

**TITLE XIX FINANCIAL MANAGEMENT REVIEW GUIDE**

**# 2: IDENTIFICATION OF INSTITUTIONS FOR MENTAL DISEASES**

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February 2002

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## I. Introduction

This guide is designed to provide specific instructions on performing a financial management review of facilities that may be institutions for mental diseases (IMDs). As such, this guide reflects current law, regulations, policy, applicable Departmental Appeals Board (DAB) decisions, and various court decisions on this subject. The methods and procedures detailed in this guide are a compilation of those that have been employed in various regional office financial management reviews and Office of the Inspector General, Office of Audit Services reviews of IMDs.

The users of this guide should understand that while the guide is intended to be comprehensive, there may be circumstances which are unique to individual reviews that require the use of additional methods and procedures not specified in this guide. The situation may also suggest the elimination or modification of methods and procedures which are herein specified. This guide should be used in conjunction with the individual reviewer's professional judgement in completing a financial management review which satisfies all of the IMD requirements.

NOTE: Recent DAB and court decisions have essentially mandated that qualified medical personnel perform certain portions of this review. Therefore, to support a finding that a facility has overall character of an IMD, you must have medical expertise on the review team.

## II. Basic References

1. See Exhibit A for list of relevant web sites which can be accessed from this guide.
2. Section 1905(i) of the Social Security Act.
3. 42 CFR 435.1008.
4. 42 CFR 441.13. (Exhibit B)
5. 42 CFR 435.1009.
6. Section 3.1 of the approved State Plan.
7. State Medicaid Manual Section 4390. (Exhibit C)
8. DAB Decision No. 231, dated November 30, 1981.
9. DAB Decision No. 413, dated April 29, 1983.
10. DAB Decision No. 529, dated April 9, 1984.
11. Supreme Court Decision No. 88-2136, dated May 20, 1985.

12. DAB Decision No. 785, dated September 8, 1986.
13. DAB Decision No. 831, dated January 27, 1987.
14. DAB Decision No. 912, dated October 13, 1987
15. DAB Reconsideration No. 1179, dated July 30, 1990
16. DAB Decision No. 985, dated September 8, 1988
17. DAB Decision No. 1294, dated January 24, 1992
18. DAB Decision No. 1313, dated March 17, 1992
19. DAB Decision No. 1528, dated August 2, 1995
20. DAB Decision No. 1339, dated June 16, 1992
21. DAB Decision No. 1495, dated September 16, 1994

### III. Background

#### A. Statutory

Prior to the Social Security Act Amendments of 1965, Federal financial participation (FFP) was excluded with respect to all payments on behalf of all individuals who were patients in IMDs. Up until that time such care had been solely the responsibility of the States. The Social Security Act Amendments of 1965 [Public Law (P.L.) 89-97] provided for the first time for medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. Additionally, the Social Security Act Amendments of 1972 (P.L. 92-603) provided for inpatient psychiatric hospital services, under certain conditions, for individuals under age 21, or in specific circumstances, under age 22. Subsequent changes to the Act have defined an IMD in Section 1905(i) as follows:

"The term "institution for mental diseases" means 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." (Emphasis added)

The statutory requirements with respect to IMDs are found at Section 1905(a) of the Social Security Act. Section 1905 (a) defines the term medical assistance as payments of part or all of the following care and services:

“(1) inpatient hospital services (other than services in an institution for mental diseases);

“(4) (A) skilled nursing facility services (other than services in an institution for mental diseases). . . ;

“(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

“(15) services in an intermediate care facility for the mentally retarded (other than such services in an institution for mental diseases) . . . ;

“(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) . . . .”

Additionally, paragraph (B) following section 1905(a)(27) provides that, except as provided in paragraph (16), the term medical assistance does not include:

“(B) any such payments with respect to care or services for any individual who has not attained 65 years of age who is a patient in an institution for mental diseases.”

In summary, the statute provides that FFP is not available for any medical assistance under title XIX for individuals who are patients in an IMD (this includes the per diem costs and any other costs) unless the payments are for optional IMD benefits which include inpatient hospital services, nursing facility services, or intermediate care facilities for the mentally retarded services in IMDs for individuals 65 years of aged or over, or for inpatient psychiatric facility services for individuals under age 21 or, under certain conditions, under age 22 as defined in section 1905(h) The State must expressly elect to provide the optional coverage through its State plan.

## B. Regulatory

Medicaid regulations implementing Section 1905(a) of the Social Security Act are found at 42 CFR 435.1008 provides that:

“(a) FFP is not available in expenditures for services provided to—

“(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.”

“(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.”

“(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.”

Additionally, 42 CFR 441.13 specifies that:

“(a) FFP is not available in expenditures for services provided to —

“(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under subpart D of this part.”

The Medicaid regulations at 42 CFR 435.1009 provide the following key definition of an IMD:

“Institution for mental diseases means 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.”

In accordance with this definition the regulatory test of whether or not an institution is an IMD 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. Towards this effort, every indication of any significance that a given facility is primarily engaged in IMD activity needs to be marshaled to implement the statutory restrictions. A final determination on the institution’s status is based on its overall character.

### C. Litigation and Appeals

During the past several years there have been many appeals to the DAB and the courts concerning the issue of IMD identification. This section will furnish a synopsis of several key DAB and court decisions and explain their effect. (Please refer to the decisions themselves for detailed discussions of the issues in each case.)

1. Litigation Resulting from DAB Decision No. 231 – From 1978 through 1980, HCFA and the OIG conducted a series of IMD identification reviews in a number of States. As a result of these reviews, disallowances were taken in four States: Connecticut, Minnesota, Illinois, and California. The States appealed (in a consolidated appeal) the disallowances to the DAB. In Board Decision No

231, issued November 30, 1981, the Board upheld each of the disallowances. Each State next sought court review of the Board's decision.

### Connecticut

Connecticut appealed the Board's decision to the District Court of Connecticut. The District Court ruled (Civil No. H-82-146, issued February 17, 1983) that the Secretary's decision was not supported by statute and reversed the disallowance. The Department appealed the District Court's decision to the Court of Appeals for the Second Circuit. The Court of Appeals reversed (Docket No. 83-6105, decided March 30, 1984) the District Court's ruling, rejecting the conclusions of the Eighth Circuit in the Minnesota case (see discussion of the Minnesota litigation below).

