Proposed IMD Plan
State of North Carolina

BACKGROUND

The Social Security Act 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." 42 U.S.C.A. §1396d(i). Similarly, an IMD is defined in the Code of Federal 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 diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." 42 CFR §435.1010(b)(2).

The Department understands that CMS is concerned that some Adult Care Homes (ACHs) operating in North Carolina may meet the definition of an IMD as set out in the statutes and regulations. ACHs licensed pursuant to Article I, Chapter 131D of the North Carolina General Statutes are expressly forbidden from admitting residents "for treatment of mental illness, or alcohol or drug abuse." 10A NCAC 13F. 0701(b)(1). Nevertheless, receiving guidance from CMS, the State Medicaid Agency (SMA) created a process to determine whether any of the ACHs meet the definition of an IMD. The SMA, with ongoing feedback and guidance from CMS, developed the written plan outlining (1) how the SMA will determine if any ACHs in North Carolina are currently at risk of being classified as IMDs, (2) how ACHs at risk of being classified as IMDs will be identified and notified, and (3) what course of action will be taken if an ACH is identified as an IMD. CMS was apprised of the plan.

In order to begin the process of determining whether any ACHs in North Carolina are IMDs, the SMA will first identify ACHs that have the following characteristics:

- More than 16 beds
- 50% or more of the licensed beds are occupied by individuals who, regardless of age:
    - have a paid claim with a primary diagnosis of mental disease, as that term is defined in Section 4390 of the State Medicaid Manual; or
    - were admitted to receive treatment that is psychological in nature for chemical dependency that follows a psychiatric model and is performed by medically trained and licensed personnel[1]

[1] [F]acilities that provide services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors" are not IMDs according to the State Medicaid Manual. Lay Counseling does not constitute medical or remedial treatment. 42 C.F.R. § 440.2(b).

To identify facilities with the above characteristics, the SMA first obtained from the Division of Health Services Regulation (DHSR) a list of all ACHs with more than 16 licensed beds. Out of those homes, the SMA reviewed Medicaid paid claims to identify individuals whose providers billed for a service AND the claim contained a primary diagnosis of mental illness or substance abuse disorder. Facilities were identified as potentially at risk of being classified as an IMD if 50% or more of the licensed beds were occupied by individuals who had one or more paid claims with a primary diagnosis of a mental illness or substance abuse disorder during the seven-month period from November 1, 2010 through May 31, 2011. A clinical behavioral health assessment will be conducted for individuals identified through this paid claims review who do not have a current behavioral health assessment on file. The SMA will use the existing assessments for those recipients receiving mental health services (as verified by paid claims and prior authorizations on file) outside of the ACH.

In order to determine whether a particular facility is an IMD, the SMA will conduct a three step facility review. First, an assessment will be done by qualified licensed professionals trained in clinical assessment for each of the residents identified above who does not have a current assessment to determine if the resident has a current diagnosis of mental illness as described in Section 4390 of the State Medicaid Manual. At the time this clinical assessment is done, the assessor will gather other information (such as pertinent medical and facility records) necessary to assist in step two of the facility assessment. Second, the Local Management Entity (LME) Medical Director will review each resident's clinical assessment, pertinent medical records, facility records and other pertinent information to verify the validity of the assessment and determine each recipient's primary diagnosis. (At this point, facilities that are at risk of being classified as an IMD will be notified in writing and offered the opportunity to submit additional arguments, evidence or documentation to rebut the IMD classification.) Third, the SMA or its vendor will determine whether each resident's current need for services in the facility results from a mental disease and whether the overall character of the facility is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases. This third step will utilize the factors set out in the State Medicaid Manual for determining whether a facility is an IMD. Each of these three steps in the facility assessment process is discussed in more detail in the action plan below.

As discussed above, the SMA intends to provide as much notice as possible (up to thirty days) to any facilities which are identified through this process as at risk of being classified as an IMD, and conduct a housing assessment at that time for any recipients who may need to be transferred as a result of the IMD classification. It is the SMA's understanding, based on guidance received from CMS, that recipients do not have any federal right to appeal the denial of payments for services provided while the recipient resides in an IMD, because those services are not within the scope of "medical assistance" under federal law. It is also the SMA's understanding that federal payment for continued benefits would not be available for services that are, as a matter of federal

law, not "medical assistance." Whether the SMA wishes to allow an appeal by the ACH provider is within the discretion of the SMA under state law.

