Report to Congress on Oversight of Institutions for Mental Diseases

DECEMBER 2019

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 USC 1396, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

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DECEMBER 2019

MACPAC
Medicaid and CHIP Payment and Access Commission

December 30, 2019

The Honorable Mike Pence
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
The Capitol
Washington, DC 20515

Dear Mr. Vice President and Madam Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit this report to Congress on *Oversight of Institutions for Mental Diseases.* This report fulfills a statutory requirement in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) to submit a report by January 1, 2020, identifying and describing facilities designated as institutions for mental diseases (IMDs) in selected states and providing a summary of state licensure, certification, or accreditation requirements and Medicaid clinical and quality standards.

Since Medicaid was established in 1965, federal statute has largely prohibited payments to IMDs. This designation, which is exclusive to the Medicaid program, is broadly defined in the Social Security Act as 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. Facilities that are considered IMDs include a variety of residential and inpatient facilities providing substance use disorder (SUD) and mental health services that are regulated under different federal and state rules. In addition, some of these facilities are primarily regulated by states and oversight is often fragmented across state agencies. Thus, it is difficult to make broad conclusions about IMDs as a group. There is also considerable variation across states in how these facilities are regulated.

The IMD exclusion is one of the few instances in Medicaid where federal funding is not available for covered services based on the setting in which they are provided. It is important to note that, despite this longstanding payment exclusion, there are several other Medicaid authorities that states are using to make Medicaid payments for services provided in IMDs. These include demonstration waivers under Section 1115 of the Social Security Act and in-lieu-of services in managed care, as well as statutory exceptions to the exclusion for services provided to adults age 65 and older and children and youth under age 21. Most recently, a provision of the SUPPORT Act allows states to make payments to IMDs that treat individuals with an SUD under the state plan.

For this study, we looked closely at policies in seven states: California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas. Among the factors we considered in selecting them were diversity in the range of services covered as well as various approaches to administering services (e.g., through the state plan, Section 1115 demonstration waivers, or in-lieu-of services) and service delivery (e.g., through managed care or fee for service). We also considered the extent to which states have been affected by the opioid epidemic.

In Chapter 1, we outline the history of the IMD exclusion and federal regulations governing Medicaid payment to IMDs. Chapter 2 estimates the number of IMDs accepting Medicaid in the selected states and describes the types of services these facilities offer. Chapter 3 looks at the federal and state roles in the regulation and oversight of IMDs and mental health and SUD treatment programs and facilities. In Chapter 4, we review state standards for behavioral health facilities, including facilities that may be considered IMDs, and we discuss how Medicaid agencies enforce these standards. The final chapter describes federal and state laws governing patient protection in IMDs, including the Americans with Disabilities Act (P.L. 101-336), the Supreme Court decision in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (P.L. 110-343).

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy, and we hope this report will prove useful to Congress as it considers future policy developments affecting Medicaid.

Sincerely,

Melanie Bella, MBA
Chair

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Special thanks to Peggy O'Brien and Ashley Palmer at IBM Watson Health for assisting us with the state policy review and interviews that were essential in understanding how states regulate behavioral health treatment facilities and determine if standards are met. We would also like to thank officials and stakeholders from California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas for taking the time to speak with us regarding oversight of behavioral health facilities in their states.

Our sincere thanks and appreciation to Calder Lynch and his team at the Centers for Medicare & Medicaid Services and experts at the Substance Abuse and Mental Health Services Administration for their technical review and assistance with analyzing data from the National Mental Health Services Survey and the National Survey of Substance Abuse Treatment Services.

We would also like to thank the following organizations for responding to our May 2019 request for public comment. Several points raised in these comments have been incorporated into our analysis.

America's Health Insurance Plans; AmeriHealth Caritas; American Society of Addiction Medicine; Association for Behavioral Health and Wellness; CARF International; Disability Rights Ohio; Federation of American Hospitals; MassHealth; National Alliance on Mental Illness; National Alliance on Mental Illness, Chicago; National Association for Behavioral Healthcare; National Association for Children's Behavioral Health; National Elder Law Foundation; National Health Law Program; Orchid Mental Health Legal Advocacy of Colorado, Inc.; Sheppard Pratt Health System; Division of TennCare; Tennessee Association of Alcohol, Drug & Other Addiction Services; Treatment Advocacy Center; and Washington State Health Care Authority.

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Oversight of Institutions for Mental Diseases

Key Points

- Federal statute defines an institution for mental diseases (IMD) as 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" (§ 1905(i) of the Social Security Act (the Act)).
- The term IMD has meaning only within the context of the Medicaid program; IMDs are not identified as a specific type of provider by other payers, state licensure agencies, or accrediting bodies.
- IMDs have been excluded from receiving Medicaid payments since 1965 to assure that states, rather than the federal government, are responsible for funding inpatient psychiatric services.
- The exclusion encompasses several different types of facilities, including inpatient substance use disorder (SUD) and mental health treatment facilities, as well as residential SUD and mental health programs. As a result, it is difficult to identify and draw conclusions about IMDs as a group.
- Even so, nearly all states are making payments for services provided in IMD settings via various exemptions and authorities, including: statutory exemptions related to older adults and children and youth; demonstration waivers under Section 1115 of the Act; a state plan option; and managed care arrangements under certain conditions.

Federal oversight and guidance related to IMD facilities varies

- Federal standards that apply to facilities considered to be IMDs are largely determined by whether or not facilities are Medicare providers. Because providers accepting Medicare payment must meet that program's standards, hospitals typically seek Medicare certification. However, because Medicare does not cover SUD treatment services in freestanding facilities, there is no Medicare certification process for these facilities.
- Unlike psychiatric hospitals and psychiatric residential treatment facilities, there is no federally mandated standard for most SUD treatment facilities.
- Federal guidance notes that state Medicaid agencies must, at a minimum, use Medicare certification standards for providers recognized by Medicare. However, states have flexibility in how they regulate all other providers, including freestanding SUD treatment facilities and residential mental health treatment programs.

State oversight of IMDs is fragmented

- States do not have licensure criteria specific to IMDs. Rather, they have separate licensure processes for facilities providing inpatient or residential treatment. Standards vary depending on whether a facility provides SUD treatment or mental health care.

- The Medicaid provider enrollment process is the primary mechanism by which states ensure that providers meet Medicaid standards. It complements the licensure and accreditation processes generally carried out by other state agencies.
- MACPAC's review of seven states (California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas) found that oversight of IMDs is fragmented and sometimes spread across multiple state agencies. Often, the single state behavioral health authority is responsible for certain licensure functions. The state survey agency determines compliance with federal quality of care and life and safety standards for a variety of health care services and programs. Typically, these agencies are part of the state health department and separate from the state Medicaid program.
- State licensure standards for facilities subject to the IMD exclusion vary considerably both within and across states. This variation includes differences in prerequisites for licensure, certification, and accreditation for inpatient and residential treatment facilities.
- Generally, state Medicaid programs require inpatient, residential, and outpatient behavioral health facilities to be licensed. In some states, providers must meet additional standards—including those related to staffing, treatment planning, discharge planning, and care coordination—imposed by either the Medicaid program or managed care plans.
- State Medicaid programs and managed care plans may also require accreditation or specific standards for utilization management for SUD and mental health treatment providers.
- States with SUD demonstration waivers approved under Section 1115 of the Act must adopt additional standards for residential SUD treatment facilities. This requirement also applies to a state's Medicaid managed care plans.

Patient protections

- Concern for the civil rights of patients in institutional settings stems from historically poor and sometimes dangerous living conditions in psychiatric facilities. While quality of care in IMDs has improved, poor living conditions and complaints related to quality of care and the rights of patients in IMDs remain an issue. Moreover, individuals with behavioral health conditions still face discrimination and stigma within the health care system.
- Protections for individuals with mental health conditions are well defined. However, whether such protections extend to individuals with an SUD is less clear.
- Patient protections for individuals with behavioral health conditions typically apply to all individuals, not just those enrolled in Medicaid. However, these protections often receive greater attention within the Medicaid program given that it is the single largest payer of behavioral health services.

Overview: Oversight of Institutions for Mental Diseases

Since its inception in 1965, Medicaid has largely prohibited payments for services provided to beneficiaries in institutions for mental diseases (IMDs). Generally referred to as the Medicaid IMD exclusion, this restriction is one of the few instances in the Medicaid program in which federal financial participation is not available for medically necessary and otherwise covered services based on the setting in which they are provided.[1]

Policymakers and advocates have long debated the IMD exclusion's role in limiting access to residential and inpatient behavioral health services for Medicaid beneficiaries. Despite the exclusion, there are several mechanisms states are using to make Medicaid payments for services provided in IMDs. These include Section 1115 demonstrations and in-lieu-of services in managed care.[2] Most recently, provisions enacted in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) let states make payments to IMDs that treat individuals with a substance use disorder (SUD) under the state plan.

Although states are increasingly making payments to facilities that are considered IMDs, there have been few federal actions to change how these facilities are regulated. In this report, MACPAC responds to a statutory requirement in the SUPPORT Act to identify and describe IMDs in selected states and provide a summary of state requirements (e.g., licensure, certification, or accreditation) and Medicaid standards (e.g. clinical and quality standards).

Federal law broadly defines an IMD as 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" (§ 1905(i) of the Social Security Act). Despite this definition, it is challenging to determine which facilities meet the criteria for the IMD payment exclusion, particularly because the exclusion applies only to the Medicaid program. Federal datasets can be used to identify residential and inpatient SUD and mental health facilities offering various treatment modalities, but these sources cannot be used to determine whether a state considers a facility an IMD, whether the facility is otherwise enrolled as a Medicaid provider, or whether it is under contract with a Medicaid managed care plan to provide Medicaid-covered services.[3] Because the IMD exclusion applies to a number of different types of facilities that are primarily regulated by states and because oversight is often fragmented across state agencies, it is difficult to determine how licensing requirements and additional Medicaid standards apply to these facilities as a group. There is also considerable variation in how these facilities are regulated across states.

Below, we provide an overview of the study requirements and MACPAC's approach to its review of state policies and identification of IMDs. In Chapter 1, we outline the history of the IMD exclusion and federal regulations governing Medicaid payment to IMDs. Chapter 2 estimates the number of IMDs accepting Medicaid in seven selected states (California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas) and describes the types of services these facilities offer. In Chapter 3, we summarize the roles of federal and state government agencies in the regulation and oversight of IMDs and selected outpatient behavioral health facilities. Then we look more closely at the selected states to examine their state licensure requirements for inpatient and residential mental health and SUD treatment facilities as well as intensive outpatient behavioral health programs (e.g., those involving partial hospitalization or day treatment services). We also discuss how states enforce licensure standards. In Chapter 4, we review standards that selected state Medicaid programs and managed care plans place on behavioral health facilities, including

facilities that may be considered IMDs, and we discuss how Medicaid agencies enforce these standards. The final chapter describes federal and state laws governing patient protection in IMDs, including the Americans with Disabilities Act (ADA, P.L. 101-336), the Supreme Court decision in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (P.L. 110-343).

Statutory Mandate for the MACPAC Study

Congress, in the SUPPORT Act, requires MACPAC to conduct a study on IMDs receiving Medicaid payment under fee for service (FFS) or managed care based on information collected from a representative sample of states (Appendix). The study must be submitted to Congress on January 1, 2020, and must include the following components:

- a summary of state requirements, such as certification, licensure, and accreditation, that IMDs seeking Medicaid payment must meet and how each state determines if these requirements have been met;
- a summary of state standards, including quality standards, facility standards, and clinical standards, that IMDs must meet to receive Medicaid payment and how each state determines if these standards have been met;
- a description of IMDs receiving Medicaid payment in each state, including the number of these facilities in the state and the types of services provided at each IMD; and
- a description of Medicaid funding authorities used by each state to pay IMDs and any coverage limitations placed on the scope, duration or frequency of services provided in IMDs.

Congress further directs MACPAC to seek input from state Medicaid directors and stakeholders, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), state Medicaid officials, state mental health authorities, Medicaid beneficiary advocates, health care providers, and Medicaid managed care organizations (MCOs). The report may include recommendations for policies and actions by Congress and CMS if such recommendations are deemed appropriate by the Commission.

Study Approach

This study has three components: (1) it documents requirements and standards applied to IMDs seeking Medicaid payment in selected states and how each state determines if requirements are satisfied; (2) it identifies and describes IMD facilities; and (3) it summarizes responses received through public comment from various Medicaid stakeholders.

To help inform our study, we interviewed relevant staff from federal agencies, including the U.S. Department of Health and Human Services Office of the Inspector General, the Office of the Assistant Secretary for Policy and Evaluation, SAMHSA, and various divisions within CMS, including the Disabled and Elderly Health Programs Group, the Clinical Standards Group, the State Demonstrations Group, and the Quality and Safety Oversight Group. We also sought input from several trade associations and advocacy groups.

State requirements applied to behavioral health facilities

MACPAC contracted with IBM Watson Health to document the standards used to regulate SUD and mental health treatment facilities in seven states (Box O-1).

BOX O-1. Seven States Selected for Detailed Review in the MACPAC Study of Oversight of Institutions for Mental Diseases

California. Selected counties in California pay for residential and inpatient substance use disorder (SUD) treatment in institutions for mental diseases (IMDs) through an SUD demonstration waiver under Section 1115 of the Social Security Act. Depending on the county, mental health and SUD treatment services are carved out of managed care and delivered through prepaid inpatient health plans.

Colorado. Colorado pays for treatment in inpatient psychiatric facilities as an in-lieu-of service. The state plans to apply for a Section 1115 SUD demonstration waiver to pay for residential and inpatient SUD treatment in IMD settings. Currently, the state does not pay these facilities using Medicaid funds.

Florida. Over 90 percent of beneficiaries in Florida receive services through managed care. In 2014, Florida implemented a fully integrated specialty managed care plan for beneficiaries with serious mental illness. Florida Medicaid does not pay for inpatient or residential SUD treatment.

Massachusetts. Massachusetts pays inpatient psychiatric facilities that are considered IMDs through a Section 1115 demonstration that was first approved in the 1990s. The state also pays for residential and inpatient SUD treatment programs through a Section 1115 SUD demonstration. The state covers the full continuum of care for both SUD and mental health treatment.

New Jersey. Nearly all beneficiaries in New Jersey receive services through managed care; however, many behavioral health services are delivered under fee-for-service arrangements. For certain populations, managed care plans pay inpatient psychiatric treatment facilities as an in-lieu-of service. The state also has an approved Section 1115 SUD demonstration to pay for residential and inpatient SUD treatment.

Ohio. Managed care plans in Ohio pay for treatment delivered in inpatient psychiatric treatment facilities as an in-lieu-of service. The state pays for residential SUD treatment through its state plan. In September 2019, the Centers for Medicare & Medicaid Services approved the state's Section 1115 SUD demonstration to pay IMDs for these services.

Texas. Over 90 percent of beneficiaries in Texas receive services through managed care. The state carved mental health rehabilitative services into managed care in 2014 and managed care plans pay psychiatric hospitals as an in-lieu-of service. Currently, payments for residential SUD treatment are limited to facilities with 16 or fewer beds.

These states were chosen to represent diversity across several dimensions, including:

- the state's approach to administering inpatient and residential services (e.g., state plan, Section 1115 demonstrations, and in-lieu-of services);
- geographic diversity;
- total Medicaid enrollment;
- Medicaid delivery system (managed care, FFS, or accountable care organizations);
- the range of coverage of inpatient and residential care through Medicaid (e.g., the full continuum of SUD services versus states with gaps in their continuum of care);
- whether the state has a certificate of need process for facilities that may be considered IMDs;
- the state's experience using federal funds to pay for care in IMDs; and
- the severity of the opioid epidemic in the state.

MACPAC reviewed standards used for behavioral health inpatient and residential treatment facilities, and, given the Commission's interest in the behavioral health continuum of care, we also examined state standards for certain specialty outpatient facilities that serve as step-down care when individuals leave inpatient and residential settings (e.g., intensive outpatient and partial hospitalization programs). For each state selected for this project, we captured the following:

- state licensure or certification requirements for each type of facility;
- Medicaid provider requirements, including requirements for facilities that are overseen by Medicaid contractors such as MCOs or administrative services organizations (ASOs); and
- when applicable, MCO or ASO credentialing requirements for these facilities.[4]

To understand how states regulate behavioral health treatment facilities, and how states determine if these standards have been met, we conducted semistructured interviews with several stakeholders in each state. Those interviewed included current and former Medicaid officials, behavioral health providers, beneficiary advocates, and non-Medicaid state agencies (e.g., the state's licensure agencies and the single state substance use or mental health authority). Preliminary themes and findings from the interviews are discussed later in this report.

Identifying IMDs

The SUPPORT Act requires MACPAC to report on IMDs that receive Medicaid payment in a representative sample of states, including the number of these facilities, a description of the facilities, and the types of services provided at each IMD. To fulfill this requirement, MACPAC examined federal studies of IMD facilities, specifically, a 2017 U.S. Government Accountability Office (GAO) report that analyzed the capacity of IMDs using data from two SAMHSA surveys, the National Mental Health Services Survey (N-MHSS) and the National Survey of Substance Abuse Treatment Services (N-SSATS) (GAO 2017).[5] MACPAC analyzed both datasets to identify the number of mental health and SUD facilities that may be considered IMDs in our sample of seven states that reported accepting Medicaid payment. Then we identified the types of services they offered, including certain treatment modalities (e.g., individual counseling, family therapy, and cognitive behavioral therapy), pharmacotherapies, peer-based services, and social services.

The SUPPORT Act further requires MACPAC to identify the process, including any time frame, used by IMDs to assess and reassess an individual's treatment needs. SAMHSA's datasets do not capture such information; however, MACPAC was able to identify whether facilities offered screening and assessment services. In addition, through our state policy review, we were able to identify any mandated time frames associated with patient assessments and reassessments.

MACPAC is also charged with describing the discharge process used by IMDs, including any relevant services or facilities provided or used in the discharge process. Using SAMHSA's datasets, we were able to identify whether facilities offered any outpatient services (e.g., regular outpatient, intensive outpatient, or partial hospitalization) or outpatient detoxification services. In addition, we identified which facilities offered discharge planning and aftercare services. Through our state policy review, we were able to identify any mandated time frames associated with discharge planning and aftercare services.

Additional public comment

To meet SUPPORT Act requirements related to stakeholder input, MACPAC conducted interviews and issued a request for public comment in May 2019, inviting any interested stakeholders to submit comments relevant to the topics covered in this study. The request was distributed to more than 3,000 contacts from the Commission's mailing list, and it was posted on the Commission's website and announced via Twitter. MACPAC received comments from 20 organizations and individuals, including Medicaid agencies, beneficiary advocates, provider associations, and managed care entities. The majority of comments we received during the public comment period fell outside the scope of our study, but we have included all relevant feedback in this report.

Endnotes

[1] There are two main statutory exemptions to this policy: (1) an exemption for adults over the age of 65 has been in place since the program's inception in 1965 with the Social Security Amendments of 1965 (P.L. 89-97); and (2) an exemption for children and youth under the age 21 that was implemented in the Social Security Amendments of 1972 (P.L. 92-603). For children and youth under age 21, only services delivered in a psychiatric residential treatment facility, a psychiatric hospital, or a psychiatric unit of a general hospital are exempted from the Medicaid IMD exclusion. Other exemptions to the IMD exclusion have been made available through regulations governing managed care, Section 1115 demonstrations, and a new state plan option. Disproportionate share hospital (DSH) payments are also used by some states to make payments to IMDs (MACPAC 2019).

[2] An in-lieu-of service is a service or setting that is not included under the state plan, but is a clinically appropriate, cost-effective substitution for a covered service or setting (42 CFR 438.3(e)(2)).

[3] Centers for Medicare & Medicaid Services guidance notes that SUD treatment facilities that rely on peer counseling and a 12-step model and that primarily use lay individuals as counselors are not considered IMDs. Moreover, the services these facilities provide are not eligible for Medicaid payment because they are not considered medical services. Although data collected by the Substance Abuse and Mental Health Services Administration identify which facilities offered peer services and 12-step facilitation, there is no way to distinguish facilities that offered a medical model from those whose services were largely delivered by lay individuals and peers.

[4] Some states contract with vendors known as administrative services organizations (ASOs) to administer elements of their programs. ASOs are typically paid a non-risk-based fee to provide administrative services on behalf of the state. However, depending on how an ASO is structured, it may or may not be classified as a managed care arrangement.

[5] The N-MHSS surveys facilities that provide mental health services and the N-SSATS surveys facilities that provide SUD services. Both surveys are a census of facilities that provide either mental health or SUD services, respectively.

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Chapter 1:

History and Federal Policies Related to the Institutions for Mental Diseases Exclusion

CHAPTER 1: History and Federal Policies Related to the Institutions for Mental Diseases Exclusion

Until the 1950s, mental health care was largely provided in state psychiatric hospitals. Poor living conditions in these facilities and changes in public perception regarding the civil rights of individuals with mental health conditions gradually led to the deinstitutionalization movement, which promoted shifting mental health care from institutional settings to the community.

Over time, deinstitutionalization of individuals with behavioral health conditions has advanced through statutory changes, court decisions, and advocacy efforts. The establishment of Medicaid in 1965 also may have accelerated deinstitutionalization by providing a new source of federal funding for outpatient mental health care, and by largely prohibiting payment for services provided in institutions for mental diseases (IMDs).

A brief history of the deinstitutionalization movement is presented below. This chapter also discusses the Medicaid IMD exclusion and how it has evolved over time to allow states to make payments for IMD services provided to certain populations and under certain delivery systems. The discussion includes populations that have been exempted from the IMD exclusion, other federal authorities that allow states to make payments to IMDs, and the extent to which these authorities are being used.

Historical Context

The IMD exclusion has been in place since 1965; however, the basis for this exclusion had already been long established. Historically, financing of inpatient psychiatric treatment was a state and local responsibility; as far back as 1890, every state had at least one publicly funded mental hospital (NLM 2017). The number of inpatient psychiatric beds grew, and by the 1950s there were approximately 559,000 beds in the United States (Murphy 2014).

States continued to act as the primary payer for inpatient behavioral health services even as the federal government began paying for institutional care for certain populations with the enactment of the Kerr-Mills Act of 1960 (P.L. 86-778). Kerr-Mills authorized federal medical assistance to persons age 65 and older with low incomes and allowed federal funds to be used to pay for institutional care for this population (Watson 2012). Although Kerr-Mills established that the federal government was partially responsible for institutional care, its provisions applied only to this limited population. When Medicaid was created in 1965, this distinction was maintained through the IMD exclusion, which prohibited Medicaid payment to IMDs for beneficiaries age 21–64 (P.L. 89-97).

It is important to note that changes in federal payment policy and treatment approaches for mental health services generally did not apply to treatment for substance use disorder (SUD), which traditionally had been delivered independently of both mental health and general health care. For example, Alcoholics Anonymous was founded in 1935 in part because psychiatric and general medical providers did not attend to individuals with SUD (OSG 2016). If treatment was available, it was often delivered in asylums and so-called narcotic farms run by prisons (OSG 2016). It was not until the 1960s and early 1970s that alcoholism was recognized as a primary disease and not a symptom of a mental health condition (Baumohl and Jaffee 2001). Despite growing recognition of SUD as a chronic disease, the lack of interest by the medical profession in caring for individuals with an SUD, and continued stigma related to the disease resulted in treatment programs being run and financed separately from other medical care for many years (OSG 2016).

Deinstitutionalization

Efforts to move the treatment of individuals with psychiatric conditions from large state-run institutions to community-based providers

predates both the Kerr-Mills Act and the establishment of Medicaid. This movement, called deinstitutionalization, began in the 1950s due to concerns about the high rates of individuals with severe mental illness living in public mental health facilities, the poor living conditions in such institutions, and the infringement of civil rights of institutionalized individuals (Parks and Radke 2014, MACPAC 2019a). The development of antipsychotic drugs created more, and often more effective, treatment options that allowed more individuals to reside in the community, which also helped advance deinstitutionalization (Shen 1999).

Deinstitutionalization as a matter of federal policy grew out of the work of the Joint Commission on Mental Illness and Health in 1955, which assessed national mental health conditions and resources and made recommendations on federal actions to provide adequate care for individuals with mental illness (Postal 2014). The Joint Commission's recommendations to Congress included ensuring that there were enough mental health clinics to meet demand (including psychiatric units in community general hospitals) and converting large state mental hospitals into intensive treatment centers. The Joint Commission called for doubling expenditures for public mental health services over 5 years and tripling expenditures over 10 years (Joint Commission on Mental Illness and Health 1961).

In 1963, and again in 1965, federal programs were created to build and staff community mental health centers, giving funds directly to providers rather than to states. This resulted in a significant increase in community mental health centers and acute care beds in the community rather than in psychiatric hospitals (Koyanagi 2007).[1] From the early 1970s until the 1990s, statutory changes, court decisions, and advocacy efforts to support community-based care for individuals with mental illness led to the closure of large state mental hospitals, reducing the number of individuals receiving care in large institutions (Bagenstos 2012, Torrey 1997). (A full listing of key events related to federal deinstitutionalization policies and the IMD exclusion is presented in Appendix 1A.)

In the 1970s, court cases resulted in the creation of new standards of care for public psychiatric hospitals.[2] To meet the new standards, most states had to direct more funding into existing state-run psychiatric facilities (Frank and Glied 2006). At the same time, states also began developing small inpatient psychiatric units in general hospitals to treat acute mental health conditions that had previously been treated at state hospitals. States also began shifting care for individuals age 65 and older with serious mental illness (SMI) from large inpatient psychiatric hospitals to nursing homes (Frank and Glied 2006).

Enactment of the Americans with Disabilities Act (ADA, P.L. 101-336) on July 26, 1990, marked a significant change in civil rights law by prohibiting discrimination against individuals with disabilities in employment and public accommodations. Under Title II of the ADA, individuals with disabilities may not be excluded from participating in services, programs, or activities provided by state and local governments, including Medicaid (MACPAC 2019a).

The ADA's integration mandate has been implemented through U.S. Department of Justice regulations that require public entities to administer services, programs, and activities in the most integrated settings appropriate to the needs of qualified individuals with disabilities (28 CFR 35.130(d)). The regulations also include the reasonable modifications provision, which states that public entities must make reasonable modifications in policies, practices, and procedures to avoid discrimination on the basis of disability, unless the modification would fundamentally alter the nature of the services, program, or activity (28 CFR 35.130(b)). This reasonable modifications provision has played a key role in litigation aimed at determining whether states are taking reasonable measures to prevent discrimination against individuals with disabilities (MACPAC 2019a). (Patient protections afforded to individuals with mental health conditions under the ADA, and the *Olmstead v. L.C.* decision are discussed in greater detail in Chapter 5.)

More recent efforts have continued to focus on supporting people with mental health conditions in the community. In 2003, the President's New Freedom Commission on Mental Health recommended creation of a more consumer- and family-oriented mental health system that would give a greater number of individuals with serious mental illness the chance to live meaningful lives in the community (New Freedom Commission 2003). In 2005, the Deficit Reduction Act of 2005 (P.L. 109-171) gave states additional resources to transition individuals from institutional settings into the community though the Money Follows the Person demonstration, which was expanded in 2010 through the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Medicaid and the IMD Exclusion

The deinstitutionalization movement coincided with the enactment of the Medicaid program in 1965 which from its inception included an explicit prohibition on providing states with federal financial participation (FFP) for IMD services. This prohibition was established for two main reasons. First, as noted above, changes in policy, clinical practice, and public opinion were working to advance deinstitutionalization and improve the care of individuals with behavioral health disorders. States were increasingly providing treatment and supports, whenever possible, to individuals with mental or physical disabilities in the community as opposed to in an institution (Frank and Glied 2006). Second, Congress intended to prevent states from shifting costs for psychiatric institutional care that had traditionally been provided by the states to the federal government.

The term IMD is broad and only has meaning within the context of the Medicaid program; IMDs are not identified as a specific type of provider by other payers, state licensure agencies, or accrediting bodies. The definition encompasses several different types of facilities, including inpatient SUD and mental health treatment facilities, as well as residential SUD and mental health programs.

In this section, we discuss the IMD exclusion, guidance issued by the Centers for Medicare & Medicaid Services (CMS) that states use to identify IMDs, and when nursing homes and SUD treatment facilities may be considered IMDs per CMS guidance.

Definition of IMD

Federal law defines an IMD as 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" (§ 1905(i) of the Social Security Act (the Act)). The term mental diseases includes diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subsection of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease. Because the ICD classifies SUD as a mental disorder, facilities providing inpatient and residential SUD treatment may be considered IMDs (CMS 2015a).

Facilities classified as IMDs are not eligible to receive Medicaid payment for services provided to Medicaid beneficiaries residing in them. It is important to note that the U.S. Department of Health and Human Services (HHS) interprets the exclusion to cover not only services furnished by an IMD to patients inside the facility, but also services furnished to the IMD's patients outside the facility. CMS has further noted in sub-regulatory guidance that the exclusion "was designed to assure that states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services" (CMS 2016).

CMS guidance

Because payment guidelines issued by CMS broadly apply to any institution that meets certain

criteria and do not specifically define categories of institutions, a state's determination of whether an institution is an IMD depends on a number of factors (Rosenbaum et al. 2002). Section 4390 of CMS's *State Medicaid Manual* defines the criteria that a state must consider in its determination, specifically whether:

- the facility is licensed or accredited as a psychiatric facility;
- the facility is under the jurisdiction of the state mental health authority;
- the facility specializes in providing psychiatric or psychological care and treatment (e.g., as evidenced by a review of patient records, proportion of psychiatric or psychological specialized staff); [3] and
- the current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases (CMS 2015a).[4,5]

CMS also offers guidance to states on situations in which a facility may have components that are commonly owned or governed (e.g., a nursing facility, or a psychiatric wing of a hospital). When multiple components are involved, the *State Medicaid Manual* advises CMS regional offices to examine the following facts related to a specific institution: [6]

- governance (whether all components of the facility are controlled by one owner or governing body);
- medical oversight (whether one chief medical officer is responsible for the medical staff activities for all the facility's components);
- administrative control (whether one chief executive officer controls all administrative activities in all of the facility's components);
- licensure (whether any components are separately licensed);
- organizational and geographic separation (whether separation of components means that it is not feasible for the institution to operate as a single entity); and
- ability of each component to meet conditions of participation independently (CMS 2015a).

If a component of a facility is determined to be its own independent entity, then that component would be examined for its status as an IMD (CMS 2015a).

SUD treatment facilities. CMS distinguishes between facilities that follow a psychiatric model, in which treatment is provided by medically trained and licensed personnel, and facilities that follow a peer counseling or 12-step model where lay persons provide encouragement and support. If services are psychological in nature, then they are considered medical treatment of a mental disease. Facilities with more than 16 beds that provide medical treatment of an SUD to the majority of their patients are considered IMDs (CMS 2015a).

In contrast, facilities that rely on peer counseling and a 12-step model and primarily use lay individuals as counselors are not considered IMDs. However, as noted above, the services provided by these facilities are not considered covered Medicaid services (CMS 2015a).

Nursing facilities. A nursing facility that participates in Medicaid may also be considered an IMD depending on its patient mix. If more than 50 percent of patients are admitted to the nursing facility based on a need for behavioral health services, then that facility is considered an IMD (Rosenbaum et al. 2002).[7]

Nursing facilities are required to screen for and provide behavioral health services to all residents requiring them (42 CFR 483.40). Under the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), the Preadmission Screening and Resident Review (PASRR) process requires all applicants to Medicaid-certified nursing facilities to be screened for serious mental illness; individuals with a positive screen are then further evaluated to determine whether they are appropriate for nursing facility admission and, if they are to be admitted to the

nursing facility, whether the individual will need specialized services to support the individual's mental illness. These specialized services, which are of a greater intensity than the behavioral health services offered by nursing facilities, must be arranged for and provided by the state rather than the facility. Although the provision of specialized services for mental illness under PASRR might cause a nursing facility to be identified as an IMD, PASRR can also serve as an important tool for avoiding such designation if it is used to divert individuals with mental illness into other, more appropriate, programs or settings, including home- and community-based settings.

Exemptions from the IMD Exclusion

Despite popular perceptions that the IMD exclusion precludes all Medicaid payments to these facilities, there are, in fact, multiple ways for services provided in IMDs to be covered. First, there are two main statutory exemptions from the IMD exclusion related to older adults and children and youth. Second, states may pay for services in IMD settings in the following ways: via a demonstration waiver under Section 1115 of the Social Security Act; via a state plan option as well as a limited exception for pregnant women recently made available through the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271); and through managed care arrangements under certain conditions (CMS 2016). Most states also make disproportionate share hospital (DSH) payments for uncompensated care to hospitals that are considered IMDs, although this is not technically an exemption to the IMD exclusion.