Connecticut then petitioned the Supreme Court for a writ of certiorari. The Supreme Court granted the petition, concluding that the decision of the Second and Eighth Circuits presented a "square conflict on an important questions of statutory construction." The Court (Docket No. 83-2136, decided May 20, 1985) affirmed the decision of the Court of Appeals for the Second Circuit. Salient points in the Supreme Court decisions are:

- a. Based on the "plain language of the statute, . . . the Secretary's reasonable and longstanding interpretation of the Act, and . . . the Act's legislative history, "IMDs and ICFs are not mutually exclusive categories; an ICF may be an IMD.
- b. The one ICF in this case was found to be an IMD. The Court found that the ICF was "primarily engaged" in providing treatment and care for persons with mental diseases within the meaning of the regulations. The Court's finding was based on "ample evidence" contained in the record including such factors as the percentage of patients having a major mental illness, the number of transferees from State mental hospitals, the specialization of the facility's staff in caring for the mentally ill, and the fact that the facility held itself out to sources of referral as specializing in the treatment of mental diseases.

The Supreme Court Decision did not specifically rule upon the sufficiency and validity of the existing criteria for determining if a facility is an IMD, but simply referred to the criteria in a footnote without further comment.

### Minnesota

Minnesota appealed the Board's decision to the District Court of Minnesota. The Court ruled (Civil No. 4-82-155, issued August 25, 1982) against HHS and

reversed the disallowance. The Department appealed the District Court's decision to the Court of Appeals for the Eighth Circuit. The Court of Appeals held (No. 82-2297, issued September 30, 1983) that "characterization of an IMD must fundamentally center on the types of care or nature of services required, not on the mere presence in a facility of patients who have, or at one time did have, diagnosis of a mental disease." The court also held that HHS had done insufficient fact finding concerning the type of care or nature of services required and remanded the case to the DAB. As a result of the Appeals Court decision, HCFA conducted a second review which focused on the type of care and nature of services required by the residents of three ICFs in this case. A disallowance was issued based on this second review and Minnesota appealed this disallowance to the DAB. In Decision No. 831, dated January 27, 1987, the DAB upheld the disallowance for one of the ICFs and reversed the disallowance for the other two. In so deciding, the Board found that "HCFA failed in its second review to follow the Eighth Circuit's directive and HCFA's own guidance. HCFA did not determine the degree of treatment required by the patients' physical disorders as well as any mental disorders (i.e., did not determine the reason for institutionalization in the facilities). Thus, HCFA's patient-counting data is not probative of IMD status (except to the extent the State conceded the reason for placement) and cannot support the disallowance absent other evidence." (Emphasis added.)

The implications of this decision for determining that the overall character of a facility is that of an IMD are discussed in detail in "Section D-Guidelines" below.

### Illinois

Illinois appealed DAB Decision No. 231 to the District Court of Northern Illinois. The District Court ruled (No. 82-C-1349, issued March 20, 1984) that the diagnosis-based criteria employed for determining if a facility was an IMD were invalid on their face. Following the Connecticut Supreme Court decision, the District Court found on remand from the Court of Appeals for the Seventh Circuit that 6 of 9 ICFs involved in the Illinois case were IMDs (No. 82-C-1349, issued June 30, 1986). In so finding, the Court stated that "the basic issue for decision is whether there is sufficient evidence. . . to support the Secretary's conclusion that each. . . nursing home. . . has the overall character of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. . . . regardless of the adequacy of the criteria . . . ." The Court relied heavily in its determination on "patient statistics" in conjunction with evaluation reports and memoranda prepared by State medical review teams.

## California

California appealed DAB Decision No. 231 to the District Court for Eastern California, which delayed action until a decision had been made in the Connecticut case. Although the California decision was an unpublished opinion (Civil No. CIV-S-82-180-EJG, decided May 21, 1986), the District Court for Northern Illinois referenced the outcome in that Court's June 30, 1986 decision (see Illinois discussion above). Without ruling on the adequacy of the criteria used by HCFA in designating the five California facilities as IMDs, the District Court for Eastern California concluded that each of these ICFs was an IMD based on the evidence in the record.

## 2. Other Litigation and Appeals

### Grandville House, Inc.

In May 1980, Grandville House, Inc., as operator of three residential chemical dependency centers in Minnesota, challenged the Department's classification of alcoholism and chemical dependency as mental diseases. The District Court of Minnesota found (Civil No. 4-80-279, decided November 10, 1982) that the Department's classification of alcoholism and other forms of chemical dependency as mental disorders is unreasonable and, therefore, the . . . characterization of (these) facilities as (IMDs) is arbitrary and capricious." On appeal, the Court of Appeals for the Eighth Circuit ordered that the case be remanded to the DAB to decide "whether alcoholism and chemical dependency, both of which are classified as mental diseases in ICD-9-CM, are properly characterized as mental diseases" for the purpose of identifying facilities as IMDs. The Board concluded in Decision No. 529, issued April 9, 1984 that "HCFA may not reasonably characterize Grandville's facilities as IMDs based merely on the predominance in those institutions of persons diagnosed and treated for alcoholism. Given the uniqueness and complexity of the disease and its treatment, we conclude that HCFA may determine IMD status for an institution treating alcoholism only on the basis of more definitive rules or guidelines which enable HCFA and its constituents to better evaluate what type of alcoholism treatment are, and are not, conclusive of IMD status."

These guidelines were issued by HCFA as part of revisions to State Medicaid Manual Section 4390.

### DAB Decision No. 785

Based on an OIG audit conducted in 1982, HCFA had disallowed FFP for an ICF in the State of Washington on the basis that the ICF was an IMD. In Decision No. 785, dated September 8, 1986, the DAB reversed the

disallowance finding that “the supporting evidence was either flawed or lacked probative value.” This decision provides valuable specifics regarding the kind and level of detail evidence needed to support the determination that the overall character of a facility is that of an IMD. We have included many of the Board’s examples in our discussion below of the individual criteria to be used in determining if a facility is an IMD (See Section D – Guidelines). The Board also affirmed, once again, “that the application of (HCFA’s) criteria is permissible to collect evidence as long as the evidence is then weighed to ensure that regulatory standard, relating to the facility’s overall character, is met.”

#### D. Guidelines

The criteria to be used in determining whether a facility is an IMD are provided in Section 4390 of the State Medicaid Manual. The criteria are all deemed useful in identifying possible IMDs, but none of them is sufficient by itself to classify an institution. While neither the DAB nor the courts specified how many of the criteria must be satisfied to establish that a facility has the overall character of an IMD, it is clear from recent decisions that the strength of the cases was evaluated on the basis of the variety and sufficiency of the evidence presented to support the IMD determination. Therefore, it is essential that you evaluate the applicability of each criterion for each facility reviewed. You must support as many of these criteria as possible with as much supporting documentation as possible. You should be familiar with all the criteria before you begin your review.

