way to predict future county costs.

Can counties deny a placement option because of the cost back to the county?

Rule 25 requires placement using the criteria in the Rule. The IMD status of a program does not affect a client’s eligibility for publically funded treatment, and we are not expecting increased barriers or delays in access to services.

Who can I contact with additional questions I have?

General questions: Jacob Owens at Jacob.owens@state.mn.us

Newly reclassified IMD questions: Patina Thomas at Patina.Thomas@state.mn.us

Posted 12/02/2015

Will the IMD status of a program have an impact on access to treatment services?

No. The IMD status of a program does not affect a client’s eligibility for publically funded treatment, and we are not expecting increased barriers or delays in access to services.
Who decides if a program is an IMD?

DHS is responsible for determining which programs are IMDs and ensuring alignment with the federal requirements for reimbursement for treatment services.

Determining IMD status is complex. Federal law defines an IMD as follows:

“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.” (Code of Federal Regulations 435.1010).

It should be noted that the International Classification of Diseases (ICD) system classifies alcoholism and other chemical dependency syndromes as mental disorders and CD programs are subject to the IMD determination.

Please refer to the CMS State Medicaid Manual for more detailed guidance.

Why is DHS reviewing the past determinations of IMD status for programs?

An internal review raised concerns about how DHS has determined the eligibility of some Rule 31 chemical dependency treatment programs for Medicaid reimbursement. Therefore, we are working with Centers for Medicare and Medicaid Services in order to ensure alignment with federal rules.

I operate a program that is currently determined by DHS as non-IMD. How will I know if this determination changes in the future?

Currently there are 37 residential programs in the state that have 16 beds or more that are not treated as an IMD. DHS will be reaching out to these programs individually to discuss their recategorization. There are also a number of Rule 31 programs, both residential and outpatient, which have other characteristics that may make them IMDs. This may result in potential IMD determination for those programs as well.

Over the coming months, DHS will be conducting a comprehensive review of all Rule 31 programs to determine IMD status. DHS will continue working in partnership with counties, managed care organizations, tribes, and providers to ensure continued availability of quality CD services in the state. The Alcohol and Drug Abuse Division will communicate and provide updates as this work progresses.
Can a program that is classified as an IMD be reimbursed by the CCDTF for treatment services?

Yes. The CCDTF is a funding source that includes federal Medicaid, state and county participation. CCDTF payments to non-IMD programs reflect federal, state and county combined reimbursement, but IMD programs are reimbursed with only state and county dollars, the reimbursement does not include a federal Medicaid share. This is why an increase in the number of treatment services provided by IMD programs is projected to result in increased costs to the state and county.

Following an initial review by DHS, there are 37 programs that were previously classified as non-IMD but going forward will be IMDs. This will result in a projected cost increase of $2.4 million to counties and $8.94 million to the state. The state and counties will see additional cost increases if further review finds that other programs are also IMDs.

Additional Questions Received

Posted 1/22/2016

Your recent e-memos regarding IMDs have created uncertainty in established funding streams. What legal assurances can you provide that eligibility and funding for CCDTF and PMAP clients will not be disrupted, today and in the future, for IMD classified facilities?

We are not able to provide legal assurance as to what disruptions might occur now or in the future. However, Rule 25 requires placement using the criteria in the Rule; the IMD status of a program does not affect a client’s eligibility for publically funded treatment; and we are not expecting to see increased barriers or delays in access to services.

If you are aware of disruptions or barriers to service that may have resulted from the change in a program’s IMD status, please provide this information to DHS so that we can review the individual circumstances. Please contact Patina Thomas at 651-431-2467.

How did you arrive at the incremental state forecast to cover the costs for IMD designation? Does this include PMAP clients?

The annual cost increase of $2.4 million to counties and $8.94 million to the state was calculated based on an expectation that 37 programs that were previously classified as non-IMD were going to be designated as IMD going forward. Actual payments in 2014 to the affected facilities were analyzed to get an accurate measure of the change in federal funding. CCDTF payments to non-IMD programs include federal, state and county combined reimbursement, but IMD programs
are reimbursed with only state and county dollars. The projected increase in costs for the state and county reflected the loss of federal participation for newly designated programs. The forecast was developed by the DHS Reports and Forecasts Division, which is responsible for forecasting CCDTF expenditures.

There were 31 programs classified as IMDs previous to the 12/3 e-memo, many or all accepted CCDTF and PMAP clients (and were reimbursed for these services). What analysis has DHS done to ensure that access and funding will not be disrupted?

Rule 25 requires placement using the criteria in the Rule; the IMD status of a program does not affect a client’s eligibility for publically funded treatment; and we are not expecting to see increased barriers or delays in access to services.

DHS is responsible to monitor placements in the state and we are developing enhancements to that monitoring process, which we expect to help identify any barriers or delays that result from the reclassifications. While the reclassifications of programs change some procedures, such as the assignment of the client to Major Program IM, the funding remains available through the CCDTF, just not MA.

If our partners become aware of disruptions or access to services then we ask that this information be provided to DHS so that we can review the circumstances reported and respond to any matters that may not be in compliance with applicable regulations. Please contact Patina Thomas at 651-431-2467.

In light of a potential 50% increase to county budgets for MA eligible clients, how do we assure that counties are not dis-incented to refer clients to IMD facilities?

We have not been able to identify the basis of the “50% increase” concern and will need further information to respond to this part of the question. We will continue to rely on the regulations applicable to the placement process.

If our partners become aware of disruptions or access to services then we ask that this information be provided to DHS so that we can review the circumstances reported and respond to any matters that may not be in compliance with applicable regulations. Please contact Patina Thomas at 651-431-2467.
What public funding will be available after 15 day IMD placements by MCOs? Are there assurances that funding will be available beyond 15 days if the proposed Federal rule goes through?

In May of 2015, CMS released proposed changes to rules allowing States to permit capitated payment for MCOS that place in IMDs for up to 15 day in that month. These changes are still being discussed. If this or other legislation is passed that has an impact on the service delivery system we will review it then and make plans accordingly.

Will DHS consider filing Waiver 1115, if not, why?

DHS has been considering the steps necessary if our State were to apply for an 1115 demonstration waiver since late July 2015. The 1115 Waiver requires significant system changes to achieve the required system transformation that is the aim of the waiver, and would require substantial time and work with CMS before it could be put in place. We have determined that there are serious impediments, a major one which is the requirement that the assessment and all resulting placement recommendations must be performed by an independent third party that has the necessary competencies to use the ASAM Patient Placement Criteria. This explicitly bars programs from assessing and placing a client in their own program. Since one of our goals is to move toward direct access, we are currently not moving forward with a waiver application.

What process did DHS use to meet the IMD requirements?

DHS is responsible for determining which programs are IMDs and ensuring alignment with the federal requirements for reimbursement for treatment services.

DHS has been aware of the IMD requirements for many years. In 2004-5, DHS interpreted the requirements based on number of beds and level of care and intensity of service. But in early 2015, as we began to develop the Withdrawal Management legislation, and also due to heightened scrutiny by CMS, we did an internal review, and over the last six months as we worked on the “Freedom of Choice” waiver application, and with CMS input, we found we had to bring into alignment our definitions and the federal guidelines. The old definitions were not in alignment, and we had to start with the basic definitions.
The Federal government requires that states must do a comprehensive review, including complex criteria, and consider the overall character of facilities to make IMD determinations, what process did DHS use to make these determinations?

In reviewing the IMD status of programs, DHS had to start with the CMS regulations. Determining IMD status is complex. Federal law defines an IMD as follows:

“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.” (Code of Federal Regulations 435.1010).

It should be noted that the International Classification of Diseases (ICD) system classifies alcoholism and other chemical dependency syndromes as mental disorders and CD programs are subject to the IMD determination.

Please refer to the CMS State Medicaid Manual for more detailed guidance.

The interpretation DHS had used which took level of care and intensity of service is not reflected in the federal rules, which are focused mainly on number of beds. So the first step was to look at all licensed residential programs that were over 16 beds. Over the coming months, DHS will be conducting a comprehensive review of all Rule 31 programs to determine IMD status. This review will look at other factors besides number of beds, and we will keep providers informed if further determinations are made.

Does DHS intend to introduce legislation in the upcoming session to address any of these issues?

There are no plans identified at this time to do this during the bonding session but if a critical need arises we will reexamine this decision.