Nearly all states use at least one of these options (in-lieu-of payments in managed care, state plan waivers services for adults over the age of 65, or Section 1115 demonstration) to draw down FFP to pay for services in IMDs (Figure 1-1).[8] In many instances, states report using more than one of these authorities.

Statutory exemptions for older adults and children and youth

From Medicaid's inception, states have been able to pay for services provided to individuals age 65 and older in IMDs as long as certain requirements are met. Specifically, states must develop alternative methods of care and individual care plans for each patient.[9] In 2018, at least 42 states covered IMD services under Medicaid for adults age 65 and older (KFF 2019).

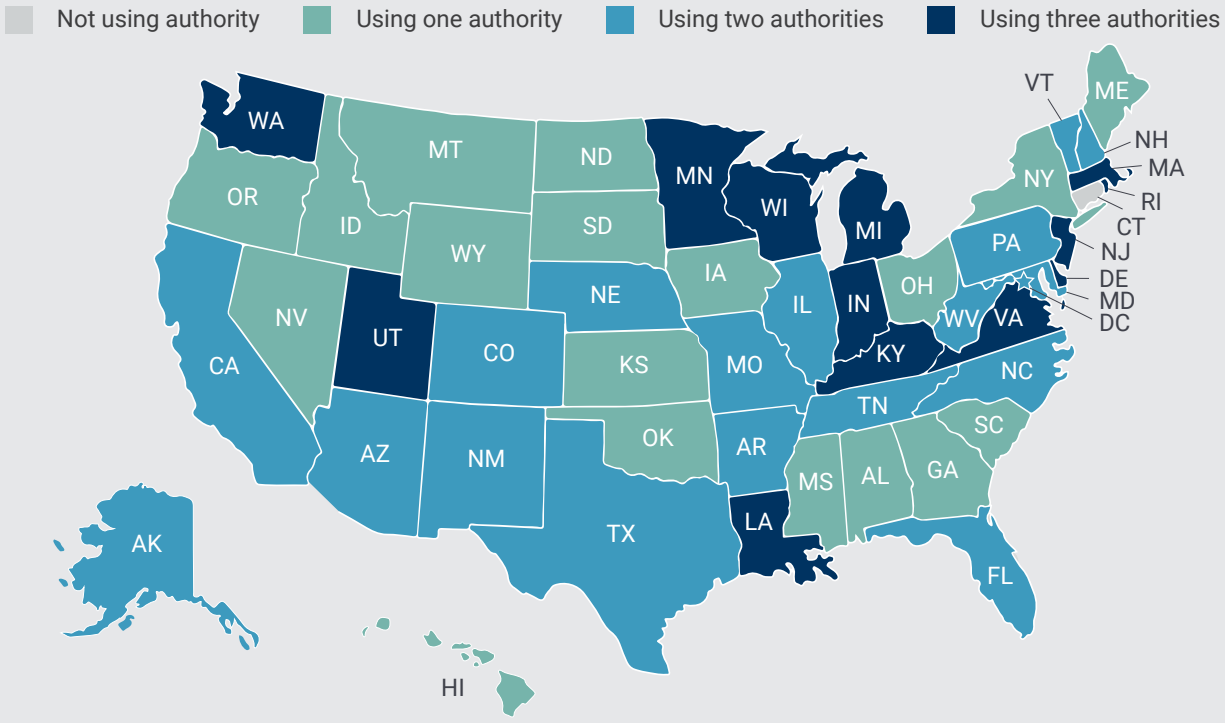
The Social Security Amendments of 1972 (P.L. 92-603) allowed states to cover IMD services for children and youth under age 21 under Medicaid (commonly referred to as the psych under 21 benefit). Originally, this benefit could be administered only in inpatient psychiatric facilities that met certain requirements. In 1990, the Omnibus Budget and Reconciliation Act (P.L.101-508) provided CMS with the authority to specify additional inpatient settings serving children and youth under the age of 21. In 1994, CMS used this authority to establish psychiatric residential treatment facilities (PRTFs) as a separate category of inpatient settings where the psych under 21 benefit could be provided; however, regulations for PRTFs were not finalized until 2002 (CMS 2007). To qualify as a PRTF, a provider must enroll as a Medicaid provider and obtain accreditation. (Additional standards for PRTF facilities are discussed in Chapter 3 of this report.)

Section 1115 waivers and demonstration programs

A number of states have been granted authority to receive FFP for services delivered in IMDs for individuals age 21–64, either through Section 1115 waivers or other demonstration programs such as the Medicaid emergency psychiatric demonstration (MEPD). For example, from 1997 to 2007, CMS approved Section 1115 waivers that permitted states to draw down FFP and make payments to IMDs in 10 states (Oss 2012).

Since the expiration of the MEPD demonstration, CMS has issued three clarifications to its guidance to states seeking Section 1115 authority to make

FIGURE 1-1. Use of Federal Authorities to Make Payments to Institutions for Mental Diseases by State, 2018–2019



Notes: This map captures instances in which states pay for services provided in institutions for mental diseases (IMDs) as a state plan benefit for beneficiaries over the age of 65, through demonstration waivers under Section 1115 of the Social Security Act, 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 waivers reflects approved demonstrations as of October 2019. States reporting use of the in-lieu-of managed care authority for 2019 were included in this chart as using at least one Medicaid authority to pay for services in IMDs. Information regarding state use of disproportionate share hospital (DSH) payments to IMDs in 2018 is unavailable and not reflected in this figure. This figure does not include states that cover IMD services for children and youth under age 21 under Medicaid per the Social Security Amendments of 1972 (P.L. 92-603). As of October 2019, CMS had not approved any state plan amendments authorized by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271) to pay for services in IMDs.

Source: KFF 2019, MACPAC 2019b, and Gifford et al. 2019.

payments to IMDs. The first clarification was issued in 2015 and is specific to short-term residential and inpatient stays in IMDs for beneficiaries with an SUD. This guidance was replaced by a clarification issued in November 2017 outlining current parameters for states to obtain a Section 1115 waiver to pay for short-term inpatient and residential SUD treatment in IMDs. In 2018, additional clarifications outlined instances in which FFP could be available for adults with SMI or children with severe emotional disturbance (SED) in IMDs.[10]

Medicaid emergency psychiatric demonstration. Established in Section 2707 of the ACA, the MEPD program permitted Medicaid payment to participating private psychiatric facilities for emergency stabilization services provided to

Medicaid beneficiaries age 21–64. Eleven states and the District of Columbia participated in this demonstration from 2012 to 2015. The authority for CMS to run the demonstration was extended through 2019 under the Improving Access to Emergency Psychiatric Care Act (P.L. 114-97) (CMS 2015b). However, CMS decided not to extend or expand the demonstration because the federal government would likely incur more costs if the demonstration continued (Mathematica 2016).

For states participating in the MEPD program, evaluators found that paying for such psychiatric services in IMDs had little to no effect on inpatient admissions, length of stay, or emergency department (ED) visits (Mathematica 2016).

Section 1115 SUD demonstrations. As of October 2019, 26 states have received approval for Section 1115 SUD demonstrations to pay for SUD treatment services in IMD settings. An additional three states have requested this authority; all are pending CMS approval. According to the CMS guidance issued in 2017, states are expected to achieve a statewide average length of stay of 30 days. Because these waivers are intended to encourage development of a comprehensive approach to treating SUDs, states must meet certain criteria meant to increase capacity and improve care:

- **Provider capacity.** States must cover services across a comprehensive continuum at the following levels of care: medication-assisted treatment (MAT), outpatient, intensive outpatient, residential, inpatient, and medically supervised withdrawal management. Within 12 months of approval, states must complete an assessment of the availability of providers who are enrolled in Medicaid and accepting new patients at these levels of care.
- **Phased-in provider requirements.** Between 12 and 24 months following demonstration approval, states must ensure that residential providers meet the American Society of Addiction Medicine criteria or other nationally recognized, evidence-based, SUD-specific program standards, and that residential providers offer their patients access to MAT. During the initial implementation period, CMS will accept interim provider qualifications so states can receive FFP as they work toward implementing the national standard.
- **Patient placement criteria.** Between 12 and 24 months following demonstration approval, states must require providers to use an evidenced-based, SUD-specific patient assessment tool. Within 24 months of demonstration approval, states must also ensure implementation of an independent utilization management approach that ensures beneficiaries have access to services at the appropriate level of care, that interventions are appropriate for the diagnosis and level of care, and that there is an independent process for reviewing placement in residential settings.
- **Opioid prescribing, naloxone, and prescription drug monitoring.** Throughout the course of the demonstration, states must implement opioid prescribing guidelines and other strategies to prevent opioid misuse. States must also expand coverage of and access to naloxone for overdose reversal. Strategies to increase the use of prescription drug monitoring programs and to improve their functionality are also required.
- **Care coordination strategies.** Between 12 and 24 months following demonstration approval, states must implement policies to ensure that residential and inpatient facilities link beneficiaries, especially those with an opioid use disorder, with community-based services and supports following stays in these facilities.
- **Evaluation and reporting.** In addition to their regular Section 1115 demonstration reports, states are required to include information on performance measures and milestones, including improved adherence to treatment and reduced use of ED and inpatient hospital settings. Specifically, they must report on progress toward meeting six standardized

milestones, some of which must be met within 12 and 24 months of demonstration approval while others may be met over the course of the demonstration. States are also required to conduct independent interim and final evaluations that address the milestones, performance measures, and other data. States are subject to a deferral of payment of $5 million per item (e.g., an evaluation report) if they fail to submit an acceptable and timely evaluation design or fail to file required reports in a timely manner.[11]

- **Availability of federal financial participation.** FFP for services in IMDs is contingent upon CMS approval of each state's implementation plan detailing how it will meet the six milestones; FFP may be withheld if there is inadequate progress toward meeting the milestones and goals. States also must be in full compliance with budget neutrality requirements at the end of the demonstration period or CMS will recover the difference from the state (CMS 2017a).

Section 1115 demonstration for adults with SMI or children with SED. As of October 2019, no state has received approval to pay for psychiatric treatment services in IMD settings under CMS guidance released in November 2018; however, Massachusetts and Vermont have authority to pay for psychiatric care in IMDs that predates this guidance. The District of Columbia, Indiana, and Vermont have applications for SMI/SED demonstrations pending CMS approval. Similar to the Section 1115 SUD demonstration opportunity, the SMI/SED demonstration allows states to pay for treatment in IMDs. As with the SUD demonstration, states are expected to achieve a statewide average length of stay of 30 days for beneficiaries receiving psychiatric care in an IMD. States must also ensure that a continuum of care is available for beneficiaries with SMI or SED and meet several evaluation and reporting requirements.

To receive approval and FFP for IMD services, states must meet a number of demonstration goals and milestones. Generally, these focus on reducing use of and lengths of stay in EDs for beneficiaries with SMI or SED, improving access to community-based services, and improving care coordination for beneficiaries leaving IMD settings. States are expected to meet the following milestones by the end of the first two years of the demonstration:

- **Increasing access to a continuum of care.** States must commit to a CMS-approved financing plan to increase availability of non-hospital-based and non-residential crisis-stabilization services, including services made through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation or assessment centers, as well as ongoing community-based services such as intensive outpatient treatment, assertive community treatment, and integrated care settings (e.g., certified community behavioral health clinics). In addition, states must implement strategies to increase capacity to track the availability of inpatient and crisis-stabilization beds to help connect individuals to care as soon as possible. States must require providers, plans, and utilization review entities, including managed care organizations (MCOs), to use a publicly available, evidenced-based patient assessment tool to help determine appropriate level of care and length of stay. States must also conduct an annual assessment of the availability of mental health services throughout the state.
- **Ensuring quality of care.** To receive Medicaid payment, participating psychiatric hospitals and residential settings must be licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and must be accredited by a nationally recognized accreditation entity (e.g., the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities). States must establish an oversight and auditing process to ensure facilities in the state

meet licensure or certification requirements and accreditation requirements; unannounced visits must be part of this process. Facilities must also meet federal program integrity requirements and must be able to address comorbid physical health conditions, either with on-site staff, telehealth arrangements, or through partnerships with local providers. In addition, facilities must screen beneficiaries for comorbid physical health conditions and SUDs.

Consistent with existing federal regulations, states must have a process for conducting risk-based screening of all newly enrolled providers, as well as revalidating existing providers. States must also use a utilization review entity, such as an MCO or administrative services organization, to ensure that beneficiaries have access to the appropriate levels and types of care, that lengths of stay are limited to what is medically necessary, and that only those who have a clinical need to receive treatment in an IMD are receiving treatment in those facilities. Finally, states must implement strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED. Such strategies may include the use of peers to help with discharge and referral to treatment providers.

- **Improving care coordination and transitions to community-based care.** States must implement a process to ensure that IMDs provide intensive pre-discharge, care coordination services to help transition beneficiaries to community-based settings, and states must require community-based providers to participate in such efforts. To enhance care coordination and improve health outcomes for beneficiaries with SMI and SED, states must implement strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health care providers. States must implement a process to assess the housing needs of beneficiaries transitioning from IMDs to the community and connect those who are experiencing homelessness or those who lack stable housing with community providers that coordinate housing services where available. A process must be established to require IMDs to have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by beneficiaries by contacting them directly and by contacting the community-based provider to which the beneficiary was referred.
- **Early identification and engagement in treatment.** States must implement strategies to identify individuals with serious mental health conditions, particularly adolescents and young adults, and engage them in treatment sooner. Engagement strategies include supported employment and supported education programs. States must also establish specialized settings and services, including crisis-stabilization services, focused on the needs of young people experiencing SMI or SED. States must also integrate behavioral health care into non-specialty care settings to improve early identification of serious mental health conditions and to improve awareness of and linkages to specialty treatment providers (CMS 2018).
- **Evaluation and reporting.** After demonstration approval, CMS and participating states will develop a monitoring protocol. States will be required to submit quarterly and annual monitoring reports as well as independent interim and final evaluations that address the milestones, performance measures, and other data. Participating states will report on a common set of measures that demonstrate progress toward reaching the demonstration's goals. States must conduct an annual assessment of the availability of mental health services throughout the state, particularly crisis-stabilization services, and provide updates on steps taken to increase availability to a continuum of care. States are subject to a deferral payment of $5 million per item if they fail to submit a timely evaluation design or any other required report. CMS will

conduct a midpoint assessment between years two and three of the demonstration to determine whether a state is making sufficient progress toward meeting the milestones and performance measure targets. States at risk of not meeting targets will submit modifications to their implementation plans. Further, FFP may be withheld if states are not making adequate progress on meeting the milestones and goals agreed upon by the state (CMS 2018).

States participating in the SMI/SED demonstration are also required to submit a health information technology (HIT) plan that describes the state's ability to leverage health IT, advance health information exchanges, and ensure HIT interoperability. The plan must address electronic care plan sharing, care coordination, and behavioral and physical health integration. In the SMI/SED guidance, CMS advises it will provide additional information on these requirements (CMS 2018).

State plan option for SUD

The SUPPORT Act created a new state plan option to allow states to pay for care for Medicaid beneficiaries age 21–64 with at least one SUD in certain IMD settings. Under this option, FFP is available to pay for services provided in IMD settings for a maximum of 30 days per 12-month period per eligible beneficiary. States may use this option from October 1, 2019, through September 30, 2023. For a state to be eligible for FFP, the following requirements must be met:

- **Coverage of outpatient, residential, and inpatient services.** States must cover services consistent with at least six levels of care; four of these services must be outpatient levels of care. The state must also cover at least two inpatient or residential levels of care.
- **Medication-assisted treatment.** Facilities that are considered IMDs must follow reliable, evidence-based practices and offer at least two forms of MAT on-site. For opioid use disorder, this must include one antagonist (e.g., naltrexone) and one partial agonist (e.g., buprenorphine).[12] IMDs must also be able to provide care at a lower level of clinical intensity or have an established relationship with another facility or provider that can deliver a lower level of care and accepts Medicaid.
- **Maintenance of effort.** States must maintain non-federal, non-Medicaid spending levels for services furnished to Medicaid beneficiaries age 21–64 with at least one SUD in IMDs that would qualify under this state plan option and for outpatient and community-based settings. Outpatient and community-based service spending includes all outpatient treatment as well as spending on drugs used to treat SUD, drug testing, monitoring for medication adherence, evidenced-based recovery support services, and other services as designated by the Secretary of HHS (the Secretary). To ensure compliance with the maintenance of effort provision, a state must submit a report to the Secretary prior to state plan approval.
- **Screening.** Prior to approval of a state plan amendment, the state must notify the Secretary how the state will ensure that individuals receive appropriate evidenced-based clinical screening before they receive services in an IMD, including the initial screening and periodic assessments to determine if care is appropriate.
- **Care transitions.** States must ensure appropriate transitions of care for individuals leaving IMDs and ensure that placement in an IMD would allow an individual to successfully transition to the community, considering factors such as proximity to an individual's support network.

Limited exception for pregnant women

Section 1012 of the SUPPORT Act creates a new limited exception to the IMD exclusion for certain pregnant and postpartum women who are eligible for Medicaid on the basis of pregnancy. Specifically, the exception allows states to claim FFP for non-IMD services delivered to women during pregnancy and up to 60 days postpartum who are patients in an IMD for the treatment of an SUD. It is important to note that this section of the SUPPORT Act does not make FFP available for services delivered in an IMD; it only makes FFP available for items and services provided outside of an IMD.[13] CMS guidance issued in July 2019 encourages states to implement this provision as quickly as possible to ensure that pregnant and postpartum women with an SUD are able to receive services (CMS 2019). However, states are expected to be in compliance by October 1, 2020, with considerations made for state legislative time frames.

In-lieu-of payments to institutions for mental diseases

MCOs and prepaid inpatient health plans (PIHPs) can pay for treatment in IMDs as an in-lieu-of service, which is a service that is not included under the state plan, but is a clinically appropriate, cost-effective substitution for a similar, covered service (42 CFR 438.3(e)(2)). Payment for treatment in IMDs as an in-lieu-of service applies to risk-based arrangements only. SUD or mental health services provided in an IMD through a fee-for-service delivery system or through non-risk-based managed care arrangements are not eligible for FFP under this provision. Of the 40 states using MCOs or PIHPs, 31 states reported that they planned to allow in-lieu-of payments to IMDs in 2018. An additional three states planned to begin using this authority in 2019 (Gifford et al. 2019).

Prior to the finalization of Medicaid managed care regulations in 2016, MCOs and PIHPs used in-lieu-of services to pay for care in alternative settings without federally mandated day limits. CMS estimates that in 2010, approximately 17 states allowed MCOs and PIHPs to use the in-lieu-of provision to pay for services in IMDs and another 9 states were potentially allowing this practice (GAO 2017). However, CMS further noted during rulemaking that it was unsure how many states permitted this practice because this information cannot be determined from the contracts between states and MCOs or PIHPs (CMS 2015c).[14]

Managed care regulations finalized in July 2016 permitted FFP for capitation payments made on behalf of a beneficiary age 21–64 who is receiving inpatient or residential treatment in an IMD for a short-term stay of no more than 15 days during the period of the capitation payment (42 CFR 438.6(e)). The SUPPORT Act codified this provision in 2018.

Even with the regulatory and statutory changes, states have retained a degree of flexibility regarding payments to IMDs. For example, CMS clarified in the final rule that states "may pay for services provided to individuals eligible under the state plan that are enrolled in a managed care program who are patients in an IMD for a longer term than 15 days within the period covered by the capitation payment, either directly or through a separate arrangement without FFP." Also in the final rule, CMS clarified that "if the managed care plan (or physician) believes that a stay of longer than 15 days is necessary or anticipated for an enrollee, the use of this specific in-lieu-of service is likely not appropriate" (CMS 2016). In addition to discussing state options in the final rule preamble, CMS published a frequently asked questions document that included clarification that a state can make a prorated capitation payment to cover the days when the enrollee is not a patient in an IMD, but FFP is not available for payments related to days when the enrollee is in an IMD when the requirements of Section 438.6(e) are not met (CMS 2017b).

Some states viewed the 15-day limit as more restrictive than prior practice. For example, Colorado paid for in-lieu-of services in IMDs through a waiver under Section 1915(b) of the Act for more than 20 years. As such, the change in policy was disruptive and created additional administrative issues for the state. For example, the state opted

to recover monies paid to facilities for lengths of stay that exceed 15 days (IBM Watson Health 2019). The state plans to submit an application for a Section 1115 SUD demonstration to pay for services in IMDs that are required beyond 15 days.

Some stakeholders have also criticized the 15-day limit as arbitrary and unrelated to meeting the needs of individuals with an SUD. Many have called for an increase in or removal of the 15-day limit (AHIP 2019, AmeriHealth Caritas 2019, TennCare 2019). However, CMS has previously advised states that if they wish to receive FFP for capitation payments made for beneficiaries with IMD stays that exceed 15 days, they may do so through a Section 1115 demonstration (CMS 2016).[15]

Disproportionate share hospital payments to institutions for mental diseases

State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. States can make DSH payments for uncompensated care costs at IMDs as long as such payments do not exceed the IMD-designated DSH limit, which is the lesser of the amount of DSH funds that the state paid IMDs in fiscal year (FY) 1995 or 33 percent of the state's total FY 1995 DSH allotment. In state plan rate year 2014, 37 states and the District of Columbia made $2.4 billion in DSH payments to IMDs. Maine made DSH payments exclusively to IMDs, and four states—Alaska, Connecticut, Maryland, and North Dakota—spent more than half of their DSH allotments on payments to IMDs (MACPAC 2019c). Eighteen states made DSH payments to IMDs up to the maximum allowable amount (GAO 2019).

Endnotes

[1] During the 1970s, Congress reduced federal funding for community mental health centers because the budget was constrained due to the Vietnam War and competing priorities (Frank and Glied 2006).

[2] *Wyatt v. Stickney* (325 F. Supp. 781 (M.D. Ala. 1971)) established that psychiatric patients treated in state mental hospitals have a right to treatment and set standards for what constituted a minimally acceptable quality of care in public psychiatric hospitals.

[3] Facilities with more than 16 beds that follow a psychiatric model (e.g., care is performed by medically trained and licensed personnel) and provide services that are psychological in nature are considered IMDs (CMS 2015a).

[4] When applying the 50 percent guideline to a nursing facility, the guideline is met if more than 50 percent of residents require specialized services for treatment of serious mental illness, as defined in the DSM. But facilities providing non-intensive care for chronically ill individuals may also be IMDs. All nursing facilities must provide mental health services which are of a lesser intensity than specialized behavioral health services to all residents that are in need of such services. Therefore, when applying the 50 percent guideline, the basis of the patient's current need for nursing facility care must be the focus (CMS 2015a).

[5] Facilities may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the Medicaid program (CMS 2015a).

[6] In reviewing a draft of this report, CMS officials commented that it is up to states to determine whether a facility is an IMD and the regional office does not involve itself in making that determination.

[7] If the percentage of the facility's patients with behavioral health disorders reaches the 50 percent mark, the facility becomes ineligible to receive FFP for any patient, including those with no behavioral health diagnosis (CMS 2015a).

[8] MCOs and prepaid inpatient health plans (PIHPs) can pay for treatment in IMDs as an in-lieu-of service, which is

a service that is not included under the state plan, but is a clinically appropriate, cost-effective substitution for a similar, covered service (42 CFR 438.3(e)(2)).

[9] Section 1905 of Social Security Amendments of 1965 (P.L. 89-97) states: "[I]f the State plan includes medical assistance on behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provisions for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases".

[10] Section 1115 demonstration waivers allow HHS to temporarily waive some requirements of federal Medicaid law in a specific state so that state can test novel approaches to furnishing medical assistance to low-income individuals. All Section 1115 demonstrations must be limited to the extent and time period needed to carry out the experiment or demonstration. This means that states must conduct a genuine experiment of some kind. As well, all Section 1115 demonstrations must promote Medicaid's objectives, which are to furnish medical assistance and rehabilitation and other services to eligible individuals. We note there is some disagreement about HHS authority to waive federal law as described above: Section 1115 of the Act authorizes HHS to waive only those requirements found in Section 1902 of the Act. Requirements found outside of Section 1902 cannot be waived. The IMD exclusion is contained in Section 1905 of the Act; for this reason and others, some have suggested that the Secretary does not have authority to waive this provision (NHeLP 2019).

[11] Evaluation and late deliverable penalties are standard requirements for Section 1115 demonstrations.

[12] Antagonists are drugs that prevent the brain from responding to opioids. Partial agonists produce euphoric effects to diminish withdrawal symptoms, but these euphoric effects are weaker than the effects of full agonists like methadone.

[13] This applies only to women who are enrolled under the state plan immediately before becoming a patient in the IMD or who become eligible to enroll while a patient in an IMD.

[14] Prior to changes in managed care regulations in 2016, managed care entities had historically used in-lieu-of services to pay Medicaid benefits in alternative settings without day limits.

[15] The final rule preamble explained that in order for a capitation payment to be made by the state to the MCO or PIHP for an enrollee in an IMD, a reasonable short-term length of stay in an IMD for individuals with an inpatient level of care need for psychiatric or SUD services needed to be defined in the regulation at 42 CFR 438.9(e) (CMS 2016). This is because there must be some period of time within the month covered by the capitation payment that the enrollee is not a patient in an IMD and may receive other Medicaid covered services for which the plan is at risk. The preamble contains extensive discussion and explanation for the selection of the 15-day limit relative to permitting FFP for capitation payments (CMS 2016).

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APPENDIX 1A: Federal Deinstitutionalization Policies

TABLE 1A-1. Key Events Related to Federal Deinstitutionalization Polices and the Medicaid Institutions for Mental Diseases Exclusion, 1935–2018

Year	Action
1935	The Social Security Act of 1935 (the Act, P.L. 74-271) establishes a system of old-age benefits but prohibits state or federal assistance to persons in public institutions unless receiving temporary medical care.
1950	The Social Security Amendments of 1950 (P.L. 81-734) allow the federal government to share in the cost of payments to recipients of old-age assistance, aid to the blind, and aid to the permanently and totally disabled living in public medical institutions other than those for mental disease and tuberculosis.
1960	The Social Security Amendments of 1960 (P.L. 86-778) establish Medical Assistance for the Aged, but excludes payments for services for any individual who is a patient in a hospital for mental illness.
1961	The Report to Congress from the Joint Commission for Mental Health recommends federal efforts for establishing home- and community-based services for individuals with mental illness.
1963	The Mental Health Retardation Facilities and Community Mental Health Center Construction Act (P.L. 88-164) was enacted, providing grants for construction of community mental health centers.
1965	The Community Mental Health Centers Construction Amendments (P.L. 89-105) allow funds to be used for staffing community mental health centers.
1965	The Social Security Amendments of 1965 (P.L. 89-97) establish Medicaid and Medicare and require that states providing services in institutions for mental diseases (IMDs) to individuals age 65 and older meet certain requirements, including the development of alternate methods of care and individual plans for each patient.
1966	Publication of *The Handbook of Public Assistance Administration* provides a regulatory definition of an IMD.
1968	The Alcoholic and Narcotic Addiction Rehabilitation Amendments of 1968 (P.L. 90-574) integrate services for the prevention and treatment of alcohol and drug addiction with the Community Mental Health Centers Construction Amendments.
1970	The Community Mental Health Centers Act Amendments (P.L. 91-211) extend federal funding of construction of community mental health centers and provide new aid for mentally ill children and for mental health centers in poverty areas.
1971	*Wyatt v. Stickney* holds that individuals who are involuntarily committed to state institutions because of mental illness or developmental disability have a constitutional right to treatment that will afford them a realistic opportunity to return to society.[1]
1972	The Social Security Amendments of 1972 (P.L. 92-603) allow states to choose to cover IMD services for children and youth under age 21 under Medicaid (referred to as the psych under 21 benefit).

TABLE 1A-1. (continued)

Year	Action
1975	The National Institute for Mental Health establishes the Community Support Program to address service delivery problems affecting mentally disabled adults in an effort to improve community-based services and keep institutionalization at a minimum.
1975	Operational policy for determining if a facility is an IMD is articulated in the Social and Rehabilitation Service Field Staff Information and Instruction Series issuance (FSIIS) FY-76-44.
1976	Two additional FSIIS issuances further clarify the definition of an IMD and expand the criteria used to evaluate a facility's possible IMD status.
1976	Final regulation (45 CFR 249) allows states to cover IMD services for children and youth under age 21 under Medicaid (psych under 21 benefit).
1978	The *Report to the President from the President's Commission on Mental Health* recommends adequate financing of mental health services and the coordination of mental health services more closely with each other, general health and other human services, and personal and social support systems.
1980	The Mental Health Systems Act (P.L. 96-398) is enacted, providing federal funding for community mental health programs and giving states additional purview regarding mental health grant programs.
1981	The Mental Health Systems Act is repealed and community mental health center programs are replaced by block grant funding.
1981	The Omnibus Budget Reconciliation Act (OBRA) (P.L. 97-35) establishes Section 1915(c) of the Social Security Act, which authorizes the Medicaid home- and community-based waiver program, providing an alternative to provision of long-term services in institutional settings.
1982	The Health Care Financing Administration (HCFA) incorporates IMD criteria into the *State Medicaid Manual*, and lists 10 guidelines to be used to determine if a facility is an IMD.
1984	The Deficit Reduction Act of 1984 (P.L. 98-369) removes the requirement for Joint Commission accreditation and adds the requirement that providers of the psych under 21 benefit meet the definition of a psychiatric hospital under the Medicare program.
1986	HCFA revises the IMD criteria within the *State Medicaid Manual* to include additional information relating to organic brain syndrome, facilities that specialize in treatment for alcoholism and drug addiction, and facility review methodology.
1988	The Medicare Catastrophic Care Act (P.L. 100-360) exempts facilities with 16 or fewer beds from the Medicaid definition of an IMD. (While many provisions of this law were ultimately repealed, the 16-bed rule remains in statute.)
1990	OBRA (P.L. 101-508) permits the Secretary of the U.S. Department of Health and Human Services to allow facilities other than hospitals to qualify as providers of inpatient psychiatric services for children and youth under the age of 21.

TABLE 1A-1. (continued)

Year	Action
1994	HCFA establishes the psychiatric residential treatment facility (PRTF) in regulation as a separate type of inpatient setting that can receive the psych under 21 benefit and establishes standards for seclusion and restraint in PRTFs.
1999	The *Surgeon General's Report on Mental Health* continues to call for community-based services and a focus on overcoming stigma.
1999	HCFA requests comments on how to apply the hospital behavioral health standards on the use of restraint and seclusion to PRTFs that provide the psych under 21 benefit.
1999	*Olmstead v. L.C.* holds that it is a form of discrimination for states to fail to find community placements and unnecessarily keep individuals with disabilities, including psychiatric disorders, in institutions.[2]
2000	The Children's Health Act of 2000 (P.L. 106-310) requires all health care facilities that receive support in any form from funds appropriated by a federal department or agency to protect and promote the rights of each resident of the facility and prohibits the use of restraints and involuntary seclusions imposed for purposes of discipline or convenience.
2001	An interim final rule published by the Centers for Medicare & Medicaid Services (CMS) establishes a definition for PRTF and sets forth a seclusion and restraint Condition of Participation that psychiatric residential treatment facilities that are not hospitals must meet to provide, or to continue to provide, the Medicaid inpatient psychiatric services benefit to individuals under age 21.
2003	The *Report from the President's New Freedom Commission on Mental Health* recommends the creation of a more consumer- and family-oriented mental health system that would give a greater number of individuals with serious mental illness the chance of regaining a meaningful life in the community.
2005	Section 6063 of the Deficit Reduction Act of 2005 (P.L. 109-171) authorizes the 1915(c) Community Alternatives to Psychiatric Residential Treatment Facility demonstration grant waiver.
2005	Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) authorizes the Money Follows the Person demonstration program designed to assist states in rebalancing long-term care systems and helping Medicaid beneficiaries transition from institutions (including IMDs) to the community.
2010	The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) establishes the Medicaid Emergency Psychiatric Demonstration (Section 2707) and expands and continues the support of Money Follows the Person demonstration programs to assist states in transitioning Medicaid enrollees from institutions (including IMDs) to the community (Section 2403).
2012	The Medicaid Emergency Psychiatric Demonstration begins in 11 states and the District of Columbia.
2012	CMS issues guidance to clarify how states can cover and pay for more robust benefits for children receiving services under the inpatient psychiatric facility benefit.
2015	The Medicaid Emergency Psychiatric Demonstration ends six months early due to exhaustion of funds.

TABLE 1A-1. (continued)

Year	Action
2016	The Improving Access to Emergency Psychiatric Care Act (P.L. 114-97) extends the Medicaid Emergency Psychiatric Demonstration until 2019.
2016	The publication of a Medicaid managed care final rule allows states to receive federal financial participation for capitation payments made on behalf of a Medicaid enrollee age 21–64 who is receiving inpatient or residential treatment in an IMD for a short-term stay of no more than 15 days during the period of the monthly capitation payment.
2017	Guidance issued by CMS in November outlines the parameters for states to obtain a Section 1115 waiver to pay for short-term inpatient and residential SUD treatment in IMDs. This guidance replaces 2015 guidance issued by CMS.
2018	The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) codifies the ability of state Medicaid programs to pay for services in IMDs as an in-lieu-of service. The SUPPORT Act also establishes a time-limited state plan option to pay for SUD treatment in IMDs. This option permits states to pay for treatment in IMDs for up to 30 days during a 12 month period. However, states must maintain a certain level of state funding and ensure that a continuum of SUD care is offered if using this option.
2018	Guidance issued by CMS in November outlines the parameters for states to obtain a Section 1115 waiver to pay for short-term inpatient and residential psychiatric care to beneficiaries with serious mental illness or serious emotional disturbance.

Notes: [1] *Wyatt v. Stickney* (325 F. Supp. 781 (M.D. Ala. 1971))
[2] *Olmstead v. L.C.*, (119 S. Ct. 2176 (1999))

Source: CMS 2018; CMS 2017; CMS 2015a; CMS 2015b; CMS 2012; CMS 2001; Smith and Moore 2008; Koyanagi 2007; Frank and Glied 2006; New Freedom Commission 2003; HHS 1999; President's Commission on Mental Health 1978; Turner and TenHoor 1978; Congressional Quarterly 1971; Joint Commission on Mental Illness and Health 1961.

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Chapter 2:

Services Provided by Institutions for Mental Diseases

CHAPTER 2: Services Provided by Institutions for Mental Diseases

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) requires MACPAC to describe institutions for mental diseases (IMDs) receiving Medicaid payment in selected states, including the number of these facilities in each state and the types of services provided at each IMD.

Identifying IMDs is challenging because the IMD exclusion encompasses multiple types of facilities.[1] In fact, guidance from the Centers for Medicare & Medicaid Services (CMS) indicates that an IMD could be any institution that meets certain criteria (CMS 2015). A facility's designation as an IMD can also change over time based on its patient mix.[2] In addition, treatment offerings also vary by state.

In this chapter, we explain the process MACPAC used to identify treatment facilities that could be considered IMDs and describe the services provided in these facilities. We differentiate between facilities providing substance use disorder (SUD) and mental health treatment since service offerings of these facilities vary depending on whether a facility is primarily engaged in providing SUD or mental health treatment. Moreover, relatively few facilities provide both types of treatment.

Methodology to Identify Institutions for Mental Diseases

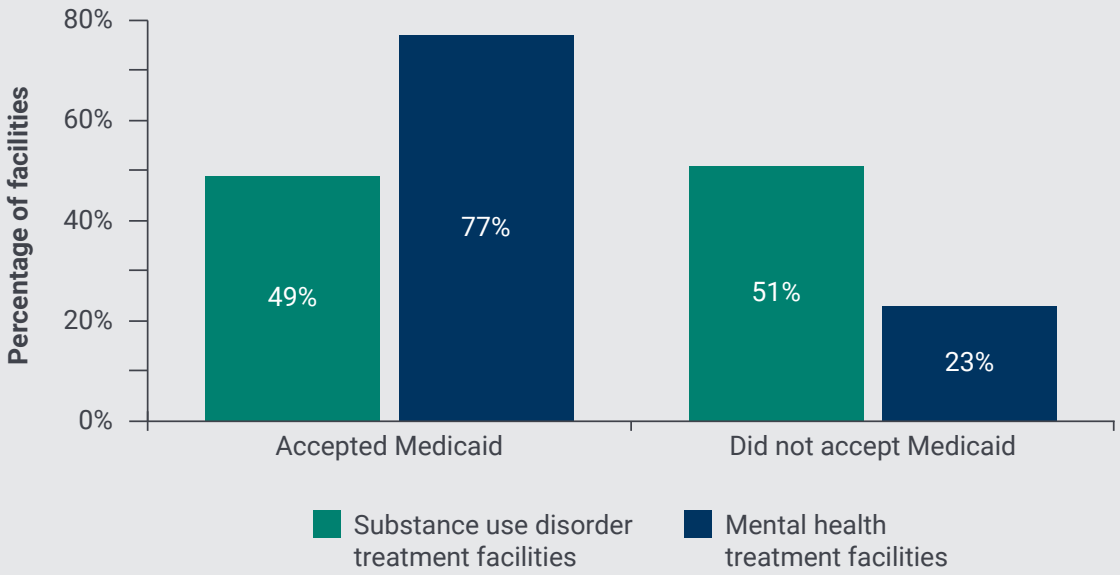
To begin identifying facilities that might be considered IMDs, MACPAC examined federal data sources that gather information on facilities that could be subject to the IMD exclusion—specifically a 2017 U.S. Government Accountability Office (GAO) report that used data from two Substance Abuse and Mental Health Services Administration (SAMHSA) surveys to analyze the capacity of IMDs (GAO 2017). The GAO report was based on the National Mental Health Services Survey (N-MHSS), which collects data from facilities that provide specialized mental health services, and the National Survey of Substance Abuse Treatment Services (N-SSATS), which collects data from facilities that provide SUD treatment. These surveys are used to conduct a census of facilities that provide specialized mental health or SUD treatment services, respectively.[3]

MACPAC developed a methodology to identify facilities that are likely to fall under the definition of an IMD. SAMHSA tabulated data using the 2016 N-MHSS and 2017 N-SSATS on facilities with more than 16 beds that provided inpatient and residential services to adults.[4] Once these facilities were identified, SAMHSA provided information on other facility characteristics, such as ownership and type of facility, for selected states. To ensure we were not over-counting the number of IMDs in a given state, we excluded any facility located in or operated by a general hospital, any mental health facility serving primarily as a residential treatment center for children, and any facility that reported serving only children. For this report, only facilities that accepted Medicaid were examined.[5,6]

For all U.S. states and jurisdictions included in the N-SSATS and N-MHSS, we identified 750 facilities that provided inpatient or residential mental health treatment and 1,600 facilities offered inpatient or residential SUD treatment that could be subject to the IMD exclusion.[7] However, in fulfilling the mandate of the SUPPORT Act to review a representative sample of states, this report examines facilities in seven selected states only.

More than three-quarters (77 percent) of mental health treatment facilities that could be considered IMDs indicated that they participated in Medicaid (Figure 2-1). In comparison, about half (49 percent) of SUD treatment facilities indicated that they accepted Medicaid. This is consistent with prior MACPAC findings indicating that a small percentage

FIGURE 2-1. Substance Use Disorder and Mental Health Treatment Facilities Identified as Institutions for Mental Diseases by Services Offered and Medicaid Participation, United States, 2016–2017



Note: Facilities classified as substance use treatment facilities include those that responded to the 2017 National Survey of Substance Abuse Treatment Services and the 2016 the National Mental Health Services Survey.

Source: MACPAC, 2019, analysis of SAMHSA 2018a and 2018b.

of SUD treatment facilities, particularly those offering more intensive inpatient and residential services, participate in Medicaid (MACPAC 2018).

Characteristics of Institutions for Mental Diseases in Selected States

We took a deeper look at the characteristics of IMDs that accept Medicaid in the following states: California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas. Due to differences in treatment approaches and survey design, the information presented for SUD treatment facilities differs from that presented for mental health treatment facilities. Where possible, we described the services offered by these facilities; however SAMHSA's survey instruments did not have definitions for every item included in the surveys.

SUD and mental health treatment facilities that we identified as IMDs varied considerably in the types of services they provided. For example, virtually all mental health treatment facilities identified through our study reported offering psychotropic medication, while only some SUD treatment facilities that could be considered IMDs reported offering medications to treat opioid use disorder (OUD) and alcohol use disorder.

In addition, many mental health and SUD treatment facilities that were considered IMDs did not offer services at less intensive levels of care, such as regular outpatient treatment, intensive outpatient treatment, or partial hospitalization. In some states, a high percentage of SUD and mental health treatment facilities that could be considered IMDs did not offer any outpatient treatment services. Specifically, in four states (California, Colorado, Massachusetts, and New Jersey), more than 50 percent of SUD treatment facilities identified did not

offer any outpatient treatment, ranging from 67 percent of facilities in New Jersey to 84 percent of facilities in Massachusetts (SAMHSA 2018a). In addition, in five other states (California, Colorado, Florida, New Jersey, and Ohio), more than 40 percent of psychiatric facilities did not offer any outpatient mental health services (SAMHSA 2018b).

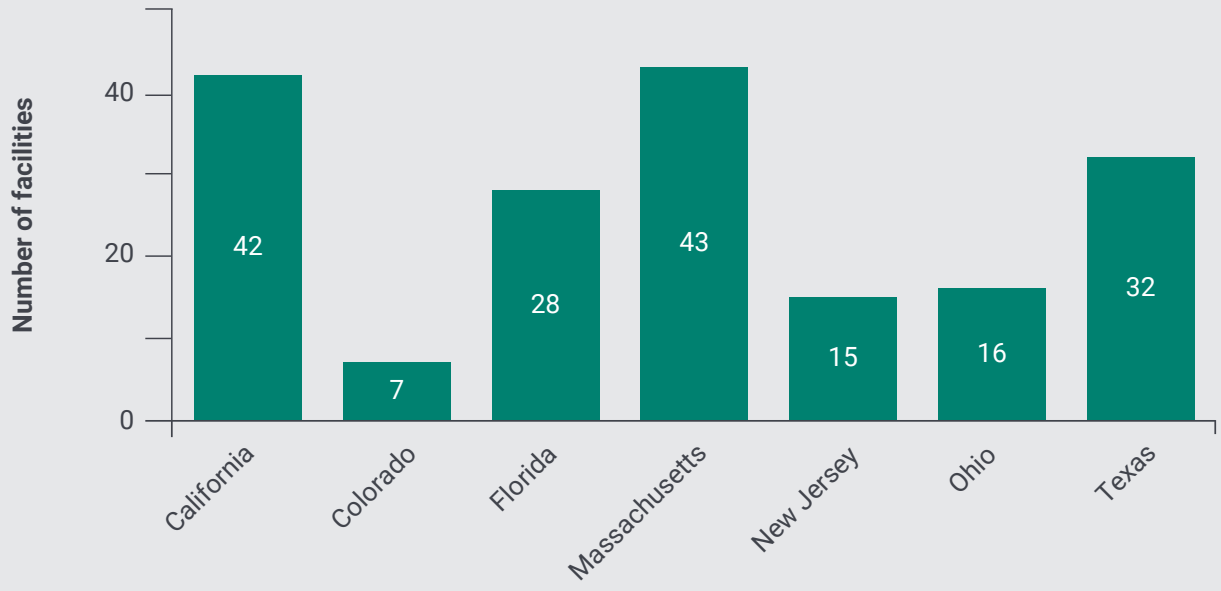
Substance use disorder treatment facilities

Using the 2017 N-SSATS survey, focusing on the seven states selected for this study, we identified 183 inpatient and residential SUD treatment facilities that could be characterized as IMDs that accepted Medicaid. The number of these facilities per state ranged from 7 in Colorado to 43 in Massachusetts (Figure 2-2).

We further examined how many of these facilities reported offering certain services, including how often the facilities indicated that they incorporated certain clinical or therapeutic approaches. We also identified the percentage of inpatient and residential facilities that offered outpatient, intensive outpatient, partial hospitalization, and detoxification services.

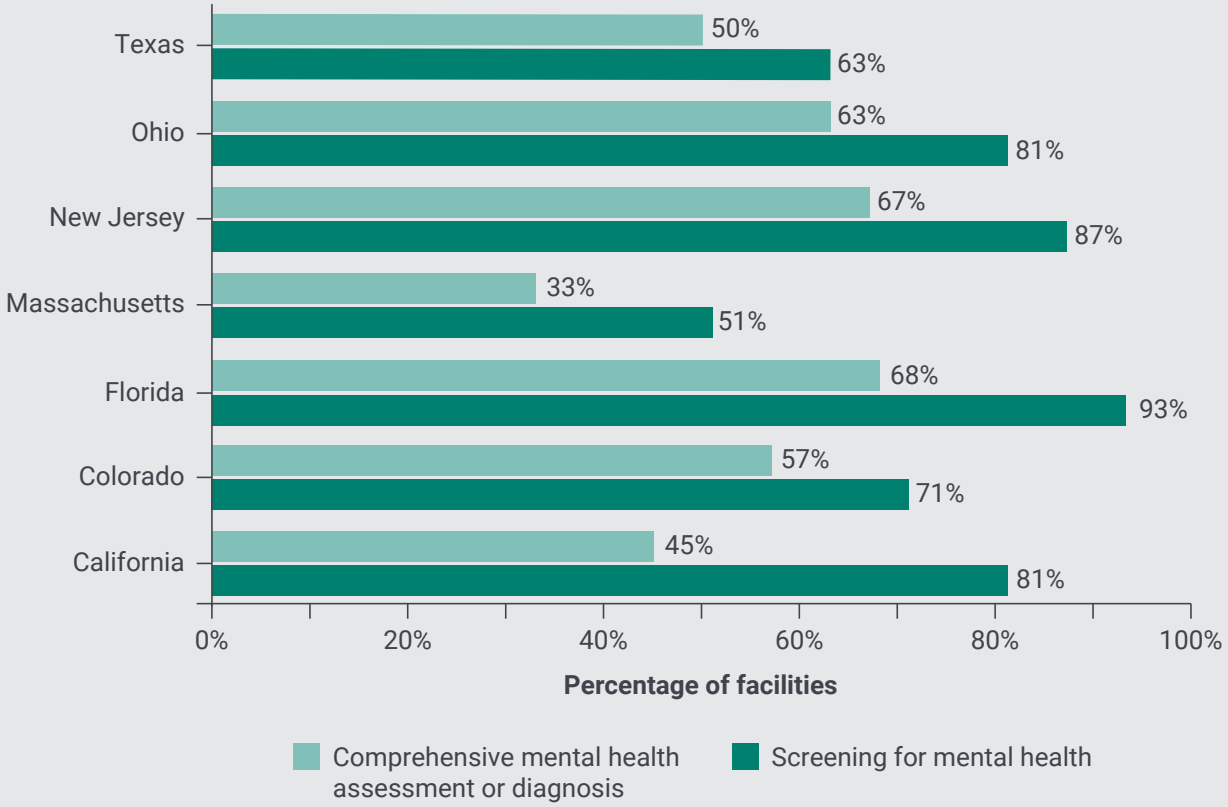
Screening services. Nearly all of the SUD treatment facilities identified as IMDs in the states we reviewed offered both SUD screening services and comprehensive SUD assessment or diagnosis. In Texas, every SUD treatment facility identified as an IMD offered both of these services. In New Jersey, Colorado, and Florida, every SUD treatment facility provided screening for SUDs. Screening for mental health disorders in facilities that primarily provided SUD treatment varied. More than 80 percent of these facilities in four states (California, Florida, New Jersey, and Ohio) also offered screening for mental health disorders, but fewer facilities in all states offered comprehensive mental health assessments (Figure 2-3).

FIGURE 2-2. Estimated Number of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Accepted Medicaid, Selected States, 2017



Source: MACPAC, 2019, analysis of SAMHSA 2018a.

FIGURE 2-3. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Conducted Mental Health Screening Services and Accepted Medicaid, Selected States, 2017



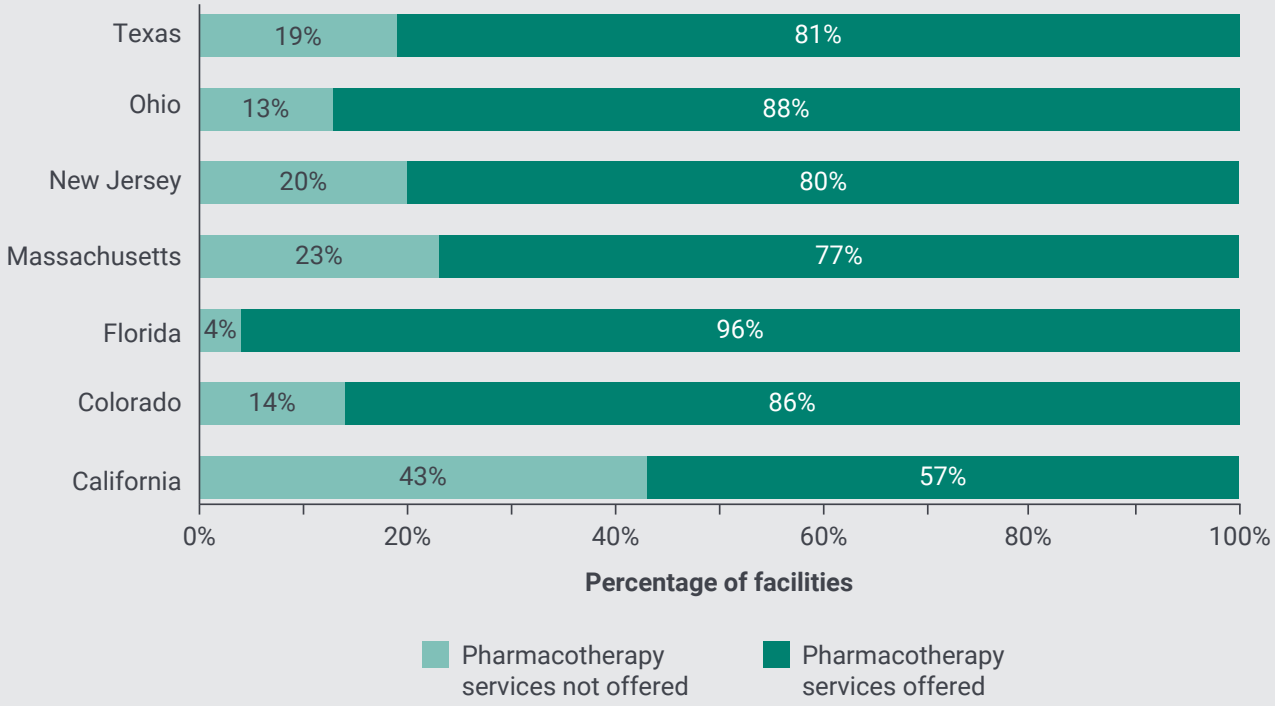
Source: MACPAC, 2019, analysis of SAMHSA 2018a.

Pharmacotherapies. The majority of SUD treatment facilities identified as IMDs offered some form of pharmacotherapy services, meaning one or more of the following: acamprosate; buprenorphine, buprenorphine subdermal implant, or buprenorphine-naloxone; disulfiram; methadone; nicotine replacement or non-nicotine smoking cessation medications; oral naltrexone or extended-release naltrexone; or psychiatric medications. California had the lowest rate, with 57 percent of SUD treatment facilities identified as IMDs offering any pharmacotherapy services. Florida had the highest rate, with 96 percent of SUD treatment facilities identified as IMDs offering some form of pharmacotherapy (Figure 2-4).

Medication-assisted treatment. Medication-assisted treatment (MAT) combines medication with a behavioral health intervention such as counseling for individuals with an OUD; the evidence for its effectiveness in promoting health and preventing relapse and overdose is strong (NASEM 2019). MAT can also be used to treat alcohol use disorder (OSG 2016). Three medications have been approved by the U.S. Food and Drug Administration (FDA) to treat OUD: buprenorphine, methadone, and naltrexone. In addition, there are three FDA-approved drugs to treat alcohol use disorder: acamprosate, disulfiram, and naltrexone (MACPAC 2019).

Specific MAT drugs offered by these SUD treatment facilities varied across states. Naltrexone can be used to treat both OUD and alcohol use disorder,

FIGURE 2-4. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Offered Pharmacotherapy Services and Accepted Medicaid, Selected States, 2017



Note: Facilities were considered to offer pharmacotherapy services if they offered one or more of the following: acamprosate; buprenorphine, buprenorphine subdermal implant, or buprenorphine-naloxone; disulfiram; methadone; nicotine replacement or non-nicotine smoking cessation medications; oral naltrexone or extended-release naltrexone; or psychiatric medications. Totals may not sum to 100 percent due to rounding.

Source: MACPAC, 2019, analysis of SAMHSA 2018a.

and SUD treatment facilities subject to the IMD exclusion are generally more likely to offer this drug than other forms of MAT. In four states (Colorado, Florida, New Jersey, and Ohio), 45 percent or more of the IMD facilities offered both oral naltrexone and extended-release formulations of naltrexone. California had the lowest percentage of facilities offering oral naltrexone, with just 19 percent of facilities offering oral naltrexone and 24 percent offering extended-release naltrexone. Texas had the lowest percentage of facilities offering extended-release naltrexone, with 19 percent offering this drug. In Massachusetts, 30 percent of facilities offered extended-release naltrexone, and 44 percent of IMDs offered oral naltrexone.

In three states (Colorado, Florida, and Ohio), at least half of the SUD treatment facilities identified as IMDs offered buprenorphine-naloxone. In comparison, 47 percent of SUD treatment facilities identified as IMDs in New Jersey and Texas offered buprenorphine-naloxone and fewer than one-third (29 percent) of such facilities in California offered this medication. In addition, some SUD treatment facilities identified as IMDs offered buprenorphine without naloxone, ranging from 9 percent in Texas to 43 percent in Florida.

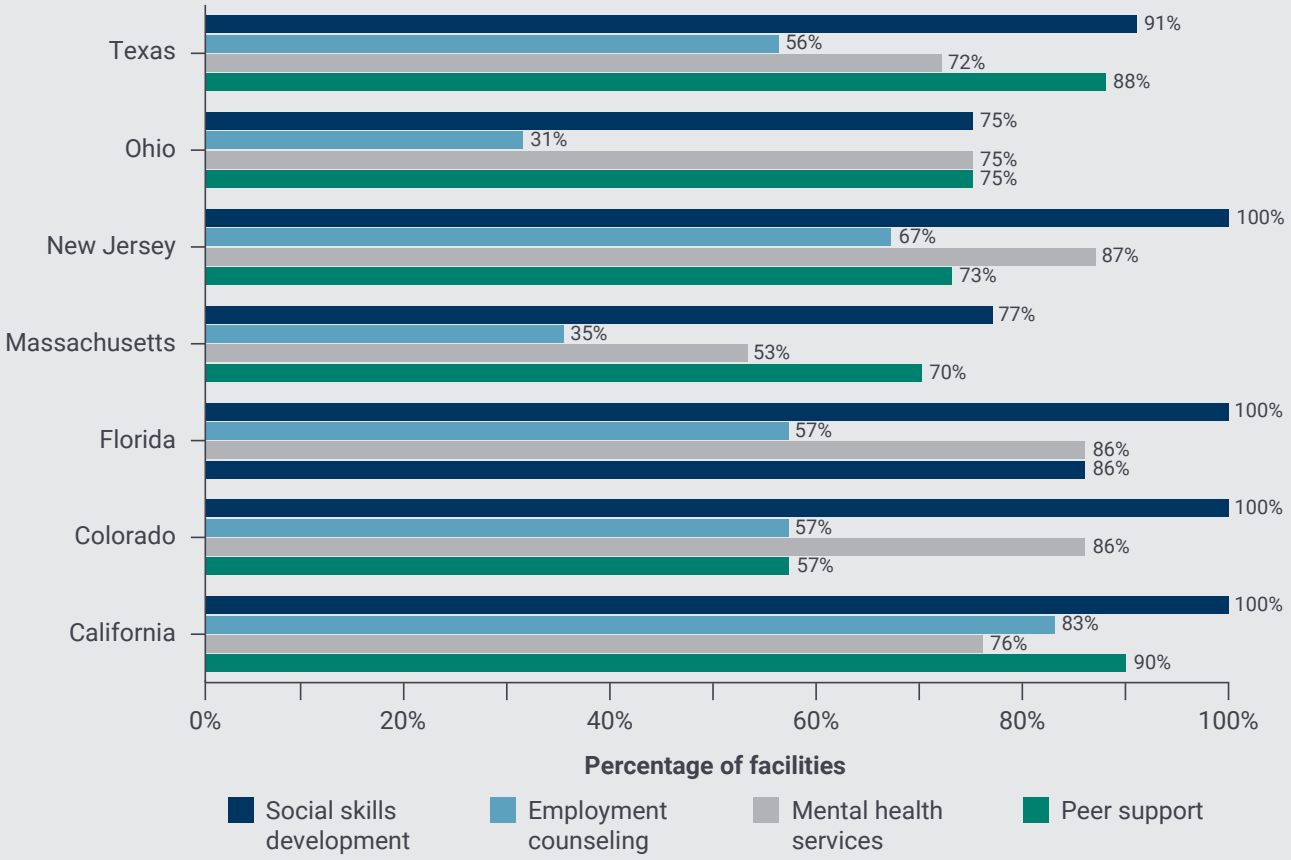
Relatively few facilities across all seven states (ranging from 2 percent in California to 33 percent in Massachusetts) offered methadone, which may reflect specific federal requirements associated with providing methadone. Generally, when used for

the treatment of OUD, methadone may be ordered and dispensed only through an opioid treatment program (OTP) that has been certified by SAMHSA and registered as a narcotic treatment program with the U.S. Drug Enforcement Administration (MACPAC 2019). As such, any facility that reported offering methadone would have to have been certified as an OTP.

A smaller percentage of the SUD treatment facilities we identified as IMDs offered drugs other than naltrexone to treat alcohol use disorder: the percentage of facilities offering acamprosate ranged from 12 percent in California to 43 percent in Colorado and the percentage of facilities offering disulfiram ranged from 7 percent in New Jersey to 43 percent in Colorado.

Social skills development, employment counseling, mental health services, and peer supports. Both within and across states, there was great variation in the types of services offered by residential and inpatient SUD treatment facilities (Figure 2-5). Social skills development services were provided in the majority of SUD treatment facilities identified as IMDs in all seven states, and these services were provided in all facilities in four of the states (California, Colorado, Florida, and New Jersey).

FIGURE 2-5. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Offered Certain Services and Accepted Medicaid, Selected States, 2017



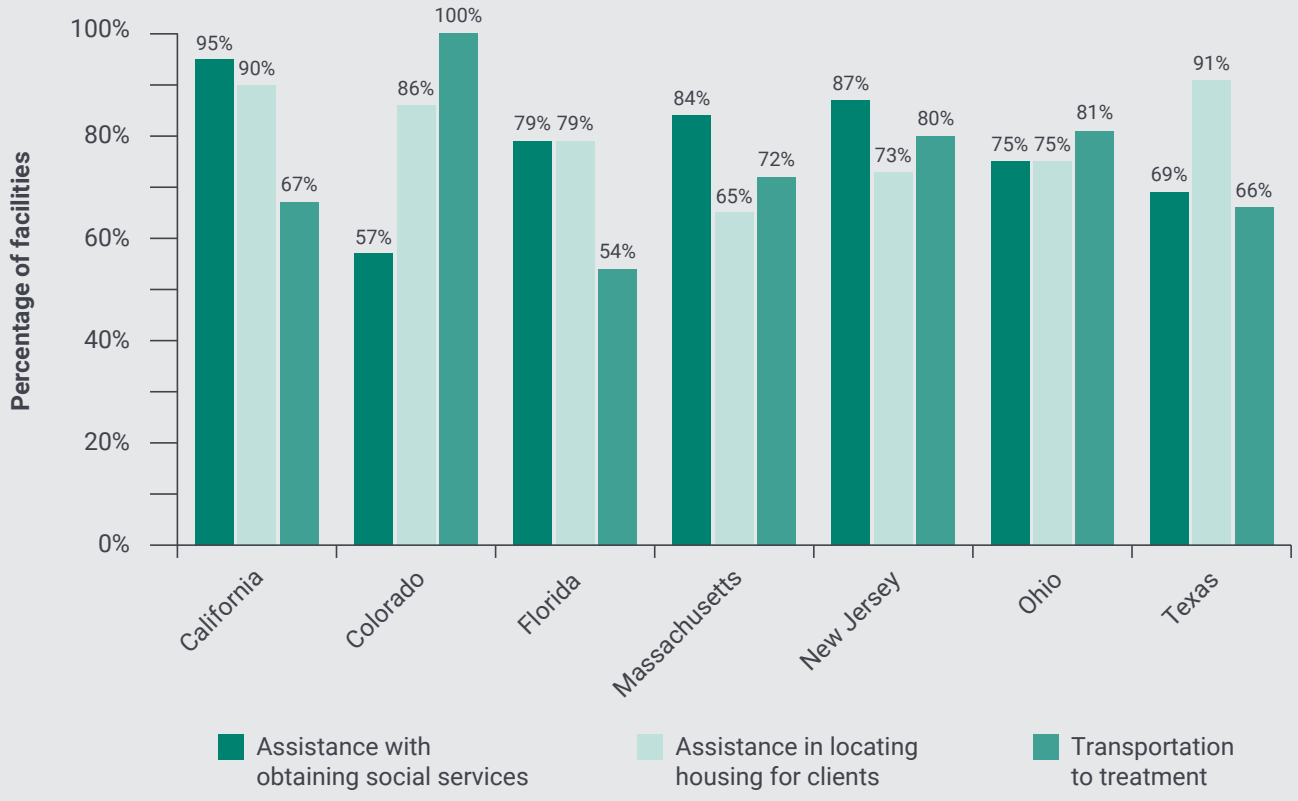
Source: MACPAC, 2019, analysis of SAMHSA 2018a.

Peer support services and mental health services were also offered by the majority of the SUD treatment facilities identified as IMDs; more than half of these facilities in each state offered these kinds of services. The percentage of IMD facilities offering employment services in each state ranged from 31 percent in Ohio to 83 percent in California.

Assistance accessing certain services. The majority of the SUD treatment facilities identified as IMDs offered assistance accessing social services, with at least 75 percent of such facilities doing so in five of the seven selected states (California, Florida, Massachusetts, New Jersey, and Ohio) (Figure 2-6). Many facilities also assisted patients with accessing housing. The percentage of IMD facilities offering this service ranged from 65 percent in Massachusetts to 91 percent in Texas. The degree to which facilities offered transportation assistance to treatment varied. For instance, 54 percent of facilities in Florida offered this service, while 100 percent of facilities in Colorado offered transportation assistance to treatment.

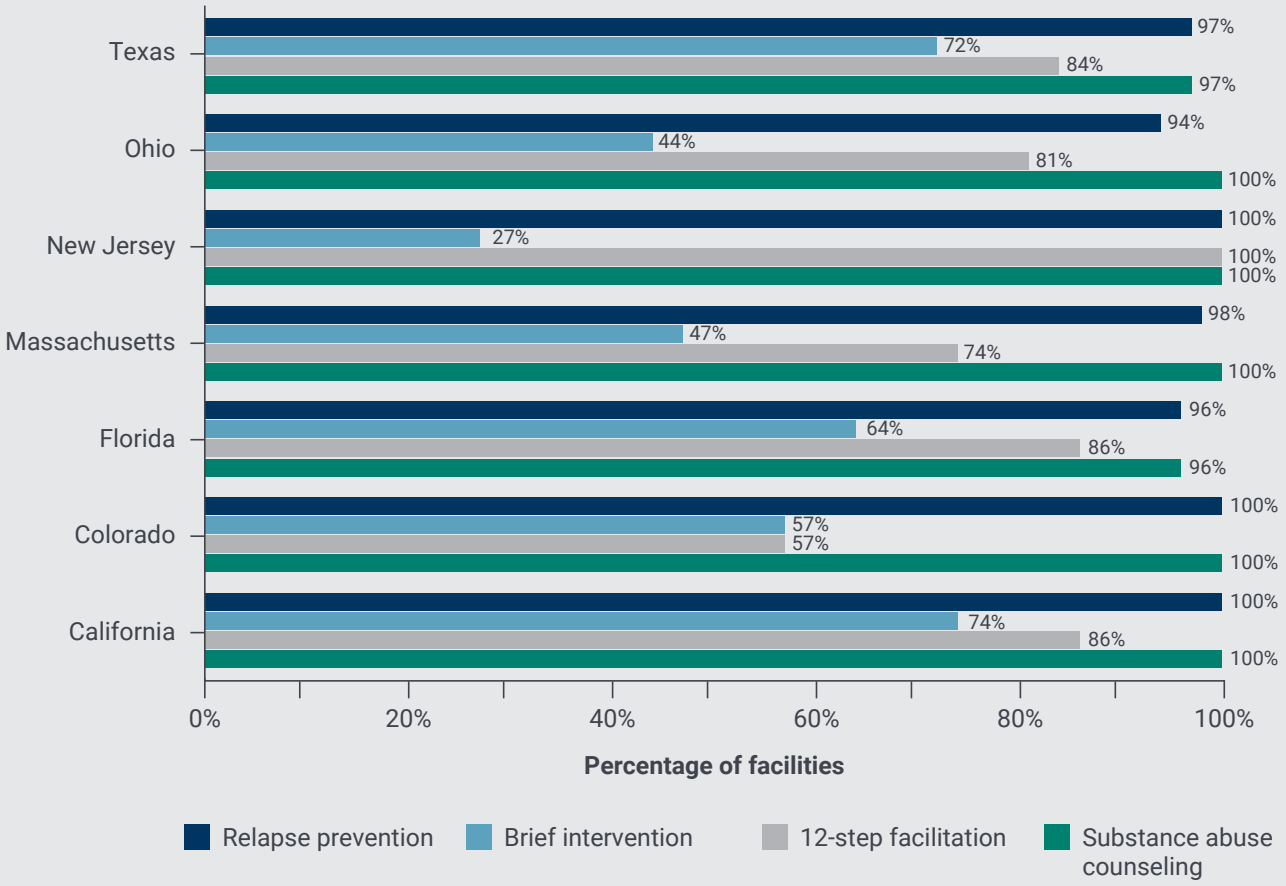
Incorporation of clinical or therapeutic approaches into treatment. All of the SUD treatment facilities identified as IMDs in five states (California, Colorado, Massachusetts, New Jersey, and Ohio) indicated that they almost always or often incorporated SUD counseling into treatment (Figure 2-7). More than 90 percent of the identified IMDs in all seven states noted that they always or often incorporated relapse prevention into treatment. More than 80 percent of facilities in

FIGURE 2-6. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Offered Patients Assistance in Accessing Certain Services and Accepted Medicaid, Selected States, 2017



Source: MACPAC, 2019, analysis of SAMHSA 2018a.