CMS uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility’s IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

- a. The facility is licensed as a psychiatric facility; (SMM 4390-Guideline No. 1).

You should review, at the licensing unit of the State, all correspondence between the State and the facility under review. The license(s) and correspondence may show that the facility was established or converted to treat primarily persons with mental diseases. In those instances where a facility is licensed by the State to provide care and treatment of individuals with mental diseases, you must document the specific provisions of that license. For example, the DAB noted in Decision No. 831 that, in Minnesota, “licensure could be obtained for a program treating

as few as five such patients.” Thus, this particular licensure requirement was not sufficient in itself to determine IMD status (although the Board noted that the requirement did “provide some cumulative support where other evidence probative of IMD status” existed). Clearly, specific licensure requirements (if any) may vary widely from State to State. Therefore, you must carefully review the provisions of these licenses to determine to what extent they may support your determination that a particular facility has the overall character of an IMD.

- b. The facility is accredited as a psychiatric facility; (SMM 4390-Guideline No. 2).

Information regarding the accreditation of a facility can be secured from the RO Survey and Certification staff, the State Agency, or the facility itself. Where the facility has been accredited as a psychiatric facility, be sure to note the beginning and ending dates of the accreditation. Also, you should obtain a copy of the accreditation.

- c. The facility is under the jurisdiction of the State’s mental health authority (SMM 4390 – Guideline No. 3).

You should determine if the facility is under the jurisdiction of the State’s mental health authority or is receiving any funding or other assistance from this authority. This information may be secured from the mental health authority or from the facility itself. Any written agreements between the mental health authority and the facility for staff, services, training, etc. are of particular significance.

- d. 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 (SMM 4390 – Guideline No. 4).

To effectively support this criterion you must compare the staffing and services of the facility under review with the staffing and services of other similar (but clearly non-IMD) facilities in the State. To accomplish this comparison you will need to document for the facility under review and each “control” facility:

- the total number of full-time employees (FTEs) on the staff;
- the number of FTEs who are mental health workers;
- the percentage of the full-time and overall staff who are mental health workers; and
- the specific types of psychiatric/psychological services provided (e.g., psychological evaluations, group counseling, individual counseling, etc.)

Any facility used for comparison should be as similar as possible to the facility under review. That is, any comparison facility should ideally be: providing the same general level of care; be of similar size; have generally the same percentage of Medicaid patients; and have similar physical facilities. In those situations where no facility suitable for comparison purposes exists (e.g., the facility under review is much larger than other facilities in the State) we recommend that your comparative analysis be made in terms of staff to patient ratios.

Following are examples of other evidence that can be used in conjunction with your comparative staffing analysis:

- written agreements with other mental health facilities to provide psychiatric/psychological treatment;
- consultant contracts with mental health professionals;
- written statements (e.g., memoranda, affidavits) regarding the nature and background of staff sought in hiring;
- in-service training programs for staff geared toward treatment of mental diseases; and
- specific in-house facilities geared toward treatment of the mentally ill (e.g., lock-up procedures, behavior modification programs, therapy treatment rooms).

To establish that a facility specializes in providing psychiatric/psychological treatment you must evaluate the treatment process for each patient (or a statistically valid sample

of patients) to determine whether treatment is geared to mental or physical illness. It is imperative that this evaluation be performed by qualified medical personnel. There are three factors that may indicate that treatment of a mental disease is being provided: use of antipsychotic drugs, care directed by a psychiatrist, and receipt of group or individual therapy. Following is a discussion of each of these factors:

(1) Use of Antipsychotic drugs

Because the term "psychopharmacological" used in Guideline 4 can encompass a wide variety of drugs, some of which are used to treat physical as well as mental conditions, we recommend that you restrict your examination of the provision of medication to antipsychotic drugs. Following is a representative list of antipsychotic drugs which patients may be receiving:

<u>Tricyclic Antidepressants:</u>
Amitriptyline =Elavil
Amoxapine =Asendin
Clomipramine =Anafranil
Desipramine =Norpramin
Doxepin =Sinequan
Imipramine =Norfranil, Tofranil
Nortriptyline=Aventyl , Pamelor
Protriptyline =Vivactil
Trimipramine =Surmontil
Trazodone =Desyrel

<u>Barbituates:</u>
Amobarbital =Amytal
Aprobarbital =Alurate
Butobarbital =Butisol, Butalan.
Mephobarbital =Mebaral
Pentobarbital =Nembutal
Phenobarbital =Luminal
Secobarbital =Seconal
Secobarbital and Amobarbital =Tuinal

<u>Benzodiazapines</u>
Alprazolam =Xanax
Chlordiazepoxide =Librium
Clonazepam =Klonopin
Clorazepate =Tranxene
Diazepam =Valium
Estazolam =Prosom
Flurazepam =Dalmane
Halazepam =Paxipam
Lorazepam =Ativan
Oxazepam =Serax
Quazepam =Doral
Temazepam =Restoril
Triazolam =Halcion

<u>MAO Inhibitors</u>
Isocarboxazid =Marplan
Phenelzine =Nardil
Tranylcypromine =Pamate

<u>Antidyskinetics</u>
Benztropine =Cogentin
Trihexyphenidyl =Trihexy , Artane

The mere fact that a particular patient is receiving an antipsychotic drug is not sufficient in itself to conclude that psychiatric/psychological care and treatment are being provided. For example, in Decision No. 831, the DAB noted that a patient may receive "a small maintenance dose for a mental disease which (is) clearly under control." In general, the higher the daily dosage of antipsychotic drugs, the stronger is the indication of the provision of psychiatric/psychological care and treatment. In addition, if a psychiatrist has prescribed the drugs, it is more likely that the patient is being treated for an ongoing mental disease.

NOTE: While a "small maintenance dose" may not be indicative of treatment of a mental disease serious enough to require institutionalization, daily dosages of antipsychotic drugs will (even for those patients clearly institutionalized for treatment of a mental disease) generally be smaller in a long term care setting. Therefore, it is essential that medical expertise be used to distinguish between "small maintenance doses" for mental conditions which are under control and doses which indicate continuing treatment of mental conditions serious enough to require institutionalization. This should be an issue where a particular patient has both a mental disability and a physical problem.

