Washington State
Department of Social
& Health Services

Transforming lives

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DBHR Guidance Document #01-17
Frequently Asked Questions
Medicaid Funding for Individuals in an IMD

When a Medicaid individual is receiving SUD residential services in an IMD beyond 14 days:

- **Is it accurate that the payment with other funds is retroactive to day 1 of SUD residential?**

  The final rule is that the state cannot make a monthly capitation payment to an MCO or BHO, or pay for any managed care costs when the individual has stayed in an IMD for more than 15 days in a calendar month. The 2017 Medicaid Managed Care Rate Development Guide states:

  States may make a monthly capitation payment to an MCO or PIHP (in a "risk contract" as defined in 42 CFR 438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR 435.1010) for a short term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR 438.6(e). The data used for developing the projected benefit costs for these services must not include:

  i. costs associated with an IMD stay of more than 15 days;
  ii. any other managed care plan costs for services delivered in a month when an enrollee has an IMD stay of more than 15 days; and
  iii. a member month for any month when an enrollee has an IMD stay of more than 15 days.

- **Is the individual's Medicaid canceled or suspended at that time? (canceled = has to reapply for Medicaid when leaves SUD residential treatment; suspended=cannot use Medicaid until the next full month). Do they have to reapply?**

  It is the use of federal funds, not the person's Medicaid eligibility that is the focus of the rule. The State in looking into options on how to operationalize this piece, our goal is to have the person in a suspended status rather than disenrolled. The challenge is that at this time the State has no way to know in real time the status of the person in an IMD. As we get further down the road on the implementation process we will provide more updates.

- **If they are in an IMD more than 15 days in month one, and get released on Day 6 of the next month, is the second month of care Medicaid?**

  In the example given, the first six days of the month would be covered (unless the individual was in an IMD during that same month and the additional days resulted in a total over 15). CMS has stated that the rule applies to the calendar month. An individual could be in and IMD for the last 15 days of one month and the first 15 days of the next month. In that case, the managed care plan would receive payment for both months (assuming those days were the only IMD days for both months).

- **Do they still have access to their Medicaid benefits/entitlements, and it is simply the BHO that must use other funds for residential payment?**
  The CMS rule states that managed care entities may not receive any capitation payment for the month when the individual is in an IMD for more than 15 days. CMS acknowledges that this will result in some cases in a recoupment of capitation payments. They offer the solution that states pay for medically necessary services during those months when a capitation payment is not available (due to a stay in an IMD of greater than 15 days).

  From Page 240 of the final rule:

  "[Comment] A few commenters stated that the preamble indicates that a state will be required to monitor beneficiary IMD lengths of stay on a monthly basis, and if such a stay lasts 15 days or longer in a month, **to seek recoupment of its total capitation payment made to the managed care plan for that month**. Commenters noted that requiring states to recoup capitation payments made to MCOs and PIHPs for an enrollee with an IMD stay that exceeds 15 days will require significant retroactive adjustments and create major financial uncertainty…

  [CMS Response] We acknowledge that this provision requires states to monitor the MCO's or PIHP's use of IMDs as an in lieu of service to ensure that capitation payments were appropriately made and that claims for FFP associated with those capitation payments are filed only when consistent with this rule…We note, however, that states may also pay independently for services provided to patients in IMDs. We emphasize that the statutory exclusion was **designed to assure that states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services."**