ACTION PLAN

The SMA will communicate in writing to the adult care home providers the possible non-compliance with the IMD exclusion and the necessary actions needed to address this potential issue (see Attachment C, "Letter to the Adult Care Home Provider"). The SMA will also communicate in writing to each of the recipients identified as potentially having a primary diagnosis of mental illness or substance abuse disorder regarding the need to conduct an assessment (if no current assessment is available) and to collect relevant medical records (see Attachment D, "Letter to the Recipient").

The LMEs and Division of Social Services (DSS) will coordinate the initial face to face meeting with the Provider to review the process in obtaining the clinical assessment, consents, and other portions of the medical record (see Attachment A, "Script for LME Initial Face to Face"). The State has selected Critical Access Behavioral Health Agencies (CABHAs) currently providing services for adults with mental health and substance abuse needs to complete the comprehensive clinical assessment for those residents without a current mental health assessment and to gather relevant medical records. All CABHAs participating in this assessment completed a one day training conducted by the State. The CABHA will certify in a Letter of Attestation that the CABHA does not have any conflict of interest (see Attachment B, "CABHA Certified Agency Letter of Attestation-Conflict of Interest"). The recipient will be provided choice as to which CABHA they wish to use to complete the assessment when there is more than one CABHA available to complete the assessment. These assessments will be completed by a qualified licensed professional trained in clinical assessment.

Phase One – Clinical Assessments and Data Collection

The CABHA will obtain consent from the recipients, or their legal guardians when applicable, to complete any necessary clinical assessment(s), to collect relevant medical records and questionnaires, and to share pertinent medical information between the CABHA, LME Medical Director, and the State (see Attachment E, " CABHA Consent Script Recipient" and Attachment F, " CABHA Consent Script Guardian"). If the recipient/guardian does not consent to the assessment, the State will be notified and the SMA will base its determination of primary diagnosis and whether each resident's current need for services in the facility results from a mental disease on an analysis of paid claims.

Each ACH will also receive a Resident Questionnaire (see Attachment I), to be completed for each resident and utilized in Phase Two, and a Facility Questionnaire (see Attachment J), to be used in Phase Three to determine its overall character.

The Clinical Assessment Elements will be completed in the least intrusive and respectful manner (see Attachment G "Clinical Assessment Elements"). Every attempt will be made to minimize the impact on the recipients and the facility.

Medical records will be collected for the recipients receiving the clinical assessment including, but not limited to: most recent FL-2, the most recent Physician Orders, Medication Administration Record (the most recent 3 months), the most recent 3050R, the Resident Register, Care Notes (the last 30 days), Home Care Visits (within the last 12 months), Hospitalizations including ED visit (within the last 12 months), any licensed health professional review (within the last 12 months), and the most recent records from a primary care physician (see Attachment H "Medical Documents Check list").

The CABHA Medical Director will review each clinical assessment and submit all data collected to the LME Medical Director. The LME Medical Director will review each resident's current assessment, and medical record information to determine each resident's current primary diagnosis. The LME Medical Director may also contact the primary care physician on record and/or access the Community Care of North Carolina (CCNC) data base. If the LME Medical Director cannot determine a primary diagnosis, the DMH/DD/SAS Medical Director and DMA Chief Medical Officer will be consulted.

Phase Two – Determination of Whether Each Resident's Current Need for Services in the Facility Results from a Mental Disease

The SMA or its vendor will then use the resident's current assessment and diagnosis, medical records, Resident Questionnaire and Facility Questionnaire to determine whether each resident's placement in the facility results primarily from a mental disease.

Phase Three – Determination of the Overall Character of the Facility

The SMA or its vendor will review the Facility Questionnaires and the findings of the CABHAs and LMEs regarding each of the recipients identified through paid claims to determine whether the facility's overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

To make this determination, the SMA will rely on CMS guidelines as set forth in the State Medicaid Manual for a determining whether an institution is an IMD:

1. The facility is licensed as a psychiatric facility;
2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State's mental health authority, DMH/DD/SAS;
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and

5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

The SMA may also review other relevant factors in making the IMD determination, which may include:

- What is the average patient age in the facility as compared to the average age of patients in a "typical" adult care home;
- Does the facility advertise or hold itself out as a facility for the care and treatment of individuals with mental diseases;
- What percentage of the patients in the facility, if any, have been transferred from a State mental institution for continuing treatment of their mental disorders;
- Does part or all of the facility consist of locked wards?