(1) Care directed by a psychiatrist

The fact that a patient's medical records show that a psychiatrist is treating the patient does not necessarily mean that the level of psychiatric care being provided requires institutionalization. The key issue is the degree of the psychiatrist's involvement in a particular case. The Board noted in Decision No. 831 that "if, for example, the psychiatrist had seen the patient only once, there is some question whether the psychiatrist was really treating the patient for an ongoing mental disease."

Therefore, to establish that a facility specializes in care directed by a psychiatrist, you must document the degree of involvement of a psychiatrist in the care provided to specific patients. Obviously, you should have medical personnel determine whether a psychiatrist's involvement in a case is sufficient to indicate treatment of an ongoing mental disease.

(1) Recipient of group or individual therapy

To establish that a facility specializes in the provision or group therapy for the treatment of mental diseases, you must document those therapies offered by the facility which are clearly for patients with mental diseases. You must also specify the type of staff that provides these services. (In general, such services will be provided or directed by mental health professionals). These services included, but are not limited to: psychiatric/psychological evaluation; group or individual counseling; and behavior modifications programs. You must establish that these services are used in the care and treatment of patients with mental diseases and are not, for example, simply directed at helping patients adjust to life in an institutional setting. To effectively make this differentiation you must relate each form of treatment provided to specific patients to show that they are receiving mental health services of a particular type for the care and treatment of a mental disease.

In Decision No. 831, the DAB expanded upon what is required to establish that certain forms of therapy are specifically provided to treat mental diseases. The Board indicated that group therapy in particular "cannot be considered evidence of a treatment of a mental disease, absent evidence that the therapy was specifically provided for this reason." The Board also noted that, in general, individual psychiatric therapy is more indicative of an ongoing treatment of a mental disease. In either case, you must identify which patients are receiving each form of therapy, the staff providing the therapy, and the intensity of that therapy.

- e. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases (SMM 4390 - Guideline No. 5).

In applying the fifth guideline, the reviewers must determine whether each patient's current need for institutionalization results from a mental disease. For purposes of this determination, the term "mental disease" includes diseases listed as mental disorders in the ICD-9-CM, with the exception of mental retardation, senility and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) provides further guidance to determine whether a disorder is a mental disease.

The following is updated procedure taken from State Medicaid Manual Section 4390, for assessing patient populations:

"For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease."

"If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear-cut distinction is possible."

"To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician."

Classification is to be based on current diagnosis; it is not necessary to document the nature of the care being provided in order to determine that a facility is an IMD. Patients are to be classified as follows:

1. Patient with a physical problem necessitating nursing home care who has no mental disorder which would require inpatient treatment;
2. Patient with a mental disability and a physical problem, either of which would independently require nursing home care;

3. Patient with a physical problem that would not independently necessitate nursing home care, but who has a mental disability that would preclude proper handling of the physical problem outside a nursing home; and
4. Patient with a mental disability necessitating nursing home care who has no significant physical problem.

Designate patients in categories 3 and 4 as mentally ill and patients in category 1 as physically ill. Special attention will be necessary for patients in category 2, and it may not be possible to make the determination solely on the basis of an individual's current diagnosis. Patients with longstanding mental disability may develop major physical problems and vice versa. When it is clear that the institutional care initially resulted from one or the other, the patient should be classified according to the initial disability in these cases. When no clear-cut distinction is possible, do not include the patient in the mentally ill category.

The DAB and the courts have repeatedly stressed that this classification of patients should be accomplished through direct review of medical records by qualified medical personnel. Therefore, you need to establish the qualifications and credibility of medical personnel on the review team. You should provide information in your review report such as where the reviewer is licensed, practicing, the extent of his or her experience in mental health, etc.

Note that the SMM instruction requires that the classification of patients be based on current ICD-9-CM diagnosis. This requirement is a direct result of concern expressed by the DAB and the courts "that discrimination against patients on the basis of diagnosis (which is prohibited) might be present to the extent that patients were classified based upon historical diagnosis which did not reflect the patients' current condition (what the states referred to as "labeling of patients)".

Even when focusing on the patient's current condition you must keep in mind that the significant element in your classification is "whether the patient's current need for institutionalization results from a mental disease." To establish this need, it is not necessarily sufficient to record the current diagnosis. You should

also document and consider information such as whether a mental condition is episodic, acute, chronic, in remission or controlled. You must also consider the reasons for institutionalization at the time of admission. In this context, historical diagnoses may be relevant.

You must document the details of treatment for patients having both a mental disability and a physical problem. You should record such information as the types, dosages, and frequency of medication, the patients' utilization of mental health services (types of services and frequency), visits by mental health professionals (types of professionals, frequency of visits, duration of visits), etc. You must also document the details of treatment for patients with diagnoses of alcoholism (See the section on Alcoholism Facilities below).

In Decision No 831, the DAB elaborated upon what must be done to establish the reason for institutionalization when a patient has both a mental disability and a physical problem. In essence, you must establish the "degree" of care and treatment required by the patient's mental or physical condition." Therefore, you must consider whether a patient's placement in facility may be due to diagnosed physical rather than mental problems. Where you determine that none of patient's physical problems are serious enough to require institutionalization, you must provide your rationale for reaching this conclusion, and demonstrate that you have weighed the relative severity of the physical and mental problems. (The DAB has clearly indicated that such weighing must be performed by a mental health professional.) This entails a detailed evaluation of the type and degree of treatment provided for each diagnosed problem.

Following are other potential problem areas of which you should be aware:

- In choosing a point in time to count and classify the patient population, you must make sure that the point in this time is representative of the entire audit period. This requires that you be alert to fluctuations in the patient population during the audit period. In Decision No. 785, the DAB acknowledged that "when a facility was not established as a facility specializing in mental diseases, but begins taking in more and more patients with mental diseases, it is difficult to draw the line in determining at what point the facility would attain the requisite overall

character of an IMD." It is, therefore, important for you to consider whether the overall character of the facility may have changed during the audit period.