FIGURE 2-7. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Reported Incorporating of a High Degree of Certain Clinical or Therapeutic Approaches and Accepted Medicaid, Selected States. 2017



Source: MACPAC, 2019, analysis of SAMHSA 2018a.

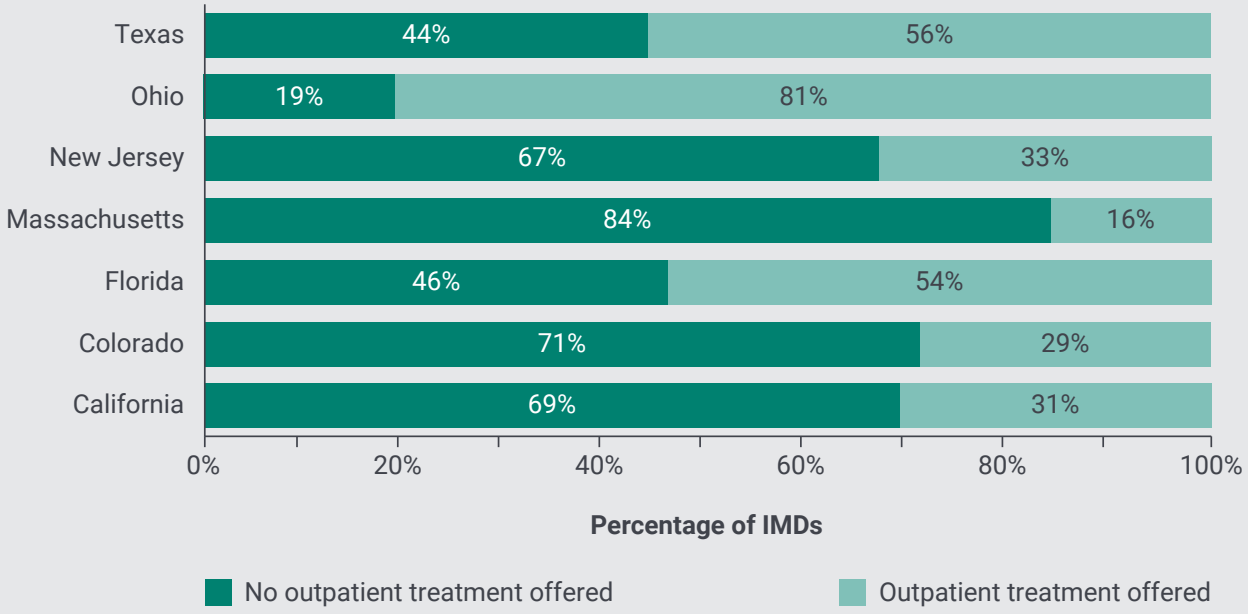
California, Florida, New Jersey, Ohio, and Texas indicated that they almost always or often incorporated 12-step facilitation into treatment. Facilities varied in how often they incorporated brief intervention into treatment, ranging from 27 percent in New Jersey to 74 percent in California.[8]

SUD treatment facilities identified as IMDs in the seven states we studied were likely to report that they always or often incorporated motivational interviewing and cognitive behavioral therapy into treatment.[9] In comparison, they incorporated other therapies such as contingency management and dialectical behavioral therapy less frequently.

Case management, discharge planning, and aftercare services. Nearly all of the SUD treatment facilities we identified as IMDs offered case management services, ranging from 94 percent in Ohio and Texas to 100 percent in California, Colorado, and New Jersey. Similarly, all of the SUD treatment facilities identified as IMDs offered discharge planning. The vast majority of facilities, including all in New Jersey and more than 90 percent in Massachusetts, Texas, and Ohio, offered both discharge planning and aftercare.

Outpatient treatment. The majority of the SUD treatment facilities we identified as IMDs in four

FIGURE 2-8. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Offered Any Outpatient Treatment and Accepted Medicaid, Selected States, 2017



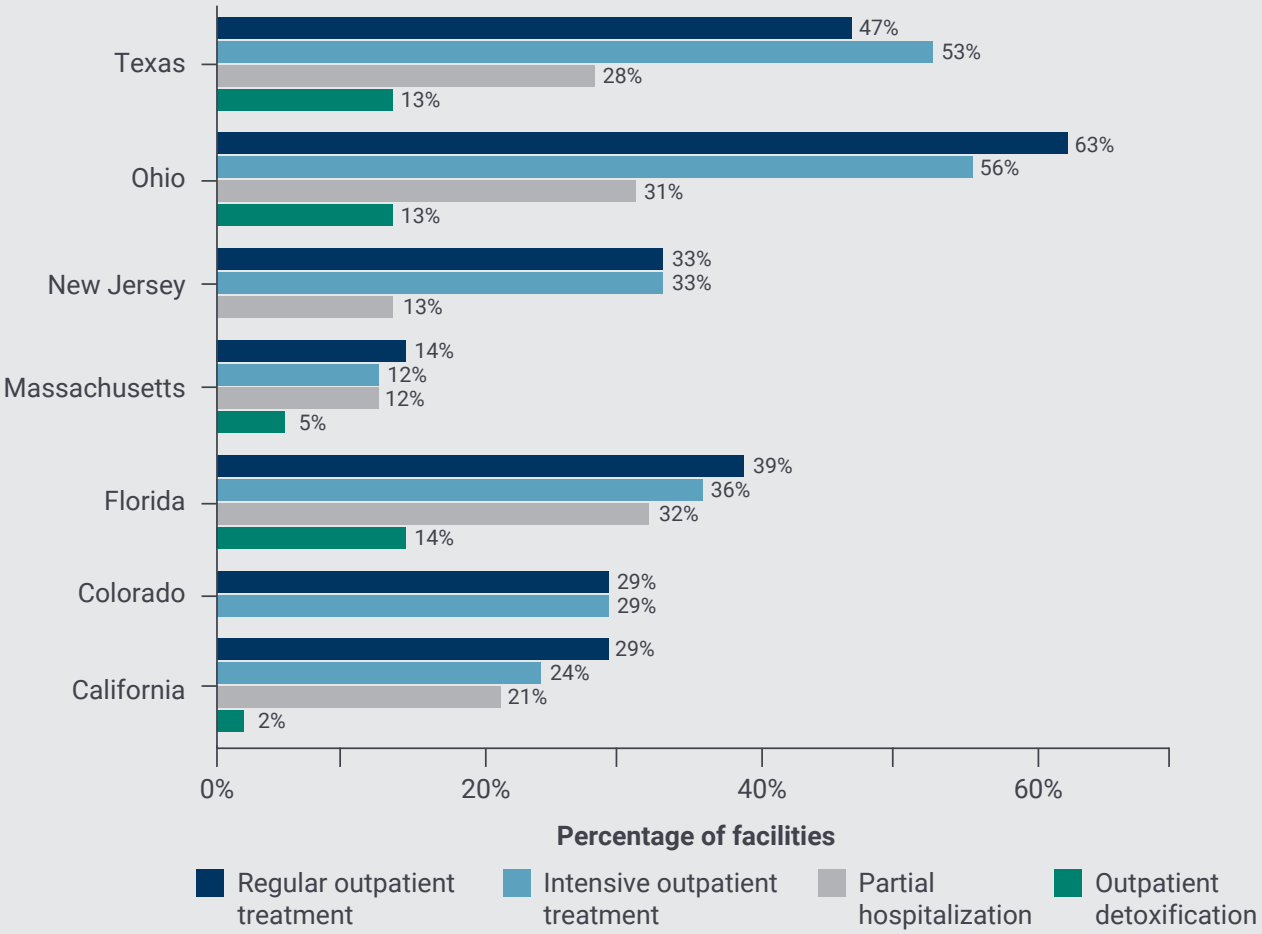
Source: MACPAC, 2019, analysis of SAMHSA 2018a.

states (California, Colorado, Massachusetts, and New Jersey) did not offer any outpatient treatment (Figure 2-8).[10] The percentage of facilities that did not offer any outpatient treatment ranged from 67 percent in New Jersey to 84 percent in Massachusetts.

Types of outpatient treatment services. More than 50 percent of the SUD treatment facilities we identified as IMDs in Texas, Ohio, and Florida did offer outpatient treatment services. In Ohio, 81 percent of the facilities provided some sort of outpatient treatment in addition to residential or inpatient SUD services. Approximately 63 percent of the facilities in Ohio offered regular outpatient treatment, 56 percent offered intensive outpatient treatment, 31 percent offered partial hospitalization, and 13 percent offered outpatient detoxification (Figure 2-9). In Texas, more than half of the facilities (53 percent) offered intensive outpatient services and almost half (47 percent) offered regular outpatient treatment. In Florida, the most common outpatient service provided by the facilities we identified as IMDs was regular outpatient treatment (offered by 39 percent of facilities), followed by intensive outpatient treatment (36 percent), partial hospitalization (32 percent), and, least common, detoxification services (offered by 14 percent of the facilities).

Detoxification. With the exception of Texas, fewer than half of the SUD treatment facilities we identified as IMDs offered detoxification services for each of the following substances: alcohol, benzodiazepines, cocaine, methamphetamines, alcohol, opioids, or other drugs. The percentage of facilities offering detoxification services for opioids ranged from 20 percent in New Jersey to 56 percent in Texas. The percentage of facilities offering detoxification for either benzodiazepines or alcohol ranged from 14 percent in Colorado to 56 percent in Texas.

FIGURE 2-9. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Offered Certain Outpatient Treatment Services and Accepted Medicaid, Selected States, 2017



Notes: Colorado did not have any substance use disorder treatment facilities identified as institutions for mental diseases that offered partial hospitalization or outpatient detoxification. New Jersey did not have any substance use disorder treatment facilities identified as institutions for mental diseases that offered outpatient detoxification.

Source: MACPAC, 2019, analysis of SAMHSA 2018a.

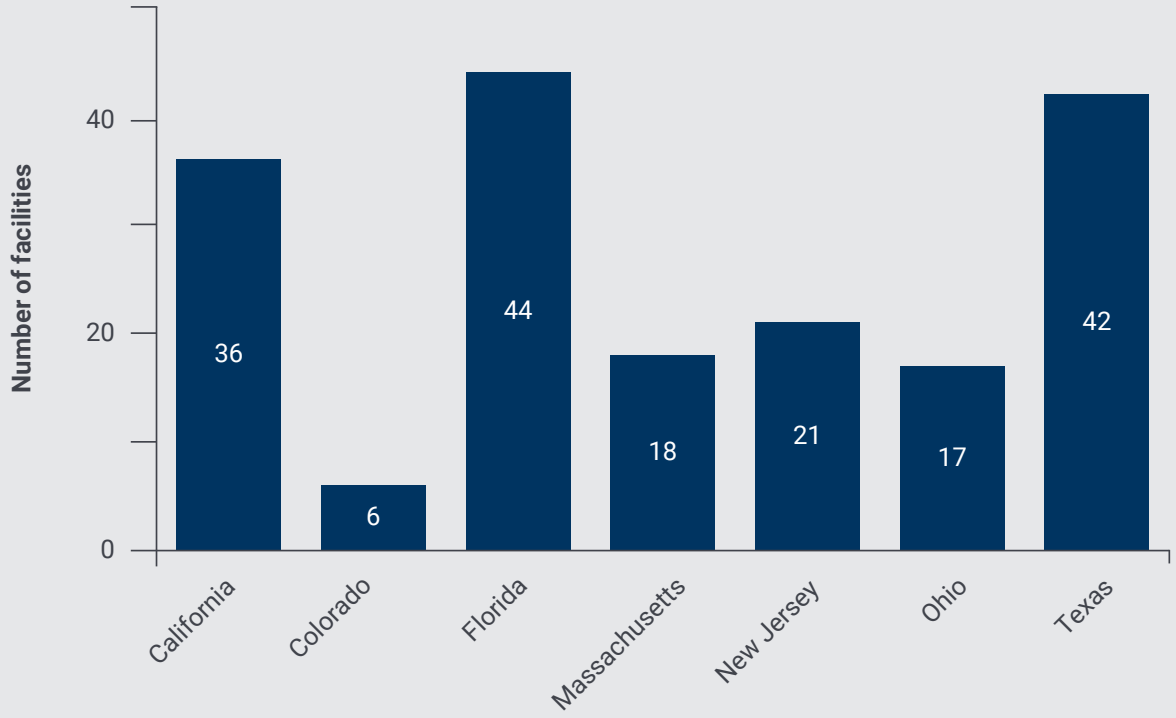
Mental health treatment facilities

Using the 2016 N-MHSS survey, focusing on the seven states selected for this study, we identified 184 inpatient and residential mental health treatment facilities that could be characterized as IMDs that accepted Medicaid. The number of these facilities per state ranged from 6 in Colorado to 44 in Florida (Figure 2-10).

We further examined how many of these facilities reported offering certain services and identified the percentage of inpatient and residential facilities that also offered outpatient services.

Counseling services and other therapies. More than 90 percent of mental health facilities identified as IMDs in California, Colorado, Ohio, and Texas offered group therapy. A high percentage of facilities also offered individual psychotherapy

FIGURE 2-10. Estimated Number of Mental Health Treatment Facilities Identified as Institutions for Mental Diseases That Accepted Medicaid, Selected States, 2016



Source: MACPAC, 2019, analysis of SAMHSA 2018b.

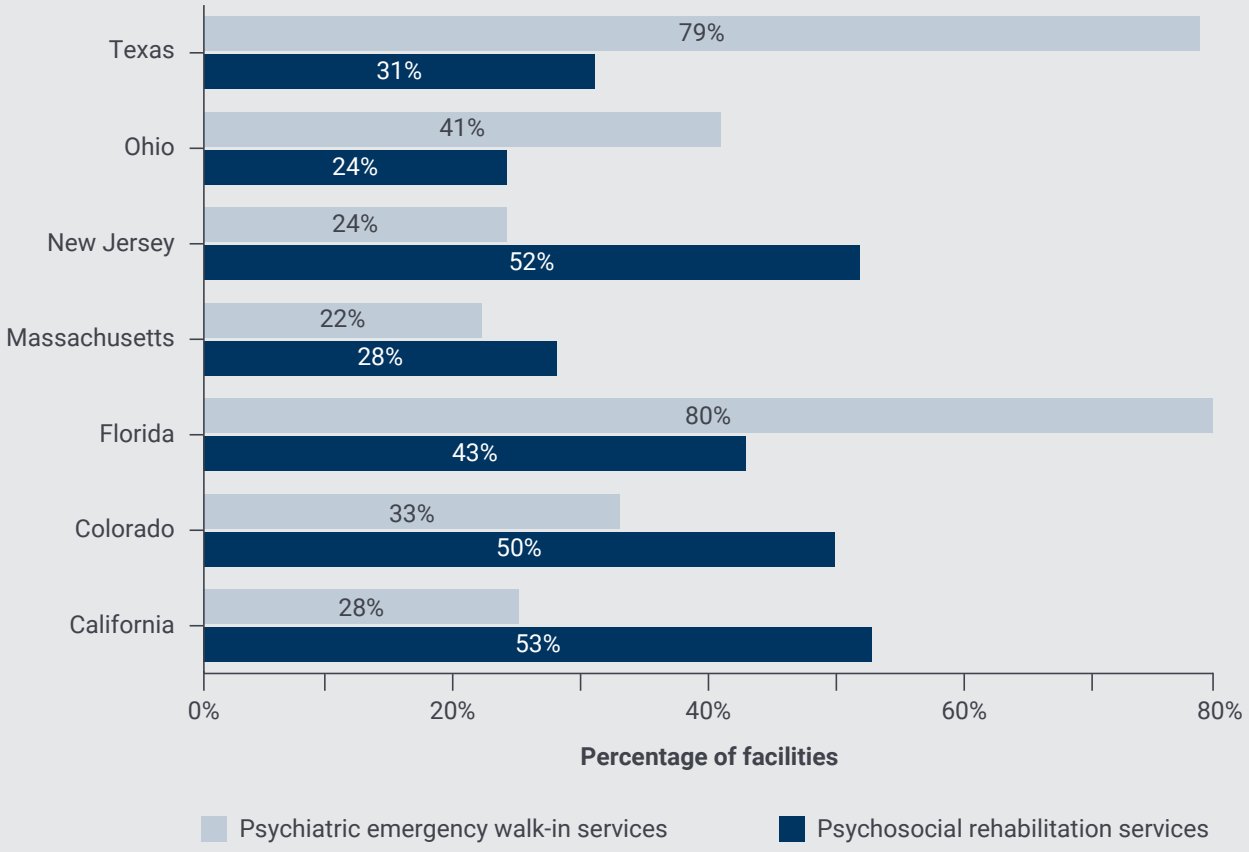
(ranging from 75 percent in California to 100 percent in Colorado). Facilities were more likely to offer group or individual therapy than family or couples therapy.

Nearly all the mental health facilities identified as IMDs in the seven states offered psychotropic medication. This included 100 percent of facilities in four states (Colorado, Florida, New Jersey, and Texas) and more than 88 percent of the facilities in California, Massachusetts, and Ohio. Few facilities (ranging from 5 percent in New Jersey to 19 percent in Texas) offered electroconvulsive therapy (ECT).[11]

With the exception of Texas and Florida, fewer than 45 percent of the mental health facilities identified as IMDs offered psychiatric emergency walk-in services, which are services, including crisis intervention, provided by staff with specific training to provide psychiatric care in emergency situations (Figure 2-11). These services enable an individual, along with family members and friends, to cope with a psychiatric emergency and help the individual function in the community to the greatest extent possible.

Approximately half of the mental health treatment facilities identified as IMDs in four states (California, Colorado, Florida, and New Jersey) offered psychosocial rehabilitation services, while fewer than one-third of these facilities in the other three states (Massachusetts, Ohio, and Texas) offered these services (Figure 2-11). Psychosocial rehabilitation provides therapeutic or intervention services including those related to daily and community-living skills, self-care and skills training (e.g., grooming, bodily care, feeding, social skills training, basic language skills); it can be offered in individual or group settings.

FIGURE 2-11. Percentage of Mental Health Treatment Facilities Identified as Institutions for Mental Diseases That Offered Certain Mental Health Services and Accepted Medicaid, Selected States, 2016

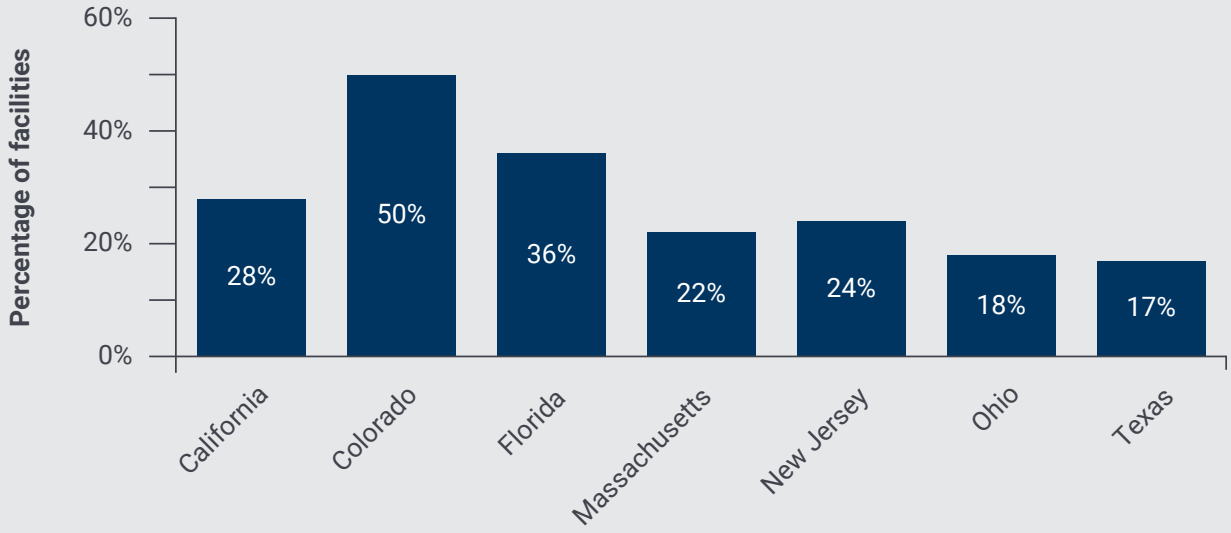


Source: MACPAC, 2019, analysis of SAMHSA 2018b.

Supported employment and vocational rehabilitation. Supported employment includes services such as assisting individuals with finding work; assessing individuals' skills, interest and attitude relevant to work; providing training; and providing work opportunities (SAMHSA 2018b). Vocational rehabilitation includes assistance with job seeking and assessment and enhancement of work-related skills, attitudes, and behavior (e.g., writing a resume, taking part in an interview). It also includes providing patients with on-the-job experience and transitional employment. Most mental health facilities identified as IMDs in the states we reviewed did not report offering supported employment or vocational rehabilitation services. Specifically, fewer than 20 percent of IMDs in each state offered supported employment. With the exception of New Jersey and Colorado, fewer than one-quarter of the mental health facilities identified as IMDs in each of the states we reviewed offered vocational rehabilitation services.

Peer support services. Mental health peer support services are delivered by consumers of mental health services and include mental health treatment or support services (e.g., social clubs, peer support groups) and other organized activities such as peer-driven consumer satisfaction evaluations of mental health services (SAMHSA 2018b). The percentage of mental health facilities identified as IMDs that

FIGURE 2-12. Percentage of Mental Health Treatment Facilities Identified as Institutions for Mental Diseases That Offered Consumer-Run Peer Support Services and Accepted Medicaid, Selected States, 2016



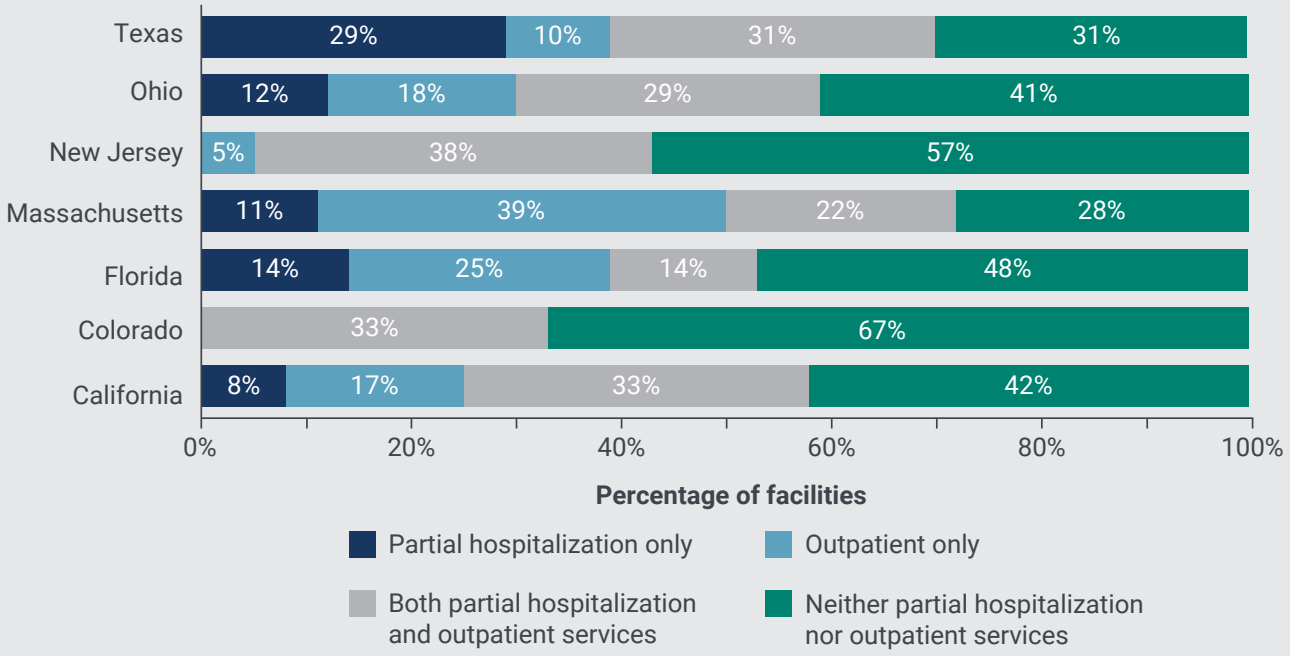
Source: MACPAC, 2019, analysis of SAMHSA 2018b.

reported offering peer support services ranged from 17 percent in Texas to 50 percent in Colorado (Figure 2-12).

Housing services and supports. The term housing services is generally used to describe services that help individuals find and maintain appropriate housing arrangements. In comparison, supportive housing is independent housing with flexible, individualized supportive services that allow individuals to maintain as much independence as possible in the community (SAMHSA 2017). In six of the seven states we reviewed (New Jersey was the exception), fewer than 30 percent of mental health facilities identified as IMDs offered supportive housing or housing services. Texas had the lowest percentage of facilities that offered these services; just 2 percent offered supportive housing and 5 percent offered housing services. In comparison, 52 percent of the facilities in New Jersey offered housing services and 33 percent offered supportive housing.

Types of outpatient treatment offered. Both within and across states, mental health facilities identified as IMDs varied in their offerings of outpatient treatment services. More than 40 percent of the mental health facilities identified as IMDs in each of five states (California, Colorado, Florida, New Jersey, and Ohio) offered no outpatient services (Figure 2-13).

FIGURE 2-13. Percentage of Mental Health Treatment Facilities Identified as Institutions for Mental Diseases That Offered Certain Services and Accepted Medicaid, Selected States, 2016



Note: Totals may not sum to 100 percent due to rounding.

Source: MACPAC, 2019, analysis of SAMHSA 2018b.

In Colorado, two-thirds of the facilities (67 percent) offered no outpatient services. In contrast, nearly three out of four (72 percent) mental health treatment facilities identified as IMDs in Massachusetts offered some form of outpatient treatment: 39 percent offered regular outpatient treatment, 22 percent offered both partial hospitalization and outpatient treatment, and 11 percent offered partial hospitalization services only.

Endnotes

[1] Federal law defines an IMD as 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" (§ 1905(i) of the Social Security Act).

[2] This particularly holds true for nursing facilities where the number of patients receiving mental health services could fluctuate based on the daily facility census.

[3] Developing a complete census of IMDs—both nationally and at the state-level—would require a level of scrutiny that is not possible given Commission resources. As such, MACPAC limited its review to inpatient and residential behavioral health facilities known to SAMHSA. Because IMD designations are not limited to facilities that provide behavioral health services, the survey does not include all facilities that could potentially be identified as IMDs (e.g., nursing facilities).

[4] We note that our study includes only facilities choosing to be listed in the N-SSATS or N-MHSS directory, and facilities that reported client counts for their facility only were included in this study.

[5] For the purposes of this study, MACPAC did not confirm whether the facilities identified as IMDs were in fact enrolled as Medicaid providers in their respective states. Rather, data

from the N-SSATS and N-MHSS surveys were used to identify facilities that self-reported accepting Medicaid.

[6] MACPAC did not include facilities that served only children in its analysis because there is no way to determine whether a facility is a psychiatric residential treatment facility (PRTF). PRTFs are excluded from the definition of an IMD. As such, the number of IMDs in each state likely exceeds the numbers estimated in this chapter.

[7] Few facilities provide both specialty SUD and mental health treatment. As such, there is some overlap between the N-SSATS and N-MHSS datasets.

[8] Brief interventions are evidence-based practices designed to motivate individuals at risk for an SUD to change their behavior. These interventions are also designed to help an individual understand how their substance use affects them (SAMHSA and HRSA 2019).

[9] Motivational interviewing is a counseling approach that acknowledges that many people experience ambivalence when deciding to make changes. As such, this form of counseling aims to enhance motivation to change. Cognitive behavioral therapy (CBT) involves recognizing unhelpful patterns of thinking and reacting. Then it focuses on modifying or replacing identified patterns with more realistic or helpful ones. CBT can be conducted with individuals, families, or groups, and clients are generally expected to be active participants in their own therapy (SAMHSA 2018a).

[10] Outpatient treatment includes regular outpatient treatment, intensive outpatient treatment, partial hospitalization, and outpatient detoxification (SAMHSA 2018a).

[11] ECT uses low-voltage electrical stimulation of the brain to treat some mental health disorders (e.g., major depression, acute mania, certain forms of schizophrenia). This type of therapy is considered only when other therapies have failed or when a person is seriously ill, unable to take medication, or at risk for suicide (SAMHSA 2018b).

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Chapter 3:

Regulation of Facilities Subject to the Institutions for Mental Diseases Exclusion

CHAPTER 3: Regulation of Facilities Subject to the Institutions for Mental Diseases Exclusion

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) requires MACPAC to summarize state licensure requirements for institutions for mental diseases (IMDs) seeking Medicaid payment.[1] However, states do not have licensure criteria specific to IMDs.[2] Rather, states have separate licensure processes and requirements for facilities offering residential mental health services, inpatient mental health services, or residential substance use disorder (SUD) treatment. Some of these facilities may be considered IMDs. Moreover, states typically do not have separate licensure requirements for facilities participating in Medicaid; requirements generally apply to facilities regardless of how the services they provide are financed. In some states, facilities may need to obtain licensure only if they plan to seek government grants or government-funded insurance. States also differ in whether they regulate non-hospital-based IMDs at all. In some states, additional standards may apply to facilities that participate in Medicaid. These standards are discussed in Chapter 4.

In this chapter we take a closer look at licensure requirements and standards enforcement for facilities that may be considered IMDs in seven states: California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas. Our review found that licensure standards for these facilities vary considerably across states and may be different for facilities that provide mental health services and facilities that offer SUD treatment. Licensure standards vary in terms of the state agencies responsible for oversight, the standards providers must meet, and the processes for application, certification, and accreditation for inpatient and residential treatment facilities. Such variation is not surprising given that there are no federally mandated standards for the majority of SUD treatment facilities (ASAM 2019).[3] In comparison, federal standards exist for both psychiatric hospitals and psychiatric residential treatment facilities (PRTFs).

Medicare program rules also play an important role in the regulation of facilities that may be considered IMDs. Because providers accepting Medicare payment must meet that program's standards, hospitals typically seek Medicare certification. However, because Medicare does not cover SUD treatment services in freestanding facilities, there is no Medicare certification process for these facilities. In addition, states may use Medicare rules as a starting point for oversight of providers serving Medicaid-enrolled patients only or non-Medicare patients as well.

We also note that state licensure agencies and accrediting organizations play an important role in Medicare certification. Specifically, through agreements with the Centers for Medicare & Medicaid Services (CMS), these bodies conduct surveys of facilities to determine whether they meet the federal standards for Medicare certification.

