

Current as of: September 7, 2011

21 questions

Medicaid and Long-Term Care

Questions and Answers for Facilities about Institutions for Mental Diseases (IMDs).

1) What is an IMD?

An Institution of Mental Disease (IMD) is defined by Medicaid regulations 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 illness including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained for the care and treatment of individuals with Mental Diseases whether or not it is licensed as such. An institution for the mentally retarded (e.g. ICF/MR, ICF/ID) is not an IMD.

2) We have a 63 bed Long Term Care (LTC) attached to a critical access hospital. Are the 25 critical access hospital beds counted in the LTC total?

Yes, the 25 critical access hospital beds are counted to determine the overall bed count. A hospital that has a nursing facility attached will have all beds counted for the purpose of determining an IMD.

3) If an assisted living facility with 60% of clients having a diagnosis of Depression, and one additional Medicaid waiver client, under the age of 65 years old residing there, would the client's medical needs not be paid for by Medicaid?

If the facility is an IMD, regardless of the age of the clients, Medicaid is not available to individuals living in an IMD under the age of 65 years. This includes Waiver clients.

4) Is Depression as a second diagnosis a mental health diagnosis for the purposes of determining the IMD definition?

Updated 08/31/11

The principal reason for the patient's need for residence in the Nursing Facility is a determining factor for IMD status. In a Nursing Facility, primary diagnosis is the only diagnosis used for the purpose of determining the Nursing Facility's IMD status. If a physical health diagnosis is the primary diagnosis, the client is not counted toward the fifty percent.

If depression is a secondary diagnosis to a primary diagnosis of dementia or Alzheimer's, the client is not counted toward the fifty percent census per the State Medicaid Manual 4390.D, "mental retardation, senility, and organic brain syndromes" are not considered mental diseases.

5) We have several people who have been placed at our facility by a Mental Health Board commitment. How is moving these people back into the community going to work?

A facility that receives a mental health board commitments will need to discuss with the Board the situation the facility may be in if the client is placed within that facility. Not all commitments will result in the facility being classified as an IMD. Each facility's composition of clients will affect the IMD determination. If a client is to move into the community, the determination is client specific and will need to be accomplished with client specific plan involving a medical consultation that would include, at minimum, the facility, family and the treating psychologist or psychiatrist.

6) In considering the 50% rule, is it 50% of an age group or 50% of the whole population in the facility?

The 50% rule applies to the entire population of clients within a facility. The age of the client is not a factor when considering the population of a facility. All licensed beds are counted when determining whether the facility is over 16 beds. All residents regardless of age are reviewed and "counted" in the population to determine if more than 51% of the clients have a Mental Disease.

7) If this issue only pertains to advanced age group, why is the whole population used in the statistical analysis?

The IMD rules apply to all age groups, not only the advanced age group.

8) If you have a child in a nursing or assisted living facility, and in addition to a severe physical health need, has a mental health diagnosis or is on psychotropic meds are they counted in the 50% limitation?

Yes, the IMD rules apply to all age groups.

9) Is anyone looking/lobbying to change federal law if the intent was not to have the federal government pay for regional centers?

This is federal law that has been in place since 1965. The intent of the federal law is to not pay for state psychiatric hospitals or psychiatric care in institutions.

10) What will be the funding source for an IMD?

Medicaid cannot reimburse for medical services provided to Medicaid eligible clients, between the ages 21 and 65, who reside in an IMD. Medicaid can reimburse for medical services provided in an IMD if the Medicaid eligible client is over 65 or under 21 and the IMD meets the requirements of a Psychiatric Residential Treatment Facility (PRTF).

11) What happens to the resident who will be displaced or if a facility closes? I do think you may have covered a piece of this with the comment that rural facilities may have to work together regarding their populations, but what about the larger urban providers?

The goal of Nebraska Medicaid is to avoid disruption or displacing residents while assisting in the transition of clients as appropriate. Medicaid continues to discuss options specific to services, providers, and plans to provide education and technical support to all residential facilities in Nebraska who provide care to individuals with a mental health diagnosis. Medicaid continues to work with providers, professional associations, Magellan and Mercer, our national contractor, to explore all options available to Nebraska to resolve the IMD issues.

12) Is it a mental health diagnosis 'AND/OR' psychotropic medications that constitutes the IMD guideline?

Psychotropic medications are used in part to determine the IMD status of an institution, as per section 4390 of the State Medicaid Manual. However, psychotropic medications are not the only determining factor, as these drugs are sometimes used for purposes other than treating primary mental health diagnoses. Mental health diagnoses and psychotropic medications are both used to establish the "overall character" of a facility, which is used to make a determination of a facility's IMD status. Please refer to section 4390.C of the State Medicaid Manual for a description of the information used to determine IMD status.

13) How is a client's reason for admission to a Nursing Home used to determine a facility's IMD status?

The principal reason for the patient's need for residence in the Nursing Facility is a determining factor for IMD status. Section 4390.D of the State Medicaid Manual states, "in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF [Nursing Facility] care, rather than the nature of the services being provided."

14) With "traumatic brain injury," many medications are ordered for behaviors related to the brain injury, yet they often add behavioral diagnosis. Is there consideration for this?

See response to question #12.

15) Does the client on psychotropic medications for pain or other purposes count toward the 50% limit?

See response to question # 12.

16) How will a history of depression be looked at?

See response to question # 4.

17) Are anti-depressants counted as psychotropic medications?

Yes.

18) Is an Alzheimer's patient using psychotropic drugs exempt?

See response to question #12.

19) What if a psychotropic medication is used for a non-psychological reason such as pain?

See response to question #12.

20) Is there a special licensure for IMD?

No.

21) Where will these individuals be expected to go if not in an IMD?

Each IMD will need to develop a plan of action that accommodates the needs of the residents. They will need assistance from their business offices, communities, other providers, the associations in brainstorming solutions.

Change Log:

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08/25/11 Updated #4, added #12 and #13

08/31/11 Updated #4

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