- In a related issue, you should ensure that multiple admissions of individual patients do not distort your statistics on the patient populations. The DAB has suggested that this problem might be avoided through the use of statistics on patient days. Thus, you should annotate your notes on each patient to show the number of days during the period reviewed that the patient was in the facility, so that patient-day statistics can be compiled.
- Persons having a diagnoses of organic brain syndrome or senility should not be counted as mentally ill. This is true even in those instances where the facility is treating these patients for the effects of a mental disorder (as opposed to providing general nursing and other medical and remedial care).
- In order to classify private patients when review of their records is not possible, rely on other factors, such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

f. Chemical dependency treatment facilities

State Medicaid Manual Section 4390 provides additional information relating to facilities specializing in treatment for alcoholism or other forms of chemical dependence. While these facilities are to be evaluated using the guidelines show above, additional care is needed to classify these patients. When reviewing a facility specializing in treatment of alcoholism and/or chemical dependence, use of the ICD-9-CM system is not sufficient in itself to determine if a particular patient's current need for institutionalization results from a mental disease.

### Psychiatric Treatment Model

- Patients in need of or receiving psychological treatment by professionally trained and licensed personnel can be classified with a mental disease. Patients admitted to a facility for medically directed services which are psychological or psychosocial in nature and which are designed to alter the patient's maladaptive behaviors are to be counted as mentally ill under guideline 5.

### Alcoholics Anonymous Treatment Model

- Patients receiving treatment through peer counseling (i.e. Alcoholics Anonymous) or other lay advisors does not constitute medical or remedial treatment. Do not count patients admitted to the facility primarily for lay counseling as mentally ill under guideline 5.

The reviewer should be aware that facilities may not avoid having their patients counted as mentally ill under guideline 5 by withholding appropriate treatment from those patients; facilities failing to provide appropriate treatment to patients risk termination from the program. In addition, the reviewer should be aware that lay counseling, when it is the primary method of care, does not constitute "medical or remedial treatment" required for Medicaid reimbursement under 42 CFR 440.2(b). When lay counseling-type treatment is the sole reason for an inpatient stay, FFP may not be claimed for hospital NF care.

### The Role of the Financial Reviewer

As noted previously, DAB Decision Nos. 785 and 831 have virtually mandated that the classification of patients be performed by persons with medical (preferably psychiatric) expertise. While this "mandate" may essentially preclude the financial reviewer from making judgements regarding patient classification, we believe that there are other areas of an IMD identification review to which the financial reviewer's energies can be effectively redirected. If IMD status can be demonstrated by fully developed evidence such as licensure, how the facility holds itself out to the public or State correspondence, etc., the emphasis placed on specific methodology used in classifying patients will be greatly reduced. In theory, if sufficient evidence confirming a facility's IMD status were

available from other sources, the laborious and sensitive practice of reviewing medical records would be unnecessary. In Decision No. 831, the DAB noted that:

" The main difference between the Board findings which were upheld in court is the extent of reliance on diagnoses-based patient counting. Where there was other persuasive evidence that a facility was an IMD (such as an admission by the facility was about the nature of the facility, which the Illinois court found was entitled to great weight), the courts have subjected the patient-counting to less scrutiny, and not required direct evidence that the patients were institutionalized for their mental diseases."

In essence you should recognize that evidence which does not involve "patient-counting" is of great significance, particularly where that evidence can be shown to constitute an admission by the State or the facility about the character of the facility. With this in mind, we recommend that you conduct a thorough review of any correspondence concerning the facility as well as any licenses, survey or inspection reports, advertisements, etc., which may support a determination of IMD status. You should also remember that, even if no clear-cut admission of the nature of the facility can be found, the cumulative effect of this evidence may become persuasive when viewed in conjunction with carefully developed "patient statistics."

#### IV. Purpose of the Review

In accordance with the requirements described above, the purpose of an IMD review is:

1. to determine which IMD options, if any, have been included in the State Plan;
2. to determine whether the facilities being reviewed meet the definition of an IMD;
3. to determine whether or not expenditures (i.e., FFP) were improperly claimed for individuals in those facilities which were determined to be IMDs; and
4. to determine the total amount of FFP, if any, that was improperly claimed during the period reviewed

A decision must be made by the reviewers as to the scope of the expenditures which are to be reviewed. Specifically, due to limitations on staff availability and staff review time you may want to consider limiting your review to only the per diem expenditures in the IMD and leaving the other costs (e.g., drugs, physicians, transportation) for a future review.

## V. Composition of Review Team

Throughout the recent litigation, the courts stressed the importance of the inclusion of medical personnel on the review team. The DAB, in Decision 231, recognized that a review team composed of the following members presented the most credible findings with respect to applying the criteria for establishing that the facility under review was not an IMD:

1. psychiatrist knowledgeable about mental institutions,
2. psychiatric nurse,
3. Medicaid program specialist for the State, and
4. Auditors/financial management specialists

It should be noted that the findings of review teams of various compositions have been supported by the courts. However, in those cases where medical personnel were not included on the review team, the strength of HCFA's findings was clearly diminished in the eyes of the courts. Therefore, it is necessary to include medical personnel in the review process.

## VI. Initial Facility Identification Process

The review team will need to initially identify those facilities that appear to have the highest likelihood of being IMDs. In this way the review team will be able to concentrate its resources on a more detailed analysis of those facilities. This initial identification process can begin in the regional office prior to actually involving the State's agency.

### A. Regional Office

1. Obtain and review copies of the pertinent Medicaid laws, regulations, guidelines and instructions with respect to IMD's. You should become especially familiar with the State Medicaid Manual Section 4390.
2. Obtain and review a copy of the State's Medicaid Plan. Does the State Plan address IMDs? What types of coverage are excluded or included? 65 and over? Under 21? Under 22, if applicable?

3. Obtain and review any State organization material, mission statements, and correspondence files, which contain issues concerning IMDs.
4. Review procedures for monitoring the State to insure that it is complying with the Medicaid law and regulations. Has there been an evaluation of the State's procedures for claiming FFP? Have there been visits to or reviews of possible IMDs? If so, consider the nature of any deficiencies disclosed by such evaluations and review and determine whether appropriate action to correct the deficiencies has been taken. Were certain nursing facilities (NFs) noted to be IMDs during the reviews and what action was taken to insure that the other NFs were not IMDs?
5. Review the Online Survey Certification and Reporting System (OSCAR) with RO Survey and Certification staff to identify NFs reporting high usage of psychiatric medications and other favorable IMD profile factors. Obtain a list of the facilities determined by this review to be possible IMDs and, therefore, ineligible to participate in the Medicaid program except for providing those specific optional coverage, if any, in the State Plan.
6. Review Preadmission Screening and Resident Review operations with RO Program Integrity staff to identify NF's with unusual numbers of mental health patient dispositions reported to CMS.