Phase Four – Notifying Adult Care Homes of IMD Determination Results and Transitioning Recipients

A. Notifying Adult Care Homes:

The SMA intends to provide as much notice as possible (up to thirty days) to any facilities which are identified through this process as at risk of being classified as an IMD, and conduct a housing assessment at that time for any recipients who may need to be transferred as a result of the IMD classification. The SMA will make a determination about any right to appeal under State law before facilities are notified of the IMD determinations. At the same time, the SMA will begin a housing assessment process and transition plan for recipients who may be displaced as a result of the IMD determination.

B. Transition Plan for Recipients Moving to a Different Location:

The SMA created an IMD Housing Task Force representing stakeholders, housing specialists, and State personnel. The first meeting convened June 8, 2011. A draft housing inventory summary was presented to the Task force. The essential elements of a housing transition plan were discussed and recommendations were documented. A draft transition housing plan was developed taking these recommendations into consideration for the affected recipient needing a housing transition. The anticipated time frame for relocating recipients may be 6-12 months. The Medicaid billing will be stopped when the facility is finally determined to be an IMD as a result of the process described above. The SMA will notify recipients immediately to allow the greatest amount of time for housing arrangements. Once a recipient is identified as residing in an IMD, and they or their guardian choose to move into a different location, the transition plan is activated. If the recipient is currently receiving a mental health service, the treatment provider will activate the transition plan. Priority will be given to those recipients that have been given a discharge notice from the ACH.

1. The LME will meet with the recipient/ guardian and if requested the Ombudsman, to offer choice of service provider or to explain the current mental health service provider will assist in the transition.
2. The service provider will conduct a Person Centered Plan (PCP) meeting or update the PCP (as applicable) with the recipient/guardian including the recipient's choice of family, friends, service providers and others to identify the recipient's needs and preferences. This PCP will reflect the development and coordination of housing, service and needs for the transition from the ACH.
3. The PCP will be developed or updated (as applicable), indicating the identified MH/SA services, natural supports, and other needed community supports.
4. The service provider will assist in obtaining benefits such as SSI/SSDI, Medicaid, Food and Nutrition Services and VA.
5. The service provider will communicate with CCNC or the recipient's primary care physician to ensure any medical needs are addressed during this transition.
6. The service provider will coordinate the recipient's PCP, implement the transition to choice of housing, and ensure the chosen services and community and natural supports are in place.
7. The LME will monitor the transition.

The LMEs are completing a housing inventory to identify available housing in their catchment area. The housing inventory will be updated regularly and will be used to identify housing options in the recipient's chosen community such as:

- Individual Apartment – living alone or with chosen roommates
- MH Group Home
- Family Care Home
- Alternative Family Living
- Oxford House

Analysis of Data

The SMA will provide weekly reports of progress regarding each of the three phases, including a list of facilities determined to be at risk of IMD classification following phase two, and will complete the determinations regarding IMD status on a rolling basis as assessments are completed and all necessary medical data is gathered. The SMA expects to complete its determination regarding IMD status for all of the identified facilities as soon as possible, but no later than the end of January 31, 2012. Once the determinations are complete, a report will be sent to CMS by February 29, 2012 indicating the number of recipients identified with a primary mental health or substance abuse diagnosis, the number of recipients whose current need for services in the adult care homes result from a mental disease, the number of adult care homes, if any, determined to be an IMD, and the number and status of recipients who may need alternative housing arrangements as a result of the IMD classification.

Notification of Other Adult Care Home Providers Monitoring

The SMA will communicate in writing to all remaining Adult Care Home Providers who have more than 16 licensed beds to notify them of the potential for IMD classification. The SMA may hold educational work groups to assist Providers and stakeholders with understanding and achieving IMD regulatory compliance. The SMA will expect each Provider to attest that the facility complies with IMD regulations initially and on an annual basis. The SMA will utilize on site surveys to ensure compliance.

PROPOSED IMD ASSESSMENT TIMELINE
STATE OF NC
Updated 9-29-11

ID	Indicator	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1	✓	**Discuss IMD issue with stakeholders**	**10 days**	**Tue 4/5/11**	**Mon 4/18/11**		
4		**Identify potential IMDs**	**119 days**	**Mon 4/11/11**	**Thu 9/22/11**		
5	✓	Identify diagnosis code range	1 day	Mon 4/11/11	Mon 4/11/11		Judy - DMA
6		Locate potential IMDs through claims database query	118 days	Tue 4/12/11	Thu 9/22/11	5	DRIVE Team - DMA
7		Identify affected ACHs, LMEs, and DSSs	0 days	Thu 9/22/11	Thu 9/22/11	6	DHHS,DMA
8	✓	**Identify individuals needing assessment**	**98 days**	**Tue 5/10/11**	**Thu 9/22/11**	**4**	
10		**Develop plan/prepare for conducting assessments**	**120 days**	**Tue 4/19/11**	**Mon 10/3/11**		
11	✓	Set up small workgroup of Dept. and LME staff	5 days	Tue 4/19/11	Mon 4/25/11		DMH,DMA
12	✓	Determine elements/content of assessment and assessment process	15 days	Mon 4/25/11	Fri 5/13/11		DMH,DMA
13	✓	Develop assessment training for LMEs and CABHAs	10 days	Thu 5/26/11	Wed 6/8/11		DMH,DMA
14	✓	Conduct training	10 days	Mon 6/27/11	Fri 7/8/11		DMH,DMA,DHSR
15		Conduct Webinar for LMEs and CABHAs	1 day	Mon 9/26/11	Mon 9/26/11	7	DMH,DMA
16		DMA Letter Preparation	2 days	Fri 9/23/11	Mon 9/26/11	7,6	DMA
17		DMA Letter to ACHs and Recipients distributed	2 days	Fri 9/30/11	Mon 10/3/11	15,16	DMA
18		Notify affected LMEs and local DSSs	2 days	Fri 9/30/11	Mon 10/3/11		DMA,DMH
19		**Conduct clinical assessments through LMEs & CABHAs and collect additional information**	**59 days**	**Mon 10/10/11**	**Thu 12/29/11**	**8**	
20		LME Letter to ACH Administrator to schedule visit	6 days	Mon 10/10/11	Mon 10/17/11		LMEs
21		LME face to face visit with ACH Administrator to discuss process	21 days	Fri 10/14/11	Fri 11/11/11		LMEs
22		LME face to face visit with recipient/guardian to offer CABHA choice	23 days	Fri 10/21/11	Tue 11/22/11		LMEs
23		CABHAs obtain consents, complete assessments and submit to CABHA Medical Directors for review	30 days	Fri 10/28/11	Thu 12/8/11		CABHAs
24		CABHAs submit completed assessments to LME Directors to make Primary Diagnosis	30 days	Fri 11/4/11	Thu 12/15/11		CABHAs,LMEs
25		LME Medical Director reviews completed assessments, makes primary diagnosis determination and submits to DMA	35 days	Fri 11/11/11	Thu 12/29/11		LMEs
26		DMA mails facility and resident questionnaires to ACHs with instructions for completion	10 days	Mon 10/17/11	Fri 10/28/11		DMA
27		DMA follows up by telephone with ACHs to confirm receipt and answer questions	10 days	Mon 10/17/11	Fri 10/28/11		DMA
28		Questionnaires due to DMA	0 days	Fri 11/11/11	Fri 11/11/11		DMA
29		DMA reviews for completeness/accuracy and contacts ACHs as needed for clarification	15 days	Mon 10/31/11	Fri 11/18/11		DMA
30		**Analyze findings and report to CMS**	**43 days**	**Mon 1/2/12**	**Wed 2/29/12**		
31		All facility/interview assessment material to Mercer and high level review to ensure completeness of information/prep for verification review	5 days	Mon 1/2/12	Fri 1/6/12		Mercer
32		Verification review (Facility and Individual Assessments) and documentation	5 days	Mon 1/9/12	Fri 1/13/12		Mercer
33		Prep summary for DMA review/IMD determination	3 days	Mon 1/16/12	Wed 1/18/12		Mercer
34		Facilitate discussion(s) with DMA re: IMD determination, including DMA-Mercer teleconference to discuss IMD determinations	9 days	Thu 1/19/12	Tue 1/31/12		Mercer,DMA
35		Finalize and submit report to CMS	26 days	Wed 1/25/12	Wed 2/29/12		DMA
36		**Develop IMD Transition Plan**	**170 days?**	**Tue 5/17/11**	**Mon 1/9/12**		
37	✓	Organize DHHS-stakeholder task force	10 days	Tue 5/17/11	Mon 5/30/11		DHHS
38		Draft transition housing plan	112 days?	Tue 5/31/11	Mon 1/9/12	37	DHHS

Project: Proposed IMD Plan V5 9-29-1
Date: Tue 10/4/11

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone