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Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)
Frequently Asked Questions (FAQs) – Section 438.6(e)

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This FAQ document addresses common questions related to section 438.6(e) for payments to MCOs and PIHPs for an enrollee that is a patient in an institution for mental disease (IMD), in the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) (hereinafter "Final Rule"). We encourage states, managed care plans, and other stakeholders to submit questions to ManagedCareRule@cms.hhs.gov to inform future guidance and FAQs. In addition, presentations from past webinars and additional guidance documents are available on Medicaid.gov at Medicaid and CHIP Managed Care Final Rule.

Note that references to pages in the Final Rule below are to the version published in the Federal Register on May 6, 2016.

Q1. What is the implementation date for the provision at §438.6(e), which would permit a state to make a capitation payment to an MCO or PIHP for an enrollee with a short-term stay in an Institution for Mental Disease (IMD)? The Final Rule at page 27560 provides that states must be in compliance for the rating period for contracts starting July 1, 2017, while the compliance date section in the Final Rule at page 27499 provides that the implementation date is July 5, 2016; which is the effective date for the Final Rule?

A1. We acknowledge and regret the conflicting dates set forth in the preamble to the Final Rule describing CMS enforcement of compliance with §438.6(e). We intended that the compliance date section at page 27499 of the Final Rule would be the applicable date for CMS enforcement of compliance; therefore, we will review compliance with this provision for managed care contracts in place on and after July 5, 2016.

Q2. Does the state need to modify managed care authority documents, such as the description of benefits in the capitation rate in 1915(b) waiver documents, to use the option in §438.6(e)?

A2. CMS understands that, for some states, the cost effectiveness section of the 1915(b) waiver documents currently list "inpatient mental health (state psychiatric hospital)" as a State plan benefit, and states identify these services as covered under the managed care program. The reference to "inpatient mental health (state psychiatric hospital)" in the 1915(b) waiver documents is used to identify benefits covered under the State plan. As such, that reference is only for such services provided to enrollees under the age of 21, or over the age of 64, that can be covered under the State plan. The IMD exclusion does not apply to the benefit for inpatient psychiatric hospital services for individuals under

age 21 (which is defined to include inpatient services at certain facilities that are not certified as hospitals), and it does not apply to individuals who are over age 64.

Q3. Does the state need to submit a State Plan Amendment (SPA) to modify the standard benefit package or an Alternative Benefit Plan (ABP) to use the option under the managed care rule to make a capitation payment to a MCO or PIHP for an enrollee with a short-term stay in an IMD as specified in §438.6(e)?

A3. No. A SPA to alter coverage under the State plan to include services for inpatients in an IMD would not be approvable due to the prohibition of federal financial participation (FFP) in subsection (B) following section 1905(a)(29) of the Act. The flexibility for states to make a capitation payment to a risk-based MCO or PIHP for an enrollee with a short-term stay in an IMD for inpatient psychiatric or substance use disorder services of no more than 15 days within the month for which the capitation payment is made is permissible under the regulation at §438.6(e) for MCOs and PIHPs to use the IMD as a medically appropriate and cost effective alternative setting to those covered under the State plan or ABP. This flexibility is referred to in the regulations as "in-lieu-of" services or settings and is effectuated through the contract between the state and the MCO or PIHP. Therefore, no modification to coverage under the State plan is required and none could be approved.

Q4. Could a state make two capitation payments to a MCO or PIHP for an enrollee with a stay of longer than 15 days that spans two months but each month includes less than 15 days of the stay?

A4. Yes. We would permit a capitation payment for a month when the enrollee is only an inpatient in an IMD for 15 days during that month. We addressed this question in the Final Rule and stated that two capitation payments for an enrollee who was a patient in an IMD for more than 15 days that spans consecutive months would be permissible so long as the stay was no more than 15 days in each month (81 FR 27561). As stated in the Final Rule, the appropriate application of the in-lieu-of services policy for use of an IMD requires the risk-based MCO or PIHP to determine if the enrollee has an inpatient level of care need that necessitates treatment for no more than 15 days. If the managed care plan (or physician) believes that a stay of longer than 15 days is necessary or anticipated for an enrollee, the use of this specific in-lieu-of service is likely inappropriate and not consistent with the Final Rule because of the prohibition in subsection (B) following section 1905(a)(29) of the Act.

Q5. Does the short-term length of stay of no more than 15 days within the month in §438.6(e) need to be a single admission?

A5. No. The enrollee may have a cumulative short-term length of stay in an IMD of no more than 15 days within the month for which the capitation payment is made. However, CMS

would expect the MCO or PIHP, as well as the state, to be concerned with such utilization practices as an indication that repeated admittances to the IMD within a short timeframe are not stabilizing the enrollee's acute psychiatric or substance use disorder condition or meeting the enrollee's medical needs. In such cases, the managed care plan should take steps to ensure that medically necessary treatment within the scope of the contract and the State plan are being provided to the enrollee.

Q6. If an enrollee is a patient in an IMD for more than 15 days within a month (for example, the enrollee is a patient in an IMD for 20 days), can the state make a pro-rated capitation payment to the MCO or PIHP to cover the remaining 10 days within the month (assuming a 30 day month) when the enrollee is back in the community (and not a patient in an IMD) and enrolled with the managed care plan?

A6. Yes, a state can make a pro-rated capitation payment to cover the days when the enrollee is not a patient in an IMD, but FFP is not available for payments related to days when the enrollee is in an IMD when the requirements of §438.6(e) are not met. In the Final Rule (81 FR 27555 – 27556), we discussed our rationale for ensuring that the use of IMD settings in-lieu-of covered settings for covered care is sufficiently limited so as to not contravene subparagraph (B) of section 1905(a)(29) of the Act. Since a capitation payment is made to the MCO or PIHP for assuming the risk of covering Medicaid-covered services during the month for which a capitation is made, there would be no such risk assumed in the case of an enrollee who is a patient in an IMD for the entire month, as the enrollee could not, by definition, be entitled to any Medicaid covered benefits during that month. However, we understand that there may be circumstances in which the enrollee will be a patient in an IMD for more than 15 days within a month, but for less than 30 days. In some of these circumstances, such enrollees will remain in states' managed care programs, and the MCO or PIHP will assume some level of risk for Medicaid-covered services once the enrollee is back in the community and not a patient in an IMD. In such cases, states are permitted to make a pro-rated capitation payment to the MCO or PIHP to cover only the days within the month when the enrollee is not a patient in the IMD. FFP is not available for payments related to days when the enrollee is in an IMD when the requirements of §438.6(e) are not met.

Pro-ration of the capitation payment to cover only those days when the enrollee is not a patient in an IMD is consistent with CMS policy regarding other periods when services for an enrollee are excluded from Medicaid coverage (see Q/A #20) and is consistent with the IMD exclusion (see our discussion in 80 FR 31117). When an enrollee is in a managed care plan for non-IMD days (that is, those days in a month when the enrollee is not a patient in an IMD), and the requirements of §438.6(e) are not met, the state may claim FFP only for a portion of the monthly capitation payment that has been pro-rated to the number of non-IMD days in that month.