Under 1919(e)(7)(A)(i) of the Act, effective January 1, 1989, a State must have in effect a preadmission screening (PAS) program for making determinations to assure that mentally ill or mentally retarded individuals are not admitted to a NF unless the individual because of his physical and mental condition requires the level of services provided by a NF, and if the individual requires such level of services, whether the individual requires specialized services for mental illness or mental retardation.

The PAS program does not apply to readmission of a patient transferred to a hospital for care. Additionally it does not apply to patients (1) who are admitted to a NF directly from a hospital after receiving acute inpatient care at the hospital, (2) who require NF services for the condition for which the individual received care in the hospital, and (3) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of NF services.

Obtain a list of the facilities determined by this review to be possible IMDs and, therefore, ineligible to participate in the Medicaid program except for providing those specific optional coverage, if any, in the State Plan

It is important that you document your findings during each of the review steps through copies of relevant information collected, and that you describe your review steps in workpapers, so that these items may be used to support your final report.

**B. State Agency**

1. Conduct an entrance conference with the State agency. The general scope and purpose of the review and planned review dates should be explained at this conference.
2. Obtain and review the following documents:
  - a. State agency and mental health organization charts and State staffing procedures and surveys.
  - b. State licensing requirements/information (e.g., State Law, Administrative Code),
  - c. Special State program information (e.g., Special Disabilities Program),
  - d. State and/or Federal correspondence, and
  - e. Medical reviews/independent professional reviews/utilization review data, etc.
1. Obtain from the State agency a list of the State mental and private inpatient psychiatric facilities that primarily care for and treat persons with mental diseases. Mental hospital discharge records should be obtained and analyzed in order to identify facilities in which patient are being placed.
2. Obtain from the State agency a list of NFs. Request that the State identify any NFs that primarily care for and treat persons with mental diseases. It should be noted that the States may have survey, reports, and statistical data which have this information.
  - a. The State's certification unit may be performing annual certification surveys of NFs. During these survey the State unit may be identifying IMDs. The reviewer also should determine:
    - (1) What were the attributes used by the State to make the decision that the facilities were IMDs?
    - (2) Does the State have a definition of mental diseases? If so, reviewer should obtain this definition and evaluate it in light

of the International Classification of Diseases, Clinical Modification (ICD-9-CM). Is it reasonable and appropriate? If the State has not developed its own definition, does the State accept the CMS definition (i.e., the ICD-9-CM classification)? If not, what is the State's position.

- a. If the State informs the reviewer that it has not identified any IMDs or it does not have any NFs or primarily engaged in the care and treatment of persons with mental diseases, the reviewer should test the validity of the State's position as discussed below.
- b. For those facilities which the reviewer has indications that they are primarily engaged in the care and treatment of persons with mental diseases, the reviewer should review, at the licensing unit of the State, all correspondence between the State and the facilities. The licenses and correspondence between the State and the facilities. The licenses and correspondence may show that the facilities were established or converted to treat primarily persons with mental diseases.

## VII. Specific Facility Review

Based upon the results of Sections V and VI, you have identified those facilities that care for and treat persons with mental diseases but which have not been identified by the State as IMDs. Therefore, the reviewer must now determine whether each individual facility is established and maintained primarily for the care and treatment of persons with mental diseases and is an IMD. In essence, the reviewer must establish (by assembling as much evidence as possible) whether the evidence indicates that the overall character of the facility is that of an IMD. Although the criteria have been developed to assist in determining whether or not a facility is an IMD, the determination will not rest on the number of criteria that are met but rather on the strength of the evidence that is assembled. In the June 30, 1986 decision rendered in the Illinois District Court, the judge stated that "the basic issue for decision is whether there is sufficient evidence, under the appropriate standard of review, to support the Secretary's conclusion that each of the . . . nursing homes . . . have the overall character of a facility established and maintained primarily for the care and treatment of individuals with mental diseases . . . Regardless of the adequacy of the criteria, there could be sufficient evidence in the record to support the Secretary's decision."

### A. Scope of Review of Patient Records

**SPECIAL NOTE:** Due to the sensitive nature of reviewing patient records the reviewer should avoid examining medical records of private pay patients or providing an opinion as to whether or not private pay patients are physically or mentally ill unless the State agency or the facility being reviewed voluntarily submits such information in their

effort to support the fact that the facilities are not IMDs. Additionally, the reviewer should insure, to the extent possible, that all workpapers and other documentation containing information subject to the Privacy Act (e.g., patient name, diagnosis) are maintained in separated files and adequately safeguarded at all times during and after the review.

1. Source of Records -- A determination should be made whether State records (e.g., utilization control, patient record summaries) or facility patient records will be reviewed in making the determinations. The quality of State records should be the prime consideration. Additionally, you may want to come to some agreement with the State over the accuracy of the information contained in the records being reviewed.
2. Use of Sampling -- A determination should be made on the number of patient records to be reviewed. If the number of patients in the facility is 200 or fewer, all patient records must be reviewed. If the number is over 200, a decision should be made on whether to sample. Naturally, any sampling must be done on a facility-by-facility basis.
3. Extent of Records Review -- Critical to a determination of the overall character of a facility are the types of illnesses that a facility is able to treat, as indicated by the patient's diagnosis when admitted. Therefore, at the minimum, you must review:  
(1) each patient's diagnosis and plan of care/treatment on the date of admission; and  
(2) the patient's diagnosis and plan of care/treatment for the most recent month of your review. The reviewer should note if the diagnoses and plans of care/treatment for the most recent month are consistent with those prepared at the time of admission. Where inconsistencies appear for a given patient, further review of the medical records is advised. We recommend that this additional review of medical records be completed by the medical member of the review team. Finally, based upon your professional judgement of the patient turnover rate in a given facility you may want to consider looking at patient records at intervals between the date of admission and the most recent month.
4. Review Team -- A decision should be made as to who will conduct the review of patient records. The decision whether to include mental health professionals should be made based on several factors (e.g., availability of staff, how clear cut the determination of overall IMD status). We strongly recommend that a qualified medical person be involved in this portion of the review if at all possible.

B. Criteria to be Determined from Review of Patient Records

1. Nature of Patient Population -- The review of patient records will be used to determine what percent of the total patient population is in the facility primarily for treatment of mental diseases, as determined by the primary/secondary diagnosis both currently, and at the time of admission.

2. Age Distribution of Patients -- The patient's records will be used to determine if the age distribution is uncharacteristic of nursing homes.
3. Previous Residence of Patients -- Patient records will be used to determine the percent of patients transferred from mental institutions.
4. Specific Characteristics of Facility -- The patients' records, as well as other facility/State records, will be reviewed to determine specific facility characteristics (e.g., extensive involvement of mental health professionals, activities such as vocational rehabilitation, group therapy sessions) which are characteristic of a facility geared toward treating the mentally ill.