This chapter describes the regulation and oversight of behavioral health facilities and summarizes standards that they must meet in selected states to obtain a license. Given the role of Medicare rules, we begin by describing the conditions psychiatric hospitals must meet for participation in Medicare. We then discuss the role of CMS-approved accrediting bodies and the role of state agencies in licensing facilities focused on mental health services and SUD treatment. The chapter concludes by discussing the mechanisms that selected states use to enforce licensure standards.

Medicare Conditions of Participation

To participate in Medicare, facilities must obtain certification, generally through a state survey agency or a CMS-approved accrediting organization. State survey agencies determine compliance with the quality of care and life and safety standards for a variety of health care services and programs. These agencies are typically a part of the state health department and separate from the state Medicaid program. In some instances, providers seek Medicare certification through accreditation by private organizations such as the Joint Commission, instead of a state survey agency (CMS 2019).

During the certification process, the state survey agency or accrediting organization conducts an investigation and survey of the facility to determine whether it complies with federal quality and safety requirements. These conditions of participation exist for approximately 20 different types of health care providers (e.g., hospitals, home health agencies, skilled nursing facilities, and federally qualified health centers). The conditions of participation ensure that minimum health and safety standards are met without dictating the use of certain treatment modalities or practices. Generally, conditions of participation are not specific to Medicare or Medicaid beneficiaries; rather they apply to all patients receiving care in a facility (CMS 2019, CMS 2018).

The Medicare certification process does not apply to many types of facilities that may be considered IMDs, including non-hospital-based residential SUD treatment facilities and mental health facilities.[4] The Medicare certification process does, however, apply to psychiatric hospitals, which must meet conditions of participation applicable to general hospitals as well as conditions of participation specific to psychiatric hospitals.

Medicare conditions of participation for hospitals

Medicare conditions of participation for hospitals include several components. First, hospitals must comply with requirements in Section 1861(e) of the Social Security Act (the Act). These include providing 24-hour nursing services and delivering care under the supervision of physicians. Hospitals must also comply with applicable federal laws related to the health and safety of patients. They must be licensed or approved as meeting standards for licensing established by the responsible state agency. In addition, hospitals are responsible for ensuring their personnel are licensed or meet applicable standards as required by state or local laws.

Medicare conditions of participation for hospitals also cover governance and operations (42 CFR 482.12–482.45). These conditions require a hospital to have a governing body, an institutional plan or budget, a statement of patient rights, emergency preparedness plans, and the capacity to perform basic hospital functions. Hospitals must ensure that their physical plant is developed and maintained so that the safety and well-being of patients is assured. For example, they must comply with fire safety standards and have appropriate ventilation, temperature control, and food preparation areas (42 CFR 482.41). Finally, if a hospital decides to contract out certain services or to provide optional services (e.g., emergency services or surgical services), the hospital must meet additional conditions.

Medicare conditions of participation for psychiatric hospitals

Section 1861(f) of the Act defines psychiatric hospitals as institutions that are primarily engaged in providing psychiatric services for the diagnosis and treatment of mental health disorders. Such services must be performed by, or under the supervision of, a doctor of medicine or osteopathy. In addition to meeting Medicare conditions of participation for general hospitals discussed above, psychiatric hospitals must meet additional specific

conditions. For example, the medical records maintained by a psychiatric hospital must permit the determination of the degree and intensity of treatment provided to each patient. This includes accounting for psychiatric evaluations for patients, treatment planning, recording processes, and discharge planning (Box 3-1). Some stakeholders have noted that additional requirements for psychiatric hospitals impose a high cost on facilities (FAH 2019, NABH 2019).

In addition to meeting conditions of participation for medical records, psychiatric hospitals must also comply with conditions of participation related to staffing standards (Box 3-2). Generally, facilities must employ or provide an adequate number of qualified professional, technical, and consultative personnel to evaluate patients, formulate treatment plans, identify active treatment, and engage in discharge planning. In addition, staffing standards require psychiatric hospitals to employ certain types of professionals, including physicians, nurses, social workers, and therapists.

BOX 3-1. Medicare Conditions of Participation for Psychiatric Hospitals: Medical Records

Medical records maintained by a psychiatric hospital must account for psychiatric components and include information on the following: documenting whether the patient was admitted voluntarily or involuntarily; the admitting diagnosis and diagnoses of other current diseases and psychiatric conditions; reasons for admission, as stated by the patient or others involved; social service records, including reports of interviews with patients, family members, and others, as well as community resource contacts and social history; and a complete neurological examination as indicated. Requirements of specific components of the psychiatric hospital medical record are described below.

Psychiatric evaluation. Within 60 hours of admission, each patient must receive a psychiatric evaluation that includes a medical history, a record of mental status, and notes on the onset of illness and circumstances leading to the patient's admission. In addition, the attitudes and behavior of the patient must be described and an estimate of their intellectual functioning and orientation must be made. An inventory of the patient's assets must be included in a descriptive, not an interpretive, fashion.

Treatment planning. Each individual must have an individualized treatment plan that is based on an inventory of the patient's strengths and disabilities. It must include a substantiated diagnosis, short-term and long-term goals, specific treatment modalities to be used, responsibilities of treatment team members, and documentation that treatment and rehabilitation activities are carried out.

Recording process. Progress notes must be recorded by certain health professionals (e.g., a physician, nurse, or social worker) at least weekly for the first two months of treatment and at least once a month thereafter. Progress notes must also contain recommendations for revisions in the treatment plan as indicated and an assessment of the patient's progress in accordance with the treatment plan.

Discharge planning and discharge summary. Each record for each patient that has been discharged must contain a discharge summary that includes a recapitulation of the patient's hospitalization. It must also include recommendations for follow-up or aftercare services as well as a brief summary of the patient's condition on discharge (42 CFR 482.61).

BOX 3-2. Medicare Conditions of Participation for Psychiatric Hospitals: Staffing Standards

Director of inpatient psychiatric services. Inpatient psychiatric services must be supervised by a clinical director who meets requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of physicians under the director's supervision must be adequate to provide essential psychiatric services.

Availability of medical personnel. Physicians and other appropriate personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If not available within the institution, the facility must have an agreement with an outside source or an agreement must be established to transfer patients to a general hospital that participates in Medicare.

Nursing services. The hospital must have a qualified director of psychiatric nursing and an adequate number of registered nurses, licensed practical nurses, and mental health workers to identify the type of nursing care necessary to implement each patient's treatment plan and to maintain progress notes. The director of nursing services must be a registered nurse with a master's degree in psychiatric or mental health nursing or be qualified by education and experience in the care of mental illness. The director must be competent to participate in formulating treatment plans, give skilled nursing care, and direct, monitor and evaluate nursing care. A registered nurse must be available 24 hours a day.

Psychological services. The hospital must provide psychological services or have them available to meet the needs of patients.

Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services. The director must have a master's degree from an accredited school of social work or be qualified by education and experience in the social service needs of individuals with mental illness. Otherwise, at least one staff member must have this qualification. Social service staff must participate in discharge planning, arrange for follow-up care, and develop mechanisms for exchanging appropriate information with sources outside of the hospital.

Therapeutic activities. The hospital must provide a therapeutic activities program that is appropriate to serve the needs and interests of patients. It must be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. The number of qualified therapists, support personnel, and consultants must be adequate to provide treatment consistent with each patient's treatment plan (42 CFR 482.62).

Psychiatric residential treatment facilities

As discussed in Chapter 1, federal law creates an exemption from the IMD exclusion for beneficiaries under the age of 21 (referred to as the psych under 21 benefit), which allows states to pay for services if they are delivered in PRTFs, psychiatric hospitals, or psychiatric units of general hospitals.[5]

Although PRTFs are not recognized by Medicare, CMS adopted Medicaid-only conditions of participation for such providers. Specifically, when Congress exempted PRTFs from the IMD exclusion, CMS engaged in a lengthy stakeholder process to develop conditions of participation for these facilities. Regulations require certain staffing and medical oversight as well as accreditation by an outside organization. Regulations also place limits on the use of physical and chemical restraints,

and seclusion. Additional requirements to protect children include notification of a parent or guardian if restraint or seclusion is used, and ensuring that emergency interventions used are appropriate for an individual child's history (e.g., history of physical or sexual abuse) (42 CFR 448.350 et seq.).

PRTFs must also notify CMS and the state protection and advocacy agency of any serious occurrence (e.g., the death of a patient or a suicide attempt) (42 CFR 483.374). Requirements for PRTFs have been cited as an example of how federal regulation can address the particular needs of the population being served in IMD settings (NHeLP 2019).

Accreditation

Accreditation is a voluntary review process that health care organizations undergo to demonstrate their ability to meet criteria and standards established by an external organization. A provider may seek accreditation to obtain Medicare certification as well as for other reasons.[6] For instance, some states require accreditation as a condition of licensure and some Medicaid managed care plans require providers to be accredited for the purposes of credentialing.

Obtaining accreditation is generally viewed as meeting a higher standard than obtaining licensure. As such, facilities that have obtained accreditation from the appropriate entity are deemed licensed by many states. In these cases, certain components of the licensure process may be streamlined or omitted. For example, in New Jersey, facilities may seek deemed status upon licensure renewal, but not at initial licensure (IBM Watson Health 2019).

Several private organizations, such as the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation (COA), accredit both inpatient and residential mental health and SUD treatment programs. These organizations review a facility's provision of care, treatment, services, emergency situation action plans, standards regarding the rights of the individuals, and performance improvement plans.

Psychiatric facilities

Inpatient psychiatric hospitals, which are Medicare-recognized providers, seek accreditation from CMS-approved organizations at high rates. In 2016, 83.3 percent of both public and private psychiatric hospitals reported that they obtained accreditation from the Joint Commission, and 7.8 percent of these facilities reported obtaining accreditation from COA (SAMHSA 2018a). Some states also require inpatient psychiatric facilities to be accredited by CARF, COA, or the Joint Commission (IBM Watson Health 2019).

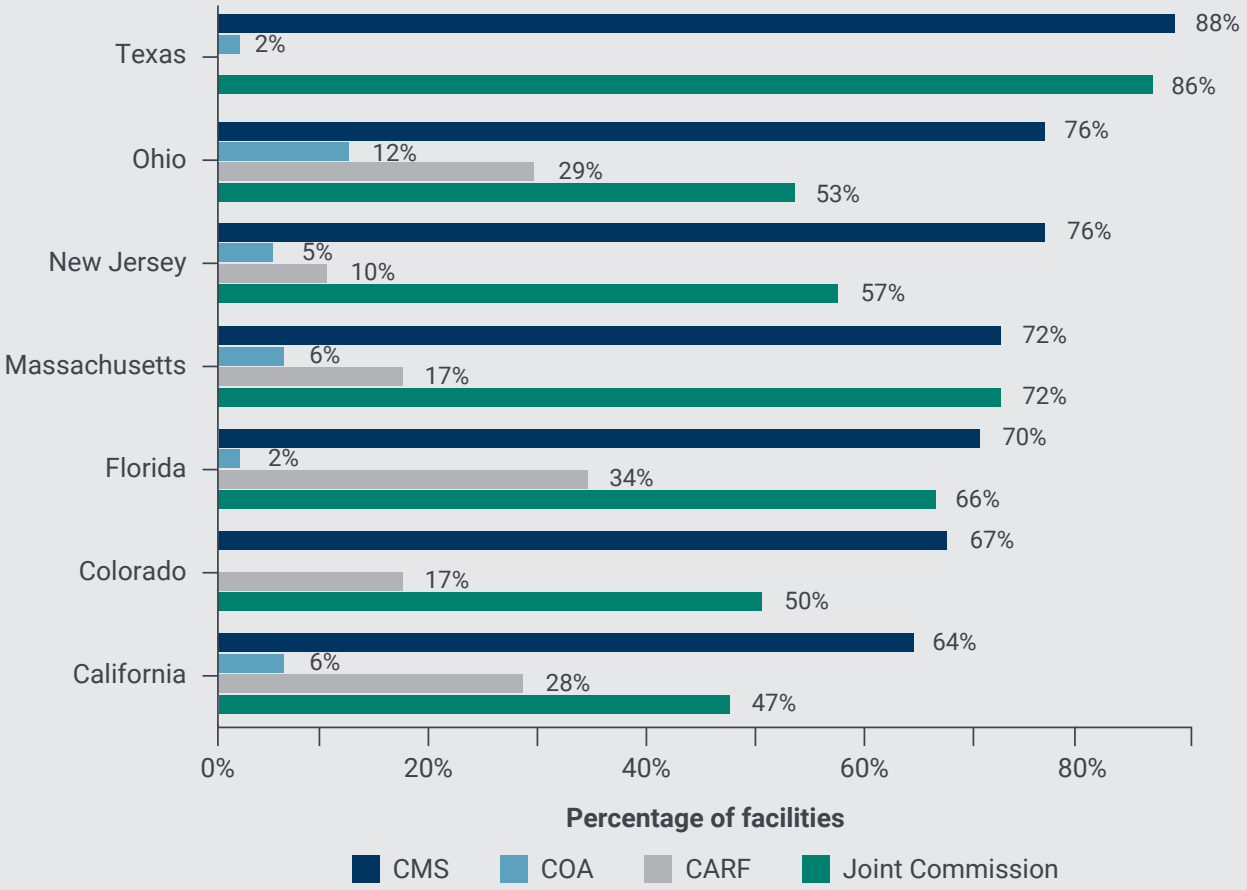
Accreditation of IMD facilities providing mental health services in selected states. MACPAC examined accreditation of mental health facilities identified as IMDs in seven states: California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas. Facilities that participate in Medicaid and provide mental health treatment obtain Medicare certification and accreditation at high rates (Figure 3-1). In 2016, the percentage of facilities reporting CMS certification ranged from 64 percent in California to 88 percent in Texas. The percentage of facilities reporting accreditation by the Joint Commission was also high, ranging from 47 percent in California to 86 percent in Texas.

Substance use disorder treatment facilities

Because residential SUD treatment facilities are not certified by Medicare, the degree to which providers voluntarily seek accreditation is lower than it is for psychiatric facilities. In 2017, 20.3 percent of non-hospital-based residential SUD facilities sought accreditation by the Joint Commission. An additional 34.2 percent of such providers reported being accredited by CARF (SAMHSA 2018b).

Accreditation of IMD facilities in selected states. Accreditation rates of SUD treatment facilities identified as IMDs varies considerably among states (Figure 3-2). For example, in Florida, more than 70 percent of treatment facilities reported being accredited by CARF in 2017. In addition,

FIGURE 3-1. Percentage of Mental Health Treatment Facilities Identified as Institutions for Mental Diseases That Obtained Accreditation or Certification from Certain Organizations and Accepted Medicaid, Selected States, 2016



Notes: COA is Council on Accreditation. CARF is Commission on Accreditation of Rehabilitation Facilities. Totals may not sum to 100 percent because facilities may obtain accreditation or certification from more than one organization. Colorado did not have any facilities accredited by COA. Texas did not have any facilities accredited by CARF.

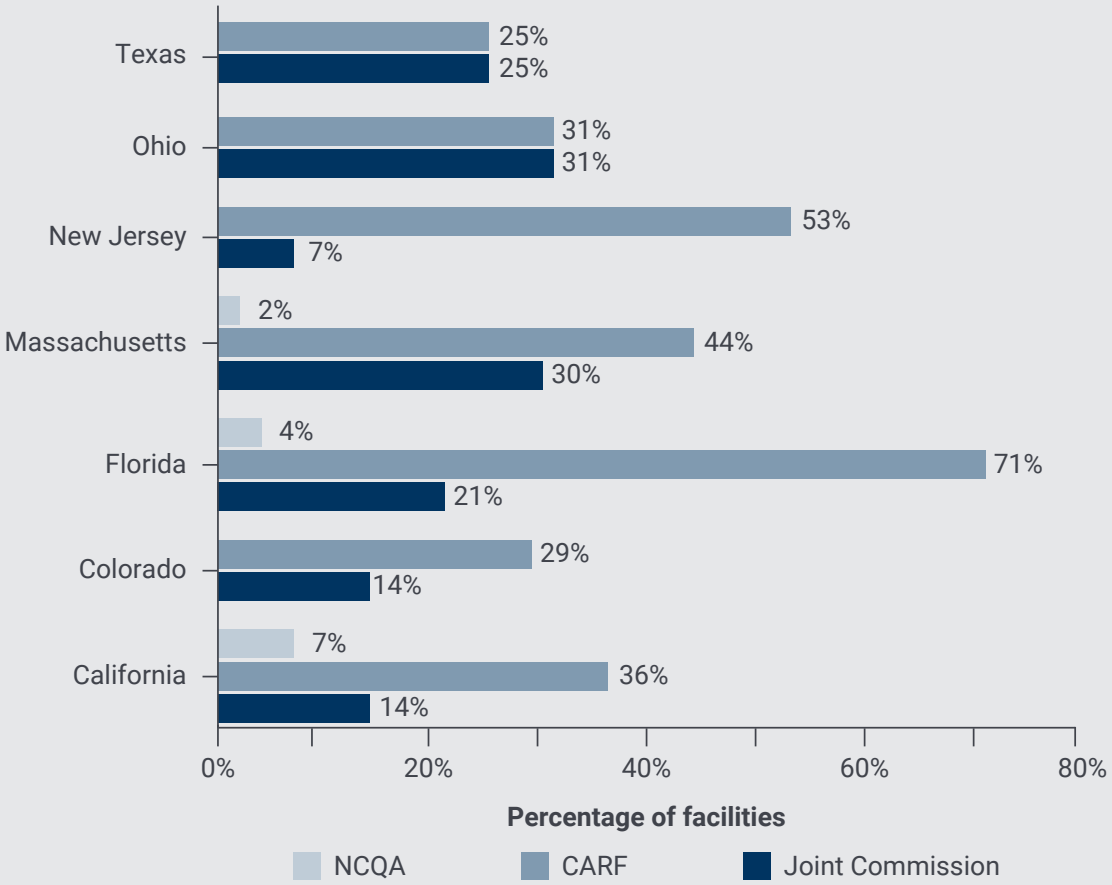
Source: MACPAC, 2019, analysis of SAMHSA 2018a.

21 percent of facilities reported that they were accredited by the Joint Commission and 4 percent reported accreditation by the National Committee for Quality Assurance (NCQA). In comparison, 29 percent of facilities in Colorado reported that they were accredited by CARF and 14 percent reported accreditation from the Joint Commission.

The Role of State Agencies in Licensure

Licensure of health care facilities varies considerably by state with respect to which providers must seek licensure to operate in a state, the number of provider types licensed, and the state agency responsible for issuing a license. Generally, facility licensure is conducted by the state survey agency, which makes certification

FIGURE 3-2. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Obtained Accreditation from Certain Organizations and Accepted Medicaid, 2017



Notes: NCQA is the National Committee for Quality Assurance. CARF is Commission on Accreditation of Rehabilitation Facilities. Facilities may obtain accreditation from more than one organization. Texas, Ohio, New Jersey, and Colorado did not have any facilities accredited by NCQA.

Source: MACPAC, 2019, analysis of SAMHSA 2018b.

recommendations to CMS for Medicare and Medicaid participation. However, for behavioral health facilities, other state entities such as substance use or mental health authorities may be solely responsible for licensure. In some states, the single state substance use or mental health authority shares licensure responsibilities with the state survey agency.

This section discusses the oversight and licensure roles of state agencies responsible for SUD and mental health treatment facilities. For selected states, we identify the state agencies involved in the licensure process and summarize licensure information for IMDs that accept Medicaid. We also discuss additional duties of state licensure agencies. Later we present information on the licensure process and facility standards.

Substance use disorder treatment facilities

Since 2013, SUD treatment facilities in most states (35 states and the District of Columbia) have been regulated by the agency responsible for administering the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) block grant, referred to as the single state substance use authority. This agency distributes SAPT funds to local government entities and non-governmental organizations that deliver SUD prevention and treatment services.

Facility oversight in selected states. MACPAC's review of seven states revealed that most SUD treatment facilities are licensed or certified by the single state substance use authority. Specifically, in four states (Florida, Massachusetts, New Jersey, and Ohio), all SUD treatment facilities subject to the IMD exclusion are licensed or certified by the single state substance use agency. However, many facilities in these states reported that they were also licensed by the state department of health, the state mental health authority, or the state hospital licensing authority (Figure 3-3). Facilities that are licensed by multiple agencies may provide multiple types of care, such as residential SUD treatment as well as outpatient mental health treatment. However, multiple licenses may also reflect shared licensure responsibilities across state agencies (IBM Watson Health 2019).

Mental health treatment facilities

Similar to the case of residential SUD treatment facilities, several agencies may be involved in the licensure of inpatient and residential mental health treatment facilities. Moreover, states may license multiple types of residential mental health treatment facilities. A 2006 SAMHSA study identified 63 different types of residential facilities for adults with mental illness across 34 states and the District of Columbia. In many cases more than one state agency was involved in the regulation of residential facilities for adults with mental illness and slightly more than half of the facility types identified in the study were licensed or certified by the state mental health authority (Ireys et al. 2006).

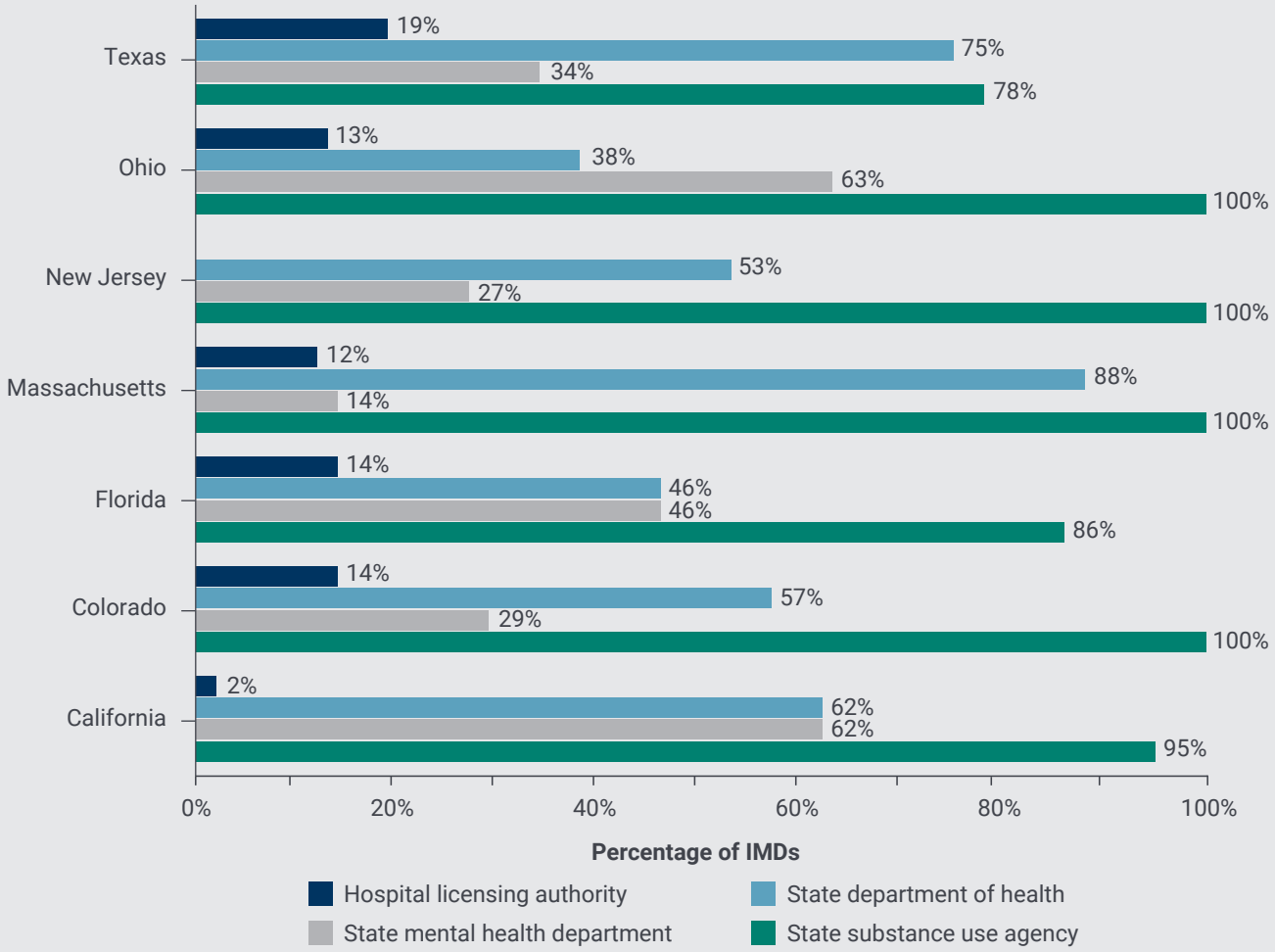
Facility oversight in selected states. Mental health treatment facilities that were identified as IMDs in the seven states included in this study reported being licensed or certified by a variety of state agencies in 2016 (Figure 3-4). More than 70 percent of mental health facilities in five states (California, Colorado, Massachusetts, New Jersey, and Ohio) reported being licensed or certified by the state mental health authority. Colorado was the only state in which all facilities reported being licensed or certified by both the state mental health authority and the state department of health. One-third of mental health facilities in the state reported that they were also licensed or certified by the state substance use authority.

Additional responsibilities for licensing agencies

Agencies responsible for licensing behavioral health providers frequently perform additional functions beyond issuing licenses to mental health and SUD treatment facilities. This includes assessing the need for new behavioral health facilities, typically referred to as a certificate of need (CON) process, and contracting directly with providers for services.

Certificate of need. Licensure agencies in New Jersey, Massachusetts, and local entities in Florida are responsible for the CON process. Officials in these states generally noted that this process is important in ensuring access to care and for monitoring the quality of care delivered in these facilities. Licensing officials in both Massachusetts and New Jersey described the CON process as important to ensuring that high-quality services are available in the state.[7] For example, New Jersey officials report that the CON process ensures that each facility offers services that will provide a continuum of care, including outpatient services, once a patient is discharged. Florida's CON process is performed by local behavioral health entities rather than state agencies (IBM Watson Health 2019).[8]

FIGURE 3-3. Percentage of Substance Use Disorder Treatment Facilities Identified as Institutions for Mental Diseases That Were Licensed or Certified by Certain State Agencies and Accepted Medicaid, Selected States, 2017



Notes: Totals may not sum to 100 percent because facilities may be licensed or certified by more than one state agency.

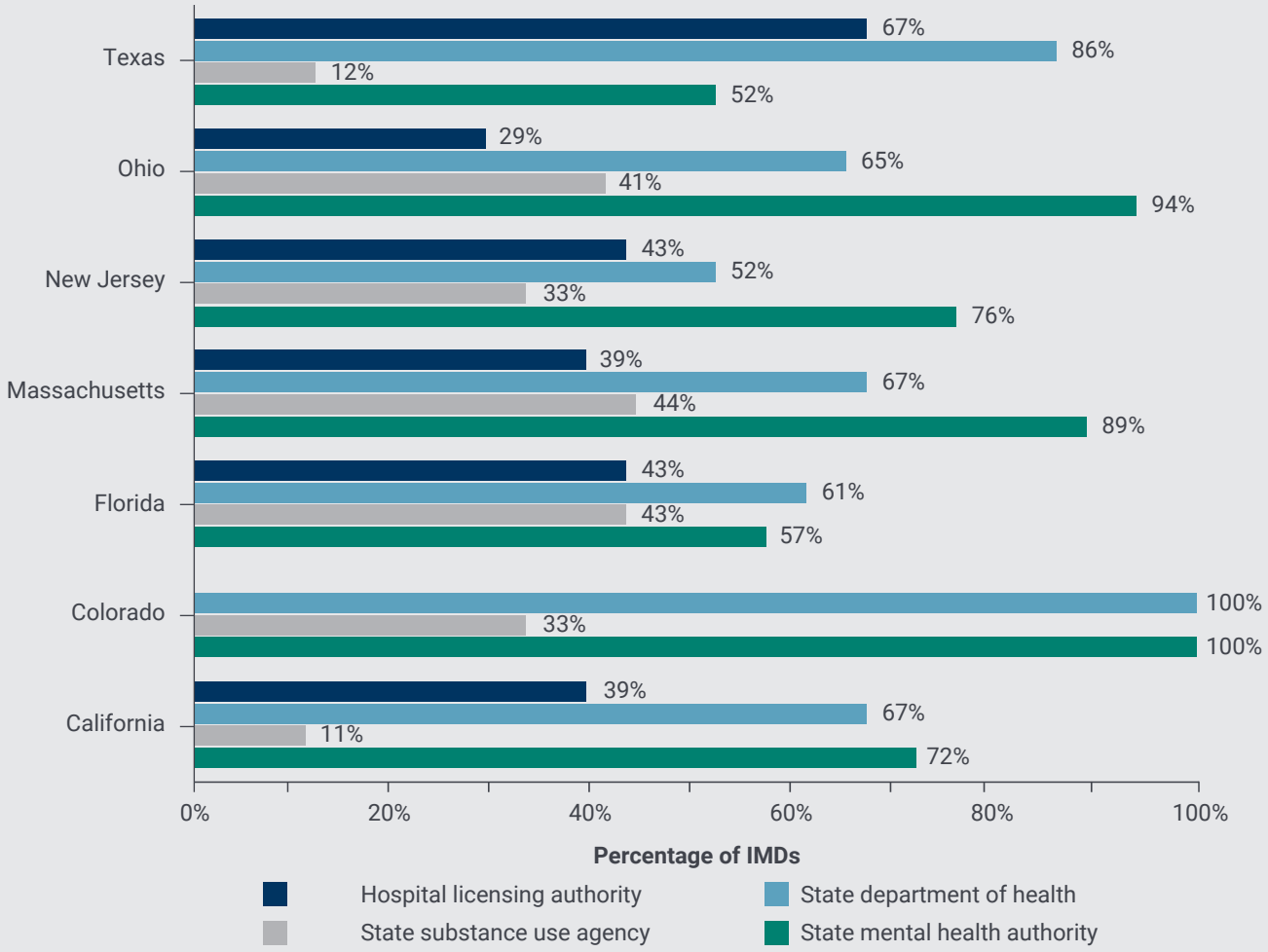
Source: MACPAC, 2019, analysis of SAMHSA 2018b.

Contracting for services. The single state substance use or mental health authority may also be responsible for contracting with providers for the provision of services. For example, in Massachusetts the single state substance use authority is responsible both for licensing facilities and for contracting with providers for the provision of SUD treatment services. Generally, the clinical standards to which facilities must adhere are outlined in the contract terms and conditions. Moreover, additional facility and provider inspections are conducted as part of the contract monitoring process (IBM Watson Health 2019).

The Licensure Process

Licensure is the primary mechanism by which states ensure facilities meet specified standards, such as those related to health and safety, patient

FIGURE 3-4. Percentage of Mental Health Treatment Facilities Identified as Institutions for Mental Diseases Licensed or Certified by Certain State Agencies and Accept Medicaid, Selected States, 2016



Notes: None of the facilities in Colorado reported that they were licensed by the hospital licensing authority. Totals may not sum to 100 percent because facilities may be licensed or certified by more than one state agency.

Source: MACPAC, 2019, analysis of SAMHSA 2018b.

care, physical plant, and, in some instances, local regulations related to zoning or fire safety. Such standards are often outlined in state statute or regulations.[9]

The licensure process is typically initiated when a facility submits an application and pays applicable fees, which can vary by state and, within each state, by facility type. For example, in Texas, the fee for an initial license or a renewal license for an inpatient psychiatric hospital is $100 per bed per 12 months, with a base annual fee of $3,000. In comparison, the base fee for an initial SUD treatment facility license is $1,200, with an additional $125 fee for each outpatient or residential site located at a separate physical address. Licensure fees increase if the facility operates a residential program, with a $35 fee per bed.[10]

The initial application usually triggers several intervening steps before a license is issued or denied. For example, in New Jersey, once an SUD facility submits an application and the state deems it complete, the facility is surveyed. If deficiencies are found, the facility must come into compliance before the license can be issued. Thereafter, the state can conduct unannounced or announced inspections to monitor compliance or investigate complaints (Box 3-3).[11]

All of the states interviewed for this study indicated that outside of the initial licensure and licensure renewal processes, state enforcement of licensure standards is largely complaint-driven. That is, the licensure agency receives complaints from the public via sources such as toll-free hotlines, agency websites, an ombudsman, or other state agencies (e.g., the office of the inspector general, a Medicaid agency, or a state fraud control unit). When deficiencies related to licensure are found, states typically develop facility-specific action plans that require the facility to correct the deficiencies within a specified time frame. However, some states use additional mechanisms, such as monetary penalties, to enforce licensure standards; these enforcement mechanisms are discussed later in the chapter.

Licensing Standards

In this section, we take a closer look at licensure requirements in the seven states. Licensure requirements include standards related to patient assessment, treatment planning, discharge planning, staffing, availability of services, and number of hours of treatment provided to each patient. Licensure standards for facilities that

BOX 3-3. Licensure Process for Residential Substance Use Disorder Treatment Programs in New Jersey, 2019

Applications and fees. Residential substance use disorder (SUD) programs pay fees of $500 for a new facility, $500 for inspection, and an additional $3 per bed. Similar fees apply at license renewal, which must be done biennially. Facilities that fail to pay these fees will not be licensed. As part of the application, residential SUD treatment facilities must submit a complete program description that includes the criteria or credentialing for staff, the number of clients to be served, the proposed treatment modality, and a detailed explanation of services to be offered. Facilities must also demonstrate compliance with physical plant standards.

Issuance or denial of license. Once an application is submitted, the applicant or the state may request a preliminary meeting to review it. If the application is deemed incomplete, the state must notify the applicant in writing, identifying the additional information needed. Once a complete application has been reviewed by the state, the state schedules a survey of the proposed facility. Within 45 days of the survey's completion, the state must notify the applicant in writing of the survey findings, including any deficiencies. If deficiencies are found, the state must schedule additional surveys within 15 working days after the applicant notifies the state that the documented deficiencies have been corrected. Generally, the state must approve an application for licensure if it is satisfied with the application and the results of the facility survey, and if the facility has received approval from the local zoning, fire, health, and building authorities.

After obtaining licensure. The state may make periodic announced or unannounced site visits to survey a facility. The visit may include reviewing the facility's physical plant and architectural plans, auditing program documents and client records, interviewing staff and clients, and verifying compliance with applicable state regulation. The state may also conduct surveys to investigate complaints of possible licensure violations.

may be considered IMDs vary considerably across states; within states, standards vary depending on whether a facility provides mental health care or SUD treatment.

Interviews with state officials in California, Florida, and Texas revealed that these states either have recently modernized their licensing standards, or are actively working to update them. In Texas, current standards of care for facilities, which must be met prior to licensure, were developed and codified in September 2017. Florida recently conducted a comprehensive update to standards for residential mental health facilities and revised specific building codes and rules that were outdated. In California, licensing standards were updated for SUD facilities as part of the state's Section 1115 SUD demonstration application which was approved by CMS in 2015.

Patient assessment

With few exceptions, all of the states we reviewed required inpatient, residential, and outpatient mental health and SUD treatment facilities to conduct an assessment of patients prior to or upon admission.[12]

Generally, a patient assessment must include:

- a history of the patient's health;
- a determination and assessment of their medical needs; and
- identification of the types of services the patient may need.

In some instances, states require facilities to use specific screening tools and to screen for other physical health conditions as part of the patient assessment. For example, New Jersey facilities must conduct a comprehensive biopsychosocial assessment for all patients within 72 hours of admission using the Addiction Severity Index or a similar tool.[13] This assessment must address several areas including communicable diseases; social, vocational, and housing needs; and the patient's readiness to change. Facilities must screen for co-occurring mental health disorders and SUDs and specific testing must also be conducted, including routine urinalysis, HIV tests, and blood work for other chronic diseases, subject to the patient's consent. The facility must also ensure that the patient is placed in the appropriate treatment facility using the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, which assesses level of care.[14]

Treatment planning

Six of the states we reviewed require licensed inpatient, residential, and outpatient mental health and SUD treatment facilities to conduct individualized treatment planning for every client.[15] Treatment planning requirements usually stipulate when treatment plans must be developed and updated, as well as what information must be included in the treatment plan. Treatment planning requirements also vary by the type of facility (Box 3-4).[16,17,18,19] Some states specify how often treatment plans must be updated, while other states do not.

Discharge planning

Discharge planning identifies specific plans to meet needs, specific resources and recommendations, and providers that will be responsible for the patient's care once they leave a facility. It includes working with the patient to develop an individualized plan and in some instances such plans are developed with the treatment provider to which the patient is being discharged.

Generally, state licensure requirements for inpatient, residential, and outpatient SUD treatment facilities include provisions governing discharge planning. For example, they typically require discharge plans to be signed and dated by the patient and to be included in their medical record. Licensure requirements for inpatient mental health facilities also address discharge planning; however, we were not able to locate these requirements for such facilities in all seven states in our review. We located licensure requirement provisions governing discharge planning for residential

BOX 3-4. Examples of Treatment Planning Requirements for Residential and Inpatient Behavioral Health Facilities, Selected States

Inpatient substance use disorder (SUD) facilities. In California, within seven days of admission, a recovery plan must be developed in consultation with each patient. Each individual plan must include goals that identify a continuum of recovery and observable, measurable objectives for each episode of hospitalization towards achieving those goals. The plan must document the success or failure in achieving goals and objectives. Factors contributing to the patient's progress, or lack thereof, must be evaluated and assessed for additional action.

Residential SUD facilities. In New Jersey, facilities must initiate the development of a measurable treatment plan at admission and enter the plan into the client record within 72 hours. The treatment plan must address vocational or educational services, orders for medication or medical treatment, the staff responsible for the implementation of the client's treatment plan, as well as long and short-term goals for treatment. At least every 30 days, the treatment plan must be reviewed and revised as appropriate.

Inpatient mental health facilities. In Texas, facilities must develop and implement a written treatment plan within 24 hours of admission. The treatment plan must be based on the findings of a physical examination, a psychiatric evaluation, and a comprehensive nursing assessment. It must also contain information about the patient's diagnosis, problems to be addressed during hospitalization, and planned treatment interventions. Within 72 hours of patient admission, the plan must be updated to include the results of a social assessment and any other assessment that was ordered. Services recommended for the patient after discharge must also be identified.

Residential mental health facilities. In Florida, treatment plan development must begin within 72 hours of admission. Within 30 days of admission, a functional assessment and individual treatment plan for each resident must be developed. Treatment plans must have achievable goals and objectives and must be updated and revised when they are achieved. Family members or significant others must be included in treatment planning to the extent it is permitted or requested by the resident. Depending on the type of treatment facility, plans must be updated every 60 to 120 days.

facilities in four states (Colorado, Florida, New Jersey, and Ohio), and for outpatient facilities in three states (Colorado, New Jersey, and Texas) (IBM Watson Health 2019).

In some states, facilities may discharge or transfer patients to other facilities only under certain circumstances. For example, in California, absent an emergency, inpatient SUD treatment facilities may transfer or discharge a patient to another facility only if prior arrangements have been made for the admission of the patient to that facility. In addition, the person legally responsible for the patient must be notified; this requirement is waived after repeated unsuccessful attempts have been made to reach the responsible individual over a 24-hour period.[20]

Some states require licensed facilities to provide services to patients after they have been discharged. For example, inpatient facilities in Ohio must provide services for up to two weeks after discharge. Such services must include medication management, a crisis management plan, referral to or provision of a support group, or a mechanism to contact an emergency services provider (IBM Watson Health 2019).

Staffing requirements

Licensure requirements in all seven states under review include provisions pertaining to staff; however, requirements vary widely depending on the type of facility (e.g., for inpatient and residential SUD and mental health treatment facilities), both within and across states. States may have standards requiring facilities to employ a medical director, maintain other specific clinical staff, and adopt staffing ratios for professional counselors and other staff.

Medical director. All seven states in our study require inpatient SUD and mental health treatment facilities to employ a medical director. However, it is less common for states to require this for residential SUD and mental health treatment facilities. Specifically, four states require residential SUD treatment facilities to employ a medical director (Florida, Massachusetts, New Jersey, and Texas). Florida is the only state to require residential mental health treatment facilities to have a medical director on staff (IBM Watson Health 2019).

Clinical staff. Generally, inpatient SUD and mental health treatment facilities must meet multiple clinical staffing requirements as a condition of licensure. Inpatient facilities and residential facilities are typically required to hire certain specialized staff, such as clinical psychologists or nurses, but such requirements usually do not apply to outpatient facilities.

Most of the states we reviewed require inpatient facilities to maintain certain professional staff for both SUD and mental health treatment facilities. However, staffing requirements vary widely. For example, in California, inpatient SUD treatment facilities must maintain minimum staffing levels for certain professionals based on the size of the facility. California defines professional staff as personnel qualified to render services in inpatient SUD treatment settings, including physicians, clinical psychologists, psychological assistants, registered nurses, licensed vocational nurses, pharmacists, psychiatric technicians, physician assistants, chemical dependency counselors, clinical social workers, and licensed marriage, family, and child counselors.[21] Prior to employment, professional staff must be free of chemical dependence for at least two years. In Ohio, inpatient facilities must be Medicare-certified or accredited by a CMS-approved accrediting body; as such, they must meet staffing requirements outlined in Medicare's hospital conditions of participation. In addition, the state requires medical services to be provided under the direction of a psychiatrist and requires that a psychiatrist is always available, 24 hours a day, 7 days a week, either in person or by telephone.[22]

All seven states have additional professional staffing requirements for residential SUD treatment facilities. Some residential SUD facilities in Massachusetts are required to have a registered nurse, nurse practitioner, physician assistant, or licensed practical nurse on site for at least four hours each day and these facilities must ensure that nursing staff are overseen by a registered nurse.[23]

Only three states have additional clinical staffing standards for residential mental health treatment facilities. For example, in New Jersey, standards are less specific, requiring only that residential mental health treatment facilities provide a sufficient number and type of staff as appropriate to the type of the facility and the individual needs of residents. In certain facilities, at least one staff person must be available to residents 24 hours a day, either on site or off the premises.[24]

Staffing ratios for professional counselors. Most of the states we reviewed did not require specific staffing ratios for counselors for residential or inpatient SUD and mental health treatment facilities. We found no licensure provisions mandating counseling staffing ratios for psychiatric hospitals. Rather, states usually required facilities to have a method for determining staffing based on the assessed needs of the patients (e.g., the degree of the patient's illness or the skill level of the staff providing care). California was the only state that requires inpatient SUD treatment facilities to meet certain counseling staffing ratios as a part of licensure (IBM Watson Health 2019).

None of the states we reviewed require staffing ratios for professional counselors in residential mental health treatment facilities; however, staffing ratios for counselors are imposed for residential SUD treatment facilities in three states (Colorado, New Jersey, and Texas) (IBM Watson Health 2019). For example, in New Jersey, facilities must maintain staffing ratios ranging from 1 counselor for every 8 clients in short-term residential treatment facilities to 1 counselor for every 15 clients in extended care facilities and halfway houses.

Staffing ratios for other staff. A few states impose staffing ratios for other types of professionals, for example, California imposes them in their licensure standards for inpatient SUD treatment facilities and Ohio imposes them in their licensure standards for psychiatric hospitals. In California, an inpatient SUD treatment facility must have at least one professional staff member for every 25 patients.[25] In Ohio, psychiatric hospitals must maintain nursing staff at an average ratio of one nurse for every four patients in any four-week period. This average does not include overnight hours, when patients are sleeping. A registered nurse must be on site 24 hours a day, 7 days a week and must be available for direct patient care when needed.[26]

State staffing ratios vary based on facility type and may also differ based on the time of day. Generally, residential facilities require at least one staff person to be awake and on site 24 hours a day. For example, in Colorado, residential SUD treatment programs must maintain staff-to-client ratios of 1:20 per agency per site during nighttime hours. Residential facilities that offer withdrawal management services may not exceed staff-to-client ratios of 1:10 and each shift must have a minimum of 2 staff members anytime a client is present.[27] In Texas, intensive residential SUD programs must maintain a direct-care staff-to-client ratio of 1:16 when clients are awake and 1:32 during sleeping hours.[28] Supportive residential SUD programs must maintain a direct-care staff-to-client ratio of 1:20 during the day and 1:50 during sleeping hours. In Ohio, psychiatric hospitals must have at least two staff members present at all times for safety reasons.[29]

Availability of services

In general, the seven states in our review have licensure requirements that identify the types of services to be delivered in inpatient, residential, and outpatient SUD and mental health treatment facilities. Four states have incorporated the ASAM criteria into their licensure standards for all SUD facility types (California, Colorado, New Jersey, and Massachusetts) (IBM Watson Health 2019).[30] Beyond that, the types of services facilities are required to provide varies within and across states by facility type.

Inpatient facilities generally have to provide a wide array of services, including nutritional services. For example, California requires inpatient SUD treatment facilities to provide patient counseling, group therapy, physician services, family therapy, and dietetic services (IBM Watson Health 2019). In Florida, inpatient mental health treatment settings must provide services including psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy, and all these services must be delivered by qualified personnel, as appropriate to the needs of the patient (IBM Watson Health 2019). Similar services are required of inpatient mental health facilities in New Jersey.[31]

Residential treatment facilities are often permitted to provide a more limited range of services than required in inpatient facilities, although nutritional services are generally required. For example, residential treatment facilities in Florida are required to offer services and activities adapted to the needs of individual residents that promote personal growth and development and prevent deterioration. Facilities must provide or refer residents to recreational and social activities during the hours they are not involved in other planned or structured activities. Residents must also have the opportunity to attend religious activities.[32]

Facilities must also provide (internally or through outside contracts) a full range of services for the treatment of illnesses and maintenance of general health. Some states require residential providers to

help patients access a broader array of treatment services. In Massachusetts, all SUD treatment facilities must—either directly or through a qualified service organization agreement—provide a wide range of health services to patients, including SUD counseling services, mental health services (including pharmacological services for those with co-occurring disorders), HIV education and counseling, family planning services, relapse prevention, and family support services.

Hours of treatment

States rarely require inpatient, residential, and outpatient mental health and SUD treatment facilities to provide a specific number of hours of treatment to each patient as a condition of licensure. Ohio is the only state we reviewed that sets treatment hour requirements for psychiatric hospitals. None of the states we reviewed applied such requirements to residential mental health treatment facilities (IBM Watson Health 2019).

Florida, New Jersey, and Texas are the only states we reviewed that require residential SUD treatment facilities to provide a certain number of hours of treatment for individuals in their care. Florida requires hours of service ranging from 2 hours of counseling per week in less intensive settings to 14 hours per week in more intensive residential programs.[33]

In New Jersey, each facility must design programs to ensure that clients spend at least seven hours a day in structured activities (e.g., individual or group counseling, vocational training, education, or recreation).[34] Counseling services must be provided on site and clients must receive a set number of hours of counseling per week, ranging from 3 hours per week in halfway houses to 12 hours per week in hospital- and non-hospital-based residential facilities. Family counseling must also be provided as clinically indicated.[35]

In Texas, intensive residential SUD treatment programs must provide at least 30 hours of services per week for each client. Services provided must include 10 hours of SUD counseling, of which 1 hour must be individual counseling; 10 hours of additional counseling, SUD education, life skills training, or relapse prevention; and 10 hours of planned structured activities that are monitored by facility staff, of which 5 hours must occur during evenings or weekends. Supportive residential SUD treatment programs must provide at least six hours of treatment services per week, to include three hours of SUD counseling and three hours of additional counseling, SUD education, life skills training and relapse prevention education.[36]

Enforcement of Licensing Standards

Facilities that are not in compliance with state standards typically must develop a corrective action plan to address deficiencies. Such plans are facility-specific and outline actions to be undertaken within a certain time period. Failure to comply may result in the license being revoked. However, interviewees in all states noted that license revocation is extremely rare for inpatient, residential, and outpatient behavioral health facilities.

Some states use additional mechanisms to enforce licensure standards. These may include monetary penalties, requiring facilities to report certain incidents, and other remedies for non-compliance.[37, 38]

Monetary penalties

States may be able to impose penalties on providers that violate the conditions of licensure. For example, in New Jersey, the state may issue civil monetary penalties for unlicensed operation of a residential SUD treatment facility.[39] Such penalties are $25 a day for the first occurrence and $50 per day for any occurrence after the date services were initiated. The state may also issue similar monetary penalties when facilities do any of the following: violate a curtailment of admissions; fail to obtain prior approval for occupancy of a new or renovated area or for the initiation of a new or enhanced service; begin constructing or renovating

a facility prior to the approval of construction plans; or transfer ownership of the facility without prior state approval.[40] Licensure agencies in California may issue monetary penalties against mental health and SUD treatment facilities under certain circumstances.[41] Texas also has the ability to impose administrative penalties for SUD treatment facilities.[42] In Massachusetts, the state can issue an administrative fine for facilities that operate without a license.[43]

Reportable incidents

All of the states we reviewed require licensed facilities to report certain incidents to the state. For example, all facilities operated by the Texas Department of Mental Health, as well as community mental health treatment centers, must report patient deaths in accordance with Texas Administrative Code. Specifically, facilities must follow clinical peer review procedures to identify clinically related problems that require correction, as well as separate administrative review procedures upon the death of a patient who was receiving services.[44] New Jersey has similar requirements for residential SUD treatment facilities: these facilities must adopt specific policies and procedures governing the reporting and management of reportable events (e.g., accidents, disasters, fires, or client injury or death) and outbreaks of communicable disease must also be reported.[45]

Waivers from certain licensure requirements

Some state licensure agencies have the authority to waive certain licensure requirements upon request from a facility. Generally, facilities must demonstrate that compliance with a specific licensure provision would have an adverse impact on the facility. For example, Colorado may grant a waiver from specific SUD facility licensure requirements if the facility proves that granting the waiver would not adversely affect the health, safety, and welfare of individuals; if the facility shows the waiver would improve care; or if application of the rule would create a demonstrated hardship on the facility seeking the waiver.[46] Ohio has a similar process for inpatient psychiatric hospitals and residential mental health treatment facilities and similar processes are available to certain facilities in California and New Jersey.[47]

Endnotes

[1] Although the IMD exclusion precludes Medicaid payment to facilities that may be considered IMDs, there are several exemptions from the IMD exclusion as well as statutory authorities that states can use to pay for Medicaid services in IMD settings. Additional information on these topics may be found in Chapter 1 of this report.

[2] This was confirmed through interviews with state officials and responses to MACPAC's request for public comment on this topic (IBM Watson Health 2019).

[3] With the exception of opioid treatment programs, which dispense and administer methadone for the treatment of opioid use disorder, there are no federal standards for other types of specialty SUD treatment facilities.

[4] Similar standards may apply to these providers under state licensure rules.

[5] A PRTF is any non-hospital-based facility with a provider agreement with a state Medicaid agency to provide the psych under 21 benefit. The facility must be accredited by the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, the Joint Commission, or any other accrediting organization with comparable standards recognized by the state. Regulations published in 2002 require PRTFs to maintain certain staffing and medical oversight and to place limits on the use of physical or chemical restraint and seclusion, as well as to adopt specific protections for children (42 CFR 441.150, et. seq. and 483.350, et seq.). Even if a state Medicaid plan does not include coverage for the psych under 21 benefit, a medical necessity determination under Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit requires a state to pay for care in these settings.

[6] CMS oversees and approves accrediting programs used for Medicare certification (e.g., for psychiatric hospitals), and ensures that accredited providers meet the quality and patient safety standards required under the Medicare conditions of participation.

[7] Massachusetts, New Jersey, Florida, and Ohio are all CON states. In Massachusetts, the CON process applies to residential and inpatient SUD providers. In New Jersey, the CON process applies to long-term care facilities, psychiatric beds, and inpatient acute care. In Florida, the CON process does not apply to SUD treatment facilities (with a partial exception for methadone clinics, which are subject to a similar needs-assessment process), but does apply to psychiatric hospitals (IBM Watson Health 2019).

[8] In Florida, the CON process is delegated to managed-service organizations. State officials noted that Florida's governor suspended the CON process for methadone clinics in response to the opioid crisis, which temporarily increased the number of facilities providing methadone (IBM Watson Health 2019).

[9] However, some states adopt standards through contracts with providers, which can be easily updated as the standard of care evolves (IBM Watson Health 2019).

[10] Tex. Health Services Code Ann. § 25.448.408(c)(3) (West 2019). http://txrules.elaws.us/rule/title25_chapter448_sec.448.408.

[11] N.J. Admin. Code §§ 10:161A-2.1—10:161A-2.8 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[12] All of the states we reviewed require inpatient facilities to perform a patient assessment at the time of admission. Licensure requirements in all seven states require outpatient SUD treatment facilities to provide each patient with an assessment upon admission. With the exception of California, all states we reviewed require both residential SUD and mental health treatment facilities to assess patients at or before the time of placement.

[13] The Addiction Severity Index is a semi-structured interview designed to assess seven potential problem areas in individuals misusing substances: medical status, employment and support, drug use, alcohol use, legal status, family and social status, and psychiatric status (TRI 1990).

[14] N.J. Admin. Code § 10:161A-9.1 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[15] We were not able to locate treatment planning requirements for mental health and SUD inpatient licensure in Colorado.

[16] Cal. Code Regs. tit. 22, § 79219 (2019). https://govt.westlaw.com/calregs/Document/I9240A2F0FB1811DEACA9F33E9EE53480?transitionType=Default&contextData=%28sc.Default%29.

[17] N.J. Admin. Code § 10:161A-9.2 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[18] Tex. Health Services Code Ann. § 25.411.471 (West 2019). http://txrules.elaws.us/rule/title25_chapter411_sec.411.471.

[19] Fla. Admin. Code Ann. r. 65E-4.016(11) (2019). https://www.flrules.org/gateway/ruleNo.asp?id=65E-4.016.

[20] Cal. Code Regs. tit. 22, § 79325 (2019). https://govt.westlaw.com/calregs/Document/IB0F75440D4BD11DE8879F88E8B0DAAAE.

[21] Cal. Code Regs. tit. 22, § 79311 (2019). https://govt.westlaw.com/calregs/Document/I0EFCB410942111E29091E6B951DDF6CE.

[22] Ohio Admin. Code 5122-14-12 (2017). http://codes.ohio.gov/oac/5122-14-12.

[23] 105 Mass. Code Regs. 164.00 (2016). https://www.mass.gov/regulations/105-CMR-16400-licensure-of-substance-abuse-treatment-programs.

[24] N.J. Admin. Code § 10:37A-1.2 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_37A%20Licensed%20Community%20Residences%20for%20Adults%20with%20Mental%20Illnesses.pdf.

[25] Cal. Code Regs. tit. 22, § 79221 (2019). https://govt.westlaw.com/calregs/Document/IADFED4C0D4BD11DE8879F88E8B0DAAAE.

[26] Ohio Admin Code 5122-14-10(c)(3)(2017) http://codes.ohio.gov/oac/5122-14-10v1.

[27] 2 Colo. Code Regs. 502-1 § 21.210.54 (LexisNexis 2016). https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7950&fileName=2%20CCR%20502-1.

[28] Tex. Health Services Code Ann. § 25.448.903 (West 2019). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=903.

[29] Ohio Admin Code 5122-14-10 (2017). http://codes.ohio.gov/oac/5122-14-10v1.

[30] ASAM is a non-profit professional medical society dedicated to improving the quality of and access to addiction care. The society represents more than 5,100 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM publishes its clinical guidelines in *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* (Mee-Lee et al. 2013). The guidelines were first published in 1991and have been updated three times, most recently in 2013. The ASAM Criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions, including service planning, placement, continued stay, transfer, and discharge decisions (ASAM 2014).

[31] In New Jersey, all psychiatric hospitals must provide certain professional departments, services, facilities, or functions, including administration; anesthesia department (only if electro-convulsive therapy is provided); dietary services; discharge planning; emergency department; employee and occupational health; housekeeping and laundry services; infection control and sanitation; medical records and medical staff; certain postmortem services; nursing service; patient rights; pharmacy services; rehabilitation therapy; physical plant and maintenance; psychiatric services; quality assurance; and social services (N.J. Admin. Code § 8:43G (2018)).

[32] Fla. Admin. Code Ann. r. 65E-4.016(12) (2019). https://www.flrules.org/gateway/ruleNo.asp?id=65E-4.016.

[33] Fla. Admin. Code Ann. r. 65D-30.007(6) (2019). https://www.flrules.org/gateway/ruleno.asp?id=65D-30.007&Section=0.

[34] N.J. Admin. Code § 10:161A-10.1 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[35] In hospital-based and non-hospital-based facilities, each client must receive at least 12 hours of counseling per week, on at least 6 separate occasions, and include at least 1 hour of individual counseling and 10 hours of group counseling. Long-term residential facilities must provide each client with eight hours of counseling per week on at least five separate occurrences with a minimum of one hour of individual counseling and seven hours of group counseling. Extended-care facilities must provide six hours of counseling a week on at least three separate occasions per client, with at least one hour of individual counseling and five hours of group counseling. Halfway houses must provide each client with at least three hours of counseling per week. At least one hour must be individual counseling and two hours must be group counseling (N.J. Admin. Code § 10:161A-10.1 (2018)).

[36] Tex. Health Services Code Ann. § 25.448.903 (West 2019). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=903.

[37] N.J. Admin. Code §§ 10:161A-2.14–10:161A-2.15 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[38] In New Jersey, the Commissioner of the New Jersey Department of Health and Senior Services, or the Commissioner's designee may impose various enforcement remedies against residential SUD treatment providers found in violation of licensure rules or other statutory requirements under certain circumstances. This includes curtailment of admissions to a licensed facility, reduction of a license or issuance of a provisional license, suspension or revocation of license, injunctions or temporary restraints, and any other remedies afforded by federal law. Notifications of violations must be served in person or by certified mail. However, similar enforcement remedies were not found for residential mental health treatment facilities in New Jersey.

[39] N.J. Admin. Code § 10:161A-2.14 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[40] N.J. Admin. Code § 10:161A-2.17 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[41] Cal. Code Regs. tit. 9, § 10547 (2019). https://govt.westlaw.com/calregs/Document/I433E6EC0D45411DEB97CF67CD0B99467.

[42] Tex. Health Services Code Ann. § 25.448.409 (West 2019). http://txrules.elaws.us/rule/title25_chapter448_sec.448.409.

[43] 105 Mass. Code Regs. 164.012(c) (2016). https://www.mass.gov/regulations/105-CMR-16400-licensure-of-substance-abuse-treatment-programs.

[44] Tex. Health Services Code Ann. §§ 25.405.261–25.405.279 (West 2019). http://txrules.elaws.us/rule/title25_chapter405_sec.405.261.

[45] N.J. Admin. Code § 10:161A-3.8 (2018). https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf.

[46] A request for a waiver must be submitted to the state licensure agency on the appropriate form and the state must notify the provider within 30 calendar days following the date of receipt of the completed waiver application, unless the state is required to make an inspection or obtain additional information from the provider. Waivers may be granted for a period not to exceed the two year licensing or designation period; however, waivers may be renewed at the time of re-licensure or designation. A provider may appeal the decision of the state regarding their waiver application in accordance with the Colorado Administrative Procedures Act (2 Colo. Code Regs. 502-1 § 21.120.7 (LexisNexis 2016)).

[47] In California, inpatient SUD facilities can request similar accommodations from licensure standards (Cal. Code Regs. tit. 22, § 79115 (2019)). In New Jersey the state allows residential mental health and SUD treatment facilities to request similar waivers (N.J. Admin. Code § 10:37A-12.8 (2018), N.J. Admin. Code §10:161A-2.13 (2018)). Ohio has a similar process for inpatient psychiatric hospitals and residential mental health treatment facilities (Ohio Admin Code 5112-14-06 (2017), Ohio Admin Code 5122-30-07 (2018)).

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Chapter 4:

Medicaid Standards for Behavioral Health Facilities

CHAPTER 4: Medicaid Standards for Behavioral Health Facilities

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) requires MACPAC to summarize standards, including the quality and clinical standards, that facilities considered to be institutions for mental diseases (IMDs) must meet to receive Medicaid payment under various exemptions to the IMD exclusion, and how states determine if these requirements have been met. (Exemptions to the IMD exclusion are discussed in Chapter 1.)

Federal standards that apply to facilities considered to be IMDs are largely determined by whether or not the facilities are Medicare providers. Under guidance from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies must, at a minimum, use Medicare certification standards for those providers recognized by Medicare (e.g., psychiatric hospitals) (CMS 2018a). States have flexibility in how they regulate all other providers; this includes freestanding residential substance use disorder (SUD) and mental health treatment facilities.

The Medicaid provider enrollment process is the primary mechanism by which states ensure that providers meet Medicaid standards. It complements the licensure and accreditation processes generally carried out by other state agencies, as discussed in Chapter 3. Providers that fail to meet Medicaid enrollment requirements are prohibited from receiving Medicaid payment.

Provider enrollment requirements may be imposed by state Medicaid agencies, Medicaid managed care plans, and administrative service organizations (ASOs).[1] Generally, state Medicaid programs require inpatient, residential, and outpatient behavioral health facilities to be licensed. In some states, providers must meet additional standards—including those related to staffing, treatment planning, discharge planning, and care coordination—imposed by either the state Medicaid program or Medicaid managed care plans operating in the state.[2] States and plans may also require accreditation or specific standards for utilization management for SUD and mental health treatment providers. Finally, if a state has an SUD demonstration waiver approved under Section 1115 of the Social Security Act, the state (and its Medicaid managed care plans) must adopt additional standards for residential SUD treatment facilities. (Standards for Section 1115 demonstrations are discussed below and in Chapter 1 of this report.)

In this chapter, we discuss Medicaid standards for facilities subject to the IMD exclusion and their enforcement in seven states—California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas. Where relevant, we also discuss additional standards that managed care plans apply to IMDs. We then summarize managed care contracting mechanisms, including policies related to the provision of behavioral health services.

Medicaid Provider Enrollment Process

States use the Medicaid screening and enrollment process as the primary regulatory mechanism for ensuring that providers meet state Medicaid standards. This process must be conducted before a provider can receive Medicaid payments; it gives states an opportunity to identify unqualified providers before they provide services to beneficiaries, which both protects patients and prevents improper payments.

At regular intervals, providers must demonstrate that they continue to meet state requirements through a process known as reenrollment or revalidation. In our review of the seven selected states, we found that behavioral health providers

must generally revalidate their status every three to five years (IBM Watson Health 2019).

Below, we discuss the components of provider screening and enrollment, including the role of provider agreements and additional enforcement mechanisms, such as administrative fines, that states may use if providers fail to meet Medicaid standards. We also discuss how the provider enrollment process applies to SUD and mental health treatment facilities that may be considered IMDs in selected states.

Components of provider screening and enrollment

The provider screening and enrollment process includes several components:

- screening and enrolling eligible providers, reenrolling providers, and revalidating providers;
- checking exclusion lists and other verification databases in accordance with state and federal screening requirements;
- ensuring that appropriate disclosures (e.g., ownership interests, tax identification number) are reported by providers;
- implementing moratoria on providers when federally approved or mandated (42 CFR 1002.2); and
- reporting any adverse provider application actions to the U.S. Department of Health and Human Services Office of the Inspector General (MACPAC 2019).

The Medicaid agency, managed care plan, or other contractor screens providers to verify that they are licensed and in good standing.[3] The screening process itself differs according to the provider's potential risk for fraud, waste, or abuse, characterized as limited, moderate, or high. This risk determination is made by CMS or the state based on the type of provider (as opposed to individual provider characteristics).

Certain providers that participate in Medicare are assigned a risk classification by CMS, for example, hospitals (limited risk), community mental health centers (moderate risk), and durable medical equipment suppliers (high risk). For these providers, states typically rely on the results of the provider screening conducted by accrediting organizations or state survey agencies, as well as Medicaid or CHIP agencies in other states. All states are required to conduct criminal background checks (including fingerprinting) on high risk providers. States may also conduct such checks on other providers at their discretion. A provider that does not pass the background check cannot participate as a Medicaid provider (MACPAC 2019).

For providers not recognized by Medicare, such as residential SUD or mental health treatment facilities, the state Medicaid agency has substantial discretion in how it conducts screening activities, including the assignment of risk level.

Provider agreement. After a provider has completed the enrollment process, it will usually enter into a provider agreement with the state. This agreement requires the provider to comply with applicable state and federal Medicaid laws and includes provisions related to fraud, waste, and abuse. The agreement may also include the following terms and standards:

- billing for medically necessary services only;
- notifying the state of material changes in the facility's practice;
- monitoring program integrity through audit and review;
- identifying requirements related to recoupment; and
- specifying when the provider must take corrective actions (IBM Watson Health 2019, CMS 2015b).

Enforcement mechanisms. State Medicaid agencies may use a number of mechanisms to enforce the standards outlined in provider agreements. Facilities that fail to meet standards

described in the provider agreement may be terminated by the Medicaid program (CMS 2018b). For example, in Massachusetts, the state may impose sanctions for violations of rules, regulations, and laws governing the state's Medicaid program, MassHealth. Such sanctions may include administrative fines, provider services restrictions, and suspension or termination from participation in MassHealth. Fines must be calculated in accordance with state regulation. Providers may appeal their sanctions to an adjudicatory hearing and judicial review; however they must do so within 30 days of receiving notice of the sanction.[4]

Provider enrollment for behavioral health facilities in selected states

States have flexibility in how they enroll residential behavioral health providers and vary in how they classify the risk level applied to these facilities. Behavioral health providers classified as moderate or high risk face a more thorough provider screening and enrollment process.

With the exception of Colorado, all of the states we examined consider inpatient mental health and SUD treatment facilities to be limited risk.

There is more variation in how states assign risk to residential and outpatient providers. Massachusetts and New Jersey consider residential mental health and SUD providers to be limited risk, but Colorado and Texas consider these facilities to be moderate risk.[5] In comparison, California and Ohio consider residential and outpatient SUD treatment facilities to be high risk (IBM Watson Health 2019).

Enrolling in Medicaid can be a lengthy process for residential and inpatient providers. For example, informants in California noted that the provider enrollment process could take up to one year for residential providers. Informants in Florida noted that the provider enrollment process takes a long time and sometimes results in the loss of some providers from the state's network (IBM Watson Health 2019).

State Medicaid agencies differ in whether they conduct site visits of facilities offering residential, inpatient, intensive outpatient, or partial hospitalization as part of provider enrollment and reenrollment processes. For example, the Texas Medicaid program performs site visits of all providers as part of provider enrollment; Massachusetts only visits selected providers. Florida Medicaid retains the right to perform site visits for any provider enrolling in Medicaid, but generally relies on the state licensure agency to perform this function. In Colorado, the Medicaid agency usually does not visit providers; rather, it conducts site visits to regional accountable entities that directly contract with providers, and in some cases, it may visit a provider as part of such a visit. Typically, states do not conduct periodic site visits of these providers as part of Medicaid oversight activities (IBM Watson Health 2019).

In some states, certain provider enrollment functions are performed by entities other than the state Medicaid agency. In California, county-based agencies conduct provider enrollment for mental health treatment facilities, while the state conducts provider enrollment for residential and inpatient SUD treatment facilities. In counties that are participating in the state's Section 1115 SUD demonstration, facilities receive an annual visit from the state. In all other counties, the state visits every two years (IBM Watson Health 2019). State standards beyond provider enrollment are discussed in more detail below.

Medicaid Standards for Facilities

In addition to requiring behavioral health facilities to meet provider enrollment standards, Medicaid agencies and managed care plans may require them to meet standards related to accreditation, staffing, utilization management, treatment planning, discharge planning, and care coordination. States with approved Section 1115 SUD demonstrations have also adopted American Society of Addiction

Medicine (ASAM) criteria for residential SUD treatment providers.[6] The ASAM criteria are a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. They cover service planning, placement, continued-stay, transfer, and discharge decisions (ASAM 2014). It is important to note that state Medicaid agencies do not need CMS approval to adopt ASAM standards for providers.

Staffing standards

Medicaid agencies sometimes adopt staffing standards that facilities must meet to receive Medicaid payments. These can include requirements for employment of certain types of practitioners (e.g., registered nurses, psychologists), additional medical oversight, or staffing ratios. Our review of seven states indicates that states are most likely to apply standards related to the types of practitioners a facility must employ.

Medical oversight. Medical oversight standards require facilities to have a medical director or to ensure that the beneficiaries are under the care of a physician while they are in a facility. California and New Jersey were the only states in our review that apply such additional Medicaid standards for residential and outpatient SUD treatment facilities. For example, in California, SUD treatment facilities must have a licensed physician who is enrolled in Medi-Cal designated as the medical director.[7] Moreover, this physician may not be excluded from participating in Medicare or any state Medicaid program. In New Jersey, Medicaid beneficiaries receiving services in residential SUD treatment facilities must be under the supervision of a physician directly affiliated with the facility. New Jersey has similar standards for inpatient SUD treatment facilities as well as for inpatient and outpatient mental health treatment facilities. Medical oversight standards in Massachusetts apply only to outpatient mental health facilities (IBM Watson Health 2019).

Only one of the managed care plans reviewed for this study requires additional medical oversight for behavioral health facilities. Specifically, a managed care plan in Massachusetts uses medical oversight requirements for both inpatient mental health and SUD treatment facilities, as well as for residential and outpatient SUD treatment facilities.

Employment of other professionals. With the exception of Colorado, all states we reviewed impose additional personnel standards for one or more types of behavioral health facility. Ohio specifies these for inpatient, residential, and outpatient mental health and SUD treatment facilities. For most types of facilities reviewed in our study, Ohio Medicaid pays for services only if the practitioners rendering them meet specified requirements; these requirements apply to physicians, physician assistants, clinical nurse specialists, certified nurse practitioners, registered nurses, licensed practical nurses, certain licensed and unlicensed practitioners, chemical dependency counselor assistants, peer recovery supporters, and care management specialists.

New Jersey and Texas apply additional personnel standards to all facility types except residential mental health treatment facilities. California applies personnel specifications on outpatient mental health and SUD treatment facilities and on residential SUD treatment facilities. Florida imposes them on outpatient SUD treatment facilities. Massachusetts imposes such requirements on outpatient mental health treatment facilities, for example, outpatient psychiatric day treatment programs must have a certain number of qualified staff from different disciplines (e.g., psychiatry, psychology, occupational therapy) (IBM Watson Health 2019).

Managed care plans in three states—California, Massachusetts, and New Jersey—have additional personnel specifications for inpatient, residential, and outpatient mental health and SUD treatment facilities. Managed care plans in the other four states reviewed for this study did not have any facility-specific standards for behavioral health facilities (IBM Watson Health 2019).

Staffing ratios. Staffing ratio standards require facilities to employ a certain number of health care professionals for each patient in a facility. Five states—California, Florida, Massachusetts, New Jersey, and Texas–apply staffing ratios to at least one type of mental health or SUD treatment facility. Texas applies staffing ratios to residential and outpatient mental health facilities; New Jersey applies them to residential and inpatient SUD treatment facilities as well as inpatient and outpatient mental health facilities; Massachusetts applies them to outpatient mental health treatment facilities; and Florida applies them to outpatient SUD treatment facilities. California applies staffing ratios to outpatient mental health and SUD treatment facilities, for example, mental health day treatment programs must maintain an average minimum staff-to-beneficiary ratio of 1:8. The staff member can be a physician, psychologist, clinical social worker, registered nurse, or other specified practitioner. Programs serving more than 12 clients must meet additional staffing ratios (IBM Watson Health 2019).

Only one managed care plan we reviewed for this study applies staffing ratios to at least one type of behavioral health facility. Specifically, a managed care plan in California uses staffing ratios for inpatient, residential, and outpatient mental health treatment facilities (IBM Watson Health 2019).

Treatment planning, discharge planning, and care coordination

Treatment planning, discharge planning, and care coordination are individualized services provided to Medicaid beneficiaries. Treatment planning typically details the types of services that will be provided to a beneficiary who is receiving care at a facility. Such planning accounts for an individual's unique treatment needs, including their medical history and psychosocial needs. Similarly, discharge planning accounts for the type of care that individuals will need when they leave a treatment facility. For example, an individual leaving an SUD or mental health treatment facility might be referred to an outpatient level of care that includes partial hospitalization or another form of intensive outpatient treatment. Our review found that managed care plans are more likely to require these services for all behavioral health facilities than state Medicaid agencies, which adopt such requirements for a more limited number of facility types.

Treatment planning. All of the states we reviewed apply treatment planning requirements to at least one type of behavioral health facility. For example, in California, the Medicaid agency applies treatment planning requirements to residential and outpatient SUD treatment facilities, Ohio's Medicaid agency applies them to inpatient, residential, and outpatient mental health and SUD treatment facilities, and Texas applies them to residential and outpatient mental health facilities.

Managed care plans in all seven states impose treatment planning requirements for all facility types reviewed in this study (inpatient, residential, and outpatient facilities) (IBM Watson Health 2019).

Discharge planning. Five state Medicaid programs—California, Florida, Massachusetts, New Jersey, and Ohio—require discharge planning for at least one behavioral health facility type. Ohio is the only state that requires discharge planning for all of the facility types we reviewed for this study. California applies these requirements to residential and outpatient SUD treatment facilities, and Florida applies them to outpatient mental health and SUD treatment facilities. Massachusetts requires inpatient mental health and SUD treatment facilities, as well as outpatient SUD treatment facilities, to comply with discharge planning requirements. New Jersey applies these requirements only to inpatient mental health and SUD treatment facilities.[8]

Managed care plans in all seven states impose discharge planning requirements for all facility types reviewed in this study (IBM Watson Health 2019).

Care coordination. Only two states, California and Texas, impose additional care coordination standards for certain facilities. California applies these requirements to residential SUD treatment

facilities, and Texas applies them to residential and outpatient mental health and SUD treatment facilities.

With the exception of SUD treatment facilities in California (which are held to care coordination requirements established by the state), all of the managed care plans in the states we reviewed impose additional care coordination requirements in all facility types we reviewed (IBM Watson Health 2019).

Section 1115 demonstration standards

CMS requires residential SUD treatment providers in states with approved Section 1115 demonstrations to meet nationally recognized, evidence-based treatment guidelines such as the standards set forth in *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* or similar standards (CMS 2017).[9,10] Providers in these states must also use an evidenced-based SUD-specific patient assessment tool.[11] In addition, states must ensure that residential SUD treatment facilities provide access to medication-assisted treatment. States implementing a Section 1115 SUD demonstration are expected to have a process in place to ensure that residential SUD treatment providers are in compliance with staffing and service standards for services delivered in these settings.

MACPAC interviews with Medicaid officials, providers, and advocates in three states with approved Section 1115 SUD demonstrations—California, Massachusetts, and New Jersey—revealed that these requirements had a meaningful effect on the treatment system.[12] In all three states, interviewees reported that use of these standards has improved quality of care and access to residential SUD treatment.

California informants also noted that clinical and administrative oversight of facilities has increased. The demonstration has also allowed participating counties to standardize the delivery of care, rather than delegating decisions about care delivery to treatment facilities. Counties now have greater insight into the types of services being provided, including use of evidenced-based treatment practices by SUD treatment facilities. On the other hand, more stringent standards have made it more difficult for some providers to meet Medicaid requirements (IBM Watson Health 2019).

Interviewees in Massachusetts reported that the Section 1115 SUD demonstration improved linkages and collaboration between state agencies. For example, many of the standards used by the Massachusetts Department of Mental Health and the Department of Public Health's Bureau of Substance Addiction Services were adopted by MassHealth (the state Medicaid agency) when it began covering new levels of residential SUD treatment.

New Jersey interviewees reported that the demonstration has led to additional emphasis on clinical standards, and that facilities are now providing case-management services. In addition, all SUD treatment providers in New Jersey received training on ASAM criteria in 2018 (IBM Watson Health 2019).

Accreditation

Few state Medicaid agencies require behavioral health facilities to seek accreditation from independent entities such as the National Committee for Quality Assurance (NCQA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission. Among the states we reviewed, only Massachusetts, Ohio, and Texas require inpatient mental health facilities to be accredited. Ohio also requires accreditation for inpatient SUD treatment facilities (IBM Watson Health 2019).

MACPAC interviews with selected Medicaid managed care plans in seven states revealed that accreditation of behavioral health facilities also varies. For example, in New Jersey, one managed care plan requires freestanding behavioral health facilities that provide 24-hour care to be accredited by CARF and medical or surgical facilities to be accredited by the Joint Commission. In Ohio, one plan requires hospitals to have behavioral

health certification and accreditation by the Joint Commission and another plan in the state has no such requirements. In Florida, one plan requires facilities to meet NCQA accreditation standards. Regional accountable entities in Colorado and Ohio noted similar accreditation requirements (IBM Watson Health 2019).

Presently, there is no national certification or accreditation program to verify that providers meet ASAM standards. However, CARF and ASAM are in the process of developing a level-of-care certification program for residential SUD treatment providers (ASAM 2018). To comply with CMS requirements for the state's Section 1115 SUD demonstration, California established its own process for certifying providers for specific levels of care. To determine whether a facility meets ASAM standards, the state examines numerous aspects of the facility, including staffing patterns, the type and frequency of services offered (e.g., individual counseling, group counseling, 24-hour services), assessment, and treatment planning offerings (DHCS 2019).

Utilization management

State Medicaid agencies and Medicaid managed care plans have flexibility to set their own utilization management criteria and use a variety of mechanisms to manage use of services. Prior authorization is considered an important tool for payers to ensure appropriate use of health care services (Townley and Dorr 2017). Prior authorization typically requires providers to submit information to insurers to justify the clinical need for a particular service, and sometimes they must justify the continuation of that service once it has been approved. Medicaid utilization management policies are not limited to prior authorization; states may also place limits on the duration of treatment for beneficiaries in SUD and mental health treatment facilities that may be subject to the IMD exclusion. Postpayment reviews may also be conducted to identify suspicious provider billing patterns (CMS 2016).

In developing utilization management policies, states also must consider their obligations under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343).[13] (MHPAEA is discussed in Chapter 5 of this report.)

Prior authorization. Generally, Medicaid will pay for certain behavioral health services provided in mental health or SUD treatment facilities that may be subject to the IMD exclusion only if these services are considered medically necessary. This determination is often made via prior authorization and continued-stay criteria. In states with Section 1115 SUD demonstrations (California, Massachusetts, and New Jersey), prior authorization requirements or continued-stay criteria for SUD treatment are derived from ASAM criteria. We did not identify prior authorization requirements for inpatient psychiatric care in five states (California, Colorado, Massachusetts, New Jersey, and Texas); however, these states typically require continued-stay criteria for this service. California and Texas also do not require prior authorization for inpatient SUD treatment, which is categorized as an ASAM level 4.0 service. (Additional information on Medicaid benefits under fee for service (FFS) in all seven states we reviewed, including state use of prior authorization and continued-stay criteria for mental health and SUD treatment, can be found in Appendix 4A.)

Most Medicaid agencies we interviewed allowed managed care plans to determine their own prior authorization criteria, although state contracts with plans often include broad guidelines. Plans in California, Florida, Massachusetts, and New Jersey reported using ASAM standards. Some plans in Florida, Massachusetts, and Ohio reported using InterQual, which offers evidenced-based level-of-care clinical criteria for certain services. In Texas, managed care plans can set their own prior authorization criteria as long as they are not more restrictive than the state's FFS requirements. In Florida, plans may adopt their own prior authorization criteria, subject to state review (IBM Watson Health 2019).

Medicaid managed care plans in New Jersey and Massachusetts must comply with certain prior authorization requirements per state law. In Massachusetts, all payers, including Medicaid, are prohibited from applying prior authorization to ASAM level 3.5 and 3.7 services, a rule that entitles patients to 14 days of care prior to any clinical review by Medicaid.[14,15] In New Jersey, managed care plans may adopt their own prior authorization criteria for all services except for partial hospitalization services, which have statutorily defined prior authorization guidelines (IBM Watson Health 2019).

Limits on duration of treatment. States also set limits on the length of treatment that Medicaid will pay for in behavioral health facilities. Generally, states with Section 1115 SUD demonstrations must limit the length of stay during which services for beneficiaries receiving treatment in residential SUD treatment facilities may receive federal financial participation (FFP). However, states must commit to covering longer lengths of stay for beneficiaries, if medically necessary, with other funding. Most states, including Massachusetts and New Jersey, must maintain a statewide average length of stay of 30 days or less, which allows for some variation in length of stay among individual beneficiaries and types of treatment settings. However, some states have authority to pay for longer stays in facilities that are considered IMDs. In Massachusetts, episodes of care in ASAM level 3.1 facilities may be as long as 90 days for the first episode of treatment. In California, adult residential services may be authorized for a maximum of 90 continuous days and payment for such services is limited to two non-continuous stays for adults in a 365-day period. One of these stays may be extended for up to 30 days beyond the maximum in any 365-day period.[16]

The in-lieu-of provision (42 CFR 483.3(e)(2)), allows Medicaid managed care plans and prepaid inpatient health plans to pay for mental health or SUD treatment in IMDs under certain circumstances. The state may receive FFP for the capitation payment made for beneficiaries that receive services in an IMD and the stay is limited to no more than 15 days in the period covered by the capitation payment. Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas all permit plans to use the in-lieu-of provision to pay for services in IMDs. Some states, however, place additional limits on acute inpatient treatment.[17] For example, Texas Medicaid limits acute care inpatient hospital services to $200,000 per client per benefit year. Stays are limited to 30 days.

Texas does not pay for residential treatment in IMD settings, and it applies limits to its residential SUD treatment benefit. Beneficiaries with an SUD are limited to two episodes per six-month period and four episodes within a year. Episodes of care exceeding 35 days are subject to prior authorization (IBM Watson Health 2019).

Postpayment review. Federal regulations require each state Medicaid agency to establish a statewide surveillance and utilization review subsystem (SURS) to analyze postpayment claims to identify suspicious provider billing patterns (42 CFR 456.3). Some states have discrete SURS units and others fold these functions into larger program integrity efforts. SURS units identify patterns of fraud, waste, and abuse and conduct reviews and preliminary investigations. As appropriate, they also refer potential cases to the Medicaid fraud control unit and assist other entities in criminal investigations (CMS 2016).

State Medicaid and managed care plan officials interviewed for this project were not aware of any pervasive fraud, waste, or abuse issues with behavioral health facilities, although some noted that these facilities needed assistance to improve documentation of services (IBM Watson Health 2019).

Medicaid Managed Care

States use contracts with managed care plans to either standardize oversight of behavioral health facilities or delegate oversight of quality of care. Below we discuss these standards for behavioral health providers and managed care plans and

how they apply to IMDs. We also summarize state enforcement of managed care contractual obligations.

Network adequacy

With the exception of Massachusetts, the states we interviewed reported that their managed care contracts did not include specific network adequacy standards (e.g., time and distance standards) for behavioral health providers that may be considered IMDs, including inpatient and residential providers (IBM Watson Health 2019).[18, 19] States may, however, require managed care entities to take certain factors into account when developing their behavioral health networks. Examples of state managed care network adequacy requirements are described below:

- **California.** Contract language related to mental health requires managed care entities to consider a number of factors when creating a network, including the anticipated number of beneficiaries, expected utilization, and geographic location. However, specific network adequacy standards for facilities that may be considered IMDs are not further defined.
- **Colorado.** Colorado's waiver approved under Section 1915(b) of the Social Security Act establishes time and distance standards for mental health and SUD providers available under its regional accountable entities. The state also requires these entities to contract with any willing inpatient psychiatric facility in the state.
- **Florida.** Managed care contracts in Florida include mental health and SUD provider time and distance standards and provider ratios for rural and urban counties, with additional requirements for tribal populations.
- **Massachusetts.** The MassHealth primary care clinician plan contract includes network adequacy requirements that the managed care plan must consider in relation to the anticipated number of beneficiaries, expected utilization, geographic location, and other factors.[20]
- **New Jersey.** The New Jersey Family Care managed care contract requires a network allowing adequate access to be reviewed and approved by the agency. The state also imposes time and distance standards for acute care hospitals and other providers.
- **Ohio.** Starting in 2019, managed care plans are required to meet time and distance standards based on Medicare requirements. In addition, managed care plans must maintain a certain number of provider types (e.g., inpatient psychiatric facilities and psychiatrists) per county.
- **Texas.** Managed care plans must submit certain information to the Medicaid agency to demonstrate geographic adequacy of the network in relation to projected population per service area, including percentages and numbers of plan members with access to a given number of specific provider types within a specified distance. Behavioral health providers must be included in these tables but the type of providers is not further specified (IBM Watson Health 2019).

Managed care oversight of IMDs

Oversight of IMDs, including the use of outcome measures, varies considerably among managed care plans. Of the three regional accountable entities in Colorado interviewed for this project, only one indicated that the quality of care was inconsistent among facilities subject to the IMD exclusion. This regional entity noted that it pays close attention to readmission rates and lengths of stay in different facilities. The other two entities in Colorado are developing a similar quality management strategy, but they only began operating in the state relatively recently (IBM Watson Health 2019).

A managed care plan in New Jersey noted that it reviews quality outcomes related to 30-, 60-, and 90-day readmission rates with the goal of eventually restricting its network to providers with strong performance on these metrics. However, few providers were performing well on these measures at the time of our interview. As such, this plan created a "select network," under which providers exhibiting superior results get enhanced payment and a reduction in case-management requirements (IBM Watson Health 2019).

A managed care plan in Texas noted that it assessed psychiatric hospital performance using readmission metrics and had developed a pay-for-performance program based on these metrics (IBM Watson Health 2019).

One managed care plan in Ohio noted that it is working with providers to improve documentation standards at psychiatric hospitals, including IMDs. This managed care plan is also examining relevant quality metrics, such as psychiatric hospital readmissions, to assess the quality of care at these facilities. This plan is also trying to encourage behavioral health providers to implement quality metrics and lead initiatives to improve performance on outcome measures. The other Ohio managed care plan we interviewed did not have any similar initiatives in place to monitor outcomes and quality metrics (IBM Watson Health 2019).

State enforcement of managed care standards

All states we reviewed use some form of corrective action for managed care plans that fail to comply with state Medicaid standards. Contracts between states and plans often incorporate corrective action requirements specific to the plan. The state may choose to terminate the contract for a managed care plan or ASO if the entity does not adhere to its contract. Alternatively, the plan could be subject to fines or civil monetary penalties. Some managed care contracts also specify actions a managed care plan must take when providers fail to meet state standards.

Endnotes

[1] Some states contract with vendors known as ASOs to administer elements of their programs. ASOs are typically paid a non-risk-based fee to provide administrative services on behalf of the state. However, depending on how an ASO is structured, it may or may not be classified as a managed care arrangement.

[2] We use the term managed care plans to include prepaid inpatient health plans, managed care organizations, and accountable care organizations.

[3] Per federal guidance, providers may include both individuals or entities.

[4] 130 Mass. Code Regs. 450.238 (2017). https://www.mass.gov/files/documents/2017/11/07/130cmr450.pdf.

[5] Massachusetts considers outpatient mental health clinics moderate risk, and New Jersey considers these facilities limited risk.

[6] CMS permits states to use a standard other than ASAM; however the standard must be nationally recognized and evidence based.

[7] Medi-Cal is the name of California's Medicaid program.

[8] In New Jersey, treatment and discharge planning is overseen by a statewide contractor.

[9] CMS allows states to propose alternative standards as long as they are evidence based and nationally recognized.

[10] The American Society of Addiction Medicine is a non-profit professional medical society dedicated to improving the quality of and access to addiction care. The society represents more than 5,100 physicians, clinicians, and associated professionals in the field of addiction medicine (Mee-Lee et al. 2013).

[11] States do not have to obtain a Section 1115 SUD demonstration waiver to incorporate ASAM or other service requirements for behavioral health providers. For example, Texas has incorporated the ASAM criteria for all levels of SUD treatment paid by Medicaid.

[12] As of September 2019, Ohio was awaiting a response on a Section 1115 SUD demonstration waiver application and Colorado was in the process of applying for one.

[13] MHPAEA prevents certain health insurance plans that provide behavioral health or SUD benefits from applying limits on those benefits that are more restrictive than those applied to medical or surgical benefits. The effect of this law on the provision of services to beneficiaries in IMDs is outside of the scope of this report.

[14] ASAM level 3.5 services are clinically managed high-intensity residential services and ASAM level 3.7 are medically monitored intensive inpatient services. (MACPAC 2018).

[15] 2014. Mass Acts CH 258. https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258.

[16] CMS expects states with day limits on the length of stay (e.g., 90 days) under their Section 1115 SUD demonstrations to pay for lengths of stay that extend beyond those limits if they are medically necessary. However, non-Medicaid funding must be used to pay for such services.

[17] Although services delivered in general hospital settings typically are not subject to the IMD exclusion, inpatient psychiatric treatment or ASAM level 4.0 services are often provided in this setting, and states may place additional limitations, such as day limits, on hospital benefits.

[18] Massachusetts adopted performance specifications used by the single state substance use and mental health agency in its Medicaid managed care contracts.

[19] To be in compliance with 42 CFR 438.68, state Medicaid agencies must require managed care plans to comply with network adequacy standards; however, states do not have to explicitly state such standards within their managed care contracts.

[20] MassHealth is the name of the Massachusetts Medicaid program.

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APPENDIX 4A: State-Level Tables of Medicaid Coverage of Selected Behavioral Health Services

TABLE 4A-1. California Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)	Yes	State plan	No	No	None
Partial hospitalization (ASAM level 2.5)	Yes	Section 1905(a)	Yes	Yes	None
Clinically managed low-intensity residential services (ASAM level 3.1)	Yes	State plan and Section 1115 demonstration	Yes	Yes	Stays limited to 90 days. Two non-continuous 90-day stays may be authorized per year.
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	Yes	State plan and Section 1115 demonstration	Yes	Yes	Stays limited to 90 days. Two non-continuous 90-day stays may be authorized per year.
Clinically managed high-intensity residential services (ASAM level 3.5)	Yes	State plan and Section 1115 demonstration	Yes	Yes	Stays limited to 90 days. Two non-continuous 90-day stays may be authorized per year.
Medically monitored intensive inpatient services (ASAM level 3.7)	Yes	State plan and Section 1115 demonstration	Yes	Yes	Stays limited to 90 days. Two non-continuous 90-day stays may be authorized per year.
Medically managed intensive inpatient services (ASAM level 4.0)	Yes	State plan and Section 1115 demonstration	No	No	Stays limited to 90 days. Two non-continuous 90-day stays may be authorized per year.
Mental health treatment					
Day rehabilitation	Yes	State plan	Yes	Yes	Services may not be delivered on the same day as crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services (day of admission excepted).
Intensive day treatment	Yes	State plan	Yes	Yes	Services may not be delivered on the same day as crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services (day of admission excepted).

TABLE 4A-1. (continued)

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Mental health treatment					
Residential treatment	Yes	State plan	Yes	Yes	Services may not be delivered on the same day as crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services (day of admission excepted).
Inpatient psychiatric treatment	Yes	State plan	No	Yes	None

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) In accordance with the California's substance use disorder (SUD) demonstration waiver under Section 1115 of the Social Security Act, the state is required to use the ASAM criteria for medical necessity. SUD services listed here are those approved under the waiver.

California's Medicaid program operates on a county-by-county basis. Services may vary at the county or plan level. Participation in the waiver was opened to counties in phases. Implementing counties must ensure that at least one ASAM level of residential treatment services is available to beneficiaries in the first year of implementation.

The length of residential SUD services range from 1 to 90 days with a 90-day maximum for adults, unless medical necessity authorizes an extension of up to 30 days (one extension allowed per year). Two non-continuous 90-day regimens are allowed per year. Payment for mental health day rehabilitation and intensive day treatment is prohibited when crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility servicers, or psychiatric nursing facility services are reimbursed, except for the day of admission to those services.

Sources: Perez 2019; Mee-Lee et al. 2013.

TABLE 4A-2. Colorado Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)	No	NA	NA	NA	NA
Partial hospitalization (ASAM level 2.5)	No	NA	NA	NA	NA
Clinically managed low-intensity residential services (ASAM level 3.1)	No	NA	NA	NA	NA
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	No	NA	NA	NA	NA
Clinically managed high-intensity residential services (ASAM level 3.5)	No	NA	NA	NA	NA
Medically monitored intensive inpatient services (ASAM level 3.7)	No	NA	NA	NA	NA
Medically managed intensive inpatient services (ASAM level 4.0)	Yes	State plan	Yes	Yes	None
Mental health treatment					
Intensive outpatient treatment	Yes	Section 1915 (b)(3)	Yes	Yes	None
Partial hospitalization	Yes	State plan and Section 1915 (b)(3)	Yes	Yes	None
Residential treatment	Yes	State plan and Section 1915 (b)(3)	Yes	Yes	None
Inpatient psychiatric treatment[1]	Yes	State plan and Section 1915 (b)(3)	No	Yes	None

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. Section 1915(b)(3) is Section 1915(b)(3) of the Social Security Act. NA is not applicable. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Services requiring prior authorization and continued-stay criteria are subject to medical necessity.

[1] Inpatient psychiatric treatment may also be delivered in freestanding psychiatric facilities as an in-lieu-of service. In-lieu-of services in freestanding psychiatric facilities are limited to 15 calendar days per month for beneficiaries enrolled in a managed care entity. For services delivered in an acute care hospital, no treatment limits are applied.

Sources: CDHCPF 2019; KFF 2019; CDHCPF 2018; Mee-Lee et al. 2013.

TABLE 4A-3. Florida Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)[1]	No	NA	Yes	No	NA
Partial hospitalization (ASAM level 2.5)[1]	No	NA	NA	NA	NA
Clinically managed low-intensity residential services (ASAM level 3.1)	No	NA	NA	NA	NA
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	No	NA	NA	NA	NA
Clinically managed high-intensity residential services (ASAM level 3.5)	No	NA	NA	NA	NA
Medically monitored intensive inpatient services (ASAM level 3.7)	No	NA	NA	NA	NA
Medically managed intensive inpatient services (ASAM level 4.0)	No	NA	NA	NA	NA
Mental health treatment					
Intensive outpatient treatment[1]	No	NA	NA	NA	NA
Partial hospitalization[1]	No	NA	NA	NA	NA
Residential treatment	No	NA	NA	NA	NA
Inpatient psychiatric treatment[2]	Yes	State plan	Yes	Yes	Services are limited to 45 days for beneficiaries over age 21.

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. NA is not applicable. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Services requiring prior authorization and continued-stay criteria are subject to medical necessity.

[1] Managed care entities operating under Florida's demonstration waiver under Section 1115 of the Social Security Act can offer expanded benefits beyond those included in the state plan. Coverage varies by plan. Managed care entities can also use in-lieu-of services to substitute for certain behavioral health services.

[2] Inpatient psychiatric treatment may be delivered in freestanding psychiatric facilities as an in-lieu-of service. In-lieu-of services in freestanding psychiatric facilities are limited to 15 calendar days per month for beneficiaries enrolled in a managed care entity. For services delivered in an acute care hospital, no treatment limits are applied.

Sources: Harris 2019; KFF 2019; Mee-Lee et al. 2013.

TABLE 4A-4. Massachusetts Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)	Yes	State plan	Yes	Yes	None
Partial hospitalization (ASAM level 2.5)	Yes	State plan	Yes	Yes	None
Clinically managed low-intensity residential services (ASAM level 3.1)	Yes	Section 1115 waiver	No	Yes	First episode of care is limited to 90 days.
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	Yes	Section 1115 waiver	No	Yes	None
Clinically managed high-intensity residential services (ASAM level 3.5)	Yes	State plan	No	Yes	None
Medically monitored intensive inpatient services (ASAM level 3.7)	Yes	State plan	No	Yes	None
Medically managed intensive inpatient services (ASAM level 4.0)	Yes	State plan	No	Yes	None
Mental health treatment					
Intensive outpatient treatment	Yes	State plan	No	Yes	None
Partial hospitalization	Yes	Section 1115 waiver	No	Yes	None
Residential treatment	No	NA	NA	NA	NA
Inpatient psychiatric treatment	Yes	State plan and Section 1115 waiver	No	Yes	None

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. Section 1115 waiver is a demonstration waiver authorized under Section 1115 of the Social Security Act. NA is not applicable. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Services requiring prior authorization and continued-stay criteria are subject to medical necessity. Insurers, including Medicaid, are required to pay for up to 14 days of ASAM level 3.5 and 3.7 services and are prohibited from requiring prior authorization during those 14 days. Individuals receiving ASAM level 2.1, 2.5, and 3.5 services must meet ASAM's clinical criteria for those levels of care.

Sources: KFF 2019; Kirchgasser 2019; Mee-Lee et al. 2013.

TABLE 4A-5. New Jersey Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)	Yes	State plan	Yes	Yes	None
Partial hospitalization (ASAM level 2.5)	Yes	State plan	Yes	Yes	None
Clinically managed low-intensity residential services (ASAM level 3.1)	No	NA	NA	NA	NA
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	No	NA	NA	NA	NA
Clinically managed high-intensity residential services (ASAM level 3.5)[1]	Yes	State plan and Section 1115 waiver	Yes	Yes	None
Medically monitored intensive inpatient services (ASAM level 3.7)[1]	Yes	State plan and Section 1115 waiver	Yes	Yes	None
Medically managed intensive inpatient services (ASAM level 4.0)[1]	Yes	State plan and Section 1115 waiver	Yes	Yes	None
Mental health treatment					
Intensive outpatient treatment	Yes	State plan	Yes	Yes	Services limited to 5 hours a day and 25 hours per week.
Partial hospitalization	Yes	State plan	Yes	Yes	Services limited to 5 units per day and 25 units per week.
Residential treatment	Yes	State plan	No	Yes	None
Inpatient psychiatric treatment[2]	Yes	State plan	No	Yes	None

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. NA is not applicable. Section 1115 waiver is a demonstration waiver authorized under Section 1115 of the Social Security Act. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Individuals receiving ASAM level 2.1, 2.5, and 3.5 services must meet ASAM's clinical criteria for those levels of care. Only one mental health service can be provided per patient per day, except that medication management can be provided on the same day as other mental health services, exclusive of partial care.

[1] The state must maintain an average length of stay of 30 days for services provided in institutions for mental diseases; however, no explicit day limits exist for treatment in residential treatment facilities.

[2] Inpatient psychiatric treatment may be delivered in freestanding psychiatric facilities as an in-lieu-of service. In-lieu-of services in freestanding psychiatric facilities are limited to 15 calendar days per month for beneficiaries enrolled in a managed care entity. For services delivered in an acute care hospital, no treatment limits are applied.

Sources: Tunney 2019; CMS 2018a; Mee-Lee et al. 2013.

TABLE 4A-6. Ohio Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)	Yes	State plan	Yes	Yes	None
Partial hospitalization (ASAM level 2.5)	Yes	State plan	Yes	Yes	None
Clinically managed low-intensity residential services (ASAM level 3.1)	Yes	State plan	Yes	Yes	None
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	Yes	State plan	Yes	Yes	None
Clinically managed high-intensity residential services (ASAM level 3.5)	Yes	State plan	Yes	Yes	None
Medically monitored intensive inpatient services (ASAM level 3.7)	Yes	State plan	Yes	Yes	None
Medically managed intensive inpatient services (ASAM level 4.0)	Yes	State plan	Yes	Yes	None
Mental health treatment					
Intensive outpatient treatment	No	NA	NA	NA	NA
Partial hospitalization	Yes	State plan	NF	NF	None
Residential treatment	No	NA	NA	NA	NA
Inpatient psychiatric treatment[1]	Yes	State plan	NF	Yes	None

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. NA is not applicable. NF is not found. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Individuals receiving ASAM level 2.1, 2.5, and 3.5 must meet ASAM's clinical criteria for those levels of care.

[1] Inpatient psychiatric treatment may be delivered in freestanding psychiatric facilities as an in-lieu-of service. In-lieu-of services in freestanding psychiatric facilities are limited to 15 calendar days per month for beneficiaries enrolled in a managed care entity. For services delivered in an acute care hospital, no treatment limits are applied.

Sources: CMS 2018b; KFF 2019; Mee-Lee et al. 2013.

TABLE 4A-7. Texas Medicaid Coverage of Selected Behavioral Health Services, FY 2018

Service	Covered service	Medicaid authority	Prior authorization required	Continued-stay criteria	Service limitations
Substance use disorder treatment					
Intensive outpatient treatment (ASAM level 2.1)	No	NA	NA	NA	NA
Partial hospitalization (ASAM level 2.5)	No	NA	NA	NA	NA
Clinically managed low-intensity residential services (ASAM level 3.1)	No	NA	NA	NA	NA
Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	No	NA	NA	NA	NA
Clinically managed high-intensity residential services (ASAM level 3.5)	Yes	State plan	No	Yes	Stays limited to two episodes per six-month period and four episodes within a year. Episodes of care exceeding 35 days are subject to prior authorization. Services may not be delivered in IMDs.
Medically monitored intensive inpatient services (ASAM level 3.7)	No	NA	NA	NA	NA
Medically managed intensive inpatient services (ASAM level 4.0)	Yes	State plan	No	No	Services are limited to $200,000 per client per benefit year. Stays are limited to 30 days. Services may only be delivered in acute care hospitals.
Mental health treatment					
Day program for acute needs	Yes	State plan	No	Yes	None
Partial hospitalization	No	NA	NA	NA	NA
Residential treatment	No	NA	NA	NA	NA
Inpatient psychiatric treatment[1]	Yes	State plan	No	No	Acute care inpatient hospital services are limited to $200,000 per client per benefit year. Stays are limited to 30 days. Services may be provided in acute care hospitals for beneficiaries of any age and freestanding psychiatric facilities for beneficiaries under age 21 or age 65 and older.

Notes: FY is fiscal year. ASAM is the American Society of Addiction Medicine. IMD is institution for mental diseases. NA is not applicable. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Although Texas does not use ASAM levels, for the purposes of this analysis, MACPAC has classified the state's residential substance use disorder treatment as ASAM level 3.5 and medically managed intensive inpatient services as ASAM level 4.0. Payment to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, payment for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

[1] Inpatient psychiatric treatment may be delivered in freestanding psychiatric facilities as an in-lieu-of service. In-lieu-of services in freestanding psychiatric facilities are limited to 15 calendar days per month for beneficiaries enrolled in a managed care entity.

Sources: Melecki 2019; TX HHSC 2018a; TX HHSC 2018b; Mee-Lee et al. 2013.

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Chapter 5:

Protections for Patients in Behavioral Health Facilities

CHAPTER 5: Protections for Patients in Behavioral Health Facilities

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) includes a directive for MACPAC to document standards for institutions for mental diseases (IMDs), including those related to licensure, clinical care, quality of care, treatment planning, and discharge planning. These standards exist to ensure the well-being of patients receiving services from these institutions.

Although not required by the statute, in the Commission's view, this analysis would not be complete without also detailing patient rights and protections. As discussed in Chapter 1 of this report, concern for the civil rights of patients in institutional settings stems from historically poor and sometimes dangerous living conditions in psychiatric facilities. During interviews conducted for this study, beneficiary advocates commented that even though the quality of care in IMDs has improved, poor living conditions and complaints related to quality of care and the rights of patients in IMDs remain issues (DRO 2019, IBM Watson Health 2019). Moreover, individuals with behavioral health conditions still face discrimination and stigma within the health care system (MACPAC 2018).

The rights and protections afforded to Medicaid beneficiaries in IMDs are not specific to these facilities or to Medicaid beneficiaries. Federal and state patient protections for individuals with behavioral health conditions typically apply to all individuals, not just those enrolled in the Medicaid program. However, these protections are often highly scrutinized within the Medicaid program because it is the single largest payer of behavioral health services, including mental health and substance use disorder (SUD) services, in the United States (CMS 2018).

Protections for individuals with mental health conditions are well defined. However, whether such protections extend to individuals with an SUD is less clear. The Americans with Disabilities Act (ADA, P.L. 101-336) prohibits discrimination against individuals with disabilities, including those with mental impairments; however, it offers more limited protection from discrimination for individuals with an SUD. Federal protection and advocacy systems that help ensure enforcement of the ADA for individuals with psychiatric disabilities do not apply to individuals with an SUD.

The passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343) took steps to correct discriminatory health care practices affecting individuals with mental health disorders and SUDs. Generally, MHPAEA requires health plans that provide behavioral health benefits to provide coverage for SUD or mental health benefits that is no more restrictive than the coverage that is generally available for medical and surgical benefits. The law prevents insurers, including Medicaid programs and managed care plans that contract with states, from imposing quantitative treatment limits (e.g., day limits) on behavioral health services that are more stringent than the treatment limits placed on medical and surgical benefits.

This chapter summarizes protections under the ADA, the subsequent Supreme Court decision in *Olmstead v. L.C.* and MHPAEA.[1] It also discusses how state policy complements federal patient protections related to SUD and mental health treatment in the seven states examined for this report (California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas).

The ADA

Enacted in 1990, the ADA prohibits discrimination against individuals with disabilities in employment, by public entities, in public accommodations, and in telecommunications.[2] Title II of the ADA prohibits excluding individuals with disabilities

from participating in services, programs, or activities provided by state and local governments, including Medicaid, on the basis of their disability. The U.S. Department of Justice (DOJ) regulations implementing this law require public entities to administer services, programs, and activities in the most integrated settings appropriate to the needs of qualified individuals with disabilities (28 CFR 35.130(d)).[3]

The ADA treats mental health conditions and SUDs differently. The ADA extends protections to individuals with a mental health condition that "substantially limits" one or more major life activities (e.g., bipolar disorder, schizophrenia, major depression) (42 USC § 12102). SUDs, including opioid use disorder, are considered a disability under the ADA only when the individual's SUD substantially limits a major life activity.[4]

Individuals with an SUD who use illegal drugs are not afforded ADA protections, because ADA protections do not extend to individuals "currently engaging in the illegal use of drugs" (OCR 2018). The point at which an individual transitions from currently using illegal drugs to having used drugs in the past is sometimes unclear under the law (LAC 2019). Although medication-assisted treatment (MAT) is not considered the illegal use of drugs under the ADA, the determination of whether an individual receiving MAT is entitled to federal disability rights protections depends on individual circumstances (OCR 2018).[5]

Olmstead v. L.C.

After passage of the ADA, cases involving institutionalization of individuals with disabilities who could be served in the community became a major area of litigation against states (Butler 2000). One of these cases, *Olmstead v. L.C.*, reached the Supreme Court, which ruled that the unjustified institutionalization of individuals with disabilities violated the ADA.[6]

The case was brought by Lois Curtis and Elaine Wilson, two women with mental health and developmental disabilities residing in state-run psychiatric institutions in Georgia. Although medical professionals determined that these women's needs could be appropriately served in the community, both women remained institutionalized. They sued, asserting that continued institutionalization violated their right under Title II of the ADA to be treated in a community-based program. The state argued that inadequate funding, not discrimination, was the reason the women remained in a hospital setting. The Supreme Court rejected the state's argument and concluded that unjustified institutionalization constitutes discrimination if the state can reasonably accommodate individuals in a community setting.

In *Olmstead v. L.C.*, the Supreme Court ruled that states must provide treatment for an individual with disabilities in the most integrated setting possible if the individual is not opposed, and if such placement is appropriate and can be reasonably accommodated by the state. This means that many individuals receiving treatment in IMD settings are entitled to receive care in community-based settings.

The ADA and the IMD exclusion

Most beneficiary advocates argue that expanding Medicaid treatment in IMD settings undermines protections afforded by the ADA and the integration mandate articulated in the *Olmstead v. L.C.* decision given that both direct states to provide community-based care for individuals with mental health conditions and SUDs. Moreover, promoting care in IMDs would, in their view, eliminate incentives for states to continue to develop community-based alternatives and lead to an over-reliance on inpatient and residential treatment (CBPP 2018, NHeLP 2018).

At the same time, advocates argue that ADA protections should and do apply to patients in IMDs. Some advocates also note that it is reasonable to interpret ADA protections as extending to individuals receiving treatment in IMDs because they are generally not currently using illegal drugs and are in supervised rehabilitation programs (NHeLP 2019).

The Centers for Medicare & Medicaid Services (CMS) have consistently reinforced the rights of patients and their preferences for community-based care when adopting policies that increase a state's ability to pay for Medicaid services in IMD settings. For example, in response to comments received through federal rulemaking, CMS has stated that allowing states to permit managed care entities to pay for stays in IMDs for up to 15 days per month as an in-lieu-of service is not intended as an incentive to admit patients to inpatient psychiatric settings for services that are not medically necessary or appropriate. Moreover, CMS has noted that states and managed care plans must adhere to the *Olmstead v. L.C.* decision's mandate to provide services in the least restrictive setting and to promote community integration (CMS 2016b). In addition, the terms and conditions of SUD demonstrations approved under Section 1115 of the Social Security Act require states to comply with federal non-discrimination statutes, specifically the ADA, and require states to expand access to outpatient levels of care, limit lengths of stay in IMDs, improve the quality of care in IMDs, and connect beneficiaries with community-based care. (Additional information on Section 1115 SUD demonstrations can be found in Chapter 1.)

Enforcement of *Olmstead*

Enforcement of the *Olmstead v. L.C.* decision largely occurs through actions taken by the DOJ and two federal protection and advocacy systems—one for individuals with developmental disabilities and another for individuals with psychiatric disabilities. Individuals with SUDs are afforded protections under a separate program intended to serve as a catchall for individuals with other disabilities that are not eligible for services under the protection and advocacy systems for individuals with developmental disabilities or psychiatric disabilities.[7]

Protection and advocacy systems are administered by state agencies or by non-profit organizations that have been designated by the governor of each state (ACL 2019, SAMHSA 2011). They employ attorneys and other advocates who investigate complaints of abuse and neglect and provide legal assistance. For example, in 2017, the protection and advocacy organization in New Jersey reached a settlement with the state which resulted in the development of 1,436 new supportive housing units for individuals with serious mental illness who were previously hospitalized and for individuals at risk of admission to state psychiatric hospitals.[8] Since the case was originally filed in 2005, the census of the state's psychiatric hospitals has decreased by more than one-third (Bazelon 2016). A similar agreement was reached in Florida in 2015.[9]

Officials from protection and advocacy organizations interviewed by MACPAC reported that they received complaints from individuals in psychiatric hospitals and residential facilities regarding potential violations of patient rights attributable to inadequate funding, insufficient staffing, and poor staff training at facilities that treat individuals with psychiatric conditions. In one state, an informant noted that a state survey of an IMD facility did not find any deficiencies; however, shortly thereafter, the state attorney general filed criminal charges against employees of the facility, which resulted in the state conducting a second survey that demonstrated non-compliance with state licensure standards (IBM Watson Health 2019).

MHPAEA

In general, MHPAEA requires that group health plans and health insurance issuers that provide behavioral health benefits, including Medicaid managed care organizations (MCOs), provide coverage for SUD or mental health benefits that is no more restrictive than the coverage generally available for medical and surgical benefits. Parity does not mandate coverage of behavioral health benefits, but if coverage is provided for behavioral health benefits in any classification (e.g., outpatient, inpatient), then behavioral health benefits must be covered in every classification in which medical and surgical benefits are covered.

In 2016, CMS clarified the application of parity to Medicaid and the State Children's Health Insurance Program (CHIP) in a final rule that addressed aggregate lifetime limits, financial requirements, quantitative treatment limitations, non-quantitative treatment limitations, and availability of information (Box 5-1). Final MHPAEA requirements for Medicaid and CHIP also require that states (and their managed care plans) perform an analysis of limits placed on mental health and SUD treatment benefits.[10]

Parity and the IMD exclusion

Some stakeholders contend that treatment limitations for in-lieu-of services delivered in IMDs and day limits for IMD stays permitted under Section 1115 SUD demonstrations conflict with MHPAEA provisions (LAC 2014). In addition, some respondents to MACPAC's request for public comment noted that a repeal of the IMD exclusion is necessary to address this conflict (TennCare 2019, OMHAC 2019). However, CMS noted in the 2016 final managed care rule that the IMD exclusion is not a non-quantitative treatment limitation; treatment and the provision of covered services may be furnished in a different setting consistent with applicable parity standards (CMS 2016b). In addition, the 15-day length-of-stay standard in this rule is not a quantitative treatment limitation; it is related to the payment of federal financial participation (FFP) for capitation rates to MCOs and prepaid inpatient health plans using substitute services or settings. Medically necessary treatment of enrollees in a non-IMD setting (for example, in a psychiatric ward of a general hospital) may continue for longer than 15 days with the capitation payment being eligible for FFP (CMS 2016b).

CMS has not fully addressed stakeholder concerns regarding day limits for stays in IMDs and MHPAEA. In the preamble to the MHPAEA final rule, CMS

BOX 5-1. Parity Requirements in Medicaid and the State Children's Health Insurance Program

Aggregate lifetime and annual dollar limits. Generally, such limits cannot be applied to behavioral health benefits unless they apply to at least one-third of medical and surgical benefits.

Financial requirements. Financial requirements (e.g., co-payments) may not be more restrictive than the predominant financial requirements that apply to substantially all behavioral health benefits in that classification (e.g., outpatient, inpatient).

Quantitative treatment limitations. Quantitative treatment limitations set numerical limits (e.g., day limits) on the scope or duration of benefits. Such limits may not be more restrictive than the predominant quantitative treatment limits that apply to substantially all behavioral health benefits in that classification.

Non-quantitative treatment limitations. Such limitations include medical management standards, provider network admission standards, payment rates, fail first policies, and other limits on the scope and duration of benefits. A non-quantitative treatment limitation may not apply to behavioral health benefits in a classification unless the same factors, (e.g., strategies, evidentiary standards, processes), as written and in operation, used in applying those limitations are comparable to and no more stringent than the factors used in applying limitations for medical and surgical benefits.

Availability of information. Criteria for medical necessity determinations regarding behavioral health benefits must be made available to beneficiaries, potential beneficiaries, and contracting providers upon request. The reasons for any denial of payment for behavioral health benefits must be made available to the beneficiary (CMS 2016a).

acknowledged that it received comments specific to the IMD exclusion and its conflict with parity and noted that the IMD exclusion is a statutory requirement and services can be provided to beneficiaries when they are in non-IMD facilities. As such, a beneficiary could receive treatment in an IMD for 15 days, but could also, if needed, continue to receive additional residential or inpatient treatment in a non-IMD setting (CMS 2016a). CMS also commented on this issue in the managed care final rule, noting that states may pay for services provided to individuals eligible under the state plan who are enrolled in a managed care program who are patients in an IMD for longer than 15 days within the period covered by the capitation payment, either directly or through a separate arrangement without FFP (CMS 2016b). Also in the final rule, CMS clarified that "if the managed care plan (or physician) believes that a stay of longer than 15 days is necessary or anticipated for an enrollee, the use of this specific in lieu of service is likely not appropriate…" (CMS 2016b).

Other State Protections

In our review of the seven selected states, we found that patients receiving mental health and SUD treatment services in inpatient and residential facilities are afforded certain additional rights by state law. Typically, these rights apply to all patients, including Medicaid beneficiaries, receiving treatment in a licensed facility. In addition, conditions under which involuntary treatment, seclusion, and restraint can be imposed are consistently outlined in state law. Federal patient protections, including those related to patient confidentiality, are also incorporated into state law.

In some states, patients receiving inpatient mental health services have the same rights as patients receiving SUD treatment. For example, in Florida, inpatient facilities must adopt policies and procedures to ensure certain rights for patients, including the right to refuse treatment; the right to formulate advance directives; the right to information regarding patient rights, including how to make a complaint; the right to participate in the consideration of ethical issues that arise during care; the right to an itemized bill; and the right to be free of restraints.[11] Ohio specifies similar patient rights.[12]

Other states take different approaches. In California, protections extended to patients in mental health facilities differ from protections extended to patients in SUD treatment facilities. (IBM Watson Health 2019). In Massachusetts, patients with an SUD are afforded the same rights whether they are receiving treatment on an inpatient or outpatient basis. For example, licensed facilities must safeguard clients' legal and civil rights, including 17 specific rights identified in state regulation. In addition, the use of physical restraints is prohibited under most circumstances. Licensed facilities must have written policies and procedures to resolve client disagreements or disputes.[13]

Endnotes

[1] 119 S. Ct. 2176 (1999).

[2] Under the ADA, disability is defined as a physical or mental impairment that substantially limits one or more major life activities of an individual; a record of such impairment; or being regarded as having such an impairment (42 U.S.C. 126).

[3] The regulations also require public entities to make reasonable modifications in policies, practices, or procedures to avoid discrimination on the basis of disability, unless the modification would fundamentally alter the nature of the services, program, or activity. This reasonable modifications provision (28 CFR 35.130(d)) would become a key component of *Olmstead v. L.C.* and other rulings in cases that determined whether states were taking reasonable measures to prevent discrimination against individuals with disabilities (MACPAC 2019).

[4] ADA protections also extend to individuals who have successfully completed or are currently being treated in a supervised SUD rehabilitation program or have otherwise been successfully rehabilitated.

[5] Individuals in recovery from an SUD and receiving MAT in programs that use medications such as methadone or buprenorphine may still face discrimination by public institutions. In 2017, the DOJ advised that individuals receiving MAT are often considered qualified individuals with a disability under the ADA, either because they have a current or past history of an opioid use disorder that substantially limits a major life activity, or they have a disabling impairment by reason of their participation in MAT (DOJ 2017).

[6] The plaintiffs in *Olmstead v. L.C.* had mental health and developmental disabilities, but a letter from CMS to state Medicaid directors clarified that *Olmstead v. L.C.* applies to all individuals with disabilities protected from discrimination by Title II of the ADA (HCFA 2000).

[7] The Protection and Advocacy System for Individual Rights (PAIR, P.L. 95-602) program was Congress's solution to the gap left by the narrow definitions of protection and advocacy organizations designed to support individuals with developmental disabilities and psychiatric disabilities. In 1992, Congress further amended the PAIR program (P.L. 102-569) to cover all individuals with disabilities not eligible for services under any of the other protection and advocacy programs.

[8] *Disability Rights New Jersey, Inc. v. Velez et al.,* C.V. 10-3950 (US DC NJ 2011).

[9] In 2015, the protection and advocacy organization in Florida reached a settlement with the state Department of Children and Families. The protection and advocacy organization sued the department on the grounds that Florida was violating the ADA by not providing enough community placements for people who were ready to be discharged from state-run mental hospitals. The settlement required the department to seek funding for a pilot program to serve more individuals in the community (DRF 2015).

[10] A review of state-level parity analyses was outside of the scope of this study.

[11] Fla. Admin. Code Ann. r. 59A-3.254 (2019).

[12] In Ohio, each patient receiving inpatient mental health and SUD treatment has several rights, including the right to receive services that are appropriate and respectful of personal liberty; the right to an individualized treatment plan; the right to decline or consent to services; the right to be free from restraint or seclusion unless there is an imminent risk of physical harm to self or others; the right to privacy and confidentiality; the right to have the grievance procedure explained orally and in writing and the right to file a grievance; the right to receive services free of discrimination; the right to an outside opinion; the right to receive services from a provider that is not the person's guardian or representative; the right to one's treatment records; and the right to be informed of discontinuance or denial of services. In addition, consumers have the right to be informed of their rights. Facilities must provide a patient rights advocate to safeguard patients (Ohio Admin. Code 5122-14-11 (2017)).

[13] 105 Mass. Code Regs. 164.079 (2016). https://www.mass.gov/files/documents/2017/09/11/105cmr164.pdf.

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Appendix

Statutory Requirement for MACPAC Study from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)

SEC. 5012. MACPAC EXPLORATORY STUDY AND REPORT ON INSTITUTIONS FOR MENTAL DISEASES REQUIREMENTS AND PRACTICES UNDER MEDICAID.

(a) In general.—Not later than January 1, 2020, the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act (42 U.S.C. 1396) shall conduct an exploratory study, using data from a representative sample of states, and submit to Congress a report on at least the following information, with respect to services furnished to individuals enrolled under state plans under the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) (or waivers of such plans) who are patients in institutions for mental diseases and for which payment is made through fee-for-service or managed care arrangements under such State plans (or waivers):

(1) A description of such institutions for mental diseases in each such state, including at a minimum—

(A) the number of such institutions in the state;

(B) the facility type of such institutions in the state; and

(C) any coverage limitations under each such state plan (or waiver) on scope, duration, or frequency of such services.

(2) With respect to each such institution for mental diseases in each such state, a description of—

(A) such services provided at such institution;

(B) the process, including any timeframe, used by such institution to clinically assess and reassess such individuals; and

(C) the discharge process used by such institution, including any care continuum of relevant services or facilities provided or used in such process.

(3) A description of—

(A) any federal waiver that each such state has for such institutions and the federal statutory authority for such waiver; and

(B) any other Medicaid funding sources used by each such state for funding such institutions, such as supplemental payments.

(4) A summary of state requirements (such as certification, licensure, and accreditation) applied by each such state to such institutions in order for such institutions to receive payment under the state plan (or waiver) and how each such state determines if such requirements have been met.

(5) A summary of state standards (such as quality standards, clinical standards, and facility standards) that such institutions must meet to receive payment under such state plans (or waivers) and how each such state determines if such standards have been met.

(6) If determined appropriate by the Commission, recommendations for policies and actions by Congress and the Centers for Medicare & Medicaid Services, such as on how state Medicaid programs may improve care and improve standards and including a recommendation for how the Centers for Medicare & Medicaid Services can improve data collection from such programs to address any gaps in information.

(b) Stakeholder input.—In carrying out subsection (a), the Medicaid and CHIP Payment and Access Commission shall seek input from state Medicaid directors and stakeholders, including at a minimum the Substance Abuse and Mental Health Services Administration, Centers for Medicare & Medicaid Services, state Medicaid officials, state mental health authorities, Medicaid beneficiary advocates, health care providers, and Medicaid managed care organizations.

(c) Definitions.—In this section:

(1) Representative sample of states.—The term "representative sample of states" means a non-probability sample in which at least two states are selected based on the knowledge and professional judgment of the selector.

(2) State.—The term "state" means each of the 50 States, the District of Columbia, and any commonwealth or territory of the United States.

(3) Institution for mental diseases.—The term "institution for mental diseases" has the meaning given such term in section 435.1010 of title 42, Code of Federal Regulations, or any successor regulation.

Biographies of Commissioners

Melanie Bella, MBA (Chair), is head of partnerships and policy at Cityblock Health, which facilitates health care delivery for low-income urban populations, particularly Medicaid beneficiaries and those dually eligible for Medicaid and Medicare. Previously, she served as the founding director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS), where she designed and launched payment and delivery system demonstrations to improve quality and reduce costs. Ms. Bella also was the director of the Indiana Medicaid program, where she oversaw Medicaid, the State Children's Health Insurance Program (CHIP), and the state's long-term care insurance program. Ms. Bella received her master of business administration from Harvard University.

Charles Milligan, JD, MPH (Vice Chair), is the national dual eligible special needs plans executive director for UnitedHealthcare Community & State. Previously, he was chief executive officer (CEO) of UnitedHealthcare's Community Plan in New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories. Mr. Milligan is a former state Medicaid and CHIP director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland at Baltimore County, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley, and his law degree from Harvard Law School.

Thomas Barker, JD, is a partner at Foley Hoag, LLP, where he specializes in Medicaid and Medicare regulatory, coverage, and reimbursement issues and is a member of the executive committee. He also has a pro bono law practice focusing on health care issues facing immigrants. Previously, he held numerous positions within the U.S. Department of Health and Human Services (HHS), including acting general counsel, counselor to the Secretary of HHS, chief legal officer for CMS, and senior health policy counselor to the administrator of CMS. Mr. Barker received his law degree from Suffolk University School of Law.

Tricia Brooks, MBA, is a research professor at the McCourt School of Public Policy at Georgetown University and a senior fellow at the Georgetown University Center for Children and Families (CCF), an independent, non-partisan policy and research center whose mission is to expand and improve health coverage for children and families. At CCF, Ms. Brooks focuses on issues relating to the policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Prior to joining CCF, she served as the founding CEO of New Hampshire Healthy Kids, a legislatively created non-profit corporation that administered CHIP in the state, and served as the Medicaid and CHIP consumer assistance coordinator. Ms. Brooks holds a master of business administration from Suffolk University.

Brian Burwell is vice president, healthcare policy and research, at Ventech Solutions, where his work includes research, consulting services, policy analysis, and technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. Previously, Mr. Burwell was a senior executive in the government health and human services unit at Watson Health in Cambridge, Massachusetts. He received his bachelor of arts degree from Dartmouth College.

Martha Carter, DHSc, MBA, APRN, CNM, is the founder and former CEO of FamilyCare Health Centers, a community health center that serves four counties in south-central West Virginia. Dr. Carter practiced as a certified nurse-midwife in Kentucky, Ohio, and West Virginia for 20 years. She is a member of the West Virginia Alliance for Creative Health Solutions, a practice-led research and advocacy network, and she serves as the chair of the Quality Leadership Committee of the West Virginia Primary Care Association. Dr. Carter was a

Robert Wood Johnson Foundation Executive Nurse Fellow in 2005–2008 and received the Robert Wood Johnson Foundation Community Health Leader award in 1999. She holds a doctorate of health sciences from A.T. Still University in Mesa, Arizona, and a master of business administration from West Virginia University in Morgantown, West Virginia.

Frederick Cerise, MD, MPH, is president and CEO of Parkland Health and Hospital System, a large public safety-net health system in Dallas, Texas. Previously, he oversaw Medicaid and other programs for the state of Louisiana as secretary of the Department of Health and Hospitals. Dr. Cerise also held the position of medical director and other leadership roles at various health care facilities operated by Louisiana State University. He began his career as an internal medicine physician and spent 13 years treating patients and teaching medical students in Louisiana's public hospital system. Dr. Cerise received his degree in medicine from Louisiana State University and his master of public health from Harvard University.

Kisha Davis, MD, MPH, is regional medical director for Aledade as well as Maryland medical director for VaxCare Corporation. Previously, Dr. Davis was a family physician at CHI Health Care in Rockville, Maryland and served as program manager at CFAR in Philadelphia, Pennsylvania, where she supported projects for family physicians focused on payment reform and practice transformation to promote health system change. Dr. Davis has also served as the medical director and director of community health at CHI and as a family physician at a federally qualified health center (FQHC) in Maryland. As a White House Fellow at the U.S. Department of Agriculture, she established relationships among leaders of FQHCs and the Women, Infants, and Children nutrition program. Dr. Davis received her degree in medicine from the University of Connecticut and her master of public health from Johns Hopkins University.

Toby Douglas, MPP, MPH, is senior vice president, national Medicaid, at Kaiser Permanente. Previously, Mr. Douglas was senior vice president for Medicaid solutions at Centene Corporation, and prior to that, a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He served as director of the California Department of Health Care Services and was director of California Medicaid for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a CHIP director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

Leanna George is the parent of a teenager with a disability who is covered under Medicaid and a child covered under CHIP. A resident of Benson, North Carolina, Ms. George is the chair of the North Carolina Council on Educational Services for Exceptional Children, a special education advisory council for the state board of education. She also serves as the secretary of the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

Darin Gordon is president and CEO of Gordon & Associates in Nashville, Tennessee, where he provides health care-related consulting services to a wide range of public- and private-sector clients. Previously, he was director of Medicaid and CHIP in Tennessee for 10 years, where he oversaw various program improvements, including the implementation of a statewide value-based purchasing program. During this time, he served as president and vice president of the National Association of Medicaid Directors for a total of four years. Before becoming director of Medicaid and CHIP, he was the chief financial officer and director of managed care programs for Tennessee's Medicaid program. Mr. Gordon received his bachelor of science degree from Middle Tennessee State University.

Christopher Gorton, MD, MHSA, was formerly president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire, as well as CEO of a regional health plan that was acquired by the Inova Health System of Falls Church, Virginia. Other positions held include vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver Spring, Maryland. After beginning his career as a practicing pediatrician in FQHCs in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

Stacey Lampkin, FSA, MAAA, MPA, is an actuary and principal with Mercer Government Human Services Consulting, where she has led actuarial work for several state Medicaid programs. She previously served as an actuary and assistant deputy secretary for Medicaid finance and analytics at Florida's Agency for Health Care Administration and as an actuary at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's uninsured work group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow of the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

Sheldon Retchin, MD, MSPH, is professor of medicine and public health at The Ohio State University in Columbus, Ohio. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2015 until 2017, he was executive vice president for health sciences and CEO of the Wexner Medical Center. From 2003 until 2015, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization, Virginia Premier, with approximately 200,000 covered lives. Dr. Retchin received his medical and public health degrees from The University of North Carolina at Chapel Hill, where he was also a Robert Wood Johnson Clinical Scholar.

William Scanlon, PhD, is a consultant for the West Health Institute. He began conducting health services research on the Medicaid and Medicare programs in 1975, with a focus on such issues as the provision and financing of long-term care services and provider payment policies. He previously held positions at Georgetown University and the Urban Institute, was managing director of health care issues at the U.S. Government Accountability Office, and served on the Medicare Payment Advisory Commission. Dr. Scanlon received his doctorate in economics from the University of Wisconsin, Madison.

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Biographies of Staff

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James Boissonnault, MA, is the chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

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Kathryn Ceja is the director of communications. Previously, she served as lead spokesperson for Medicare issues in the Centers for Medicare & Medicaid Services (CMS) press office. Prior to her tenure in the press office, Ms. Ceja was a speechwriter for the Secretary of HHS as well as the speechwriter for a series of CMS administrators. Ms. Ceja holds a bachelor of arts in international studies from American University.

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Kate Kirchgraber, MA, is a policy director. Prior to joining MACPAC, she led the private health insurance and Medicaid and CHIP teams at the CMS Office of Legislation. She has held health policy and budget analysis positions on the federal and state levels, including with the U.S. Senate Committee on Finance, OMB, and the New York State Assembly Ways and Means Committee. She also has worked as a private consultant on Medicaid, health coverage, and financing issues. Ms. Kirchgraber has a master of arts in teaching from the State University of New York at Albany and a bachelor of arts in economics and history from Fordham University.

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