MACPAC

Draft Report on Oversight of Institutions for Mental Diseases

Medicaid and CHIP Payment and Access Commission

Erin K. McMullen

Legislative Requirements for MACPAC Study

MACPAC report to Congress due January 1, 2020. It must include the following:

- summary of state requirements (e.g., certification, licensure) for IMDs and how state determines requirements are met
- summary of state standards (e.g. quality, clinical) for IMDs and how state determines standards have been met;
- description of IMDs, including services provided; and
- description of Medicaid funding authorities and coverage limitations place on IMD services

Legislative Requirements for MACPAC Study

- Congress directed MACPAC to seek input from stakeholders (e.g., state Medicaid directors, beneficiary advocates, providers) in carrying out study
- If determined appropriate, report may include recommendations for policies and actions by Congress and CMS. Specifically, recommendations on:
  - how state Medicaid programs may improve care and improve standards for IMDs; and
  - how CMS can improve data collection for these facilities

Study Approach

Study has three components:

- State requirements for behavioral health facilities
  - MACPAC contracted with Watson Health to document standards in seven states
  - Also conducted semi-structured interviews with state-level stakeholders
- Identifying and describing IMDs using two SAMHSA facility surveys
- Additional formal public comment

Draft Report

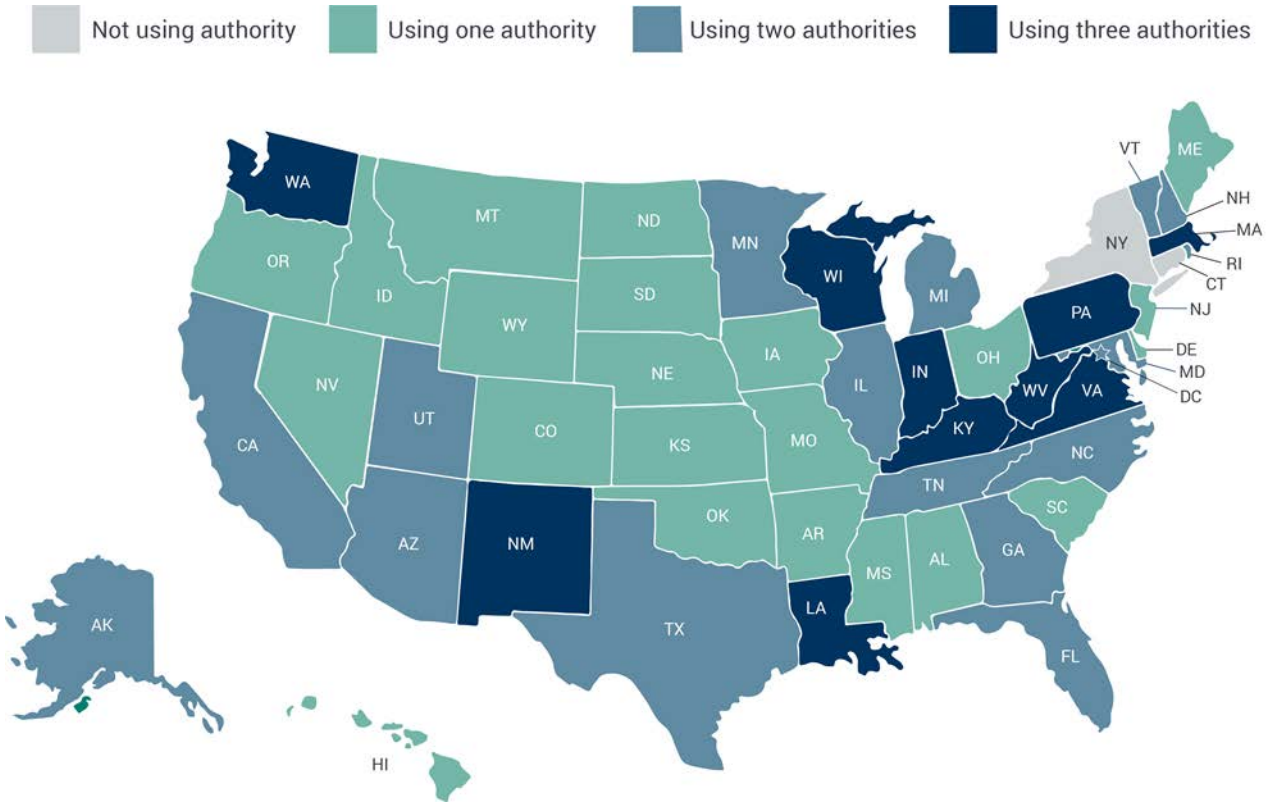
- Divided into five chapters:
  - CH 1, History and Federal Regulation of IMDs
  - CH 2, Services Provided by IMDs
  - CH 3, Regulation and Oversight of IMDs and Outpatient Behavioral Health Facilities
  - CH 4, Medicaid Standards for Behavioral Health Facilities
  - CH 5, Protections for Patients in IMDs and Outpatient Behavioral Health Facilities
- Report does not include recommendations

Chapter 1: History and Federal Regulation of IMDs

Key Findings

- The IMD exclusion has been in place since 1965 to assure that states, rather than the federal government, are responsible for funding inpatient psychiatric services
- The exclusion is broad and applies to any institution that meets certain criteria. It does not define categories of institutions affected by the exclusion
- Despite the exclusion, nearly all states are making payments to IMDs via other authorities including:
  - two main statutory exemptions related to older adults and children and youth; as an in-lieu-of service in managed care;
  - Section 1115 demonstrations;
  - a new state plan option under the SUPPORT Act; and
  - disproportionate share hospital payments

Federal Authorities Used to Make Payments to Institutions for Mental Diseases, 2018 – 2019



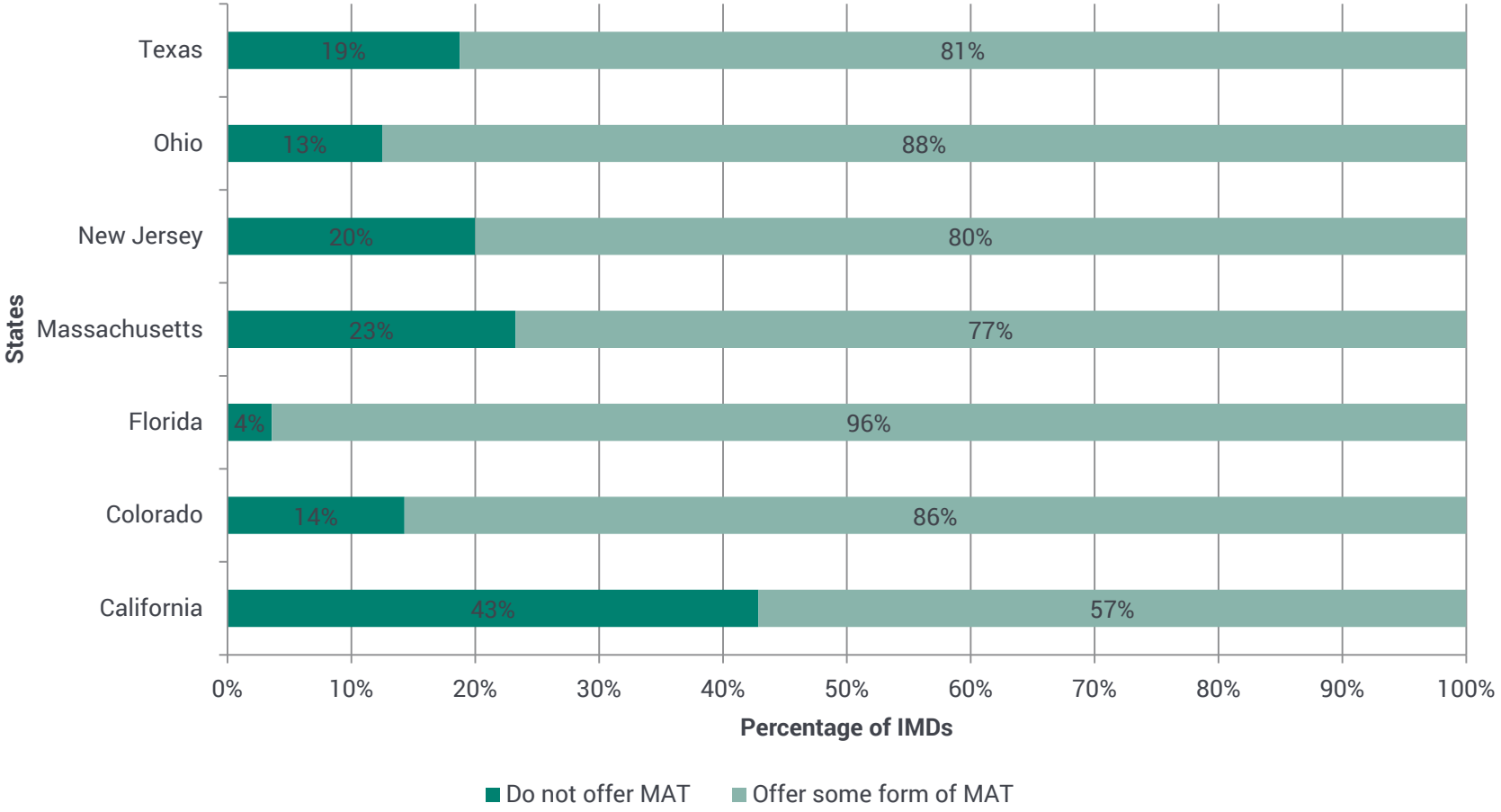
Note: This map captures instances under which states make payments to IMDs as a state plan benefit for beneficiaries over the age of 65, through Section 1115 demonstrations, and as an in-lieu of service. Information on the state plan IMD benefit for beneficiaries over the age of 65 reflects coverage as of 2018. Use of Section 1115 demonstrations reflects approved demonstrations as of March 2019. States reporting use of the in-lieu of managed care authority for either 2018 or 2019 were included in this chart as using at least one Medicaid authority to pay for services in IMDs. Information regarding state use of DSH payments to IMDs in 2018 is unavailable and not reflected in this figure.
Source: KFF 2019, MACPAC 2019b, and Gifford et al. 2018.

Chapter 2: Services Provided by IMDs

Key Findings

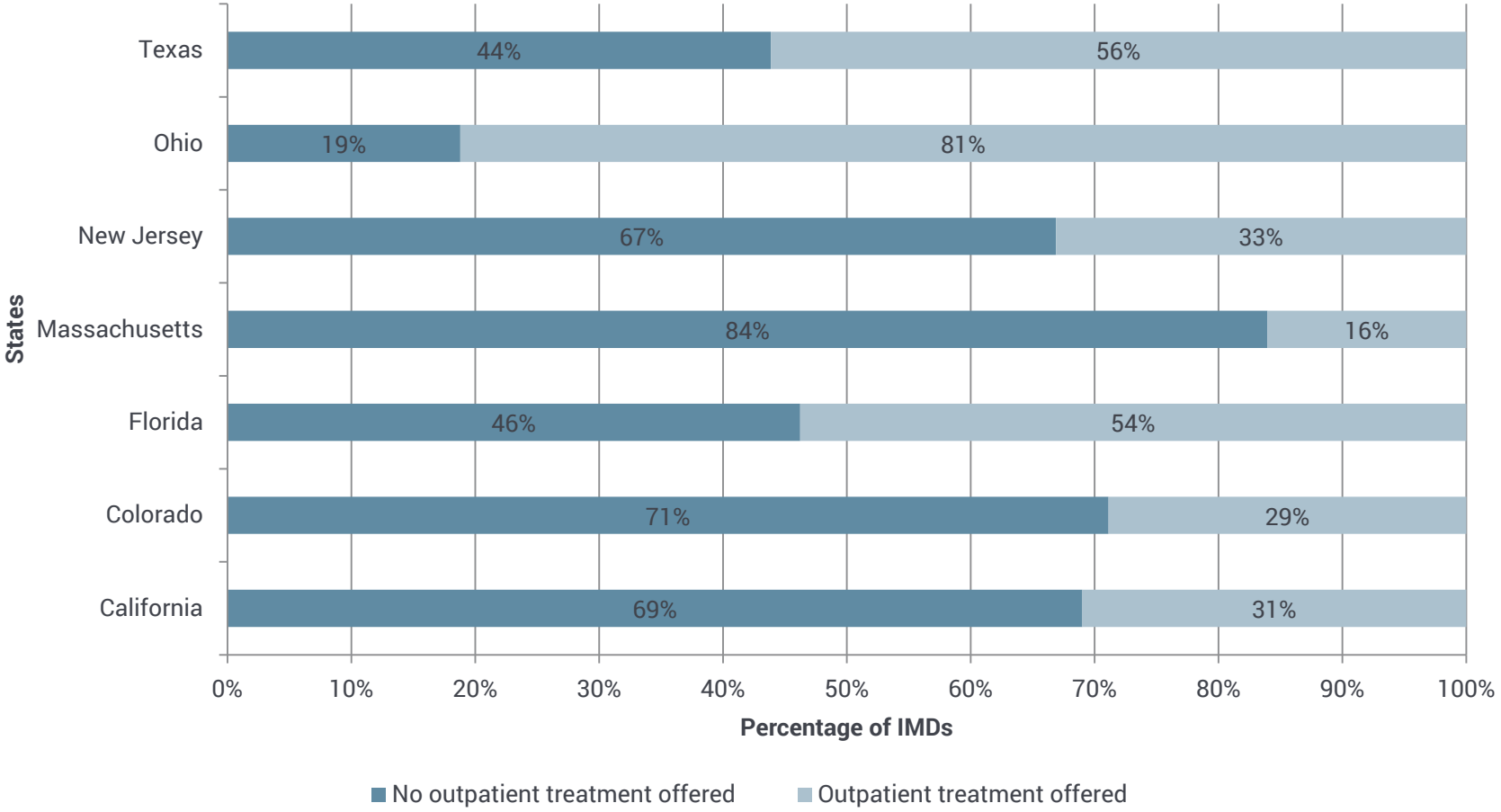
- Identifying IMDs is challenging; an IMD is not one type of facility. Rather, the term IMD encompasses a number of facilities, including inpatient and residential mental health and SUD treatment facilities
- Designation as an IMD can change based on patient mix
- Some of the facilities identified as IMDs do not offer any forms of medication-assisted treatment, and those that do are less likely to offer methadone when compared to other medications used to treat opioid use disorder
- Many facilities that are considered IMDs do not offer lower levels of outpatient care

Percentage of IMDs that Offer Medication-Assisted Treatment, 2017



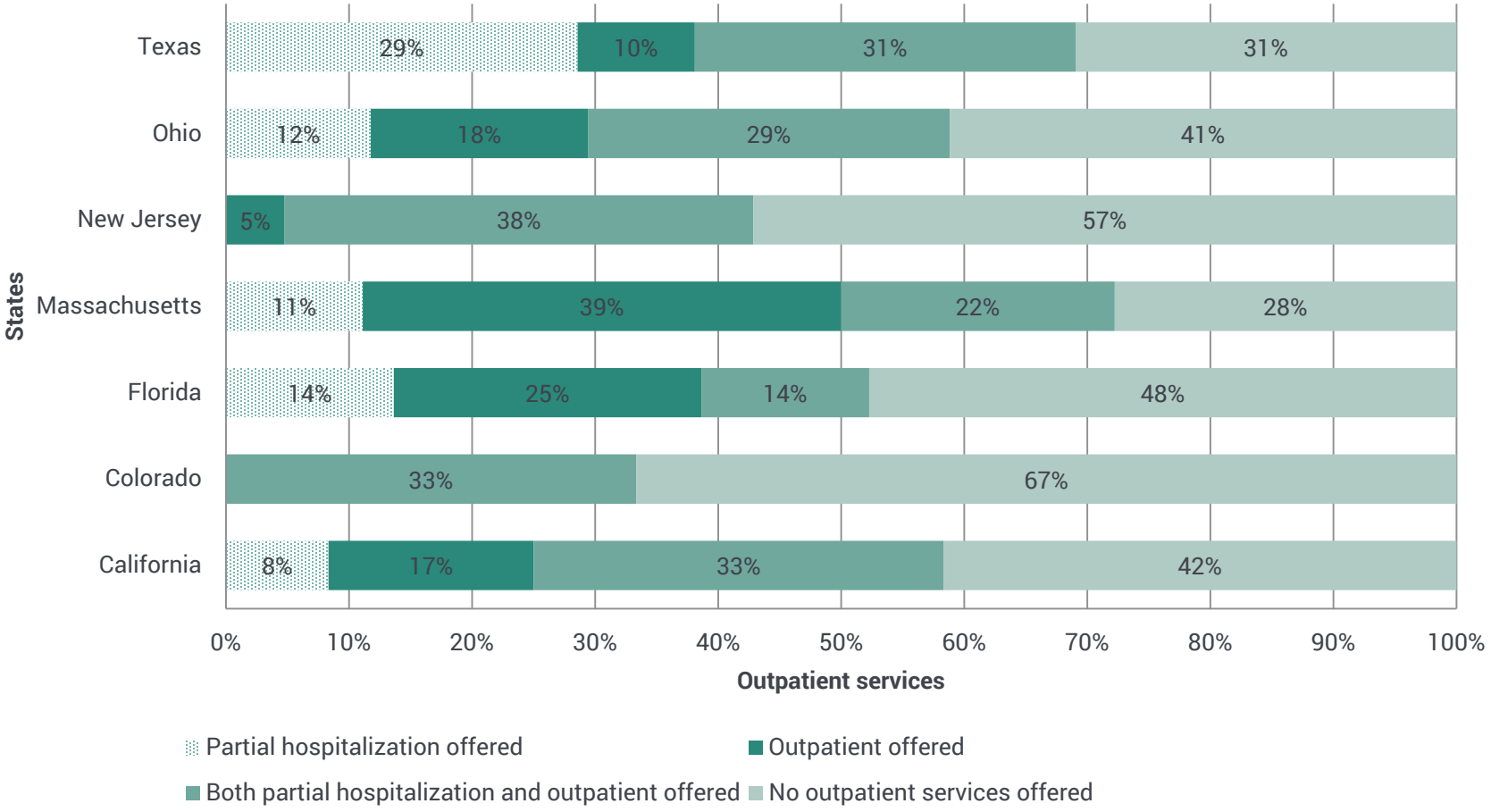
Source: MACPAC 2019, analysis of SAMHSA 2018.

Percentage of IMDs Offering Any Outpatient SUD Treatment



Source: MACPAC 2019, analysis of SAMHSA 2018.

Percentage of IMDs Offering Certain Outpatient Mental Health Services



Source: MACPAC 2019, analysis of SAMHSA 2017.

Chapter 3: Regulation and Oversight of IMDs and Outpatient Behavioral Health Facilities

Key Findings

- Generally, the federal oversight that applies to the majority of the nation's health care facilities via Medicare certification does not apply to many IMD facilities
- State oversight of IMD facilities is fragmented, sometimes spread across multiple agencies
- The degree to which IMDs seek accreditation varies; psychiatric hospitals seek accreditation at high rates
- In comparison, residential mental health and SUD treatment facilities seek accreditation at lower rates
- States do not have licensure criteria specific to IMDs

Key Findings

- Review of seven states found licensure standards for facilities vary considerably
- Generally, all states require inpatient, residential, and outpatient mental health and SUD treatment facilities to:
  - conduct patient assessments prior to or upon admission;
  - provide certain types of services; and
  - provide individualized treatment planning
- Standards related to staffing (e.g., medical director, clinical staff, staffing ratios) vary to a large extent
- States rarely require inpatient, residential and outpatient facilities to provide a specific number of hours to each patient

Key Findings

- Outside of initial and renewal licensure processes, enforcement of state standards is largely complaint based
- Licensure standards may be enforced through:
  - monetary penalties
  - reportable incidents
  - waivers from certain licensure requirements

Chapter 4: Medicaid Standards for Behavioral Health Facilities

Key Findings

- Medicaid provider enrollment process is primary mechanism by which states ensure providers meet Medicaid standards
  - Complements the licensure and accreditation processes
  - Enforcement mechanisms outlined in their provider agreements
  - Providers that fail to meet Medicaid enrollment requirements may not receive Medicaid payment

Key Findings

In some states, providers must meet additional standards imposed either by the state Medicaid program or managed care entities to receive Medicaid payment.

- Standards often related to staffing (e.g., employing certain types of practitioners, staffing ratios)
- All of the states we reviewed apply treatment planning requirements to at least one type of behavioral health facility
- Most of the states we reviewed required discharge planning for one or more behavioral health facility
- Only two states have additional care coordination standards
- Services must be medically necessary

Key Findings

- States with approved Section 1115 SUD demonstrations require providers to meet additional standards
- Few state Medicaid agencies require behavioral health providers to seek accreditation
- States set limits on length of treatment that Medicaid will pay for in some behavioral health facilities
- Generally, we did not find specific language in state managed care contracts related to behavioral health network adequacy requirements
- Oversight of IMDs, including the use of outcome measures, varies considerably among managed care entities.

Chapter 5: Protections for Patients in IMDs and Outpatient Behavioral Health Facilities

Key Findings

- Protections for patients treated in IMDs governed by federal statute, regulations, and court decisions
- Protections may apply differently for individuals with psychiatric disorders and individuals with SUDs
- Federal protection and advocacy systems that help ensure the ADA is enforced only apply to individuals with significant psychiatric disabilities
- The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343) treats individuals with mental health and SUD conditions more equitably, generally preventing health plans that provide mental health or SUD benefits from imposing more stringent benefit limitations on those benefits than on medical or surgical benefits

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