C. Review Procedures for Patient Records

1. Individual determinations on whether each patient is primarily in the facility for treatment of a mental disease should be based on the following:
  - a. Evaluation of primary/secondary diagnosis based on ICD-9-CM listing of mental diseases.
  - b. If a physical illness is also involved, a judgement as to whether it is extensive enough to warrant inpatient care irrespective of the mental illness. (This judgement must be made by a qualified medical person.)
  - c. Evaluation of treatment to determine whether treatment is geared to mental or physical illness. (Nature of medication, type of psycho-social treatment, involvement of mental health professional in treatment plan, etc.)
  - d. Review of selected medical records of Medicaid patients noting:
    - (1) The patient's name
    - (2) The patient's Medicaid number.
    - (3) The patient's birth date.
    - (4) The patient's primary and secondary diagnosis upon admission.
    - (5) The patient's current primary and secondary diagnoses.

- (6) The facility's treatment plan of each patient indicating type of treatment of the patient's physical and/or mental illnesses. This is a critical step when reviewing facilities specializing in the treatment of alcoholism or other forms of chemical dependence as each patient's treatment plan is the key to determining whether an Alcoholic Anonymous or a psychiatric model of treatment is followed.
- (7) Medical—whether the primary medication is an antipsychotic drug.
- (8) Specialized mental health consultation visits with psychiatrists, psychologists, psychiatric social worker, etc.
- (9) Admission date.
- (10) Discharge date (if applicable)
- (11) From where the patient was admitted (i.e., home, state, mental hospital, acute care facility, NF, etc.)

D. Additional Review Procedures

1. Other Facility Specific Criteria – The evaluation of State records (e.g., patient records from IOC/UC, survey report forms, surveyor evaluations, agreements with local/community/country mental health centers) and/or facility records should be used to determine the overall character of the facility. The following areas should be evaluated:
  - a. Advertising and public relations documents should be reviewed to determine how the facility represents itself to the public. Facility brochures also can provide insight into specific treatment areas being emphasized, which can help in the evaluation (e.g., emphasis on vocational rehabilitation, freedom of patients to leave the facility during the day, affiliations with outside sheltered workshops).
  - b. Contracts/relationships with mental health professionals in treatment of patients.
  - c. Admissions policies which can indicate the type of patients generally admitted.
  - d. Information about the facility's licensing. Determine if the facility is designated as a facility primarily treating persons with mental illnesses.
  - e. Specific in-house facilities geared toward treatment of the mentally ill (e.g., lock-up/procedures, behavior modification programs, therapy treatment rooms).
  - f. Arrangements with outside groups to provide psychiatric rehabilitative services (e.g., day-care, sheltered workshop, mental health clinics).
  - g. In-service training programs for staff geared toward treatment of mental diseases.
  - h. Nature and background of staff which is sought in hiring. Is the percentage of staff experienced in treatment of mental illness unusually high?
  - i. The existence of locked wards in the facility. If so, you must establish the reason that locked wards are maintained, and note the number of beds in such wards relative to the total beds in the facility.

After completion of all the necessary procedures in this section, the reviewer should be able to draw a conclusion with respect to all of the IMD criteria for each of the facilities that was reviewed.

E. Development of Questioned FFP

If, after having assembled and weighed the available evidence, you conclude that a particular facility is an IMD, you must determine the amount of unallowable FFP that has been claimed for patients in the facility.

VIII. Development of Findings and Recommendations

The findings and recommendations established through your review will normally be developed and presented in a final financial management review report. The report generally should be structured as follows:

- A. Background
- B. Purpose and Scope
- C. Findings
- D. Conclusions
- E. Recommendations
- F. Supporting Attachments/Appendices

You should insure that your report details your findings with respect to the IMD criteria for each facility and the reason why you conclude that these establish that the facility is an IMD. It is also especially important that you establish how the amounts of the FFP being questioned were computed and how these amounts trace to the State's quarterly expenditure reports. The report will then serve as the basis for any future disallowance action.

Upon completion of your review you should conduct an exit conference with State agency officials regarding review findings.

The final report should then be transmitted to the State agency with your recommendations. You should indicate in the transmittal the actions you expect from the State agency as a result of your recommendations and specify that a formal disallowance will be issued if necessary financial adjustments are not made promptly.

# MEDICAID, SCHIP AND RELATED ONLINE INFORMATION RESOURCES

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AUGUST 2001; Doc: infocite4.doc

## INTRODUCTION

This document contains website addresses for selected Medicaid and State Children's Health Insurance Program (SCHIP) financial management (FM), program, and related information resources. "Clicking" on the website addresses (indicated below in blue) will enable the user to directly access the actual information indicated by the website.

Example. The text for section 1920A of the Social Security Act is desired. This would be obtained by first clicking on the blue webaddress under section I.B. below for "Title XIX Of The Social Security Act - Medicaid." This will bring up the table of contents for title XIX. Then click on 1920A (in blue) on the table of contents; this will bring up the actual text for 1920A.

This document is intended to serve as a tool to facilitate access to significant and most frequently used information sources for Medicaid, SCHIP and related issues. We expect that over time, as appropriate, this information will be updated at regular intervals, whether through revisions, additions, or deletions. In that regard, if there are comments, questions, or suggested changes, please provide them at the contacts above.

## I. STATUTORY

- A. Table Of Contents Entire Social Security Act  
[http://www.ssa.gov/OP\\_Home/ssact/comp-toc.htm](http://www.ssa.gov/OP_Home/ssact/comp-toc.htm)
- B. Title XIX Of The Social Security Act - Medicaid  
[http://www.ssa.gov/OP\\_Home/ssact/title19/1900.htm](http://www.ssa.gov/OP_Home/ssact/title19/1900.htm)
- C. Title XXI Of The Social Security Act - SCHIP  
[http://www.ssa.gov/OP\\_Home/ssact/title21/2100.htm](http://www.ssa.gov/OP_Home/ssact/title21/2100.htm)

D. Public Laws – Browse Public Laws from the 93<sup>rd</sup> Congress to Present  
<http://thomas.loc.gov/bss/d107/d107laws.html>

E. US Code

<http://uscode.house.gov>

F. Legislative Information on the Internet

<http://thomas.loc.gov/>

## II. REGULATORY

A. Code Of Federal Regulations (CFR) All Titles 1 - 50:

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

B. 42 CFR Parts 400 - 424 (Medicare):

[http://www.access.gpo.gov/nara/cfr/waisidx\\_00/42cfrv2\\_00.html](http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfrv2_00.html)

C. 42 CFR Part 430 - 498 (Medicaid and SCHIP)

Part 1000 - 1008: (OIG)

[http://www.access.gpo.gov/nara/cfr/waisidx\\_00/42cfrv3\\_00.html](http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfrv3_00.html)

D. 45 CFR Parts 1 - 199:

[http://www.access.gpo.gov/nara/cfr/waisidx\\_00/45cfrv1\\_00.html](http://www.access.gpo.gov/nara/cfr/waisidx_00/45cfrv1_00.html)

E. Federal Register

[http://www.access.gpo.gov/su\\_docs/aces/aces140.html](http://www.access.gpo.gov/su_docs/aces/aces140.html)

## III. OMB CIRCULARS AND RELATED INFORMATION

A. Index To All OMB Circulars

<http://www.whitehouse.gov/omb/circulars/>

B. OMB Circular A-87 -Cost Principles for State, Local, and Indian Tribal Governments

<http://www.whitehouse.gov/omb/circulars/a087/a087-all.html>

C. OMB Circular A-133 – Audits of State, Local Government, and Non-Profit Organizations

<http://www.whitehouse.gov/omb/circulars/a133/a133.html>

D. ASMB C-10 - Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government

<http://www.hhs.gov/grantsnet/state/asmbc10.pdf>

- E. **Program Service Center - Financial Management Service, Division of Cost Allocation (Access to Statewide Cost Allocation Plans)**  
<http://rates.psc.gov/>

#### IV. MANUALS AND OTHER POLICY RELATED SOURCES

- A. Departmental Appeals Board (DAB) Decisions  
<http://www.hhs.gov/dab/>
- B. State Medicaid Plans  
<http://www.hcfa.gov/medicaid/stateplan/default.asp>
- C. State Medicaid Manual (SMM)  
<http://www.hcfa.gov/pubforms/pub45pdf/smmtoc.htm>
- D. Medicare & Medicaid Program Manuals Transmittals & Program Memos  
<http://www.hcfa.gov/pubforms/progman.htm>
- E. Letters to State Medicaid Directors (Medicaid-Related)  
<http://www.hcfa.gov/medicaid/smdhmpg.htm>
- F. Letters to State Medicaid Directors (SCHIP-Related)  
<http://www.hcfa.gov/init/chstltrs.htm>
- G. February 2000 Draft Medicaid School Based Administrative Claiming Guide  
<http://www.hcfa.gov/medicaid/schools/macguide.pdf>

#### V. FM AND RELATED DATA

- A. Federal Medical Assistance Percentage (FMAP) and Enhanced FMAP Rates  
<http://aspe.hhs.gov/health/fmap.htm>
- B. CMS SCHIP Information  
<http://www.hcfa.gov/init/children.htm>
- C. Medicaid/SCHIP Budget and Expenditure Data  
<http://www.hcfa.gov/medicaid/mcaidpti.htm>
- D. Medicaid Statistics and Data Sources  
<http://www.hcfa.gov/medicaid/mcaidsad.htm>

E. *U.S. Budget Information*  
<http://w3.access.gpo.gov/usbudget/>

F. **MBES/CBES System Log-In (ONLY for Authorized Users)**  
<http://204.156.28.211/mbescbes/>

## VI. OTHER

A. **American Public Human Services Association (APHSA)**  
<http://www.aphsa.org/>

B. *CMS Medicaid Experts Contact List*  
<http://www.hcfa.gov/medicaid/fcontact.htm>

C. *General Accounting Office (GAO)*  
<http://www.gao.gov>

D. *HHS Employee Directory (Including CMS)*  
<http://directory.psc.gov/employee.htm>

E. **HHS Office of Inspector General**  
<http://www.os.dhhs.gov/oig/>

F. **National Council of State Legislatures (NCSL)**  
<http://www.ncsl.org/>

G. **National Governors Association (NGA)**  
<http://www.nga.org/>

H. *State and Local Government Sites on the Internet*  
<http://www.piperinfo.com/state/index.cfm>

[Code of Federal Regulations]  
[Title 42, Volume 3, Parts 430 to end]  
[Revised as of October 1, 2000]  
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TITLE 42--PUBLIC HEALTH

CHAPTER IV--HEALTH CARE  
FINANCING ADMINISTRATION,  
DEPARTMENT OF HEALTH AND  
HUMAN SERVICES--(Continued)

PART 441--SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES--  
-Table of Contents

Subpart A--General Provisions

Sec.441.13 Prohibitions on FFP: Institutionalized individuals.

(a) FFP is not available in expenditures for services for--

(1) Any individual who is in a public institution, as defined in Sec. 435.1009 of this subchapter; or

(2) Any individual who is under age 65 and is in an institution for mental diseases, except an individual who is under age 22 and receiving inpatient psychiatric services under subpart D of this part.

(b) With the exception of active treatment services (as defined in Sec. 483.440(a) of this chapter for residents of ICFs/MR and in Sec. 441.154 for individuals under age 21 receiving inpatient psychiatric services), payments to institutions for the mentally retarded or persons with related conditions and to psychiatric facilities or programs providing inpatient psychiatric services to individuals under age 21 may not include reimbursement for formal educational services or for vocational services. Formal educational services relate to training in traditional academic subjects. Subject matter rather than setting, time of day, or class size determines whether a service is educational. Traditional academic subjects include, but are not limited to, science, history, literature, foreign languages, and mathematics. Vocational services relate to organized programs that are directly related to the preparation of individuals for paid or unpaid employment. An example of vocational services is time-limited vocational training provided as a part of a regularly scheduled class available to the general public.

(c) FFP is not available in expenditures for services furnished by an organ procurement organization on or after April 1, 1988, that does not meet the requirements of part 485, subpart D of this chapter.

[43 FR 45229, Sept. 29, 1978, as amended at 51 FR 22041, June 17, 1986; 53 FR 6549, Mar. 1, 1988; 57 FR 54709, Nov. 20, 1992]

03-94

**REQUIREMENTS AND LIMITS  
APPLICABLE TO SPECIFIC SERVICES**

4390

**4390. INSTITUTIONS FOR MENTAL DISEASES**

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases 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. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines

to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?

5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?

6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

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. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);
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.

D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to 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. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients